

suicide

NEED FOR NEW CLINICAL, WORKPLACE & COMMUNITY

STIGMA

declining longevity  
hopelessness REJECTION

**CONFERENCE SUMMARY:**

Behavioral Health Aspects of  
Depression and Anxiety in the American Male

*A Expert Panel Report from Men's Health Network*

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**Author — Armin Brott, MBA**

AREAS FOR OUTCOMES RESEARCH

Isolation • male suicides up 20%  
no emotional vocabulary  
expert perspective  
lack of self-esteem

POTENTIAL SOLUTIONS  
CALL TO ACTION

October 2019

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# 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 in Washington, DC, on May 10, 2019, 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 behavioral health in 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 remains a significant challenge, as evidenced by the continual increase in truly tragic outcomes including addiction, depression, suicide, and violence. Our goal in organizing the May 10, 2019, meeting was not just to facilitate a vigorous discussion 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**  
**Vice President**  
**Men’s Health Network**

## 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 Program Principal

Mental health issues can be an especially problematic area for society. Defining exactly what constitutes deliberate unlawful behavior, immorality, or conduct resulting from involuntary brain dysfunction is often challenging. Unlike most medical illnesses, there are usually few specific objective and measurable factors by which to establish diagnosis. Unlike most physical health disorders, mental health disorders are frequently stigmatized. People may be labeled crazy, leading to persons being ostracized, ashamed, and reluctant to seek help.

For men and boys, these problems can be amplified by cultural expectations that men be stoic. Men are told they are not supposed to cry or show their emotions outwardly, that they are supposed to be self-reliant, to not ask for help, and that any illness, mental or physical, is a sign of weakness and a source of personal shame.

Men's health has a great impact on society as a whole that we are only beginning to recognize. Unnecessary illness and disability among men lead to diminished work productivity, greater work absenteeism, and employers incurring the expenses of training replacement workers. Families may be impacted with increased health care expenses in the face of reduced ability to earn. Jails have taken the place of many US mental hospitals, leading to costly but ineffective interventions.

Life expectancy in the United States has been declining in recent years owing in large part to increased suicide rates. An alarming aspect of this increase is that suicide is about 4 times as common among males who may be suffering from unrecognized and untreated depression. Another factor in the falling life expectancy has been the drug overdose epidemic. Addiction has long been classified as a mental health disorder, but it has only recently been recognized that drugs alter brain function, making addiction an actual physical disease of the brain.

The PCORI activities outlined in the following are a major step in addressing these concerns. Distinguished health professionals from around the United States gathered to discuss the mental health issues facing men and boys, with emphasis on depression. The role of stigma, lack of access to health care, lack of public awareness of mental health disorders, evaluating testing instruments for identifying depression among males, the state of screening for mental health disorders, the role of race, ethnicity, and socioeconomic status, and many other issues were discussed in depth. By sharing these discussions, we hope the reader will discover a wealth of insights and new information that will inform future discussions for years to come.

**Jean Bonhomme, MD, MPH**  
**Founder and Chair**  
**National Black Men's Health Network**

## Commentary by Dr. Demetrius Porche

Men's Health Network provides purposeful, steadfast leadership and advocacy to create an awareness of and support for disease prevention messages, screening programs, and the development of educational materials regarding the health of men, boys, and their families throughout our country. The Men's Health Network endorses the American Journal of Men's Health (AJMH). The AJMH supports the purposeful leadership activities of the Men's Health Network with the specific aim of serving as a peer-reviewed, indexed open-access journal that disseminates cutting-edge information on a variety of men's health issues and illnesses to build a body of science regarding the health of men and boys. AJMH in association with the Men's Health Network leads our country in the development and dissemination of men's health science as evidenced by the 2017 journal impact factor of 2.306 and ranking as 39 out of 156 journals in the Public, Environmental & Occupational (SSCI) index.

Since the inception of the AJMH in 2007, there have been more than 70 AJMH peer-reviewed papers focusing on male depression. These papers focused on masculinity and depression; depression with male-specific illnesses such as prostate cancer, infertility, erectile dysfunction, and spinal cord injuries; paternal, perinatal, and postpartum male depression; clinical and research assessment scales and tools for reliable and accurate diagnosis of depression; intersectionality of comorbid mental disorders such as suicidality, anxiety, and substance use; depression and sexual violence; treatment-induced depression; support systems needed; HIV transmission risks and depression; male cancer and depression; sexuality and depression; gender role conflict and depression; risk assessment of and predictors of depression; health-seeking behaviors and depression; and cognitive-behavioral treatment of depression. AJMH also published depression-focused papers about various populations such as Caucasians, African Americans, Hispanics, Mexicans, Saudi Arabians, Canadians, prisoners, male truck drivers, gay/bisexual men, same-sex relationships, hepatitis C-infected men, military veterans, and adolescent males. It is evident that male depression is a critical topic for the improvement of men's health in our country and that it intersects many aspects of men's lives.

The Men's Health Network–PCORI Conference on Behavioral Health Issues in Males is a needed, timely topic for national dialogue to advance the health of men in our country. This conference brought together national experts to discuss the relevant topic of male depression. As editor-in-chief of the American Journal of Men's Health, it is my privilege and desire to work with the Men's Health Network and the resultant dialogue from this PCORI conference to disseminate salient and relevant information and recommendations to scientist, clinicians, policymakers, health care consumers, health care administrators and providers, and the public.

**Demetrius L. Porsche, PhD**  
**Dean, Louisiana State University College of Nursing**  
**Editor-In-Chief, American Journal of Men's Health**

# 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 grants and other types of 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 and partially funded by the Patient-Centered Outcomes Research Institute (PCORI) Engagement Award Initiative (EAIN12780). 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."

The conference was structured by the conveners to examine what is known about these conditions and how they are identified and dealt with by both clinicians and those in the community who interact with boys and men. The backdrop for this discussion is the overall health disparity for American boys and men. The fact of the matter is that despite significant advances in the recognition and treatment of medical conditions—and despite the growing resources dedicated to health and wellness—men in America live shorter, less-healthy lives than do American women. In addition, men die younger and at higher rates than women from nine of the 10 leading causes of death in America.

The June 2018 Centers for Disease Control and Prevention (CDC) report, *Suicide Rising in the US: More Than a Mental Health Concern*,<sup>i</sup> sent shock waves through many quarters of the mental health, health professions, and men's health advocacy communities because of its unprecedented findings. The report found an increase in US suicides of more than 30% in half of the states since 1999, with a national-level model-estimated average annual percentage change for the overall suicide rate to have increased 1.5%. The report also looked at the association of diagnosed mental health conditions to successful suicides. The results were startling. To start with, nearly half of those who commit suicide have no known mental health condition. Compared with those with known mental health conditions, those without were more likely to be male (83.6% vs 68.8% female) and belong to a racial/ethnic minority.

## Panel Discussion Summary

The panel discussed in depth many of the potential root causes of the crisis in behavioral health and suicidality in American boys and men. As part of the discussion, the panel looked at the various factors and theories as to why the overall health disparity exists and in particular those that may relate to the recent qualitative and quantitative trends. The panel discussed various American cultural influences, including those from the media, sociologic, demographic, racial, and economic factors that elucidated the underpinnings of behavioral health issues. There was broad discussion about the pervasiveness of behavioral health issues across many environmental boundaries, including in schools, the workforce, and military, and the adverse impact these have on homes, community, business, and our nation. There are many reasons why boys and men of color are more frequently and more intensively affected by these conditions.

Two particularly important areas of discussion were the various sociocultural influences that drive the issue, including the lack of a fundamental “emotional descriptive lexicon” for many boys and men, and the significant and overpowering impact that stigma plays. Many of the panel members noted significant differences in how boys and men display signs of depression and potential suicidality and how many of these outward signs are often misconstrued and interpreted as preferred self-isolation, shyness, or, all too frequently, criminality. The panel also discussed the impact of substance abuse as both part of the cause of depression and a symptom of the problem.

Several panel members discussed the landscape of managing depression in the community setting and in the workplace. There was a general consensus that one of the first places where behavioral health issues can and should be picked up is outside the clinical setting. Those who interact with boys and men in the home, in educational settings, and in the workplace have an important role to play in correctly recognizing, providing “emotional first-aid” for, and triaging males who may be suspected of behavioral health issues into the health care system before a personal or community devastating event occurs. While there are numerous opportunities for family, friends, educators, community leaders, coaches, and employers to help boys and men with emotional hurt, there are also many impediments. These include lack of awareness of the problem and valid signals, no vocational training in recognition, issues of privacy, lack of support, training and development of skills, and, very importantly, a lack of skills, systems, or guidance in triaging to needed next steps.

The panel provided several examples of ways these issues in the community are being addressed but also called for enhanced efforts across environments to broaden outreach and triage. The panel also discussed the need for research and documentation, appropriate to the community, to help better understand and evaluate the outcomes and effectiveness of programs at this level. As an illustration, community leader Marty Ward, MSW, in Melbourne, Florida, has a program based on building positivity and confidence in teachers and nurses to help them deal with challenges—

many with origins in behavioral health conditions. But when asked by potential clients in medical, assisted living centers, and schools to provide data from her successful pilots, she came up short of expectations. According to Ward, this was not because of lack of program success and acceptance by participants but because she does not have the skills or financial resources to establish, collect, and appropriately analyze data. Panel members agreed that the inability for community leaders with useful programs to grow them and find funding for them is impeded by the leaders' inability to provide outcomes and impact data. This is an area for future work.

Many panelists expressed their deep concern that, because of sociologic prejudice and fundamentally poor understanding of depression in males at both the community and professional levels, all too many males are moved into the criminal justice system rather than into an active health care or community support environment.

Several of the 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 so. Topics covered included the disconnect between reimbursement and the realities of screening and 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 education and training in addressing behavioral health issues in general and specifically in boys and men, and lack of meaningful guidelines to guide both screening priorities and its timing across the male lifespan. Compelling data were discussed by the group concerning the lack of behavioral health guidelines in medical encounters; lost opportunities, in part driven by the lack of covered annual "well-man" medical visits similar to that offered to all women; and the lack of trained behavioral health providers, particularly in family practice environments. All panelists agreed that these and a myriad of other opportunities and challenges are important ones to study in depth and to build effectiveness-oriented outcomes research. All agreed that without such systematic and meaningful scientific study that is translated into practice, there will be little progress in addressing behavioral health issues in males.

Representatives of various patient advocate groups in attendance, such as the National Alliance on Mental Illness, National Black Men's Health Network, Mental Health America, and the Southern Plains Tribal Health Board, discussed their frustrations with the poor state of preventing, recognizing, and managing behavioral health issues in boys and men for their constituencies. Several of these representatives talked about the significant harm that has come to individuals, families, and communities because of poor behavioral health care.

During the discussion on key aspects of addressing these important issues, MHN outlined several of its recommendations to enhance the intersection of male patients and providers.

Finally, the panel discussed the potential links between behavioral health issues and violence and other forms of criminal behavior. Many panelists expressed their deep concern that, because of sociologic prejudice and fundamentally poor understanding of depression in males at both the community and professional levels, all too many males are moved into the criminal justice system rather than into an active health care or community support environment. Although this adversely impacts all boys and men, it has a particularly extensive and devastating impact on those from dysfunctional living environments, those from low socioeconomic circumstances, and ethnic and racial minorities.

## Next Steps

The panel discussed key areas of focus as important next steps to take to address this issue and stem the trend of increasing behavioral health issues and suicide in boys and men. Broadly, these are:

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

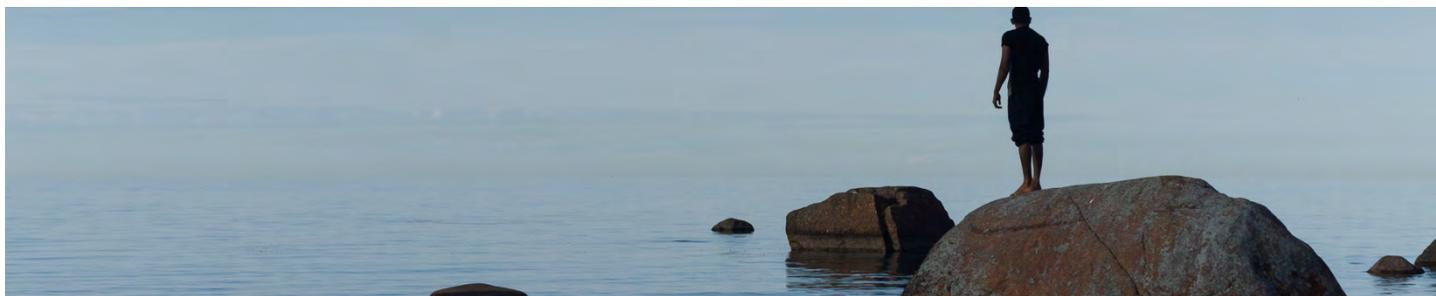
behavioral health.'

**Develop meaningful quality metrics** for individual practices and health systems, including federal systems, to evaluate behavioral health care for boys and men.

**Create health-related legislation** to support the fundamentals of well-care for boys and men across the lifespan.

**Better define the role of telemedicine and telehealth** technologies' ability to provide screening, ongoing care, and patient and community support in addressing behavioral health issues.

**Embark on a series of public 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.



## Conference Background and Support

The following report is based on an expert panel convened in Washington, DC, on May 10, 2019, by MHN and partially funded by the PCORI Engagement Award Initiative (EAIN12780). 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, “Behavioral Aspects of Depression and Anxiety in the American Male: Identifying Areas for Patient-centered Outcome-oriented Needs, Practices and Future Research,” 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.

Participants came from both 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 clinicians who deal with boys and men in a clinical setting. Participants brought a wide range of perspectives and were selected to ensure a geographically and socio-culturally diverse representation. (See Participant List, Appendix I, Page 43.) The program was professionally moderated and followed a Socratic Dialogue format. That is, the moderators followed a structured discussion guide (Appendix II, Page 57) 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.

### Conference Goals

The overall goal of the conference was to discuss the behavioral health aspects—and consequences—of depression and anxiety, with a focus on the subpopulation of boys and men within the general US population. More specifically, the conference was structured to examine what is known about these conditions and how they are identified by both clinicians and those in the community who interact with boys and men. To augment the lively, facilitator-led discussion about the issues (See Conference Facilitator Guide and Agenda, Appendix BB), the conference included 2 short presentations. In the first, “Challenges Facing Boys & Young Men: Depression and Juvenile

Delinquency,” Anthony James Roberson, PhD, PMHNP-BC, RN, FAANP, director of Western Carolina University School of Nursing, reviewed the complex issue of adolescent males who are the victims or perpetrators of parental violence, depression, and anxiety. This presentation summarized a project designed to help foster resiliency and mitigate further behavioral health conditions as well as begin a path toward addressing existing depression and anxiety.

In the second presentation, “Keeping Veterans Tethered to Society: A Community Engagement Approach,” Cheryl A. Krause-Parello, PhD, RN, FAAN, professor, Christine E. Lynn College of Nursing and Faculty fellow, Institute for Healthy Aging and Lifespan Studies, Florida Atlantic University, summarized an important PCORI-funded project that paired veterans suffering from posttraumatic stress disorder (PTSD) or other service-related traumas with service dogs. Krause-Parello presented valuable information on the effectiveness of using nontraditional approaches to help men deal with trauma and the associated psychiatric symptoms. She also provided insight into the self-identified “needs triggers” that these men associate with behavioral health challenges.

In addition to the professional facilitator, Sara van Geertruyden, 2 co-moderators (Anna Fadich-Tomsic and Salvatore Giorgianni, BSc, PharmD) were charged with encouraging robust interactive dialogue and keeping the panel’s discussions focused on depression, stress, related behavioral health issues, and suicide in men and boys. To do that, the 3 moderators posed the following questions:

- What screening tools for behavioral health issues are available to clinicians and others, such as teachers, coaches, and employers, who may need to be alerted to those issues?
- How do boys and men express depression differently than their female counterparts?
- What is the state of the art in terms of the need for and existence of gender-specific tools for screening?
- What research has been done on gender-specific outcomes of existing screening tools?
- How do clinicians and others use tools for screening, and what is the process for managing potential problems that may be identified?
- What role does insurance/Medicare reimbursement play in the clinical assessment of behavioral health?
- What social, economic, legal, humanistic, and medical factors impinge on screening, identifying, managing, and treating behavioral health issues?
- What are the social, economic, legal, humanistic, and medical consequences of poorly engaging boys and men?
- What programs either are being used or could be developed to better understand the approaches that have produced both positive and negative outcomes to help organizations

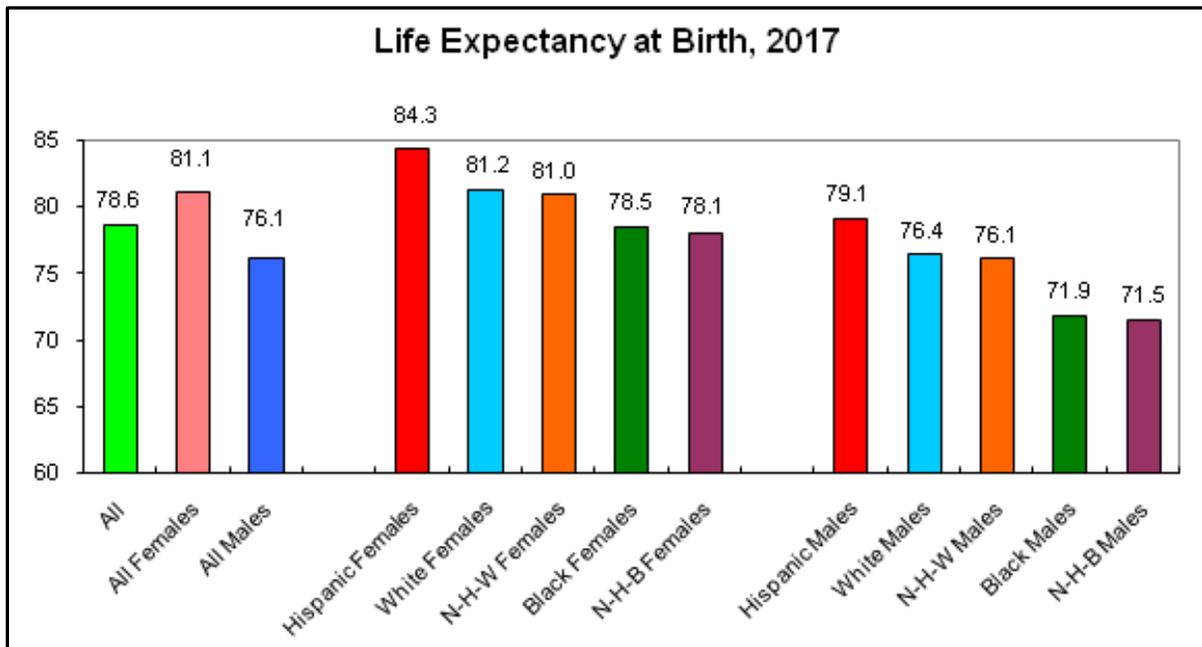
like PCORI craft and disseminate better, more gender-specific and socio-culturally optimized tools?

## Defining the Problem

Jean Bonhomme, MD, MPH, founder of the National Black Men’s Health Network and member of the MHN Board of Directors, noted that despite significant advances in the recognition and treatment of medical conditions, and despite the growing number of resources dedicated to health and wellness, men in America live shorter, less-healthy lives than American women. In 1900, life expectancy, while decidedly shorter for both genders than it is now, was almost the same for men and women (women outlived men by 2 years). In the early 1990s, women outlived men by nearly 7 years. By the end of the 20th century, that gender gap had shrunk somewhat, to 5.2 years, and has remained relatively constant for almost 2 generations.

In addition, men die younger and at higher rates than women from 9 of the 10 leading causes of death in America. According to David Gremillion, MD, Colonel (Retired), former president of the Society of Air Force Physicians and board member of the MHN,<sup>ii</sup> and many other health professionals and researchers, much of this early mortality and high degree of morbidity among males is preventable.

Table 1



Source: Centers for Disease Control/National Vital Statistics Report Vol. 68, Number 7, June 2018

One important contributing factor to increased mortality and morbidity among males is the difference in the ways males and females engage in the health care system. As Bonhomme<sup>iii</sup> and

Brott<sup>iv</sup> pointed out, 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). When men do engage the health care system, it’s usually focused on a particularly troubling set of symptoms or medical event. By the time they engage a provider their conditions are typically much further advanced—and therefore far more difficult to treat—than women’s. For example, in the case of diabetes, Bonhomme 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. Clearly, for a woman and a man diagnosed on the same day, the prognosis will be drastically different. As Bonhomme put it, “That’s like waiting to treat a patient for high blood pressure after he’s just had a heart attack.”

In one of the few published papers examining the fiscal impact of these significant male-health disparities, Brott et al<sup>v</sup> estimated that in 2011 dollars the cost to the US public and private sectors exceeds \$470 billion annually. 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.

Table 2

**Top Causes of Death by Race, Sex, and Ethnicity\* – 2016**

\* Age-adjusted death rate per 100,000 populations

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	728.8	861.0	617.5	1.39	729.9	749.0	857.2	591.2	392.6	525.8
Diseases of the Heart	165.5	209.1	130.4	1.60	184.6	188.7	205.3	115.4	85.2	115.8
Diseases of the Heart Ischemic heart disease	94.3	128.3	67.5	1.90	94.8	96.6	108.3	71.3	53.0	72.7
Cerebrovascular diseases	37.3	37.5	36.5	1.03	36.1	36.1	50.5	23.8	30.7	32.1
Malignant Neoplasms	155.8	185.4	134.0	1.38	158.6	160.8	177.9	103.4	87.1	110.0
Malignant neoplasms Trachea, bronchus, and lung	38.4	46.7	31.9	1.46	39.2	41.6	40.0	25.1	21.5	16.6
Malignant neoplasms Colon, rectum, and anus	13.9	16.4	11.8	1.39	13.6	13.9	18.5	9.9	9.3	10.8
Malignant neoplasms Prostate	19.3†	19.3	§	~	~	~	~	~	~	~
Malignant neoplasms Breast	20.1‡	§	20.1	~	~	~	~	~	~	~
Chronic lower respiratory disease	40.6	45.1	37.4	1.21	43.3	45.8	29.3	29.7	11.7	17.1
Influenza and pneumonia	13.5	15.9	11.8	1.35	13.4	13.5	15.0	12.7	12.9	11.1
Chronic liver disease and cirrhosis	10.7	14.3	7.5	1.91	11.6	11.0	7.1	26.7	3.4	14.7
Diabetes mellitus	21.0	26.0	16.9	1.54	19.3	18.6	36.8	34.3	15.5	24.7
Kidney disease (Nephritis & related)	13.1	15.9	11.2	1.42	12.0	11.9	25.1	11.6	8.1	11.4
Alzheimer's	30.3	24.3	33.9	0.72	31.4	31.8	27.5	17.3	15.0	24.3
HIV disease	1.8	2.7	0.9	3.00	1.0	0.8	7.2	1.0	0.4	1.7
Unintentional injuries	47.4	65.0	30.8	2.11	50.4	53.9	42.7	53.9	16.8	31.4
Unintentional injuries Motor vehicle-related injuries	12.1	17.6	6.9	2.55	12.4	12.4	13.5	17.8	5.2	11.0
Drug overdose	18.2	25.1	11.4	2.20	20.3	23.0	15.4	18.1	2.9	9.5
Suicide	13.5	21.4	6.0	3.57	15.2	17.0	6.1	13.5	8.7	8.7
Homicide	6.2	9.9	2.5	3.96	3.5	2.9	21.4	8.7	1.8	5.3

† 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, 2017 Trend Tables: With special feature on mortality.* (Trend Tables) Hyattsville, MD, 2016. Retrieved March 1, 2019

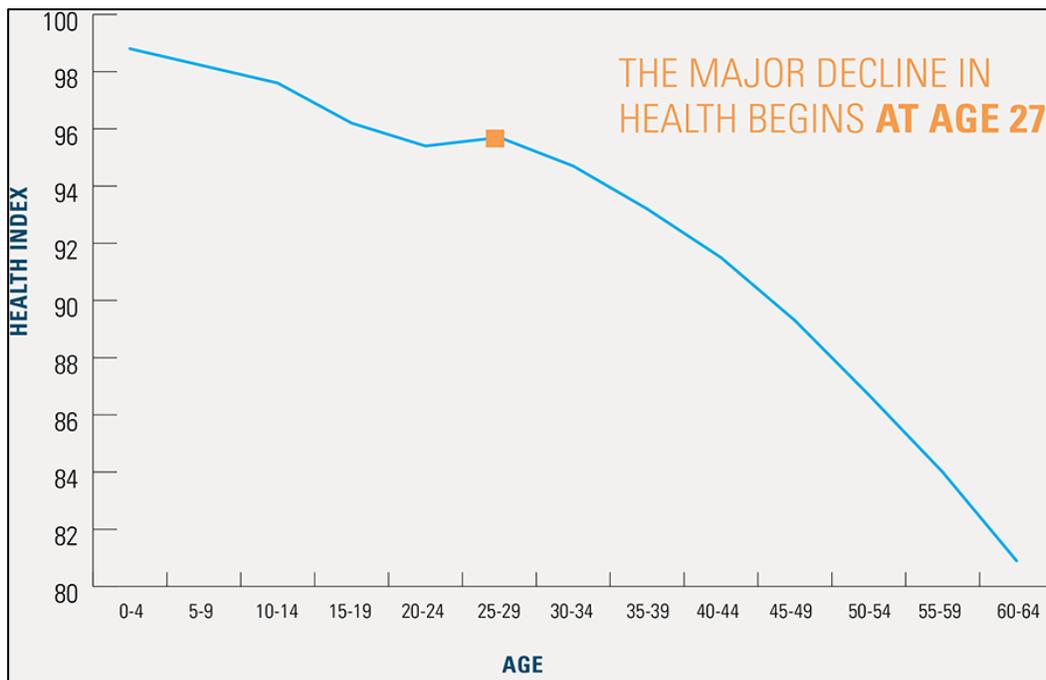
Source: Centers for Disease Control/National Vital Statistics Report Vol. 68, Number 7, June 2018

## Millennials May Be Worse Off Than Their Parents and Grandparents

The health problems that plague males in our society don't appear to be getting any better. In fact, things may be getting worse. Blue Cross Blue Shield's (BCBS's) 2019 report, *The Health of Millennials*, found, in general, Millennials (those born between 1981 and 1996) were living only at about 95% of their projected optimal health.<sup>vi</sup> In addition, older Millennials (age 34-36) have higher prevalence rates for nearly all of the top 10 conditions than did Generation X (born 1961-1981) members when they were the same age.

YouGov released a report in August 2018 (<https://today.yougov.com/topics/lifestyle/articles-reports/2019/07/30/loneliness-friendship-new-friends-poll-survey>) that found 30% of Millennials self-reported feeling lonely and were more likely than older generations to report that they had no acquaintances (25%), no friends (22%), no close friends (27%), and no best friends (30%). These findings show a dramatic difference when compared with prior generations. While not conclusive, this survey suggests some interesting insight into possible reasons for observations of behavioral health issues in this large cohort.

**Table 3**  
**BCBS Health Index by Age 2017**



*BCBS: The Health of Millennials, 2019*

Experts reviewing this report suggested a myriad of important associations with the increased reliance on social media for interactions as opposed to in-person interactions. These include feelings of social isolation, and, importantly, for issues related to behavioral

health, a lack of social networks for support, identification, and possible mitigation of potentially disastrous consequences of this lack of support.

## **Underdiagnosing Mental Health Issues: Do We Need Male-specific Screening Tools?**

Many mental health professionals and clinicians 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 problem and the true incidence of undiagnosed depression. Jimmy Boyd, executive director of the MHN, and Giorgianni, a former chair 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, as noted above, men present for medical encounters half as often as women do. And they’re even less likely to seek help for mental health issues than physical health issues.<sup>vii,viii</sup>

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. There is other strong evidence, most recently the June 2018 CDC report of suicide in the United States (see below), that mental health issues in men are dramatically underreported. A main reason for this, 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<sup>ix</sup> includes questions about more stereotypically “female” symptoms of depression, such as feeling sad, crying, and feeling old or unattractive, yet has no questions about stereotypically “male” symptoms, such as anger, frustration, social isolation, substance abuse, or workaholism.

This view is shared by Marianne J. Legato, MD, professor of clinical medicine at Columbia University College of Physicians & Surgeons and founder and director of the Partnership for Women’s Health at Columbia University. Dr. Legato, who was not a panelist but who has studied and written extensively on gender issues and mental health, stated that while the incidence of depression seems greater in women than in men on a 2:1 ratio throughout the world, it is her conviction that depression is more common than we realize in men. It’s just that we don’t know how to read the signs as well as we do for women.<sup>x</sup>

The question of the effectiveness of available screening tools and the need for male-focused tools was a major topic throughout the MHN–PCORI panel. Some on the panel, including Boris Birmaher, MD, who is the endowed chair in early onset bipolar disease and professor of psychiatry University of Pittsburgh School of Medicine, felt the signs and symptoms of depression are the same in male

and female patients. Others (including Brott, Bonhomme, and Roberson) felt there are clear, demonstrable differences in how depression, anxiety, and potential suicidality present to clinicians and pointed to the propensity for males to act out, whereas females tend to speak out. Famously, one member of the discussion group recounted asking her preteen son about his views on mental health. “If I get asked one more time to ‘get in touch with my feelings,’ I’m going to throw up,” he replied.

Despite the disagreement about whether men’s and women’s symptoms of depression are different, both sides agreed there are significant differences between males’ and females’ willingness to recognize their symptoms, their willingness to discuss their problems, and the ways symptoms manifest during clinical encounters. More on this below.

## More on Millennials

In *Out of Touch: American Men and the Healthcare System*,<sup>xi</sup> David Sandman and his colleagues

An age-related gap exists in health care participation for males. In particular, younger males are generally disconnected from the health care system, causing less opportunity for early intervention and mental health screening.

David Sandman  
*Out of Touch: American Men and the Healthcare System*

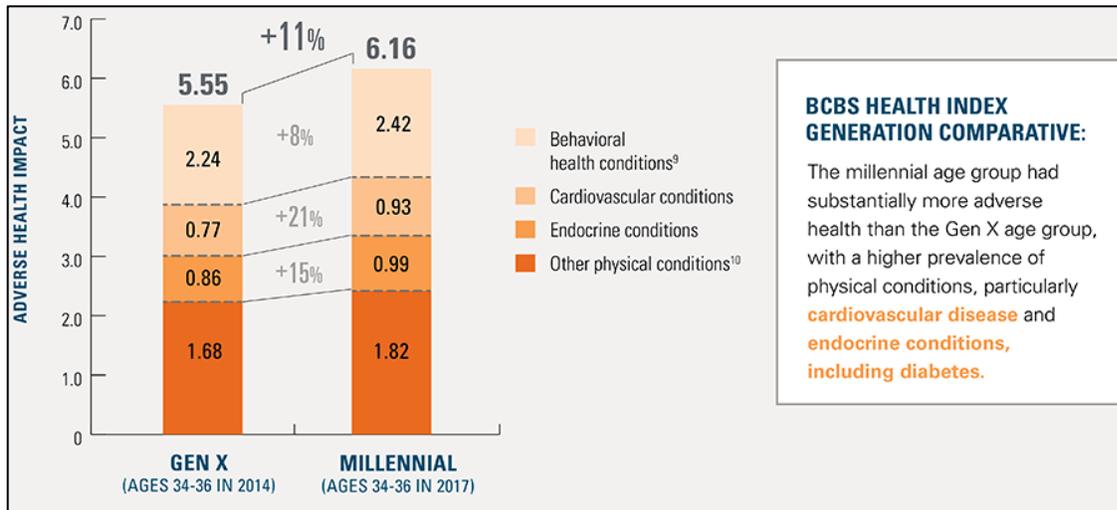
noted that an age-related gap exists in health care participation for males. In particular, younger males are generally disconnected from the health care system, causing less opportunity for early intervention and mental health screening. This observation is underscored in the 2019 BCBS report referenced earlier, which found that of the top 10 conditions affecting Millennials, depression is number 1, followed by substance abuse disorder and alcohol abuse disorder.

An analysis of these conditions by gender showed the prevalence of behavioral health conditions of substance abuse, alcohol use disorder, and hyperactivity and psychotic conditions was demonstrably higher in men than in women. Furthermore, when compared with the national population Millennials were more affected by behavioral health conditions, most notably major depression and hyperactivity.

The BCBS report found that based on their data women were twice as likely to be depressed as men. However, the panel and many experts in men’s health believe that this higher incidence of depression is reported because of the significant differences in how women utilize health care services and actively seek treatment for depression. Thus, if medical treatment claims data is used as the base metric it is not surprising to find more cases of depression treated in female than in male patients.

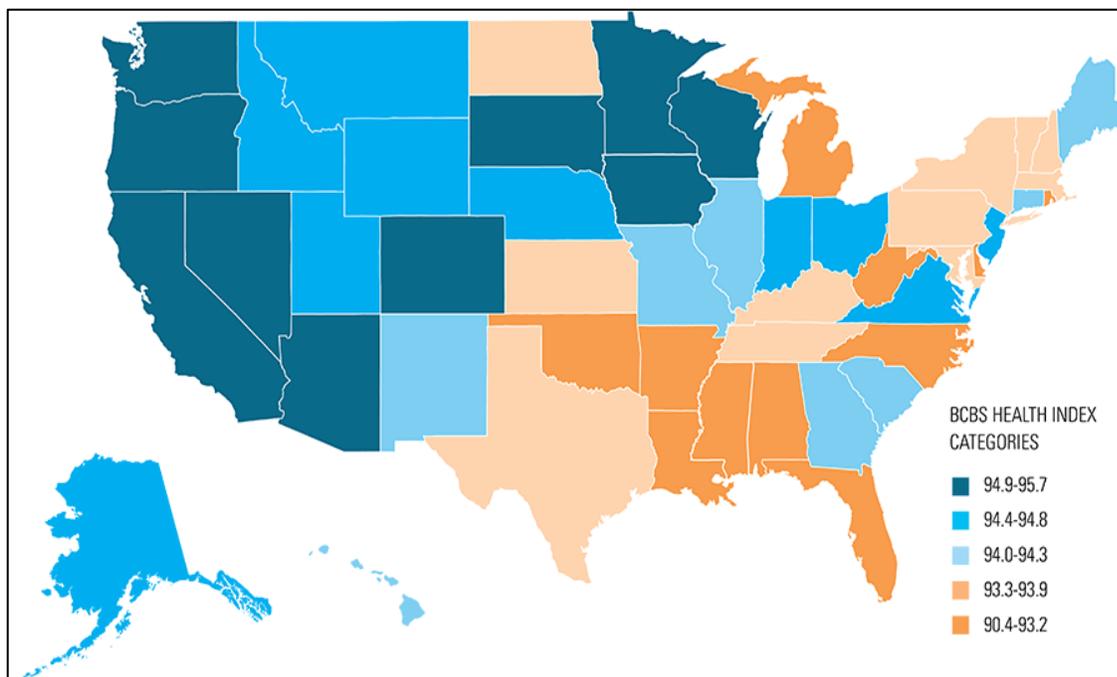
This should not be interrupted as representing the true incidence of depression in male patients – which is very much under reported. The most importance evidence for this is the significantly higher end-game to depression, namely suicide, in men.

**Table 4**  
**Adverse Health Impact for Major Condition Categories 2017**



BCBS: *The Health of Millennials, 2019*

**Table 5**  
**Blue Cross Blue Shield Health Index for Millennials (Ages 34-36) by State (2017)**



BCBS: *The Health of Millennials, 2019*



## The Role of Stigma

Another major obstacle to recognizing, diagnosing, and treating mental health issues in men and boys (and, to a lesser extent, in women and girls) is stigma. The 2000 US Surgeon General’s Report<sup>xii</sup> addresses the issue of stigma and its role in advancing the care of 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 Dr. 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.”

Most panel members felt that how stigma is perceived, reacted to, and dealt with is very different for men and women. Chapman commented that some men are not even aware that their reactions or aversion to dealing with depression or other behavioral health issues are the result of their concern about stigma, and thus don’t even identify with the term. Gremillion noted that the way men interact with other men is also different than the way women interact with other women. As a result, even the coping mechanisms boys and men may develop to deal with perceived feelings of stigma are different. Some on the panel felt men and women react similarly but that the essential difference is women tend to react verbally and emotionally, while men react in a physical way. This can be manifested in many behavior traits such as anger, substance abuse, or withdrawal.

Brott noted that the underpinnings of how men and boys react to and deal with emotional hurt and issues such as stigma begin at a very young age. 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 quickly gets him shut down—with a phrase or reaction that telegraphs “Big boys don’t cry,” “Play through it,” or “Man up!” One of the consequences of this, observed Brott, is that boys often do not develop a comfortable vocabulary to help them express emotional hurt.

Overall, parents speak more to infant girls than to infant boys.<sup>xiii,xiv</sup> But 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.<sup>xv</sup> 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?

Other panelists agreed. Giorgianni noted the role of media, including popular action games, which stress physical over emotional vocabularies. Likewise, according to Giorgianni, movies and reality programming frequently show men undergoing emotional hurt commenting, "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 perhaps toxic.

Urging boys to suppress and even ignore their emotions starts long before children are even able to play. Several studies have found that both 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. Similarly, observers perceive the identical behavior differently, depending on whether we think we're watching a boy or a girl. In one experiment, researchers John and Sandra Condry<sup>xvi</sup> 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, 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 of us would respond very differently to a frightened child than to an angry one.

## Teaching Emotional Vocabulary in Boys

Part of the solution to addressing stigma is to help males feel it is 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 sociologic cues that work against building these skills. A full discussion of this topic is beyond the scope of this panel and paper; additional readings and commentary are suggested.<sup>xvii</sup>

A direct and dire offshoot of stigma is the impact it has on boys and men of color with behavioral health conditions. The degree to which stigma impacts these communities and individuals cannot be overstated. When considering minority men, Richard Allen Williams, MD, FACC, president and CEO of Minority Health Institute Inc and clinical professor of medicine, UCLA School of Medicine,<sup>xviii</sup> noted that African American boys and men in particular are, from a young age, vigorously told to "keep your feelings to yourselves" because of the fear by parents and older peers that expressions

of feelings might fuel hostile racial stereotypes. Andrew L. Yarrow, author, journalist, historian, and policy analyst, agreed, noting that in minority communities stigma against “weakness” or any semblance of mental health issues is very pronounced. He offered this analogy: “When looking at stigma by race and ethnicity, if stigma was the common cold among white men, it is a lethal flu among men of color.” Williams noted that minority boys are often more vigorously told by parents, community influencers, and peers to “keep their feelings to themselves,” as discussion may lead to isolation or in some cases become an entry point into the criminal justice system.

Native American, Latino, and Asian men are also affected by stigma in a destructive way that impedes patients and those who love them from identifying problems for what they are and interferes with the clinical process. Manifestations of behavioral health conditions, even early manifestations, are all too often determined to be occasions not to treat as a clinical condition but to funnel the affected boys and men into the criminal justice system. According to Bonhomme, Judge Greg Mathis, a retired Michigan district court judge and board member of the NAACP and Morehouse School of Medicine, has ominously and rightfully observed that “the mental hospitals

are closing, the mentally ill are sent to jails and prisons.”<sup>xix</sup> One area in need of better research is in using within-the-community programs to help identify early signs of mental health problems and to triage them to proper and supportive clinical providers. There are several successful localized efforts in this direction.

Fadich-Tomsic 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.

One such program is led by David Sullivan, MPA, public health training coordinator, Southern Plains Tribal Health Board in Oklahoma schools. Sullivan noted that students often serve as the eyes and ears of counselors and educators regarding emerging behavioral health issues in their peers. 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. Sullivan added that developing and implementing such programs is very difficult and time consuming, but the efforts are well worth it. Others on 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. Fadich-Tomsic 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 peer-support entities would make it much easier for others to launch their own programs based on those best practices.

Captain Mike Colston, MD, director for mental health programs at the Department of Defense Health Services Policy and Oversight Office, noted that stigma plays an especially large role in the military. There is a policy in the Department of Defense against penalizing careers because of behavioral health issues. Colston was noted that the bar to separate military personnel due to mental health issues is set so high it is designed to be cautious and thus the number of members who are separated is low. Nevertheless, the policy and approach about this doesn't filter out to the rank and file in a way that encourages members to seek help. More of a frustration to military personnel dealing with mental health issues is how to get care to active duty personnel when they need it and how to provide evidence-based care. Colston also noted that having the proper gatekeepers to triage at-risk personnel is of paramount importance. He added that, in reality, referrals for care often don't come from the chain of command. Chaplains, who have an important relationship with active duty and military medical officers, play a key role in screening for behavioral health issues and referring service members for care. Colston questioned whether training chaplains in mental health screening and management techniques could be effective.

Benita Chatmon, MSN, PhD, instructor at Louisiana State University New Orleans School of Nursing, who served as a combat munitions specialist in the Army, noted that among active duty personnel, expressions of behavioral health issues were almost universally viewed as weakness. All too often when behavioral health concerns are expressed by active duty members it can lead to social isolation by colleagues and all too often may raise subtle but perceptible concerns about the reliability of the soldier next to you. In both scenarios, men who are desperate for care are driven further from it.

Birmaher<sup>xx</sup> had a different—and somewhat dismal—take on stigma. “I am not trying to be pessimistic about our ability to deal with stigma. But I do think that until we find more and hard evidence of biologic causes for mental disorders as we have for, say, hypertension or kidney disease, and this is accepted by the public, we will have to deal with the impact of stigma.”

## **How Boys and Men Express Behavioral Health Issues**

The combination of genetics, evolution, acculturation, lack of emotionally expressive vocabularies, and the impact of stigma levied against “weak” boys and men all factor into how many males outwardly express emotional pain and behavioral health issues. These factors similarly also affect the way observers, including health care providers, receive and perceive social, behavioral, and even diagnostic clues given by men about behavioral health issues.

Consistent with the available literature on the topic, panelists were in general agreement that girls and women outwardly express emotional pain differently than boys and men do. According to

Marianne Legato, boys and men 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.<sup>xxi</sup> These are all mechanisms to escape the pressures of their lives. Similar to the panel’s consensus view, Dr. Legato noted that the warning signs may be a change in personality, increased irritability, even turning to violence.

Colston noted that technology can also be a factor in fostering social isolation, particularly in children, Millennials, or others who become absorbed in smartphones, social media, and other technology surrogates as 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—become a fantasy-world coping mechanism that may in a few susceptible individuals morph into real-life actions.

According to Legato, women are much more likely to reach out to others and verbalize their unhappiness, at least in the earlier stages of depression. They will call their friends, ask for advice, research what medications might help them, and go to their health care professionals much more readily than men.<sup>xxii</sup>

A 2010 paper by Aaron Rochlen and his colleagues characterized the experiences of a focus group of men with a history of depression<sup>xxiii</sup> and identified 3 core learnings: The participants described aspects of the male gender as being in conflict or incongruent with their experiences of depression and beliefs about appropriate help-seeking behaviors; the men outlined alternative symptom profiles that could interfere with the recognition of depression and willingness to seek help; and the men expressed a range of positive and negative reactions toward depression treatments and providers. The authors outlined the following implications for clinicians: Men may not spontaneously report feeling sad or even blue or distressed, and may not even recognize anything abnormal; health care providers should consider certain male role norms, including self-reliance, courage, and the role of family breadwinner in discussions with men; men present depression in an atypical manner at times, often masked as difficulty with

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anger or other outward actions such as substance abuse; and clinicians should recognize the relational and potentially threatening nature of depression-related discussions with male patients and the importance of describing depression as a medical illness that has both a biological and a social component.

Many boys and men do attempt to be open about their emotional challenges, but this frequently comes with societal obstacles. Chatmon was concerned that even when boys and men develop a lexicon and express emotional pain, it is all too often viewed as weakness by those in the best positions to help. Martin agreed, adding that boys and men who try to express their emotions frequently discover there is no incentive to recognizing their problems, speaking up, and trying to deal with these problems. The negative (or, at best, neutral) feedback they receive leads males to suffer in silence. In some, this leads to further issues such as isolation or antisocial behavior; in others, it can lead to destructive behaviors toward themselves and/or others.

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 and the treatment. Brott and Birmaher 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 some other mental or behavioral health issue will be left to their own devices, and their symptoms and underlying conditions untreated.

Birmaher, a noted expert in adolescent psychiatry, believes that until age 12 the symptoms and signs of depression and emotional pain are virtually the same in boys and girls, and that it's only after puberty that those responses begin to differ. He has seen boys referred out because of observed maladaptive behavior in school. If that behavior isn't seen by an alert teacher, parent, or family member, the boy in question may not receive care until circumstances have reached a critical—and sometimes tragic—point. Birmaher 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, resulting, all too frequently, in an emotional explosion.

Martin noted that because of the way boys and men act out when depressed, anxious, or suffering from other behavioral health conditions they are considered by society and occasionally health care providers as “bad” or “dangerous.” As a result, he says, those boys and young men are punished (either by the school or the criminal justice system) instead of receiving much-needed therapy or treatment.

Several panelists, including Jei Africa, PsyD, MSCP, CATC-V Africa,<sup>xxiv</sup> noted that the situation is made even more complex because men, like most large groups, are not homogenous.

Sociocultural, socioeconomic, racial, educational, vocational, age, and myriad of other factors play a large role in both the predisposition to and determinants of mental health in males. According to Martin, the veteran community served by the VA has its own diversity challenges. For example, veterans of the Korean Conflict differ from those who served in Vietnam and the post-Vietnam

Veterans of the Korean Conflict differ from those who served in Vietnam and the post-Vietnam years, and these veterans are also very different than those who served in Iraq and Afghanistan.

years, and these veterans are also very different than those who served in Iraq and Afghanistan. They differ not only in the nature of their service but also in the social order of their day. Another factor in the equation is that today's military is all volunteer, which makes younger veterans react to stressors differently than those who were drafted. The VA needs to adjust its approach to each of these different subgroups.

Sullivan<sup>xxv</sup> stated that part of his job in addressing mental health issues in his school system is to serve as the eyes and ears of the teachers and students and to foster change. Approximately 75% of the students he serves are Native Americans, a far different demographic breakdown than that of the teachers. The expressions of depression and other behavioral issues are even more complex and challenging under this scenario.



## Suicide

Suicide is only one—albeit the most serious—manifestation of depression or other mental health issues. Across all ages and ethnicities, American men commit suicide at far higher rates than women. According to the most recent CDC data, between the ages of 15 and 64 roughly 3.5 times more men than women commit suicide. From 65 to 74, male suicides outnumber females by more

than 4:1. For those over 74, the difference is a startling 9.3:1.<sup>xxvi</sup> Overall, for males suicide is the seventh leading cause of death; for females it's 14th.<sup>xxvii</sup>

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CDC  
*Suicide Rising in the US More than a Mental Health Concern, June 2018*

Regardless of what base year is taken or what comparison years are used, for the past 2 decades the incidence of suicide in men has dramatically outpaced that of women.<sup>xxviii</sup>

The June 2018 CDC report, *Suicide Rising in the US: More Than a Mental Health Concern*,<sup>xxix</sup> sent shock waves through many quarters of the mental health, health professions, and men's health advocacy communities because of its unprecedented findings. The report found an increase in US suicides of more than 30% in half of the states since 1999, with a national-level model-estimated average annual percentage change for the overall suicide rate to have increased by 1.5%.

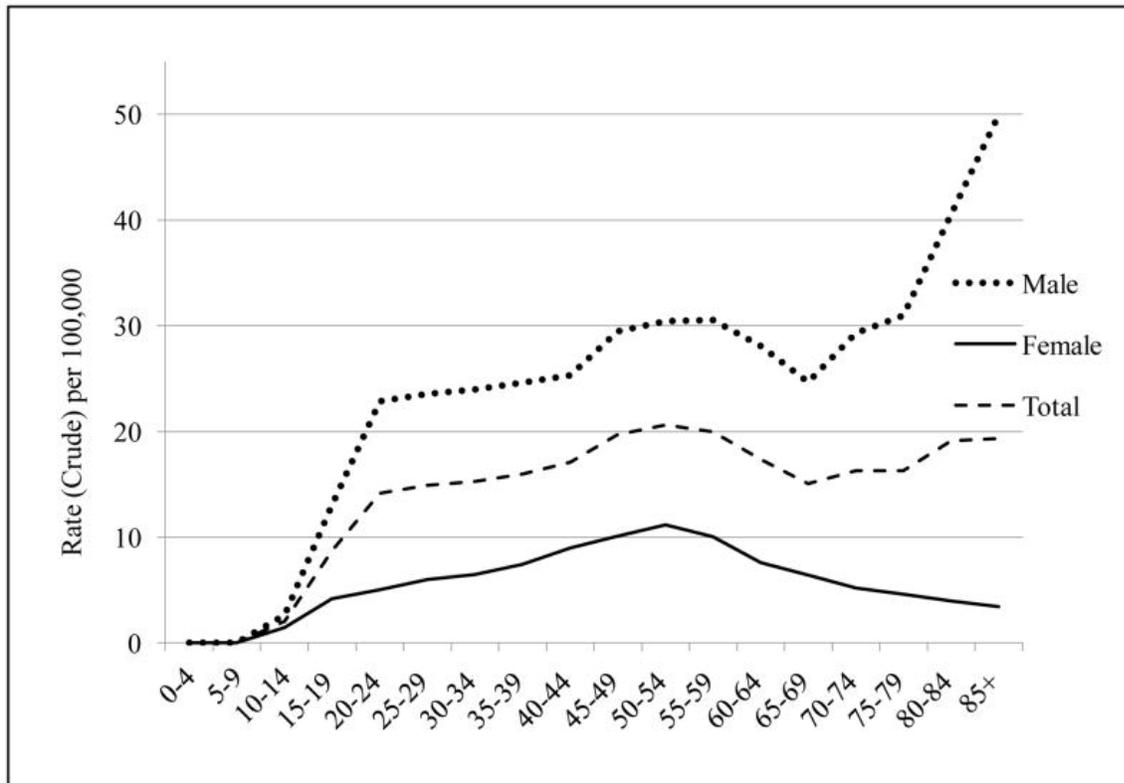
Meshing perfectly with the focus of this conference, the report found that victims of successful suicides were predominantly male (76.8%) and non-Hispanic white (83.6%), followed by African American males (6.0%) and Hispanic males (5.4%). Also, the age cohort (not gender adjusted) between 25 and 64 years of age (Millennials through Generation X<sup>xxx</sup>) comprised an astounding 69.3% of all successful suicides.

The report also looked at the association of diagnosed mental health conditions to successful suicides. The results were startling. To start with, nearly half of those who commit suicide have no known mental health condition. Compared to those with known mental health conditions, those without were more likely to be male (83.6% vs 68.8% female) and belong to a racial/ethnic minority.

Those involved in successful suicide without known mental health conditions also had significantly higher odds of committing homicide before committing suicide. "Those without a known mental health condition suffered more from relationship problems and other life stressors such as criminal/legal matters, eviction/loss of home, and recent or impending crises," said the authors.

Meshing perfectly with the focus of this conference, the report found that victims of successful The report also noted that suicide prevention efforts are "often oriented toward mental health conditions alone with regard to downstream identification of suicidal persons, treatment of mental health conditions, and prevention of reattempts."

Table 6

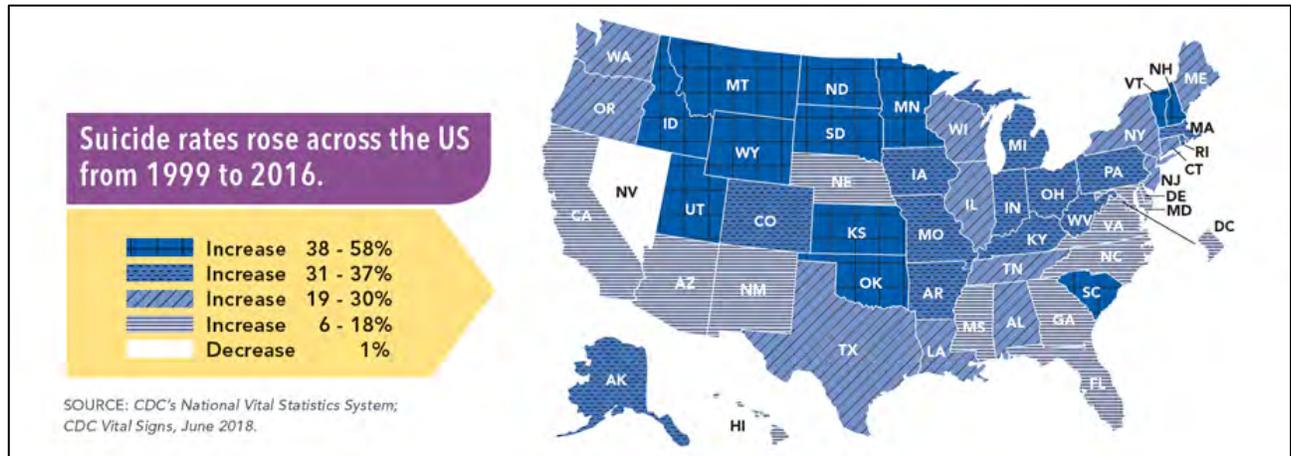


CDC: *Suicide Rising in the US*, June 2018

The fact that half of those committing suicide had no known mental health condition indicates that “additional focus on non-mental health factors further upstream could provide important information for a public health approach.” In the opinion of many conference attendees, this last statement confirms and underscores the need for tools specifically designed to screen for mental health issues in men and boys. If such tools existed, perhaps some of those with “no known mental health issues” could be flagged, referred to an appropriate provider, and receive treatment that might prevent unnecessary loss of life.

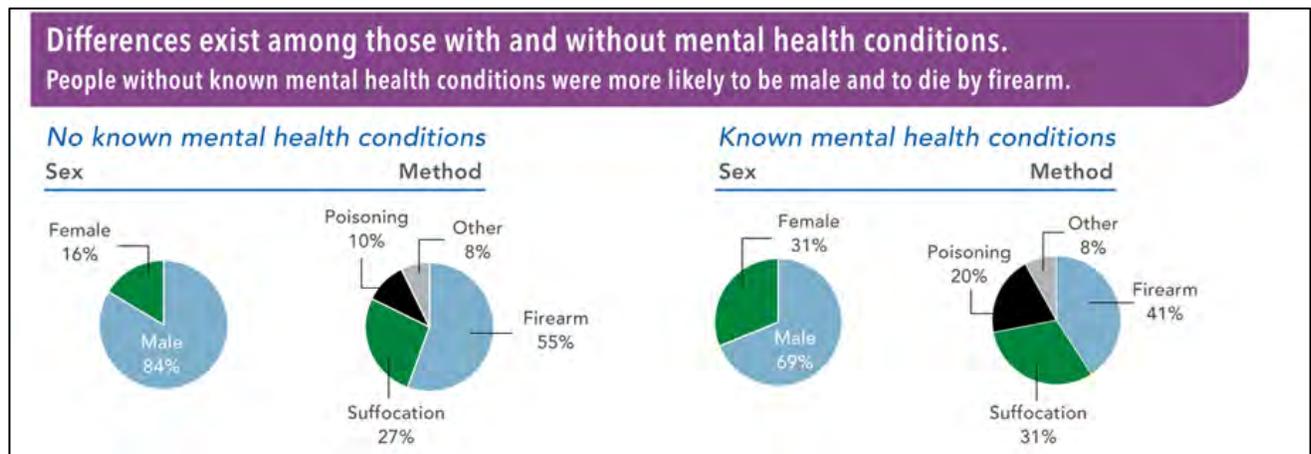
A secondary analysis of these data identified a linked relationship between alcohol and substance abuse in middle age as a likely significant factor in this dramatic change. Bonhomme noted that, as a physician who practices in a substance abuse setting, he believes this to be a correct relationship. Further, he observed that it is often difficult to determine if death due to substance abuse is accidental or a deliberate suicide. “There is much work to be done to more closely look at these relationships and understand the dynamics before we can realistically expect to address these serious problems adequately.”

Table 7



What was most alarming about the 2018 CDC report is the significant jump—an increase of 0.2% in one reporting period—which, in terms of population-based demographics, is quite significant. In addition, the age demographic that had the most significant increase in male suicides was among middle-age working males. This is a stunning jump in this demographic. In a subsequent paper, the CDC assessed the potential cause of this unusual rise overall and specifically the rise in middle-age working men. It concluded that these rises were in large part due to substance abuse, including abuse of opiate analgesics.

Table 8



CDC: National Vital Statistics

Colston noted that most males who commit suicide use guns to do so and suggested a solution to the problem. “Take away guns and male suicide decreases.” Brott, Giorgianni, Gremillion, and several other panelists felt that if guns were no longer available, males would simply find other means to end their lives.

## No Socioeconomic Boundaries

The pervasiveness of behavioral health issues, including suicide, knows no socioeconomic boundaries. For example, several studies document the levels of stress and depression and expression of both in medical students.<sup>xxxix,xxxii</sup> Another demonstrates that although estimates of its prevalence vary, depression is more common among medical students, residents, and physicians than in the general population.<sup>xxxiii</sup> Similarly, studies of the prevalence of depression in various occupations show lawyers and other white-collar workers have relatively higher incidence of depression than the general population.<sup>xxxiv</sup>

That said, the prevalence of behavioral health conditions and the lack of recognition and care in African American and Latino boys and men is shockingly high. The discussion by the panel was underscored by a comprehensive report issued to the nation by then Surgeon General David L. Satcher in 2000 on mental illness.<sup>xxxv</sup> In this document, Satcher made several important points, including:

- 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, religious, and social communities for emotional support rather than mental health professionals.
- African 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 120% among Caucasians in the same age group.
- 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. Latina teenage girls have more depressive symptoms than that of African American or Caucasian girls and the rate of attempted suicide is higher as well.
- American Indian 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.

Communities can work to reduce stigma, support more culturally specific initiatives, and collaborate with respected local institutions (such as churches and community groups).

According to a recent report from the CDC, 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.<sup>xxxvi</sup>

These concepts formed an important part of the panel’s discussion throughout the remainder of the day. Aside from the emotional toll on individuals and families, behavioral health issues in boys and men also have a significant economic impact. In a landmark report, the CDC estimated the medical and business costs of intentional injury.<sup>xxxvii</sup> 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 for men—especially those aged 24 to 64—were 4 times those for women.

Unfortunately, very little research has been devoted to analyzing the economic and social impacts on families and communities. Clearly, there is a significant need not only to better understand the damage done but also to determine whether broad-based initiatives in preventing suicides are having an effect.



## Challenges of Understanding and Reporting Behavioral Health Concerns

In the workplace, behavioral health issues—and in particular depression—have dramatic impacts not only on employers but also on the men affected. This includes concerns of staff turnover, absences, lack of focus and errors (which in some scenarios can have deadly consequences), burnout, decreased motivation and creativity, and lost productivity.

The CDC reported in November 2018 that for the period 2000-2016 the suicide rate for US workers aged 16 to 64 years increased 34%, from 12.9 per 100,000 to 17.3 per 100,000. Overall, for men, the occupations with the highest suicide rates are construction and extraction—jobs such as

carpenters, electricians, and miners; arts, design, entertainment, sports, and media—jobs such as illustrators, tattooists, and professional sports players; and installation, maintenance, and repair—jobs such as mechanics, cable installers, and commercial divers. The greatest suicide rate increase from 2012 to 2015 was among males (47%) and occurred in men employed in the arts, design, entertainment, sports, and media occupational group (26.9 to 39.7 per 100,000).<sup>xxxviii</sup>

A survey by the National Business Group On Health (NBGH) released in June 2019 (<https://www.businessgrouphealth.org/news/nbgh-news/press-releases/press-release-details/?ID=358>) shows that nearly 1 in 3 US employees would like their employers to provide more assistance in the area of mental health. Employees responding to the survey noted they would like to see more help in dealing with burnout as well as other aspects of emotional health. Brian Marcotte, president and CEO of the NBGH, noted that “employees are looking to their employers to provide support on all areas of well-being, not just physical health.”

Many employers have begun to provide line management with simple tools to help assess behavioral issues.<sup>xxxix</sup> An example of such a program is found in a recent initiative by Walgreens. This large community pharmacy company has 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. Hopefully, this initiative will provide outcome information about the effectiveness of both patient care and employee wellness.<sup>xl</sup> As similar programs begin to populate the workplaces, it would be helpful to have a component to measure results and publish them.

Employers and managers are not the only people who could benefit from tools (and training in how to use them) designed to help flag signs of mental health issues. Parents, teachers and school administrators, law enforcement personnel and other first responders, camp counselors, community and youth group leaders, and many others are regularly in situations where knowledge of how to decipher complex signals could be helpful.

However, as Sullivan and others on the panel noted, providing mechanisms to follow through on observations and concerns in ways that protect the privacy of individuals as well as the integrity of the organization is becoming increasingly complex. Giorgianni noted that in far too many mass shootings in schools or other highly populated places, officials and sometimes even law enforcement had been informed of warning signs.

However, the conflict between privacy rights and the fear of becoming the subject of a legal action prevented reporting and affirmative action, such as disarmament or temporary containment, which

might have averted mass casualties. If society wishes to more effectively prevent individual catastrophes such as suicide and mass catastrophes such as school or workplace shootings, we need to strike a better balance between seemingly opposing legal and societal interests.

Africa<sup>xli</sup> discussed an innovative program in California designed to address potential suicide risk and mitigate it through an online peer-to-peer support program. This program, funded through a statewide initiative created under the California Mental Health Services Act, represents one of the many ways online services can reach at-risk individuals and to augment person-to-person encounters. In general, the panel felt such online services are an important innovation that can be used to reach individuals, particularly in rural and underserved communities.

Several panelists noted, however, that these are not as effective as face-to-face encounters and suggested much more work needs to be done to assess the impact of these technologies and to refine their use. Williams noted that remote technologies are the most progressive and moving forces in medicine today, and that policymakers, providers, and payers need to pay attention to how technological approaches are evolving and how they enhance health and wellness.

The panel discussed some of the important challenges that need to be addressed to fully leverage this new technology. These include patient privacy and HIPAA concerns; access, particularly for the poor, to appropriate computer and internet services; sporadic coverage of services by third-party payers; and credentialing of licensed health care providers and community-based personnel using this type of intervention. Williams added that the legal and regulatory frameworks that address this technology are being developed only on a state-by-state basis. He suggested that such a haphazard approach is fraught with problems and inconsistencies and the issue needs to be addressed at a federal legislative level.

The panel clinicians—Roberson; Chatmon; Sarah Coles, MD, assistant professor University of Arizona College of Medicine and practicing family physician; and Justin Sparkes, DO, family practice physician at Integris Baptist Medical Center—were unanimous in emphasizing that providing adequate screening support, treatment, and returning patients to active community life is not just the responsibility of mental health professionals and clinicians. Resources of the entire

If society wishes to more effectively prevent individual catastrophes such as suicide and mass catastrophes such as school or workplace shootings, we need to strike a better balance between seemingly opposing legal and societal interests.

community must be brought to bear on the problem. Community organizations, schools, law enforcement, social workers, and others who touch the lives of boys and men need to be aware of, appropriate to their level of responsibility, how to recognize signs and symptoms of impending or developing behavioral health problems, including suicide risk, and to triage at-risk males to the most appropriate resources and clinical care.

This is also the position the MHN staff echoed. Our experience at MHN, noted Fadich-Tomsic, tells us that working with and educating local community leaders about men's health issues bring very impactful results and outreach into the community. MHN has developed and disseminated programs to both train and do programs in the workplace, at sporting venues, and with faith-based and service organizations. There is a continued need for these programs to expand into the area of behavioral health.

In the workplace, the situation is especially complex. Efforts to address behavioral health issues in the workplace have generally focused on early detection by personnel trained in recognizing potential behavioral issues and how to bring these to the attention of appropriate individuals in the organization. In our hypersensitive and litigious society and work environment, senior executive leadership, human resource professionals, line managers, and health benefit managers all wrestle with issues of behavioral health challenges, including substance and alcohol abuse, in the workplace. The issues and signs may differ dramatically given the immense variety of nonmilitary workplace scenarios for men. These can range from hourly workers in service industries and fast food establishments to tradesmen and white-collar workers and professionals and, as a particularly important group, first responders.

To illustrate an interesting component of the problem in clinical care, Giorgianni noted that in a 2017 survey<sup>xlii</sup> 43.9% of doctors in the United States exhibited at least 1 symptom of burnout and depression. The study authors' noted in their commentary that "symptoms of depression among physicians have continued to worsen." Just how this translates into physicians', particularly male physicians', ability to screen patients, especially male patients, and their ability to objectively interrupt the results is not yet clear.

Giorgianni feels this may be an important area of outcomes research to help unpack the level of depression and burnout among clinicians who deal with symptoms of behavioral health in practice. In addition, physician suicides are a growing problem in health care. According to a recent article, the suicide rate for male physicians is 1.41 times higher than the general male population (for female doctors the rate is even higher, at 2.27 times the general female population).<sup>xliii</sup> The suicide rate is even worse for medical students—3 times higher than for their nonmed-student peers, according to the American Medical Association.<sup>xliv</sup>

Martin noted that most physicians (and other providers and clinicians) who have behavioral health

issues, including depression, tend to suffer in silence because there is no incentive to get help. In fact, many fear that seeking treatment or admitting their problems to a colleague might hurt their practice or result in a loss of license or privileges at hospitals. This suffering, as would be expected in any walk of life, too often leads to attempted or successful suicide. Assisted living facilities are another unique living environment where, outside the medical management of diagnosed or preexisting mental health conditions, there are significant barriers to identifying and managing behavioral health issues. For example, many older men are on multiple prescription and nonprescription medications for nonpsychiatric medical conditions, such as blood pressure control, allergies, or pain management, and these medications can precipitate behavioral health problems. As a result, it is often difficult for clinical staff to identify the root causes of abnormal behavior or emotions—and to manage dangerous physical conditions without aggravating or precipitating behavioral health conditions. This is an emerging area of research interest for those caring for older patients. As in all other environments, the role of stigma looms large in all of these scenarios.<sup>xlv</sup>



## Tools to Screen for Depression and Other Behavioral Health Conditions

This topic consumed a significant portion of the dialogue, both as a specific topic and as part of the deliberations related to workplace, community, and clinical identification of boys and men.

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 that they are optimizing diagnostic opportunities.

Bonhomme provided a vivid example of the rhetorical questions in one of the most widely used depression screening scales, the Beck's Depression Inventory.<sup>xlvi</sup> The Beck's Inventory is a multiple-choice, self-reporting psychometric test designed to measure the severity of depression.

Bonhomme specifically noted that the phrasing of several of the questions doesn't resonate as strongly with most boys or men as it does with girls and women. Specifically, he cited the following items taken from the Inventory:<sup>xlvi</sup>

**Question 1:**

- 0 I do not feel sad.
- 1 I feel sad.
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

**Question 10:**

- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now.
- 3 I used to be able to cry, but now I can't cry even though I want to.

**Question 14:**

- 0 I don't feel that I look any worse than I used to.
- 1 I am worried that I am looking old or unattractive.
- 2 I feel there are permanent changes in my appearance that make me look unattractive.
- 3 I believe that I look ugly.

Bonhomme emphasized that 9 of the Inventory's 21 questions mention feelings or crying or other symptoms that boys and men would be less responsive to. Further, he added, there are no questions at all that 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.

Others on the panel, including Tamara James, PhD, acting director of Indian Health Service, Division of Behavioral Health, pointed out another deficiency of existing screening tools: Their language and approach frequently make them culturally irrelevant to many Native American boys and men.

Gremillion summarized the view of the Men's Health Network by noting there is very little in the literature that points to studies that show development of validated behavioral health screening tools for boys and men or the outcomes on diagnostic accuracy of any one tool when used to screen men and women. This is an area of deficiency that needs to be studied more thoughtfully and systematically.

One potentially promising approach to reducing suicide is to conduct suicide risk screenings in health care settings. Several studies have found that "in the month prior to their death, half of

suicide decedents received healthcare services and 24% received mental healthcare services.”<sup>xlviii</sup> Other studies have demonstrated that this type of screening is feasible and may help identify individuals who hadn’t previously been screened.<sup>xlix,l</sup> Cheryl A. King and her colleagues (none of whom were present at the conference) summed it up nicely: “Taken together, studies indicate that suicide risk screening in healthcare settings—particularly primary care, medical specialty clinics, and educators—can reach large numbers of individuals at risk for suicide whose risk would not otherwise be identified. Such screening is acceptable to patients, and because most people will not

“Taken together, studies indicate that suicide risk screening in healthcare settings—particularly primary care, medical specialty clinics, and educators—can reach large numbers of individuals at risk for suicide whose risk would not otherwise be identified. Such screening is acceptable to patients, and because most people will not proactively disclose thoughts of suicide, it is the best way to identify many of the individuals at risk.”

Cheryl A. King

proactively disclose thoughts of suicide, it is the best way to identify many of the individuals at risk.”<sup>li</sup> Because, as noted above, the overwhelming majority of completed suicides are male, the panel believe that screening for suicide risk could have a significant impact in reducing male casualties. In particular, a short, simple screening designed to be used in nonclinical environments (by teachers, coaches, and others) could help flag at-risk males and facilitate the handoff to an appropriate professional.

Andrew Sperling, Director of Legislative Affairs and Public Policy at the National Alliance on Mental Health (NAMI), was very concerned that all current screening tools require a high level of subjective interpretation and that the education and training of providers to do proper and appropriate interpretation of results is significantly inadequate. This problem is exacerbated for boys and men, as there is little training in gender-specific interpretation of screening results and coupling those results with physical findings or behavioral patterns. According to Sperling, this lack of interoperations sophistication has led to many problems, including delays, misdiagnoses, and inappropriate treatment for too many patients. In some cases, patients and those around them have suffered irreparable emotional harm.

Birmaher and others on the panel agreed that, across the board, providers’ skill levels and ability to interrupt results need to be elevated. This is particularly important in primary care, not only for physicians but also for nurse practitioners and physician assistants, who are providing increasing amounts of first-line care for patients. Marsden McGuire, MD, MBA, director of Continuum of Care and General Mental

Health, Veterans Health Administration Office of Mental Health and Suicide Prevention, stressed that better screening tools are warranted, particularly for men, but that screenings are just one component of a diagnosis and management continuum and that fundamental changes in how behavioral health issues are identified and managed in day-to-day practice are also needed.

Most panelists agreed on the need to develop gender-specific screening tools for depression and suicide risk. Some of the panel, however, felt that existing screening tools were adequate, some felt existing tools could be changed to better address male-specific symptoms, and others felt that screening tools were ineffective and the focus should be on face-to-face encounters between individuals and trained clinicians.



## Diagnosing and Managing Depression

Male patients with potential symptoms of behavioral health issues are part of every practice, whether it's a family practice, pediatrics, urology, oncology, geriatrics, or any of the other medical specialties recognized by the American Board of Specialties.<sup>lii</sup> All providers, whether they're physicians, nurse practitioners, physician assistants, medical assistants, or someone else, should be able to identify patients with behavioral health concerns. However, too many symptoms of depression and behavioral health issues are either overlooked or misdiagnosed and too many boys and men are not getting the treatment they need. The consequences, both to individual boys and men and to those around them, can be devastating. As pointed out earlier, of those who committed suicide without a prior history of a mental health condition, 86% were male. That is an astounding percentage. If this level of diagnostic imprecision were present for most any other lethal condition, it would likely be the focus of significant efforts to address it and its root causes.

Yet, for suicidality in undiagnosed depressed males, little or no research has focused on the causes. There are myriad possibilities—including the inaccuracy of screening tools, men's lack of participation in the health care system and the resulting paucity of opportunities to diagnose them, the sting and chilling impact of stigma, misinterpretation and mischaracterization of male's symptoms, racism, socialization ("Big boys don't cry," "Man up," etc.)—that inhibit healthy

expression of emotional injury, men's and women's naturally different expressions of emotional distress (with men and boys acting out physically), and the lack of training of clinicians in how to properly communicate with men around mental and behavioral health issues. Other systemic factors certainly play a role, such as the lack of sufficient mental health providers, misaligned financial incentives for clinicians, and lack of training and guidelines for triage by community workers to provide early identification of issues that need professional attention.

Clearly, to identify and diagnose depression and related mental health conditions, clinicians must have enough time during their encounters with patients. Given the realities of day-to-day practice for most clinicians, this is a challenge. In one important study, Tara Bishop and her colleagues<sup>liii</sup> looked at how often mental health is evaluated in routine medical encounters. They found "significantly less use of protocols for depression than for asthma, congestive heart failure, or diabetes."

On average, practices used fewer than 1 care management process for depression—a level that is consistent regardless of practice size and that hasn't changed in a dozen years. "By and large, primary care practices don't have the infrastructure or haven't chosen to implement [best] practices for depression," said 1 of the study's coauthors. "The approach to depression should be like that of other chronic diseases [but], by and large, primary care practices don't have the infrastructure or haven't chosen to implement those practices for depression."

Sparks noted that most of a primary care providers' attention is focused on diagnosing and managing symptoms. Thus, there is a need to better train practitioners in discerning which symptoms may actually be manifestations of underlying behavioral health issues rather than organic disease. This is particularly important with male patients because of their tendency to manifest behavioral health issues with physical symptoms. All of the clinicians on the panel agreed that separating mental health problems from physical problems is, in and of itself, stigmatizing and can lead to treating one component or the other rather than both conditions together.

Coles related a particularly resonant real-life scenario that illustrated many of the day-to-day barriers that primary care providers face when deciding to do or not do behavioral health screenings. The concerns boil down to 3 major elements: time, tools, and desire. She noted that, in her practice, behavioral health screenings are part of their regular protocols for patient care and

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that providers in her practice are rated on a myriad of quality metrics, including behavioral health screenings periodically or when there is any clinical impression of need.

In one case, a male patient presented for a regularly scheduled exam, which, according to timed protocol at the practice, included a behavioral health screening. The screening identified the patient as being in imminent risk of self-harm. On identifying this life-threatening psychological condition, Coles began the practice protocol to keep the patient in the facility and under observed care while paperwork and required secondary support was put in place. This process, which included periodic physician activities as well as activities of the interdisciplinary team in the practice, took approximately 7 hours to complete. The reimbursement for this encounter was billed at the general family physician Work-Relative Value Units. (WRVUs are a method of evaluating the risk, time, and skill needed to engage in an episode of care and is related to the direct and indirect expenses associated with the work performed by the provider.<sup>liv</sup>) Clearly, once the screening was done there was an ethical duty to provide appropriate care to the patient, regardless of reimbursement or resource utilization. Other clinicians on the panel had experienced similar scenarios where the time and level of expertise when engaging a behavioral health issue did not adequately map with reimbursement.

Patients who have dire medical conditions such as cancer, or chronic conditions such as multiple sclerosis, often get boundless support and encouragement from clinicians, family, and friends, but when the toll of these same physical conditions manifest in psychiatric symptoms, particularly depression, these same people tend to pull away and curtail or even abandon their support role.

The panel discussed this at some length. Most agreed that unless and until reimbursement for behavioral health screening becomes aligned with the amount of time and intensity of services it consumes, these screening will not be a common practice. As a result, patients in need of care may go unrecognized and untreated until a catastrophic event occurs. Given the vagueness of behavioral health screening guidelines from organizations such as the US Preventive Services Task Force (USPSTF), and the potential liability that accompanies diagnosis and treatment of mental health disorders and inequitable reimbursement, the low level of screening in clinics will likely continue. Thus, this represents an important area for better reimbursement policy and outcome-oriented research.

In addition, given the severe time constraints on physicians and other first-line clinicians, it was the consensus of the panel that non-first-line staff (including nurse practitioners, physician's assistants, and others whose time is not as regimented) can and should be trained to conduct basic mental health screenings and to notify a provider if necessary.

The bottom line is that little routine screening is done for depression and related behavioral health issues in boys and men, despite the dramatic level of depression and suicide. Worse yet is the lack

of nationally recognized standards for screening boys and men. While the USPSTF assigned a “B” rating for depression screening and specifically recommends “with at least moderate certainty that there is a moderate net benefit to screening for depression in adults, including older adults, who receive care in clinical practices that have adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up after screening. The USPSTF also concludes with at least moderate certainty that there is a moderate net benefit to screening for depression in pregnant and postpartum women who receive care in clinical practices that have continuing behavioral therapy or other evidence-based counseling available after screening.”

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Unfortunately, as is all too often found, the guidelines regarding screening males is nonspecific and noncommittal in terms of desirability, periodicity, and impact on overall health. USPSTF recognizes the paucity of data regarding when screening should be done and at what intervals repeat screening should be done. Specifically, its 2019 guidelines state: “There is little evidence regarding the optimal timing for screening. The optimum interval for screening for depression is also unknown; more evidence for all populations is needed to identify ideal screening intervals. A pragmatic approach in the absence of data might include screening all adults who have not been screened previously and using clinical judgment in consideration of risk factors, comorbid conditions, and life events to determine if additional screening of high-risk patients is warranted.” It should be noted that these guidelines are non-gender specific, and work to examine optimum time to begin and repeat screening based on biologic and adapted gender as well as age are important areas for further research.

Nurse practitioner faculty member Chatmon and Matthew Von Zimmerman, MPHS, Medical Student (OMSIII), Lake Erie College of Osteopathic Medicine, also noted a lack of training for clinicians on how to select, administer, and interrupt screening for boys and men. The authors of this monograph could not find any medical association guidelines that provide adequate, clear guidance to clinicians in this important area. Clearly, Giorgianni noted, such guidelines need to be vetted, promulgated, and adopted if we are to stem the tide of behavioral health issues and their consequences—including violent, maladaptive, and suicidal behavior.

In some cases, medical providers avoid conducting mental health screenings for financial reasons. Dr. Wanda Filer, a former president of the American Academy of Family Physicians and a practicing

family physician in York, Pennsylvania, has stated that “despite federal law, it’s still difficult to get insurers to pay for mental health care. That circumstance,” she said, “could discourage or impede primary care doctors from taking a comprehensive approach to treating it.” She added, “Most depression cases we can manage quite easily—family physicians are well-trained to manage this particular condition.” . The problem is there are all these barriers to improving mental health.<sup>lv</sup>



## The Role of Substance Abuse

There is a clear link between substance abuse disorder or overuse of substances such as alcohol and marijuana and depression. For example, in one study by Matthew Hirschtritt et al <sup>lvi</sup>, primary care physicians rarely package depression assessments with patient screenings for hazardous alcohol use. Overall, depression screening is part of about 1.4 percent of adult ambulatory care visits nationwide. Within 30 days of routine, in-clinic alcohol use screening by medical assistants, 2.4% (n = 68 686) of patients also completed a standard patient health issues questionnaire (PHQ-9); these patients were more likely to be female, younger, white, Medicaid insured, and have a nondepressive psychiatric diagnosis and a lower Charlson comorbidity score. Only a small fraction of patients in this cohort were screened for depression. It is also instructive to note that screening rates were found to be particularly low among men in general as well as in nonwhite people and more medically ill patients. Nonwhite patients and those with higher comorbidity burden were more likely to report depression but less likely to be screened.

Fadich-Tomsic noted that the lack of a men’s health specialist in the medical profession is a systems deficiency that needs to be corrected.<sup>lvi</sup> While some urologists are attempting to provide some level of care beyond the urogenital system, they are not widely accepted as providers who can treat or triage the broad range of conditions that impact men such as cardiac, behavioral health, injury, and substance abuse. In addition, the lack of a men’s health specialist is particularly missed in health care of adolescent men through early midlife, when consulting with a urologist is unlikely. Osteopathic family physicians recognize the important role that family physicians can and should

play in providing comprehensive men’s health care as a subspecialty with specialized focused continuing education.

John J. Dougherty, DO, FACOFP, FAOASM, FAODME, FILM, founding dean and chief academic officer of Noorda College of Osteopathic Medicine (proposed), echoed the concerns raised by Coles, while also noting that as more patients with behavioral health issues are identified and as practices begin to add behavioral health screening into their quality metrics to meet network payer and Center for Medicare & Medicaid Services standards, concerns about clinician time, training, and reimbursement will become even more critical to resolve. He also noted that training for providers—particularly at all levels of primary care—must be reconfigured and enhanced with gender- and socioeconomic-specific skills. The lack of experienced, trained providers is likely to drive patients with identified behavioral health issues away from the very care they need most. As a medical school dean, Dougherty is concerned that training in the complex interdisciplinary skills and resource allocation needed to adequately care for patients with behavioral health issues for current and future practitioners is sorely lacking. He also believes existing training doesn’t emphasize gender-specific approaches and feels this area requires strong consideration both in medical and nursing curricula and in postgraduate training.

As illustrated in the scenario relayed by Coles, in order for any initiative or practice-based convention for screening and managing behavioral health to be successful, payment policy at both the public and private levels must be aligned with the time and effort practitioners must spend to adequately screen, triage, or treat. Dougherty provided a provocative example of how the current WRVU assessment in primary care works against the goals of screening for behavioral health issues. He noted, for example, that an orthopedic surgeon can do a repair of an ACL in about an hour and is reimbursed at a rate approaching 22 WRVUs. Similarly, an ear nose and throat specialist (ENT) will get reimbursed approximately 12 WRVUs for insertion of otic drainage tubes. An experienced ENT could easily do 10 of these procedures in a morning and be reimbursed for 120 WRVUs. A family practitioner, such as Sparks, Chatmon, and Coles, may be reimbursed 8 WRVUs for a full day’s work. In the very realistic scenario Coles presented, the reimbursement is simply out of alignment for both the amount of effort, time, and skill needed to care for the man in crisis.

One very cogent area of research in the behavioral medicine domain would be to systematically reevaluate the relevant time, risk, and skill algorithms for primary care providers to better align them with reimbursement. David Johnson, operations and management officer in the Office of Population Affairs, US Department of Health and Human Services, agreed that misalignment of reimbursement, particularly in primary care, is an area of focus in the public sector and encouraged additional outcomes-based research to support better-aligned reimbursement in behavioral health. The panel was in consensus agreement that if reimbursement algorithms for primary care better recognized the effort and the medical need and benefits of mental health screening, these efforts

would be applied more frequently in practice. The lack of reimbursement for “well man’s visits” analogous to “well woman visits” provides fewer opportunities for screening, according to Fadich-Tomsic. Providing equal access to this important service for men would be very beneficial to help identify medical and behavioral problems earlier.

MHN has outlined several recommendations to enhance the intersection of male patients and providers.<sup>lvii</sup> These include the following:

- Education for boys about health and wellness in a gender-specific manner needs to have a greater emphasis in primary and secondary education.
- Institutes of higher education should offer educational and career tracks in male-gender-focused areas related to psychosocial, environmental, and lifestyle skills.
- Organizations representing medicine and other clinical disciplines should consider ways to address the “doctor for guys” gap.
- All stakeholders in the clinical care space should encourage, implement, and evaluate additional gender-specific approaches to engaging boys and men in wellness and health care.
- All stakeholders in communications and mass media should increase male-centric media outreach intended for boys and men that encourages them to view active engagement in health and wellness as part of modern masculinity.
- Foundations and public sector and commercial sector stakeholders should give greater emphasis to providing male-gender-focused programs for education and screening.
- Organizations and groups that sponsor lifestyle programs that attract boys and men should begin to incorporate health- and wellness-related participation that shows how health is part of masculinity.
- Health providers and product managers for health-related products and services should embrace men as a target audience and offer more male-centric services and promotion.

The Department of Defense (DoD) and Department of Veterans Affairs (VA) both interact with many patients with mental health concerns.

Richard McKeon, PhD, MPH, chief for the suicide prevention, Center for Mental Health Services Substance Abuse and Mental Health Services Administration, noted that historically suicide rates have been lower in the military than in the general population, but that this changed dramatically after Vietnam. Now suicide is a significant problem across the military and within the VA system. As of 2007, to identify military members and veterans in need of behavioral health care or at risk of suicide, most facilities have an on-staff suicide prevention coordinator. This type of early alert

measure is, he believes, unprecedented in any other health system. This approach parallels with peer-to-peer programs being piloted in many nonmilitary environments.

Brott, a former US Marine, noted that he and other experts in military matters feel that much of the difference in the ability for the contemporary cohort of military to cope with the mental and emotional trauma of service and combat emanate from their environmental circumstances preservice and post-service. All too many male service members come to military service from families with substantially challenging home and community environments, lack of in-home or even in-community father or positive male-role model, and little community support structures. Brott feels this leads to male service members coming into the military with a base of social trauma that becomes exacerbated by their service, particularly when engaged in combat. Post-discharge, many of these veterans return home to the same, or substantially similar, environments where needed support networks are, by and large, absent.

Martin noted that while an estimated 20 veterans a day commit suicide, only 6 of those are being cared for within the VA system. Thus, providers in the civilian community are the ones most likely to identify a behavioral health or mental health red flag. It's unclear whether these mostly nonmilitary providers are able to fully understand or assess the emotional scars of veterans and even to interpret the way they may express mental health conditions such as PTSD, depression, and suicidality.

Some of the challenges in managing depression are related to the poor engagement of boys and men in the health care system. As noted earlier, men generally engage in health care later on in a disease process than do women, making management more difficult in most instances. As Birmaher put it, "I think that we are worse in diagnosing men with mental health than we are in diagnosing cardiovascular illness and our male patients are worse because they wait too long to come to care than women do for such conditions." Giorgianni noted that this most likely relates back to the "big-boys-don't-cry" attitude so prevalent in our society.

"I think that we are worse in diagnosing men with mental health than we are in diagnosing cardiovascular illness and our male patients are worse because they wait too long to come to care than women do for such conditions."

Dr. Boris Birmaher,  
Professor of Psychiatry,  
University of Pittsburgh  
School of Medicine

## Links Between Male Depression and Violence

Most individuals with psychiatric problems are not violent. Yet, in a minority of cases, there are real links between mental health issues and antisocial and/or violent behavior. The news is replete with

horrific stories of young men—often characterized by peers and those who know them as “loners,” always sad or morose—who engage in heinous and tragic actions, including mass murder. Frequently, but not always, these young men had been “flagged” by school officials and occasionally law enforcement and should have been kept under a watchful eye. Too often, though, they were never offered the type of help and emotional or psychiatric support they so desperately needed because they did not seek care and their activities did not rise to the level where such could have been mandated.

In older individuals, particularly men who are engaged in work that involves immersion in dangerous, traumatic, and life-threatening activities—such as military, first responders, and law enforcement—PTSD can manifest in subtle and sometimes not-so-subtle ways. Typically, PTSD creates difficult socialization issues, but occasionally it results in violent behavior. There are numerous other examples of male loners and even seemingly “everyday Joes” who have emotional pain—never recognized, disclosed, or identified in a medical encounter—that at some point manifests as violent rage.

A 2015 study of 47 000 people in Sweden found that the risk of violent crime was increased in persons diagnosed with depression.<sup>lviii</sup> A subanalysis by gender found that 3.7% of men and 0.5% of women committed a violent crime after being identified as clinically depressed. This compared with 1.2% of men and 0.2% of women in the general population. This study is one of the few in the medical literature to examine this link and is frequently cited as an important source study. While not definitive, the medical literature strongly suggests that a link exists between depression and other behavioral health issues and violence. In an analysis of the relevant medical literature on the topic, Toshi Furukawa concludes that “the association between depression and violence has been fairly under-studied, especially in comparison with schizophrenia, and this has led to inconsistent results.”<sup>lix</sup> Certainly, additional work in this area is warranted to characterize the link between depression and violence, particularly in males.

As noted earlier, boys and men tend to deal with depression and other forms of emotional harm by acting out in aggressive ways (as opposed to females, who more typically act out verbally or emotionally). Martin made the point that that these individuals are often considered by society as being “bad” rather than having underlying depression or other psychiatric conditions and they all too often end up in an escalating spiral of punishment and incarceration rather than treatment. For many of these boys and men, this scenario of punishment rather than treatment fosters and breeds criminality, including violence. The panel discussed the link between behavioral problems and violent behavior by boys and men during the session. (Panel discussion summary to follow.)



## Areas for Further Work

At the end of the day's discussion, the panel, led by Bonhomme, reviewed the conversations with an eye toward crafting recommendations to advance and enhance the capabilities of various clinical and nonclinical stakeholders involved in the health and welfare of boys and men, particularly in the areas of behavioral health. The following summarizes 4 core domains that will form the elements of a platform to move forward. It is understood that for each of these core domains, assessment of their effectiveness in enhancing the public health and care of boys and men needs to be an active component of any program.

### Key Action Items

#### I. Screening Tools

- a. Conduct a systematic survey of major validated tools to screen for behavioral health conditions. Evaluate them rhetorically, graphically, and structurally for male-specific appropriateness.
- b. Work to develop male-specific screening tools with variant structures based on male demographic and cultural needs. Field-test and assess the outcome in identifying patients at risk of behavioral health abnormalities.
- c. Critically reevaluate current national clinical and community level guidelines in terms of male-specific appropriateness, ability to be implemented and relevance.
- d. Establish standards for periodic screenings in the health care continuum of care.

#### II. Education and Training

- a. For Clinicians
  - i. Develop educational components in health professional curriculum to establish skill sets for future clinicians' ability to effectively communicate with boys and men about behavioral health conditions.

- ii. Develop postgraduate and continuing education training of clinicians across disciplines to help guide clinicians' interactions with male patients.
  - iii. Establish quality metrics to be applied to practices in assessing their quality improvement programs similar to those for physical conditions, with a specific emphasis on behavioral health aspects of care.
- b. For Community
  - i. Develop site/environmentally relevant education and training for non-health care personal in the community to recognize, understand, triage, counsel, and mitigate behavioral health issues for boys and men in their sphere of influence.

### **III. Public and Private Policy**

- a. Create health-related legislation that supports fundamentals of well care for boys and men across the lifespan.
- b. Review and revise both public and private sector reimbursement structures to create a more realistic and equitable payment system in primary care for male behavioral health screening, treatment, and follow up.
- c. Create better guidelines for clinicians, nonclinical health care workers, and community members to use to structure, time, and implement behavioral health screenings for boys and men.
- d. Embark on a series of public 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.
- e. Better define the role of telemedicine and telehealth technologies ability to help provide screening, ongoing care, and patient and community support in addressing behavioral health issues.
- f. Examine important implementation issues surrounding telemedicine initiatives, particularly regarding provider skills in providing care using this technology, patient privacy and security, and adequacy of reimbursement.

### **IV. Dissemination**

- a. Create a series of training programs for clinicians in practice to help them better screen, diagnose, triage, communicate, and treat male behavioral health conditions.
- b. Create a series of train-the-trainer programs for community stakeholders—such as educators, law enforcement, youth program leaders and coaches, and workplace human resource personnel—on recognition, communication, and triaging potential behavioral health issues.
- c. Create a centralized Resource Center to collect, characterize, catalog, store, and actively

disseminate information about programs, policies, and best practices in male behavioral health.

## Key Areas for Future Outcomes and Effectiveness Research

The following list is a compilation of suggestions and recommendations based on panel discussions of important areas to conduct research on the impact, effectiveness, and outcomes of various male-specific approaches to addressing behavioral health issues:

- Male-specific screening tools for behavioral health in both the clinical and community settings;
- Assessing potential suicidality and non-self-inflicted violence in males who have no underlying diagnosis of behavioral health issues;
- Various national and local guidelines and protocols for initial and periodic clinical behavioral health screening;
- School, criminal justice, workplace, and other community service organization programs to identify, manage, and triage potential behavioral health issues;
- Programs to develop a lexicon and communication technique training for boys and men about emotional and behavioral health issues;
- Various types of support programs in community, educational, criminal justice, and workplace environments;
- Community men’s health educator training and resource availability programs and initiatives;
- Training and microgrants to help grassroots, community-based entities capture concerning behavioral health-focused initiatives;
- Programs and training of clinical and other staff in assisted living, skilled nursing, and other facilities serving older persons;
- Various reimbursement algorithms and scenarios for screening and managing behavioral health issues in various nonpsychiatric medical practice environments, particularly in family practice;
- The utility of “Well-man”-type annual medical evaluations and sports-physical exams for early identification and management of behavioral health issues;
- Nontraditional programs and services to develop expression and coping skills for males (including those who may be incarcerated), veterans, and first responders with diagnosed or suspected PTSD;
- Impact of home life and community support networks on veterans’ ability to return to civilian life;
- Social and financial impact of various community-based programs in male behavioral health; and
- Support programs for health care providers to address issues of burnout and depression.

# Appendix I

## Program Panelist—Brief Bios

### **Jeï Africa, PsyD, MSCP, CATC-V**

Director of Behavioral Health and Recovery Services, Marin County, California

Dr. Jeï Africa is an innovative thought leader and behavioral health clinician who is passionate about fostering a climate of culturally responsive practices throughout county health services. He has more than 20 years of counseling, teaching, and consulting experience in behavioral health, domestic violence, cultural competence, and diversity.

His prior roles include director of the Office of Diversity and Equity with the San Mateo County Health System, clinical director at Community Overcoming Relationship Abuse, and manager of youth treatment services at Asian American Recovery Services.

### **Boris Birmaher, MD**

Endowed Chair in Early Onset Bipolar Disease and Professor of Psychiatry,  
University of Pittsburgh School of Medicine

Dr. Boris Birmaher is the endowed chair in Early Onset Bipolar Disease and professor of psychiatry at the University of Pittsburgh, School of Medicine and serves as codirector of the Psychiatry Research Pathway program and director of the Child and Adolescent Bipolar Spectrum Services. He received his medical degree from Valle University in Cali, Colombia. He completed training in general psychiatry at the Hebrew University in Jerusalem, Israel, and child psychiatry at Columbia University, New York.

Dr. Birmaher is a leader in the study and treatment of pediatric mood and anxiety disorders. In addition, his research is concentrated in describing the predictors, risk factors, course, and treatment of childhood-onset bipolar disorder. Throughout his career, he has served as the principal, coprincipal, or coinvestigator for more than 25 federally sponsored research grants and projects. He has authored or coauthored more than 430 publications and numerous book chapters as well as his own book, *New Hope for Children and Teens With Bipolar Disorder*.

Dr. Birmaher has been the recipient of numerous awards over the years, including the Colvin Prize for Outstanding Achievement in Mood Disorders Research in 2013 and the Ittleson Award for Research in Child and Adolescent Psychiatry in 2014. In 2018, he received the Gerald L Klerman

Senior Investigator Award and the Lifelong Fellow Award from the American Psychiatric Association. For 4 years, until October 2018, he was the program chair of the American Academy of Child and Adolescent Psychiatry and recently was named counselor-at-large of the same association. Through his research, clinical, and mentoring activities, Dr. Birmaher has increased our understanding of the risk factors for mood and anxiety disorders, developed and implemented innovative treatments to improve the lives of patients and their families, and trained the next generation of educators, clinicians, and researchers.

**Jean Bonhomme, MD, MPH**

**Founder, National Black Men's Health Network**

Dr. Jean Bonhomme is an expert on men's health, minority health, and the impact of poor men's health on families. From 2003 to the present, 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. Also during this time, he has served as staff physician for Toxicology Associates of North Georgia, a drug treatment facility in Marietta, Georgia.

He has served on the editorial board of the *Journal of Men's Health* and from 2006 to the present on the editorial board of the *American Journal of Men's Health*. Dr. Bonhomme earned a bachelor of arts degree with honors, College of the City of New York, and a doctor of medicine, State University of New York at Stony Brook. His postgraduate medical education includes categorical internal medicine and psychiatry, Grady Memorial Hospital and Emory University Affiliated Hospitals, and a master's degree, public health, Emory University, field of concentration: epidemiology. He also serves on the Men's Health Network (Board of Directors).

**Armin Brott**

**Author, Speaker**

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 male target. 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 worldwide become the fathers they want to be—and that their children need them to be.

Host and producer of an internationally syndicated radio show, airing on the American Forces Network, with more than 200 stations, he addresses a wide range of issues of interest to

servicemembers and their families around the world, including mental health, fatherhood, parenting, depression, and suicide. He is the managing editor of *Talking About Men's Health* (talkingaboutmenshealth.com), an award-winning blog, creating content and working with other writers on many subjects for and about men and their health. He has also written a series of books on men's health, including *Blueprint for Men's Health* and *Your Head: An Owner's Manual*, which have been adopted by numerous organizations (including the Department of Homeland Security) around the country.

He has been a guest on hundreds of national and regional TV and radio shows, including *Today*, *The Early Show*, Fox News, CNN, and *Politically Incorrect*, speaking on issues that illuminate men on specific health-related topics and concerns. His work has appeared in hundreds of print and web outlets, including *The Wall Street Journal*, *Time* magazine, *Times of London*, *Life* magazine, *Men's Health*, *Sports Illustrated*, and *Redbook*.

### **Benita Chatmon, MSN, PhD**

**Instructor, Louisiana State University (LSU), New Orleans School of Nursing**

Dr. Benita Chatmon is the course coordinator for the Mental Health Practicum course for both the traditional and accelerated BSN programs. In addition, she is course faculty for the courses Mental Health Theory and Issues in Professional Nursing. Dr. Chatmon teaches across all the undergraduate programs to include the RN-BSN track. In addition, Dr. Chatmon is a certified peer reviewer through Quality Matters.

Dr. Chatmon has extensive experience in medical–surgical nursing, mental health nursing, nursing education, and nursing leadership. She serves her academic community as the chair of the Faculty Organization Council, a member of the Curriculum Committee, a member of the Administration Council, and a member of the Undergraduate Academic Council. In addition, she belongs to several LSU Health-NO Taskforces that entail research, policy review, and interprofessional education. Furthermore, she represents the school of nursing as a member of the LSU Health-New Orleans Faculty Senate and serves on the Children's Evidence-based Practice and Research Committee.

Dr. Chatmon received a bachelor of science in nursing in 2007 and a master's of science in nursing education in 2010 from Southern University and A&M College in Baton Rouge, Louisiana. She received her PhD in education with a focus in nursing education in 2016 at Capella University, Minneapolis, Minnesota. She was recently certified as a nurse educator through the National League for Nurses.

### **Sarah Coles, MD**

**Assistant Professor, University of Arizona College of Medicine**

Dr. Sarah Coles is a family physician with Banner University Medical Group and assistant professor at the University of Arizona College of Medicine–Phoenix in the Department of Family, Community, and Preventive Medicine. She trained in family medicine at the Banner University Medical Center–Phoenix Family Medicine Residency. She is a graduate of the University of Arizona College of Medicine–Phoenix.

After completing residency she stayed on as faculty at the family medicine residency and at the medical school. In addition to practicing full-spectrum primary care, she is involved in curricular development, integrated behavioral health, evidence-based medicine, and advocacy. She is an active member of the American Academy of Family Physicians and sits on the Commission on Health of the Public and Science.

### **Captain Mike Colston, MD**

**Director for Mental Health Programs,  
Department of Defense Health Services Policy and Oversight Office**

In previous medical corps assignments, Captain Mike Colston served as the director of the Defense Centers of Excellence for Psychological Health (PH) and Traumatic Brain Injury (TBI), a 600-employee national laboratory focused on implementation science for PH, TBI, suicide, and addiction. As director of the Mental Health Program in the Office of the Assistant Secretary of Defense for Health Affairs, Captain Colston oversaw a mental health board project that reviewed more than 200 000 cases involving PTSD and depression diagnoses, led a mental health team in the independent investigation of the Washington Navy Yard tragedy, and cochaired DoD's Addictive Substances Misuse Advisory Committee, helping address the nationwide scourge of opiate addiction on several fronts. During deployment in support of Operation Enduring Freedom, he led a combat and operational stress team that supported a catchment of 10 000 service members.

Captain Colston has represented the DoD in testimony to both chambers of Congress and at Executive Offices of the President, including the Office of National Drug Control Policy, the Domestic Policy Council, and the National Security Council. He serves on panels for the Military Suicide Research Consortium, the Consortium to Alleviate PTSD, and the National Academies of Medicine. He authored a chapter on the forensic aspects of PTSD in the *Textbook of Military Medicine* series and has been published in peer-reviewed journals on uncertainties in diagnosis and treatment of mental illnesses and bioethical considerations related to PH, TBI, and suicide research. Captain Colston joined the Navy as a line officer, serving as a nuclear engineer and surface warfare officer aboard USS Carl Vinson (CVN-70), deploying twice to the Arabian Sea and completing a

Pacific Rim Exercise. Transitioning to Medical Corps service, he earned an MD from the Uniformed Services University of the Health Sciences, trained as a resident in psychiatry at Walter Reed Army Medical Center, and completed a fellowship in child and adolescent psychiatry at Northwestern University. Captain Colston holds a bachelor's degree in industrial and management engineering from Rensselaer Polytechnic Institute and a master's degree in marine affairs from the University of Rhode Island. He is a fellow of the American Psychiatric Association and is board certified in child and adolescent psychiatry by the American Board of Psychiatry and Neurology.

**John J. Dougherty, DO, FACOFP, FAOASM, FAODME, FILM**

**Founding Dean and Chief Academic Officer, Noorda College of Osteopathic Medicine (proposed)**

After earning an undergraduate degree in education, Dr. John Dougherty graduated medical school from Kansas City in 1992. He is board certified in family medicine and holds a Certificate of Added Qualifications in sports medicine.

He is recognized as a fellow in both family and sports medicine as well as 2 Academic Leadership colleges. Immediately prior to joining Provo, Dr. Dougherty served as dean of the medical school for Touro University in Henderson, Nevada. For 20 years prior to that, he served in a variety of senior leadership roles at his alma mater in Kansas City.

**Dr. Salvatore (Sal) Giorgianni, PharmD**

**Advisor, Men's Health Network**

Dr. Sal Giorgianni received his bachelor and doctor of pharmacy degrees from Columbia University in the city of New York. 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. Dr. Giorgianni is a licensed pharmacist in his home state of New York and in Florida he holds both a general and consultant pharmacist license. In addition to his general and specialist studies in pharmacy, he has completed formal training in pharmacognosy and the preparation and use of natural botanicals as well as pharmacogenomics and pharmaceutical compounding.

Dr. Giorgianni's professional career includes 27 years at Pfizer Headquarters in New York City, where he held various responsibilities in the medical, regulatory affairs, corporate planning, and marketing groups. He was involved in the development and market launches of more than 15 multi-billion-dollar products, including Viagra. He is senior science advisor to the national Men's Health Network and cofounder and chair-emeritus of the American Public Health Association section on men's health. He is the author of more than 70 publications and scientific presentations and is an

editor/reviewer for the *American Journal of Men's Health*. He is a recognized expert in the effect of culture, advertising, and socialization on male perceptions of health and wellness and is a frequent speaker on the topic.

**Colonel David H. Gremillion, USAF Retired, MD, FACP, FIDSA**

**Emeritus Professor of Medicine at the University of North Carolina (UNC) School of Medicine,  
Chapel Hill, North Carolina**

Dr. David Gremillion is a Louisiana native and attended LSU School of Medicine in New Orleans. After medical school, he completed a 20-year United States Air Force (USAF) career and retired as Colonel, USAFMC. During his Air Force years, he was infectious diseases fellowship director at Wilford Hall Medical Center and later residency director, David Grant Medical Center. He served as president of the Society of AF Physicians and Consultant to the USAF Surgeon General for ID. After Air Force retirement, he joined the faculty of UNC School of Medicine as director, Medical Teaching Service, WakeMed in Raleigh, North Carolina. In 2004, after 17 years at UNC, Dr. Gremillion joined the faculty of Nippon Medical School as visiting professor and professor in residence at Kameda Medical Center. Beginning in 2011, he reduced his time in Japan to part time with part-time clinical and teaching roles in North Carolina.

He is a member of the board of directors, Men's Health Network in Washington, DC; fellow of the ACP; and fellow of IDSA. He has served as president of the Wake County Medical Society and president, Wake Medical Staff Foundation. Dr. Gremillion was presented with the Laureate Award for lifetime achievement by the American College of Physicians (ACP) at a ceremony in 2019. As an expert in health issues affecting men, Dr. Gremillion serves as a director of the Men's Health Network. In this capacity, he is a featured speaker and a founding member of the American Society of Men's Health. He has testified before Congress and has spoken at the White House on issues affecting men's and veterans' health. Dr. Gremillion is clinically active in the outpatient setting 2 days per week at Louisburg, Volunteers in Medicine, and at Goshen Medical Center, Faison, North Carolina.

**Stanley Ip, MD**

**Associate Director for Clinical Effectiveness Research, PCORI**

Dr. Stanley Ip's primary responsibility is to help develop research topics for the Clinical Effectiveness and Decision Science program. Before joining PCORI, Dr. Ip, a board-certified pediatrician, was an associate professor at Tufts University School of Medicine. He was also an associate director of the Agency for Healthcare Research and Quality-funded Evidence-based Practice Center Program at Tufts Medical Center. He has extensive experience in comparative effectiveness and the science of systematic reviews.

Dr. Ip received his BS from the University of California, Berkeley, and an MD from the University of Southern California.

### **Tamara James, PhD**

**Acting Director, Indian Health Service (IHS), Division of Behavioral Health (DBH)**

Dr. Tamara James serves as the primary source of national advocacy, policy development, management and administration of behavioral health, alcohol and substance abuse, and family violence prevention programs. Working in partnership with Tribes, Tribal organizations, and Urban Indian health organizations, DBH coordinates national efforts to share knowledge and build capacity through the development and implementation of evidence-/practice-based and cultural-based practices in Indian Country.

She joined IHS in 2016 as the national data coordinator within DBH, Office of Clinical and Preventive Services. In this role, she has supported DBH program priorities, including reporting and evaluation efforts related to suicide prevention, alcohol and substance abuse, and the Community Health Representatives programs. She received her PhD in biomedical sciences from New York University School of Medicine and completed postdoctoral fellowships at the National Institute of Child Health and Human Development and a bioinformatic startup, GeneCentrix Inc. Throughout her career, Dr. James has worked as a health science resource within tribal, nonprofit, and federal settings to promote the health and well-being of the American Indian and Alaska Native (AI/AN) population. Her transition from “bench science” to health science administration was possible through her selection into the American Association for the Advancement of Science, Science and Technology Policy fellowship program. As a policy fellow within the National Institute of Dental and Craniofacial Research, she participated in science policy activities to advance the mission of the Institute.

Prior to joining IHS, Dr. James worked with the Southern Plains Tribal Health Board as a project coordinator to promote tribal public health development and capacity building. She is passionate about strengthening AI/AN families and communities, with a focus on the promotion of well-being and resilience among AI/AN males.

### **David Johnson, MPH**

**Operations and Management Officer in the Office of Population Affairs (OPA),  
US Department of Health and Human Services**

David Johnson develops, executes, and reconciles the budget as well oversees the administrative operations for OPA. Additionally, he executes and oversees the Title X family planning service delivery grants. He is responsible for the program management of several National grant programs

administrated as part of the national Title X Family Planning Program, including the OPA National Training Systems.

Johnson also participates on several interdepartmental and public–private workgroups focused on expanding access to health care, educational, and employment services for males. Johnson is a performance management and budget lead within OPA and serves as a performance management liaison to other agencies within the Office of the Assistant Secretary for Health.

He joined OPA in January 2004. Prior to working in the Office of Family Planning, Mr. Johnson served as a public health analyst at the Office of HIV/AIDS Policy’s the Leadership Campaign on AIDS and in the Office of the Secretary’s, Office of Global Health Affairs.

### **Marsden McGuire, MD, MBA**

Director of Continuum of Care and General Mental Health,  
Veterans Health Administration Office of Mental Health and Suicide Prevention

Dr. Marsden McGuire serves as acting chief consultant in the Office of Mental Health and Suicide Prevention in the Department of Veterans Affairs (VA). Since March 2013, he has also served as deputy chief consultant for Mental Health Standards of Care, where he oversees national policy covering integrated care, recovery services, evidence-based therapies, and geriatric mental health. He has led several interprofessional collaborative teams within VA to ensure provision of high-quality patient-centered care that is safe, effective, accessible, and measurable.

Dr. McGuire received his medical training at the University of North Carolina and Johns Hopkins Hospital. He worked in academic psychiatry and the private sector before joining the VA in 2009. He is board certified in general and geriatric psychiatry, is a distinguished fellow of the American Psychiatric Association, holds academic appointments at Johns Hopkins and the University of Maryland, and received an MBA from Johns Hopkins in 2013.

### **Richard McKeon, PhD, MPH**

Chief for the Suicide Prevention,  
Center for Mental Health Services Substance Abuse and Mental Health Services Administration

Richard McKeon, PhD, MPH, received his PhD in clinical psychology from the University of Arizona and a master’s of public health in health administration from Columbia University. He has spent most of his career working in community mental health, including 11 years as director of a psychiatric emergency service and 4 years as associate administrator/clinical director of a hospital-based community mental health center in Newton, New Jersey. In 2001, he was awarded an American Psychological Association Congressional Fellowship and worked for US Senator Paul

Wellstone, covering health and mental health policy issues. He spent 5 years on the Board of the American Association of Suicidology as clinical division director and has also served on the Board of the Division of Clinical Psychology of the American Psychological Association.

He is chief for the suicide prevention branch in the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, where he oversees all branch suicide prevention activities, including the Garrett Lee Smith State/Tribal Youth Suicide Prevention, and Campus Suicide Prevention grant programs, the National Suicide Prevention Lifeline, the Suicide Prevention Resource Center, and the Native Aspirations program. In 2008, he was appointed by the Secretary of Veterans Affairs to the Secretary's Blue Ribbon Work Group on Suicide Prevention. In 2009, he was appointed by the Secretary of Defense to the Department of Defense Task Force on Suicide Prevention in the Military. He served on the National Action Alliance for Suicide Prevention Task Force that revised the National Strategy for Suicide Prevention and participated in the development of WHO's World Suicide Prevention Report. He is also the cochair of the Federal Working Group on Suicide Prevention.

### **LCDR Rashid Njai, PhD, MPH**

**Health Scientist for the Office of Noncommunicable Diseases, Injury and Environmental Health (ONDIEH)**

Dr. Rashid Njai supports the senior advisor for science of ONDIEH on cross-cutting science activities and opportunities in the area of noncommunicable diseases (chronic diseases, birth defects and developmental disabilities, injury, and environmental health).

Dr. Njai received his PhD and MPH in health behavior and health education from the University of Michigan and his BS in biology from Pennsylvania State University. He joined the CDC in 2008 as an epidemic intelligence service officer assigned to the Community Health Equity Branch in the former Division of Adult and Community Health.

He is a recognized leader championing work focused on the epidemiology of mental and physical health disparities among racial and ethnic minorities as well as other vulnerable populations, as they relate specifically to the social determinants of health, behavioral resiliency, and wellness. He recently received a Commendation Medal from the US Public Health Service in recognition of his exceptional leadership, subject matter expertise, and technical guidance in improving public health surveillance and research on social determinants of health from 2009 through 2015.

### **America Paredes, MS**

**Associate Vice President of Partnerships and Community Outreach, Mental Health America (MHA)**

America Paredes has more than 20 years of experience within the mental health field. In her current role, she leads the development of strategic alliances and partnerships aimed at leveraging MHA's experience and knowledge in addressing mental health as a critical part of wellness.

Her experience as a bilingual professional within the mental health field is wide ranging, including federal grant program oversight, cultural competency, community development, community engagement, and outreach strategies, specifically within multicultural and marginalized communities. Given her experiences, Paredes has extensive knowledge of the complexity that exists within the mental health field, including client- and community-based services, early intervention and prevention efforts, and recovery and advocacy initiatives. She has worked with community-based, state, and national organizations and leaders and the public to increase awareness of mental health. Furthermore, Paredes has led MHA's social media marketing and messaging, has facilitated various workshops, particularly within family systems and with multicultural populations, is a certified mental health first aid instructor, and has had experience within the crisis counseling field. She is a doctoral candidate, doctor of philosophy in human services, Capella University, Minneapolis, Minnesota, anticipated 2020, holds a master of science, counseling studies, graduation with distinction, Capella University, Minneapolis, Minnesota, and a bachelor of arts, psychology, George Mason University, Fairfax, Virginia.

### **Cheryl A Krause-Parello, PhD, RN, FAAN**

**Professor, Christine E. Lynn College of Nursing and Faculty Fellow, Institute for Healthy Aging and Lifespan Studies  
(I-HeAL), Florida Atlantic University**

Dr. Cheryl Krause-Parello's program of research examines the relationship between human–animal interaction and stress biomarkers in active duty military and veterans. Her research goals include implementing effective interventions to modulate the long-term effects of PTSD on returning active duty military and veterans. She is the founding director of a university-based health research initiative for veterans, Canines Providing Assistance to Wounded Warriors TM ([www.nursing.fau.edu/c-paww](http://www.nursing.fau.edu/c-paww)).

Dr. Krause-Parello's funded community engagement and research projects, peer-reviewed journal publications, and professional presentations at numerous conferences have garnered national and international accolades and media attention. Dr. Krause-Parello was inducted as a fellow in the American Academy of Nursing (AAN) in 2015. In 2017, she was recognized by the AAN as an edge runner for her nurse-designed model of care focusing on how health care providers may use the

human–animal bond to provide quality care to veterans and their families. Dr. Krause-Parello is an active member of the AAN Military and Veterans Health Expert Panel.

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

**Professor and Dean of Louisiana State University Health Sciences Center in New Orleans, LA  
School of Nursing;  
Founder, Editor-in-Chief, Journal of Men’s Health**

Dr. Demetrius Porche received his undergraduate 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. Dr. Porche earned a PhD from Capella University in organization and management with a specialization in leadership. He also holds an appointment in the School of Public Health at Louisiana State University Health Sciences Center.

Dr. Porche is certified as a clinical specialist in community health nursing and family nurse practitioner. He was the associate editor of the *Journal of the Association of Nurses in AIDS* for 10 years. He is the chief editor of *American Journal of Men’s Health*. Dr. Porche serves on the editorial board of *The Journal for Nurse Practitioners*. He served as president of the American Assembly for Men in Nursing for 2 terms.

Dr. Porche is a gubernatorial appointed member of the Louisiana State Board of Nursing. He serves as president of the Louisiana State Board of Nursing. Dr. Porche has chaired the Louisiana State Nurses Association Continuing Education Committee. He served at the national level on the Governing Council of the American Public Health Association and served as chair of the Public Health Nursing Section Development Committee. Dr. Porche also served on the Research Committee of the Association of Community Health Nurse Educators, Education Committee of the National Association of Clinical Nurse Specialists, and Doctoral Conference Planning Committee of the American Association of Colleges of Nursing, and served 2 terms as treasurer of the Southern Nursing Research Society.

**Anthony (Tony) James Roberson, PhD, PMHNP-BC, RN, FAANP**

**Director of Western Carolina University School of Nursing**

Dr. Tony Roberson serves as the chief academic officer for the school and provides the strategic and academic mission while serving as the leader for all programs of study. His previous academic appointments include service as administrator, educator, and clinician at the University of Miami

School of Nursing & Health Studies, University of Alabama, Capstone College of Nursing, and the University of Alabama at Birmingham, School of Nursing.

He has authored numerous publications and presented at national and international conferences in the area of his research and clinical expertise, adolescent psychiatric mental health. Dr. Roberson holds the certification as a Psychiatric Mental Health Nurse Practitioner (PMHNP) and has been intimately involved in the creation and implementation of PMHNP programs at various universities. He has a solid history of collaboration with the Veterans Administration, particularly in meeting the psychiatric mental health needs of those veterans who reside in rural areas. In addition, he has extensive clinical and research expertise within the juvenile justice system. Dr. Roberson is also a fellow of the American Association of Nurse Practitioners.

Dr. Roberson earned the PhD from the University of North Carolina at Chapel Hill, School of Nursing, the MSN (psychiatric mental health nurse practitioner) at the University of South Florida, College of Nursing, Tampa, Florida, and the ADN at St. Petersburg College, St. Petersburg, Florida. He also holds an MS in counseling psychology earned at Troy University and a bachelor's degree in piano performance from the University of Alabama.

### **Justin Sparkes, DO**

**Integris Baptist Medical Center**

Dr. Justin Sparkes is a board-certified internal medicine physician and a fellow of the American College of Osteopathic Internists. He is a graduate of Nova Southeastern University College of Osteopathic Medicine and completed his residency at the Osteopathic Medical Center of Texas, where he served as chief resident.

Dr. Sparkes lives in his hometown of Edmond, Oklahoma, with his wife, Elisa, and 2 children. Elisa is an OB/GYN at INTEGRIS Family Care Edmond Renaissance. In his spare time, he enjoys family time, hunting, fishing, and outdoor activities. Dr. Sparkes believes the roles people play in their lives affect their health and wellness. He strives to balance his patients' care with an emphasis on health maintenance and prevention.

### **Andrew Sperling, MA, JD**

**Director, Legislative and Policy Advocacy,  
National Alliance on Mental Illness (NAMI)**

Andrew Sperling has been director of legislative and policy advocacy at NAMI since 1996. In that role, he oversees NAMI's federal policy agenda in Congress and before federal agencies. He also

serves as a consumer representative to the National Association of Insurance Commissioners and as cochair of the Consortium for Citizens with Disabilities Housing Task Force. Andrew received his BA from Tulane University, his MA from The George Washington University, and his JD from Franklin Pierce Law Center. He was part of the successful passage of (1) the Medicare Modernization Act that established the Medicare Part D program, (2) the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, and (3) the Frank Melville Supportive Housing Investment Act.

### **David Sullivan, MPA**

#### **Public Health Training Coordinator, Southern Plains Tribal Health Board**

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 27 years. The focus of his work centers on systemic literacy, holistic thinking, systemic impact leadership, family/community strengthening, indigenous language revitalization, and partnership formation.

Sullivan has carried out this work in various capacities in Oklahoma and the nation through multiple grassroots community coalitions, the University of Oklahoma-American Indian Institute, the Anadarko Public Schools, and numerous partnership-based projects. He graduated from the University of Science & Arts of Oklahoma with a bachelor's degree in history/American Indian studies/political science and went on to the University of Oklahoma, where he received a master's in public administration. Sullivan serves as a governing board member for the Southwest Regional Educational Laboratory at the American Institutes for Research in Austin, Texas. He has been a federal consultant to American Indian tribes across the country for the past 19 years, providing support in social and economic development, indigenous language revitalization, and youth empowerment.

### **Ana N. Fadich-Tomsic, MPH, CHES**

#### **Vice President, Men's Health Network**

Ana Fadich-Tomsic serves as vice president at Men's Health Network (MHN), where she oversees outreach, promotion, and health education to men, boys, 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 in an effort to reduce health disparities and educate the consumer.

Fadich-Tomsic is actively sought out as a speaker and resource on men's health issues and sits on many advisory councils where a voice for the male patient is vital. She has been featured as an expert in many media outlets and has presented at the FDA Federal Government Agencies, American Public Health Association (APHA), corporate employer sites, and conferences. She is a contributing author for the international book *Sports-based Health Interventions: Case Studies from Around the World*, journal articles such as "The Economic Burden Shouldered By Public and Private Entities as a Consequence of Health Disparities Between Men and Women," published in the *American Journal of Men's Health*, and also contributes to white papers such as "A Framework For Advancing the Health of Men and Boys in America, a Position Paper Issued by the Men's Health Braintrust." Within APHA's Men's Health Caucus, Fadich-Tomsic serves as the caucus chair, increasing the physical presence of the Men's Health Caucus within APHA, advocating for more men's health research. Fadich-Tomsic holds a bachelor's degree in biological sciences from Mount St. Mary's University in Los Angeles, California, and a master of public health degree from the University of Southern California Keck School of Medicine.

### **Sara Traigle van Geertruyden, JD**

#### **Executive Director of the Partnership to Improve Patient Care (PIPC)**

Sara Van Geertruyden joined PIPC in January 2011 and also serves as a partner at the firm Thorn Run Partners. Her work is focused on policies to advance a patient-centered health system, from patient engagement in research to driving outcomes that matter to patients in health care payment and delivery.

Van Geertruyden is a health care and welfare policy expert with more than 20 years of experience. She began her career on Capitol Hill, working for former Senator John Breaux (D-LA) from 1996 until 2003, first as a project's assistant handling Congressional appropriations and advising constituents on the federal grant process and ultimately spending more than 3 years as a legislative assistant overseeing Senate Finance Committee issues for health and welfare.

In 2003, she joined the law firm Patton Boggs, where she practiced in the public policy group handling regulatory and legislative issues related to health care, welfare, and appropriations for clients. Van Geertruyden has represented clients including hospital systems, pharmaceutical companies, health care provider associations, and coalitions. Her scope of work in health policy combines expertise in working with all of the major health care agencies, including PCORI, the Centers for Medicare and Medicaid Services, and the Center for Medicare and Medicaid Innovation. Van Geertruyden received her bachelor's degree from Wake Forest University and earned her juris doctor at the Catholic University Columbus School of Law.

**Matthew (Matt) Von Zimmerman, MPH, ENS, MC, USNR**

**Medical Student (OMSIII), Lake Erie College of Osteopathic Medicine Bradenton**

Matt Von Zimmerman began his career at the University of Florida in Gainesville, Florida, where he earned his bachelor of science in chemistry with a specialization in biochemistry. After graduation, he enrolled in the University of Florida's College of Public Health, earning a master's in public health science and specializing in epidemiology.

While learning the public health sciences, depression, suicide, and substance abuse became a focus due to Von Zimmerman's belief in properly managed mental health being the most predicative of a healthy life. He traveled to Oklahoma to work as a substance abuse and mental health epidemiologist intern for the Southern Plains Tribal Health board and to Washington, DC, as a mental health epidemiologist for Men's Health Network (MHN). With the help of many contributors at MHN, he pursued researching and developing MHN's novel hypothesis for the need to implement a male-specific screening tool for depression, which he ultimately wrote and presented as his exit thesis.

Von Zimmerman is finishing his third year of medical school at Lake Erie College of Osteopathic Medicine in Bradenton, FL as an Ensign in the US Navy. Von Zimmerman looks forward to pursuing his interest in psychiatry during his third-year clinical sessions, rotating with various medical institutions.

**Richard Allen Williams, MD, FACC, FAHA, FACP**

**President and CEO, Minority Health Institute, Inc;  
Clinical Professor of Medicine, UCLA School of Medicine**

Dr. Richard Allen Williams was born and raised in Wilmington, Delaware, the youngest of 8 children. Upon graduating from Howard High School at the top of his class with a 4.0 grade-point average, he was awarded a full scholarship to Harvard University, from which he graduated with honors as the first African American student at Harvard from Delaware.

He received the MD degree from the State University of New York Downstate Medical Center, performed his internship at the University of California San Francisco Medical Center, internal medicine residency at the Los Angeles County-USC Medical Center, and cardiology fellowship at Harvard Medical School and Brigham and Women's Hospital in Boston.

Dr. Williams was an instructor in cardiology at Harvard Medical School, and while in this position he founded and directed the Central Recruitment Council of Boston Hospitals, which recruited significant numbers of black medical trainees to Boston hospitals for the first time in its history.

He then served for 3 years as the inaugural assistant medical director at the Dr. Martin Luther King, Jr Hospital in Watts, California, and was charged with the responsibility of opening the hospital. During this time, he and Dr. David Satcher collaborated on writing the grant proposal, which was awarded \$2.5 million by the National Heart, Lung, and Blood Institute of the National Institutes of Health to establish the King-Drew Sickle Cell Center, of which he became the director. Following this appointment, Dr. Williams took a position as chief of the Heart Station and Coronary Care Unit at the West Los Angeles VA Hospital, eventually becoming head of cardiology at that institution as well as the first black full professor in the history of the Department of Medicine at the UCLA School of Medicine.

### **Andrew L. Yarrow, PhD**

#### **Author**

Andrew Yarrow is a journalist, historian, and policy analyst; his new book is *Man Out: Men on the Sidelines of American Life*. He has been a *New York Times* reporter, a speechwriter in the Clinton Administration, and a US history professor at American University, and has been affiliated with several Washington think tanks, including the Brookings Institution and the Progressive Policy Institute.

Yarrow has published 4 books, writes frequently for many major media, and has worked or consulted for Public Agenda, Oxfam, the World Bank, UNICEF, the US Department of Education, and the Export-Import Bank. He lives in the Washington, DC, area.

# Appendix II

## Program Guide and Discussion Guide

<p><b>Event:</b> Behavioral Health Aspects of Depression and Anxiety in the American Male: Identifying Areas for Patient-centered Outcome-Oriented Needs, Practices, and Future Research</p> <p><b>Date:</b> Friday, May 10, 2019</p> <p><b>Time:</b> 7:30 AM-4:00 PM</p> <p><b>Location:</b> F Street Conference Center, 20 F Street, NW, Washington, DC 20001</p> <p><b>Facilitators:</b> Ana Fadich-Tomsic, Sara van Geertruyden, Dr. Sal Giorgianni, Dr. Jean Bonhomme</p>		
<p>This conference will focus on to the subpopulation of boys and men. Developing a dialogue by experts in various sectors of health, community, and research to examine the outcomes of existing screening tools and programs that can be used as a distinctive platform to better understand which approaches have produced positive and negative outcomes and to help organizations like PCORI craft and disseminate better, more gender-specific and socio-culturally optimized tools. It will also assist in identifying the programmatic failure, if there is failure, to identify depression, stress, and related mental health issues in males that may adversely affect intended outcomes.</p>		
<p><b>Conference Objectives</b></p> <ul style="list-style-type: none"> <li>• Determine the consequences of depression in the home, the community, and the nation as an area of significant need.</li> <li>• Review and evaluate existing tools and procedures that are adequate to identify mental health issues in males.</li> <li>• Identify the current clinical best practices for identifying male depression.</li> <li>• Highlight areas for further gender-specific research and protocols to address gaps in our current knowledge and tools.</li> </ul>		
<p><b>Friday, May 10, 2019</b></p>		
Timing	Activity	Lead
<p>7:30- 8:30 AM</p>	<p><b><u>Continental Breakfast</u></b></p>	
<p>8:30- 8:45 AM</p>	<p><b><u>Welcome</u></b> Welcome, opening comments</p>	<p>Ana Fadich-Tomsic</p>
<p>8:45- 9:00 AM</p>	<p><b><u>Introductions</u></b> Speaker panel overview</p>	<p>Dr. Salvatore Giorgianni</p>
<p>9:00- 10:30 AM</p>	<p><b><u>Defining the Problem</u></b> What do we know about prevalence, recognition, and management of depression in males? How is it the same/different in subpopulations such as youth, adolescents, young adults, elderly, and vulnerable populations?</p>	<p>Ana Fadich-Tomsic Sara van Geertruyden</p>

<p>10:35 AM-12:00 PM</p>	<p><b><u>Group Discussion</u></b></p> <p>Many abstracts in peer journals and news releases from researchers fail to provide gender stratification data up front.</p> <ul style="list-style-type: none"> <li>• Is this a problem in better identifying BH issues for boys and men?</li> <li>• What tools are available for screening depression in males?</li> <li>• Tool validity in males and subpopulations?</li> <li>• How do we assess their effectiveness?</li> <li>• How and by whom are their outcomes measured?</li> </ul>	<p>Ana Fadich-Tomsic Sara van Geertruyden</p>
<p>12:00-1:00 PM</p>	<p><b><u>Working Lunch/Presentation</u></b></p> <ul style="list-style-type: none"> <li>• Challenges facing boys and young men: depression and juvenile delinquency</li> <li>• Keeping veterans tethered to society: a community engagement approach</li> </ul>	<p>Anthony (Tony) James Roberson, PhD, PMHNP-BC, RN, FAANP Director, Western Carolina University School of Nursing</p> <p>Dr. Cheryl Krause-Parello, Florida Atlantic University PCORI Awardee</p>
<p>12:45-1:45 PM</p>	<p><b><u>Consequences of Male Depression</u></b></p> <ul style="list-style-type: none"> <li>• How are the clinical outcomes of properly managed depression measured?</li> <li>• How are the consequences of unrecognized and inadequately addressed depression measured             <ul style="list-style-type: none"> <li>○ In the clinical setting, home, and educational environment?</li> <li>○ In the workplace, in military/first responders, in the incarcerated, and in ALF residents?</li> </ul> </li> <li>• What are the direct and indirect consequences of clinical depression in males?</li> <li>• What is the link between depression and violence in at-risk males?</li> </ul>	<p>Ana Fadich-Tomsic Sara van Geertruyden</p>
<p>1:45-3:00 PM</p>	<p><b><u>Moving Forward</u></b></p> <ul style="list-style-type: none"> <li>• What outcome-oriented research is needed in these areas?</li> <li>• How do programs with successful outcome become adopted—what are drivers, what are impediments?</li> <li>• How to best disseminate information to stakeholders?</li> </ul>	<p>Ana Fadich-Tomsic Sara van Geertruyden</p>
<p>3:00-3:30 PM</p>	<p><b><u>Closing Comments and Next Steps</u></b></p>	<p>Dr. Jean Bonhomme</p>

## References and Further Readings

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<sup>xviii</sup> See bio in Appendix I.

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Graphic A Conventions for Generational Designations

Generation	Born Between Age Range in 2019	
Gen Z	1996-2012	7-22
Millennials	1981-1996	23-38
Gen X	1965-1980	39-54
Baby Boomers	1946-1964	55-73
Silent Generation	1928-1945	74-91

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