Canadian Institutes of Health Research | Instituts de recherche en santé du Canada

Canada

BEST BRAINS EXCHANGE REPORT

MASCULINITY AND MALE SUICIDE PREVENTION

The Canadian Institutes of Health Research
in collaboration with
The Public Health Agency of Canada, the Mental Health Commission of Canada, the Movember Foundation, and the Men's Depression and Suicide Network

CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

Public Health Agency of Canada / Agence de la santé publique du Canada

Mental Health Commission of Canada / Commission de la santé mentale du Canada

Movember Foundation – Changing the face of men's health

Men's Depression + Suicide Network

Evidence on Tap – Best Brains Exchange

THE WESTIN OTTAWA
GOVERNOR GENERAL III ROOM
OTTAWA, ONTARIO
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Table of Contents

vi. **Presentation #4: Some observations from the Antipodes – men's suicide prevention in Australia** by Dr. Susan Beaton, Independent Suicide Prevention Consultant, Australia

d. **Discussions**
   i. **Break Out Group Exercise/Discussion and Report Back** facilitated by Dr. Joy Johnson
   ii. **Plenary Discussion – Next Steps** facilitated by Dr. Joy Johnson
e. **Closing Remarks** by Dr. Joy Johnson

Appendices

A. Best Brains Exchange Agenda, September 22, 2016
B. Speaker and Presenter Biographies
C. Participants List
D. Best Brains Exchange Objectives Backgrounder (English and French)
E. List of references/recommended reading

1. Executive Summary

On September 22, 2016, the Canadian Institutes of Health Research (CIHR) in collaboration with the Public Health Agency of Canada (PHAC), the Mental Health Commission of Canada (MHCC), the Movember Foundation, and the Men's Depression and Suicide Network hosted a Best Brains Exchange (BBE) which brought Federal, Provincial and Territorial (F/P/T) decision-makers together with leading researchers, clinicians, survivors of suicide attempt or loss, non-governmental organizations, frontline providers, and other experts working in the field of masculinity and male suicide prevention. The BBE provided a platform for participants to discuss how the use of research and innovation in men's mental health may be accelerated through the identification of best practices for suicide prevention, and the promotion of the use of research and evidence-based practices across the suicide prevention continuum. The BBE provided the opportunity for continued partnerships, collaboration and innovation in order to prevent suicide in Canada, while respecting the diversity of cultures and communities that are affected by this issue.

Participants raised a need for Federal, Provincial, Territorial and regional policies in Canada that are specifically designed to support or coordinate research pertaining to health equity in suicide prevention strategies, especially those that are effective in addressing the unique and gender-specific needs of men and boys universally, as well as vulnerable sub-groups.

The BBE objectives were to:

1. Explore how governments, organizations working in suicide prevention, and health and social care providers can better address the gender-specific needs of men in both universal (population level) and targeted sub-population specific suicide prevention strategies.
2. Consider what key elements community-based suicide prevention interventions need to take into account to reduce suicide rates among men.
3. Begin to explore how to scale up and sustain effective men-centred interventions in diverse settings across Canada.
4. Identify areas for future research on masculinity and male suicide prevention.

Throughout the morning session experts provided an overview of suicide in Canada, identified current policy questions and challenges, and shared experiences and existing evidence of what works for men and male suicide prevention in several Canadian and international contexts. This included a comprehensive overview of the *From Soldiers to Civilians* program, and *The Dudes Club*. The afternoon session was dedicated to group discussions focused on the Canadian and international examples of community-based interventions that have been shown to be effective with other populations that could be built upon or applied to men-centred interventions in Canada. After considering various aspects of the male suicide prevention strategies in Canada and abroad, several gaps in prevention and postvention were identified, including:

1. community surveillance and ability to identify high risk indicators of male depression or suicidality
2. community information sharing/knowledge dissemination
3. resources and tools for individual, family or community response and recovery
    a. identification of key actors/stakeholders who can help guide communities

   b. training opportunities for healthcare providers, first responders, communities, others (e.g. Mental Health First Aid Training)
   c. evaluation tools for communities to monitor and evaluate and modify (as needed) community-based interventions
4. Federal, Provincial and Territorial strategies and guidelines, for:
   a. integration of men's mental health, depression and suicide prevention in policy frameworks
   b. access to means reduction
   c. scientific research procedures & protocol (including definitions, culturally appropriate and effective language and messaging in terms of masculinities, coding of determinants of suicidality)
   d. safe and effective messaging and promotion of men's mental health and programs
5. financial support and partnerships
   a. for research on men's mental health, depression and suicide prevention
   b. for scale up of interventions shown to be efficacious on a small scale
6. data management
   a. repository of reliable data
   b. increase the number of suicide and self-harm reporting tools – increase reporting of suicide and-self harm by first responders, etc.
   c. systematic evaluations of men-centred interventions in mental health, depression or suicide prevention (including providing communities the ability to evaluate their own programs)
   d. compilation of locations that provide access to means reduction programs
   e. means to increase information access for knowledge sharing
   f. ethical review (pre-established templates)

The BBE discussions will be summarized and shared with meeting participants in a BBE Report. This summary of discussions will inform PHAC's activities on suicide prevention and on related mental health and men's health issues. For example, research gaps identified during the BBE will inform the suicide prevention research priority setting project being undertaken by PHAC and the MHCC, as well as ongoing activities that support sharing evidence and best practices. In addition to the immediate outcomes described in the first scene setting presentation, this BBE is expected to inform future mental health policy or legislative processes that include gender consideration. This event will also inform the work of various groups across governments who work on mental health issues by raising awareness on the impact of masculinities on men's behaviors and attitudes, and highlight the gender specific needs of boys and men. It is also expected that this important event will promote the inclusion of men's health issues in decision-making discussions.

2. Best Brains Exchange Overview

a. Best Brains Exchange Program Overview

CIHR's mandate includes the creation of new scientific knowledge and enabling its translation into improved health, health services and products, and a strengthened Canadian health care system. Best Brains Exchanges are one-day, in-camera meetings that focus on Ministry/Health Portfolio-identified policy issues. Researchers and implementation experts are invited to BBEs to share high-quality, timely and accessible research evidence and engage in discussions with relevant policy makers and stakeholders. The BBE follows a deliberative dialogue model where a solution to a policy issue is not the intended immediate outcome, but rather next steps and recommendations are considered with the intention to move a policy issue forward.

b. Policy Background

On average, more than 10 Canadians die by suicide each day. In 2012, 3,926 Canadians died by suicide. Canadian males die by suicide at three times the rate of females. Within the context of male suicide, sub-groups of men experience disproportionately higher rates of suicide. Suicide is a significant men's health issue; yet it is not often publicly acknowledged or addressed as such. In order to effectively reduce male suicide in Canada, all levels of government, non-governmental organizations, health care providers, people with lived experience related to suicide, and researchers must work together to address this health inequity with suicide interventions that are effective for men. These strategies need to acknowledge and attend to the unique needs of men generally as well as vulnerable sub-groups of men.

c. Policy Context

The Government of Canada recognizes that suicide is a public health issue that affects people of all ages and backgrounds. It has devastating impacts on families and on communities. To address this issue, the Public Health Agency of Canada led the development of the Federal Framework for Suicide Prevention in collaboration with suicide prevention stakeholders across Canada. This framework aims to prevent suicide in Canada, through partnership, collaboration and innovation while respecting the diversity of cultures and communities that are touched by this issue.

The Government of Canada provides or funds mental health services for Canadian Armed Forces personnel, Veterans, current and former members of the Royal Canadian Mounted Police, First Nations and Inuit, as well as federally incarcerated individuals. The federal government is also investing in research and programs that focus on suicide prevention and that enhance mental well-being in communities, especially amongst the more vulnerable populations.

The federal government has also renewed an existing (since 1995) Government of Canada commitment to promote gender equality by formally integrating gender-based analysis to all policies, programs and research. As such, the Health Portfolio renewed its Sex and Gender Based Analysis (SGBA) policy in 2015. In addition, the Auditor General recently released a report on GBA implementation, which calls for more comprehensive monitoring of a GBA application by departments; and the Privy Council Office has also committed to the development of a checklist that consolidates policy considerations including gender and other social, economic and

demographic priorities.

d. Best Brains Exchange Objectives

The BBE allowed participants to:

1. Explore how governments, organizations working in suicide prevention, and health and social care providers can better address the gender-specific needs of men in both universal (population level) and targeted sub-population specific suicide prevention strategies.
2. Consider what key elements community-based suicide prevention interventions need to take into account to reduce suicide rates among men.
3. Begin to explore how to scale up and sustain effective men-centred interventions in diverse settings across Canada.
4. Identify areas for future research on masculinity and male suicide prevention.

e. Meeting Participants

The BBE was organized by CIHR in collaboration with PHAC, MHCC, the Movember Foundation and the Men's Depression and Suicide Network to engage F/P/T policy makers, with national and international researchers, clinicians, survivors of suicide attempt or loss, suicide prevention practitioners and other key stakeholders (see Appendix C for Participant List).

f. Format of the Best Brains Exchange

The BBE was organized to encourage active participation or participants throughout the day. The morning was dedicated to presentations that highlighted the role of public health research in men-centred suicide prevention strategies, and explored policies and interventions from Canada and around the globe. Opportunities for participants to pose questions to the presenters were built into the agenda. The afternoon session was dedicated to group break out and plenary discussions that focused on future research and recommendations for effective men-centred suicide prevention interventions for diverse male populations across Canada.

3. Summary of the Best Brains Exchange Meeting

a. Welcoming Remarks by Dr. Joy Johnson, Vice President, Research, Simon Fraser University

On behalf of the organizing committee, Dr. Johnson welcomed participants to the BBE. Participants were provided an overview of the BBE program and its objectives, and were reminded that the desired outcome of this BBE is not an immediate solution to policy and program issues; rather, it is intended to bring decision-makers, researchers and those affected by men's suicide together to share evidence specific to men and vulnerable sub-groups of men, as a means to thoughtfully consider male suicide prevention policy and programs.

b. Roundtable of Introductions, Overview of the Day & Review of Objectives facilitated by Dr. Joy Johnson

Following a quick tour de table where participants introduced themselves and their respective organization, Dr. Johnson gave a brief overview of the day's activities. Dr. Johnson encouraged

discussions that would achieve the BBE objectives (please see section 2d. Best Brains Exchange Objectives). Participants were also reminded that this event was in-camera and that no attributions were to be made outside of this meeting in order to ensure participants were comfortable sharing their views.

c. Presentations

i. **Scene Setting Presentation: Overview of suicide in Canada and explanation of current policy questions/challenges** by Ms. Marie-Pierre Jackson, Director, Population Health and Innovation Division, Public Health Agency of Canada; Ms. Isabel Giardino, Manager, Population Health and Innovation Division, Public Health Agency of Canada; by Mr. Ed Mantler, Vice-President, Programs and Priorities, Mental Health Commission of Canada; and by Mr. Paul Villanti, Executive Director, Movember Foundation

Ms. Marie-Pierre Jackson opened the presentation on behalf of PHAC. Ms. Jackson provided some context about suicide in Canada, including an overview of suicide rates, risk factors and protective factors associated to suicide, and identifying vulnerable populations in Canada. Approximately 4,000 Canadians die by suicide each year. For every suicide death there are many more suicide attempts. The impact of a suicide death is profound, with a minimum of 7 to 10 people affected by each loss.

Suicide is a significant issue across the lifespan and can impact anyone regardless of age, background, gender or socio-economic status. Among children and youth (10 to 19 years) and young adults (20 to 29 years), suicide is the second leading cause of death. Thoughts of suicide and suicide-related behavior are disproportionately prevalent among LGBTQ youth. Males account for 3 in 4 suicide deaths among adults, with the highest suicide rate among middle-aged men (45 to 59 years). Among seniors (65+ years), males account for 80% of suicides. Other segments of the population that have higher rates of suicide include some First Nations and Métis communities, all Inuit regions, individuals who are Federally incarcerated, and survivors of suicide loss and suicide attempt.

Ms. Jackson invited Ms. Isabel Giardino, Manager of the Population Health and Innovation Division at PHAC to present on some of the federal initiatives in suicide prevention, and review current policy questions on suicide prevention. Ms. Giardino highlighted that the risk of suicide can be mitigated by building resilience by strengthening protective factors, instilling strong self-esteem, creating healthy relationships, cultural identity, and learning and having the ability to apply adaptive coping and problem solving skills. PHAC is working with the MHCC and other key stakeholders to identify, organize and present data on positive mental health outcomes and protective and risk factors.

Individual behaviours and experiences associated with positive mental health include participation in physical activity and exercise and adult drinking habits staying within the low risk alcohol drinking guidelines. Healthy family relationships and strong ties to a community provide an important foundation for positive mental health. At the societal level, factors such as discrimination and stigma are related to lower positive mental health. While social isolation is a key suicide risk factor, social support helps to increase resilience and positive mental health. Adults who feel loved and cared for, have a network of family, friends, neighbors, co-workers or community members that offer support in times of need are more likely to report being happy, have high psychological well-being, report high life satisfaction, report a strong sense of belonging, and report their mental health as 'very good' or 'excellent'.

The Government of Canada plays an important role in suicide prevention, by supporting programs that improve mental health and well-being and prevent suicide, conducting surveillance on suicide, and conducting and funding research to better understand suicide. The Federal government also funds some mental health services for specific populations, including indigenous people living on reserve or in Inuit communities, serving members of the Canadian Armed Forces, Veterans, current and former members of the Royal Canadian Mounted Police, newcomers, and federally incarcerated individuals. The Federal public health activities focus on the most vulnerable populations and are aimed at all ages and life spans. PHAC has a specific focus to promote mental health and wellbeing by supporting programs that build resilience in individuals and communities to help overcome adversity. Examples of PHAC-led activities include, the Innovation Strategy, the Federal Framework for Suicide Prevention, setting a suicide prevention research agenda, and data collection on the mental and emotional health of youth through the *Health Behaviour in School Aged Children Survey*. In the context of the Federal Framework for Suicide Prevention, the Federal government is taking action related to the objectives of the Framework to: (1) reduce stigma and raise public awareness, (2) make information and resources about suicide and its prevention available to all Canadians, and (3) increase the use of research and best practices.

PHAC and MHCC have launched a project aiming to identify research priorities for Canada that will meet the needs of communities, frontline providers and decision makers, and facilitate knowledge uptake, particularly among populations that have higher rates of suicide. Understanding and preventing suicide in Canada requires information from multiple, reliable sources. As such, PHAC shares information and expertise across federal departments on suicide-related surveillance data and works with a number of Federal departments that serve specific populations, collect data on suicide and conduct research related to mental health and suicide prevention. PHAC is currently exploring activities to enhance its suicide surveillance system to improve timeliness and quality of existing data, optimize use of data through data linkages, and advance use of networks and emerging data sources. The United States Substance Abuse and Mental Health Services Administration (SAMHSA), PHAC and MHCC will be co-hosting a series of webinars on advancing comprehensive community suicide

prevention. This series aims to disseminate comprehensive models of community suicide prevention based on the best existing evidence and drawing on experiences from across the globe. These webinars build on the *2015 Community Action for Suicide Prevention Match*, led by the *International Initiative for Mental Health Leadership (IIMHL)*. This meeting raised several needs including sharing the meeting findings with a broader group of international stakeholders interested in suicide prevention, and the development a blueprint for community action on suicide prevention. IIMHL is a unique international collaborative that focuses on improving mental health and addictions services. This initiative is a collaboration of eight countries: Australia, England, Canada, New Zealand, Republic of Ireland, Scotland, USA and Sweden.

Prior to finishing her presentation, Ms. Giardino raised several policy questions that may be discussed or kept in mind throughout the course of the day at the BBE, including: (1) What are the best or promising practices for suicide prevention? (2) How can we improve understanding and uptake of evidence-based approaches for suicide prevention? (3) What are the factors that protect against suicide across the lifespan? (4) How can we better understand research at the national, provincial, territorial and regional levels?

Following the PHAC presentations, Mr. Ed Mantler was invited to discuss the work of the MHCC. Mr. Mantler opened his presentation by recounting his personal experience with suicide and David, a former colleague at a Canadian mental health hospital, who died by suicide. This story highlighted the profound personal impact of this loss. It also demonstrated that while some interventions for suicide prevention are working, the system has gaps and more needs to be done to fill them. In 2015, a group led by MHCC developed various community-based interventions for suicide prevention in Canada. The community-based approach aimed increase community awareness, builds the response skills of responders, and identify the risk factors specific to communities. This approach has been successful with a focus on vulnerable populations – specifically middle-aged men.

Mr. Mantler emphasized the current need for commitment by all stakeholders to support the interventions that are effective and the work of communities that face heightened vulnerability to suicide. This BBE is an opportunity to illuminate the issue across Canada, engaging government officials, policy makers, community leaders and others, and identifying the programs that are working and those that may be scaled up.

Dr. Johnson thanked Mr. Mantler for his moving remarks and invited Mr. Paul Villanti to present on behalf of the Movember Foundation, a men's health charity that was founded in Australia in 2003. The Movember Foundation is heavily invested in prostate cancer research, and added a mental health focus in 2006. The Foundation began investing in men's health initiatives in Canada in 2013. The Foundation is a catalytic funder with a lens of making sure that investments are made in programs that are sustainable and scalable across populations. The Foundation invests in high risk

new ideas that focus on prevention and early intervention, and have the potential to scale across systems. This is a challenge in that there are only a few mechanisms in place to take funded ideas to the next level (scale up).

The Foundation has noted trends in men's mental health research, particularly, that knowledge of men's mental health is locked in silos, which creates difficulties in identifying the programs that are effective, and generating a significant amount of duplication in research efforts. In an effort to bridge this gap in research, the Foundation explores men's experiences with suicide and mental health, and use of mental health services. The Foundation found evidence suggesting that men have difficulties in dealing with transition points in their lives, and aim to identify the interventions that will give men the skills they need to manage these times. Overall, the Foundation feels that interventions must be designed with a men-centered focus, as men and women not only process life's transitions and issues differently, but also engage health services differently. The logistics of interventions must be designed through a gendered lens. For instance, the language used in the promotion and implementation of mental health interventions should consider masculinities. For example, language implying vulnerability should be avoided, such as the word 'help'. Rather, action-based and sense of control are perceived to be more masculine and more relatable to men when engaging mental health services. Additionally, the Foundation found that it is important to bring community-based mental health services to men where they are within their community (for example, outreach through workplace programs and online environments as opposed to medicalized settings).

Prior to ending his presentation with a short video that was launched on International Suicide Day, Mr. Villanti highlighted that we need to harness the positive aspects of masculinity and build on these strengths. This BBE provides an excellent opportunity to answer the question of how we may build on positive mental health and strengths in a way that leads to healthier behaviours.

ii. **Scene Setting Presentation: Situating masculinities in male suicide and targeted prevention programs** by Dr. John Oliffe, School of Nursing, University of British Columbia & Founder and Lead Investigator, Men's Health Research Program; and Dr. John Ogrodniczuk, Department of Psychiatry, University of British Columbia, co-lead Men's Depression and Suicide Network

Dr. John Oliffe shared a presentation that situated masculinity in the conversation of suicide prevention in Canada. Rather than thinking of suicide prevention as a gender mainstreaming issue, Dr Oliffe suggests it should be seen as a men's health issue. Mental health researchers should discuss what men do to prevent suicide. In a recent intervention at the Men's Health Research Program, there was plurality in men's narratives: injury, interiority and isolation. Patterns of abandonment and the position of injury impact how men move forward with managing their mental health.

Internalizing the injury (interiority) gives men the time to think about the abandonment, and figure out how to manage the injury. When men know that they are likely to attempt suicide, they have the inability to see hope or way to get out of the depression. Despite the feelings of isolation and inability to self-manage during these difficult times, a lot of the men involved in the research program were surrounded by many people, they had jobs, and a community. Dr. Oliffe stressed that community-based programs are needed to deliver the support necessary to reduce feelings of social isolation and bring men together to share their challenges during difficult times.

The epidemiology of suicide is an important issue to address. There is a need for a baseline, as suicide has been underreported. This BBE provides everyone the opportunity to think about what is unique to specific populations of men, to life up principles that can appeal to all men in suicide prevention.

Following up on Dr. Oliffe's presentation, Dr. John Ogrodniczuk proceeded to discuss the discord between low rates of male depression and high rates of male suicide, highlighting the challenge to address the discord and pathways to self-harm and suicide. The variety of ways in how men express their distress makes it difficult to routinely monitor risks or indicators of depression. This diversity among men who have a great likelihood of experiencing depression demonstrates the need to engage these populations in the design, implementation and evaluation of solutions. Dr. Ogrodniczuk noted that the website, www.headsupguys.org, is an example of an anonymously accessed service that is brought to where men are, and serves as a conduit to increase men's ability to self-manage and improve health literacy among men – addressing two major issues among men: high self-stigma in perceiving mental issues as a weakness, and low literacy in male depression.

A discussion period ensued and focused on the following themes:

Postvention - Participants noted the importance of incorporating postvention (including bereavement and grief solutions) into the male suicide prevention circle, as this is very different than women's experiences.

The Injury Model - The Injury Model presented by Dr. Oliffe is an approach which takes solutions from a clinical treatment and medicalized environment to the community level. It was noted that prevention has been modeled the same way as infectious disease – to protect people against suicide. Some participants stressed that they were wishing for a move to the injury model whereby suicide would be presented the same way as chronic diseases, with the focus across the lifespan starting from childhood and including protective factors. In this case, the rehabilitation sciences would need to be incorporated into the solutions, with physicians dealing with injury to not only repair but to manage life post-injury. To make this work, the relationship between medicalized and the social

determinants of suicide and men's health must be explored further – especially among Indigenous peoples and vulnerable populations who are at heightened risk.

Reflection on gender and masculinity - Participants highlighted the need to focus on our changing reflection of gender and the conforming ideas of gender. Participants discussed how solutions can be men-centred without being considered women's social exclusion. Participants also raised the outstanding need to establish clear and safe messaging and support of men's health without going into the men's rights discourse that can places blame on feminism for being a source of men's poor health and creating barriers to services for men. A participant noted that this must be viewed as a discussion of the breadth of men and how they express themselves in diverse ways. Participants agreed that interventions, when designed, should consider how masculinity is expressed in a variety of ways as some men want to conform to traditional gender norms, whereas others openly choose to violate traditional norms associated with masculinities.

Language and terminology – Participants noted that defining masculinities and male-centred terminology, and using plain language or metaphors that are appropriate and relatable to diverse sub-populations of men is an essential component in the design, implementation and evaluation of male suicide prevention programs.

Linkage to care – A participant reminded the group that each case of male depression and suicide is unique which makes it difficult to make sense of the reality of those men as individuals and their individual lives and experiences with depression. It was also mentioned that over half of serving members of the Canadian Forces who died by suicide were in care. This demonstrates the need for interventions that understand and address issues, such as1) why those in care perceived suicide as an option? And, 2) why were half of these serving members not in care?

Bringing interventions to men – Building on Dr. Ogrodniczuk's presentation, a participant highlighted the potential in interventions that provide solutions to men. It was noted that most men have a 'wait and see' approach. In addition, men-centered interventions should not be presented as "psychotherapy" (or peer-support or group therapy) as these terms may discourage men from participating. However, once they participate, men enjoy and derive benefits from these activities. This statement was raised by other participants throughout the day. Using tools like virtual reality and Internet-based solutions have the potential to be far-reaching and largely impactful; however, the face-to-face involvement of interventions has proven to be successful in the area of male suicide prevention in Canada.

iii. **Presentation #1: Group Action Based Therapeutic Approaches for Working with Male Clients** by Dr. Marvin Westwood, Counseling Psychology, University of British Columbia

Dr. Marvin Westwood's presentation *From Soldiers to Civilians* highlighted a successful group-based model for men's behavioural change. Similar to the issues captured during the discussion period that followed the Scene Setting Presentations, Dr. Westwood confirmed that in his clinical practice and research, gender issues are found to be critical drivers in both men's suffering and in their healing. Post-Traumatic Stress Disorder (PTSD) and trauma are gendered experiences. He also mentioned that health-seeking behaviors are also found to be largely gendered and rooted in traditional gender norms. Men with high conformity to gender norms are less likely to seek therapy, and more likely to drop out early. Only 1 in 7 men seek help, compared to 1 in 3 women. The attributes and characteristics of traditionally socialized men include norms of toughness, intensity, strength, competition, discipline, courage, sacrifice and aggressiveness. The commodification of masculinity involves the hegemonic ideal and abject identity whereby men feel they have failed the attributes associated with masculinity, thus resulting in shame, silence and isolation. The abject identities are often associated with high self-perceived stigma, making it difficult for men to reconcile who they thought they were – that is, someone who provides assistance to others – to the man they actually are – someone who needs the help of someone else.

The personal conflict between the hegemonic ideal and abject identities of masculinity is often observed in men who suffer from PTSD and depression. Men suffering from PTSD and depression often experience feelings of helplessness, hopelessness, emotional hijacking, and hypo/hyperarousal when they perceive themselves to fail in mastering their environment, thoughts, emotions, and physical body – traditional masculine gender norms. There is a negative association with these abject identities and the mental health services that are available to support men who experience PTSD and depression.

A gender relevant design is essential to the success of male-centred, suicide prevention interventions such as the *Veterans Transition Program (VTP)*, which starts by focusing on strengths to establish cultural safety and social cohesion, leveraging gender relevant values, language and metaphors, and combining talk with action. Together, men learn CPR for their relationships: to **C**larify the story by listening carefully and with curiosity and check out what you think you heard from others, **P**araphrase and identify personal and probably impact and content, and **R**espectfully resist giving advice or moving the conversation to themselves.

Theoretically, engagement in therapy involves rewriting of masculine social norms to include participation and a broader range of emotion as a badge of male pride. The *VTP* faced difficulty in recruiting participants at the study onset. However, once the recruits started to participate, a snowball effect occurred as participating soldiers recruited others. The soldiers were screened and selected to perform in a play that was written and performed by them. The soldier archetype is

difficult, and the benefits of theatre, public speaking and performance are social interactions that engage them in their community in a different light.

The therapeutic gains from soldiers performing in a public sphere are significant, demonstrating that with the right conditions for men to engage in therapy, they will dig deep and work hard to make therapy effective. Over 79% of soldiers in the VTP who reported frequent suicidal thoughts at baseline did not have frequent suicidal thoughts at 18-month follow-up. The program also saw a 62% increase in veterans with no suicidal thoughts from baseline to 18-month follow-up. Veteran participants reported a 65.2% decrease in severe depression from baseline to 18-month follow-up. These data demonstrate how creative group therapy can be effective in terms of men who are helping each other, something that has proven successful in similar programs with civilian men across the lifespan.

Following Dr. Westwood's presentation, participants were invited to participate in a discussion period. The majority of the discussion was centered on how programs such as the *VTP* get past the stigma of non-traditional masculine identity. Programs such as the *VTP* leverage a masculine action-oriented process that focuses on doing, rather than talking. The program focuses on physical engagement such as role-play or acting, as opposed to talking from the onset. Through this form of engagement, the soldiers are taught the skills to talk and share. Shame often silences soldiers, but the group brings the soldier out of this state.

iv. **Presentation #2: The DUDES Club: An Innovative Model for Indigenous Men's Health Promotion** by Dr. Paul Gross, Clinical Assistant Professor, Department of Family Practice, Faculty of Medicine, University of British Columbia

The DUDES Club was established in 2010 at the Vancouver Native Health Society (VNHS). The DUDES Club is an innovative model for Indigenous men's health promotion that aims to build solidarity and brotherhood between the members of the group, to promote men's health through education, dialogue and health screening clinics, and to enable men to regain a sense of pride, purpose and fulfillment in their life. In Vancouver, a group of 50-60 men meet biweekly to participate in organized activities such as sharing a meal, getting haircuts, playing poker and bingo, participating in hockey pools, sharing stories, using the Internet and watching sports on television. Each meeting has opening and closing remarks with Musqueam Elder Henry Charles. A Public Health nurse, Clinical Counselor, and a Social worker are available and participate in men's health discussions.

The second project of the Men's Depression & Suicide Network (MD&S-Net) consisted of three phases: (1) a program evaluation of the Vancouver DUDES Club, (2) support the establishment of

pilot sites in Northern BC, and (3) development of an online toolkit. The project was designed with a participatory/collaborative approach using mixed methods and a logic model evaluation framework. The mean age of the Dudes Club participants was 46.8 years, with 77.3% of men over the age of 40 years. Findings from the program evaluation revealed that 64% of men experienced unstable housing in the past month, 56% were unemployed in the past six months, and 40% of the projects' participants volunteer more than 10 hours a week. Only 11.4% of the men were married. Over fifty-eight percent of men have children; however, only 4.5% of the men have children currently living with them in the same dwelling.

Overall, the vast majority of participants of the DUDES Club feel satisfied or very satisfied with the program (97.3%), and feel that it is a very safe environment to connect and share (74%). Ninety-two percent of the men find the health presentations helpful or very helpful. With consistent attendance, the men were found to have improved quality of life, mental health benefits and health confidence. Indigenous men derived particular benefits from the DUDES Club, including increased trust in people, greater social/peer support, and connection to heritage and culture.

The success of the DUDES Club starts with relationships and emphasizing the role of elders, building trust and cultural safety. The hierarchy of the traditional medical model is flattened in the program design, and the healthcare providers who are involved exhibit and nurture cultural competence and safety, knowing how to connect with the men, providing support to navigate the healthcare system. The program is community-driven, highlighting the importance of peer champions, and flips the paradigm of accessibility and help seeking, creating land based retreats and activities that are non-threatening and engage Indigenous communities. Adjustments of parameters for evaluation must be continual and focus on maintaining a program that is sustainable and scalable for future generations.

Following Dr. Gross's presentation, participants highlighted some key policy and program considerations:

Funding – Overall, participants felt that further dedicated funding in mental health for boys and men's health is needed in order to operate successful programs in a sustainable manner.

Community-based approach – A participant reminded the group that comradery and community is essential to ensure feelings of safety and trust in programs. Therefore, programs must be community-driven. Further, community and key leader buy-in is essential. When communities are interested in the program or model being proposed, and see how men's health has been neglected, they can harness the community strengths and decide what they want to do and what best fits their community.

Bridging the gap – A gap was identified between the medicalized, formal healthcare system and community programming for suicide prevention and postvention. Participants felt that the barrier needs to be removed so that the lines to health and community services are no longer in isolation of one another. When survivors of suicide attempts are released from hospital wards they and their family, friends, colleagues and those impacted by the suicide attempt should be connected with support programs within their community.

Discourse across the lifespan – It was noted that all discourse need to include rural and urban indigenous populations, and attract younger men and youth in addition to older men. For example, the community elders do recruit and encourage young men to participate in the DUDES Club in Vancouver. Nonetheless, a youth gap persists, especially regarding male youth-centered programs that combine modern art forms offered through traditional means. Participants mentioned that they feel that it is difficult to secure funding that falls between pediatric and adult programming in Canada.

Cultural competence – Participants stressed that programs should be based on community-specific and traditional ways of connecting, employing language that is meaningful and resonates with local populations. The individuals who facilitate the programs need to be culturally competent in their engagement and approach to crafting and delivering community-, culture- and gender-sensitive health and wellness information. A participant provided the example of female health professionals who are aware of gender differences and use men-centered approaches in their interventions with men.

v. **Presentation #3: What will it take? New perspectives on suicide prevention for gay and bisexual men** by Dr. Olivier Ferlatte, Post-doctoral Research Fellow, Men's Health Research program, University of British Columbia

Dr. Olivier Ferlatte provided a comprehensive overview of the rate of suicide in gay, bisexual and queer men (GBQM), who are 2 to 5 times more likely to report lifetime suicide attempts compared to heterosexual men. In Canada, evidence suggests that the lifetime suicidality is 25.2% among gay men, 34.8% among bisexual men, and 7.4% among heterosexual men (Brennan et al, 2010). In his own research, Dr. Ferlatte found that among GBQM, the lifetime prevalence of suicide ideation and attempts were respectively 49.9% and 17.0%. Within the last 12 months, prevalence was 17.0% for ideation, and 1.7% for attempts (Ferlatte et al. 2015).

Providing examples from the *Man-Up Against Suicide* and the *Sex Now Survey*, in his presentation Dr. Ferlatte explored the factors that promote suicide among GBQM and the opportunities for intervention, how successful and promising initiatives may be scaled up, and identified some of the

ways to respond to the suicide epidemic affecting GBQM. Most notable, Dr. Ferlatte found that stigma and marginalization are contributing factors to recent suicide attempts, as Canadian gay and bisexual men who had recent suicide attempts faced increased verbal and physical violence, bullying, sexual violence and workplace discrimination. Cumulative psychosocial and health problems, socio-economic status, Indigenous and ethnic status, and partnership status also have a significant correlation to recent suicide attempts.

The research findings of Dr. Ferlatte suggest a pressing need to apply a holistic approach to tackle the diverse forms of homophobia, stigma and marginalization and other psychosocial and health problems experienced by gay and bisexual men. In addition, Dr. Ferlatte highlighted the need for an intersectional approach in developing and implementing suicide prevention interventions that will be effective in meeting the needs of the most vulnerable sub-populations of GBQM.

Key themes that emerged in the discussion that followed Dr. Ferlatte' presentation included:

Reflection of gender and masculinity – Participant discussed that a lot of GBQM are fluid and do not measure themselves by binary definitions of being more masculine or feminine, or falling into gender stereotypes. Many view themselves as not being born as either a man or a woman. On the other hand, other men have internalized feelings of gender and reject the idea of fluidity, which generate negative stereotypes and feelings of shame. These comments highlighted the complexity of the issue and reinforced the need for suicide prevention programs to be tailored specific to the community and populations' needs. There is no 'one size fits all' approach.

Intersectionality – Participants noted that we must work together and form alliances that include all groups of men who have been traumatized, including especially those who do are reluctant to speak up. Participants felt that it is important that we not concentrate on the diversity and label the men who have been more affected, as this is not a comparison.

vi. **Presentation #4: Some observations from the Antipodes – men's suicide prevention in Australia** by Dr. Susan Beaton, Independent Suicide Prevention Consultant, Australia

Dr. Susan Beaton, Suicide Prevention Consultant, provided insights into men's suicide statistics, reasons for gender disparity, correlates of suicide in men, and treatment and prevention programs and policies in Australia. Throughout her presentation Dr. Beaton highlighted how psychological and cultural realities and demands on men's lives must be understood to act on what we know, and continue to build on this knowledge base to address the large gender disparity in suicide in Australia and around the globe.

From the 1970s to the 1990s Australia experienced a rapid increase in suicide among young men between the ages of 20 and 34 years. As a result, the First National Youth Suicide Prevention Strategy (NYSPS) was developed from 1995-1997. Key health and social service providers for young people were resourced to implement and integrate youth suicide prevention programs. In 1998, the focus of this strategy broadened across the lifespan and became the National Suicide Prevention Strategy (NSPS) and Living Is For Everyone (LIFE) Framework. Since the development of this national legislation, Australia has experienced a sharp decrease in suicides among young men.

In 2010, the Senate Inquiry into Suicide in Australia put forward 42 recommendations, of which, one specifically focused on an increase in the funding and number of projects targeting men at greater risk of suicide, which the Commonwealth responded to with an increase in funding for Suicide prevention. The Mental Health: Taking Action to Suicide (TATS) package commenced in 2010-11 whereby 274 million in funding was committed over a four-year period, of which $23.2 million was targeted towards men who are at greatest risk of suicide but least likely to seek help. More targeted crisis support services, workplace programs, and anti-stigma and help seeking campaigns were developed to better support men.

In recent years there has been an increased focus on the lived experiences of suicide, qualitative research, and inclusion of peers in service delivery. The *Men's experiences with suicidal behavior and depression* project was launched in 2014 with the aim to understand men's experiences with depression and suicide, and what contributes to taking action, or not taking action, during a suicidal crisis. The project found the most common risk factors and common pathways leading to suicidal behavior among men experiencing suicidal thoughts or behaviors included depression or disturbed mood, beliefs and personal values with strong emphasis on masculinity and stoicism, stressful life events, and a tendency to withdraw or avoid problems. Awareness of these patterns of risk factors associated with suicide are important because they provide a guide for when and how to interrupt suicidal behavior, and what warning signs may look like.

Dr. Beaton noted that accurately interpreting the risk factors associated with suicide and behavioural change is critical to interrupting suicide in men. Therefore, there is a pressing need for public education for men and their families and friends. In addition, health professionals and allied service providers play a critical role in interpreting risk factors and in preventing suicide. Professional assessments and interventions should address not only suicidal behavior, but also the core contributors to suicidality, including depression or unhealthy masculine beliefs.

Various initiatives are underway in Australia, which aim to reduce suicide rates in men. A Male Depression Risk Scale (MDRS-22) is in development and a preliminary validation stage, which may assist professionals in furthering their assessment of depression in men. Other comparative studies are exploring the experiences of symptoms of depression between men and women. Surveillance

efforts have increased, with accurate, reliable and timely data one suicide and suicidal behavior being made available. The Australian Bureau of Statistics revision process (since 2006) and the National Committee for Standardized Reporting on Suicide are pushing toward better surveillance mechanisms for suicide attempt behavior, such as the creation of standardized nomenclature, unified Police Forms. Other research explores the role of masculinity in men's help seeking for depression. Evidence suggests that men find it difficult to recognize and communicate symptoms of depression, masculine norms like stoicism conflict with depression, heighten self-stigma, and inhibit help-seeking and reinforce maladaptive coping styles. Interventions such as *Ten to Men* and *Mates in Construction* are examples of suicide prevention programs that are collaborative, involve action-oriented problem solving, and reframe a more fluid masculinity to integrate depression and boost help seeking.

According to Dr. Beaton, the success of suicide prevention policies and programs, and the sharp decrease in suicide in men in Australia is largely contingent on several factors:

- The National Strategy adoption and implementation applied in all of Australia.
- Australia has a Centre for Excellence, a centralized hub to govern funding, policies and programs.
- There has been genuine collaboration of men, capturing voices of lived experience across the lifespan.
- Peer workforce has been considered.
- The workplace has been used as a setting to access men, offering workplace wellbeing and mental health programs specifically targeting men.
- There has been a universal definition and expansion of masculinity and men's roles, relationships and possible identities.
- Interventions focus directly on suicide and the suicidal narrative (e.g. CAMS).
- There has been improved depression diagnosis and treatment for men including use of gender sensitive scales and measures.
- Support services have been developed for men who are experiencing significant life stress, especially relationship breakdown, employment and financial problems.
- Routine depression and suicide screening is being used.

d. Discussions

i. **Break Out Group Exercise/Discussion and Report Back** facilitated by Dr. Joy Johnson

The Break Out Group session provided participants with the opportunity to discuss the development, evaluation and implementation of interventions for suicide prevention. Groups were

asked to consider promising/best practices in suicide prevention, including identifying interventions that have been successful in Canada and abroad. While looking at promising/best practices, groups were also asked to identify examples of community-based interventions that have been shown to be effective with other populations that could be applicable to men-centred interventions. Finally, the groups were asked to explore interventions that are specific to vulnerable sub populations, including for LGBTQ, military/veterans, and indigenous communities, and how interventions address the main risk and protective factors associated with suicide for boys/men across the lifespan.

Promising/best practices

In considering vulnerable populations, groups identified interventions that cover the whole spectrum of services, systems and human and financial resources involved in suicide prevention, including:

Training for primary and mental healthcare providers – In all aspects of suicide prevention, participants agreed that care providers must focus on behaviour that people want to change – from suicidal thoughts or behaviours. Participants felt that family doctors/general practitioners must be given the tools to help open dialogue between themselves and patients. Health providers (and gate keepers) also need to be able to address transition periods where men struggle and be able to identify the prime time to act to help men before depression escalates or suicide occurs. It was suggested that First Aid Training be mandated to include mental health first aid.

Public awareness campaigns and workshops – Participants stressed the importance that interventions not be a health professional model that sends men or boys to get help, rather being peer supported and in spaces where men already find themselves. Bringing men and boys together to talk with one another, help one another, make each other feel useful in achieving action-oriented activities and helping other men/boys. For example, the Canadian Rangers program was identified by participants as a successful program in offering land-base, social activities that connect people within networks.

Training for community facilitators and gatekeepers – Participants noted that gatekeeping programs need to include training for community leaders. Leadership in the community play a critical role in establishing trust. Leaders are relatable and can build bridges between different groups. Key community and thought leaders are perceived to be role models within the community and connect not only people with one another, but connect people with community interventions/programs. The Deadly Choices program in Australia is an example of an intervention that uses sports figures to encourage health literacy and life skills to middle school-aged Indigenous children. Role models can also speak out, being motivational heroes that can talk about stress, emotional issues, transitions in

their lives, demonstrating that it is acceptable to discuss these topics. Learning of the role models' experiences encourages men to talk about sensitive topics.

The Department of National Defence has a program named Road to Mental Readiness (R2MR) that has been effective in training members of the police force and other gatekeepers on how to de-escalate a situation. A participant stated that police-based interventions should build the capacity among police to deal with suicide and self-harm calls.

Community suicide prevention awareness programs – Participants suggested leveraging existing spaces as schools, workplaces, and using resources such as local and national media to deliver positive messaging about men's mental health. Understanding the language used and the right words for men is essential, as is broadening the definition of masculinity. Despite the innovative approach of using technology and media to connect people, participants felt that the face-to-face element of interventions, the language and messaging used and the way that stories are communicated is important to establish a sense of safety and trust, which are critical in suicide prevention.

Leveraging existing spaces where men congregate provides a starting point to discuss the link between injury and suicide prevention. Participants noted that it is important to reach men in terms of place and not emotion. Tim Hortons was an example provided on how important it is to meet men where they are, where existing networks of men meet over coffee in a safe space. Overall, participants felt that men can help each other and initiate discussion among men.

Gender conformity – Participants mentioned that interventions that are gender specific should be gender conformative, as well. This is especially important for people who do not identify as LGBTQ, but do not conform to traditional ideals of masculinity. Inclusive masculinities should be promoted in diverse ways.

Support for vulnerable groups, survivors of suicide attempts or loss – Participants stated that men and their support networks need to be engaged before the trauma or difficult transition periods occur, and also post trauma/transition. Postvention support is especially critical. Programs should be created for both men who have attempted suicide, and for those who have lost someone to suicide.

High risk interventions – One of the barriers identified by participants on scaling up community-based programs is related to the perception that these programs are high risk. Funding for these initiatives is often limited and hard to obtain for scale up and hence making it difficult for programs to sustain themselves. However, organizations such as the Movember Foundation fund higher-risk initiatives that other organizations may not fund.

Men-centered program evaluations

Lastly, participants were asked to discuss approaches to evaluate men-centered interventions and identify what mechanisms would need to be in place to further support program evaluation and implementation science.

Community evaluation – Participants mentioned that partnerships should be established between skilled evaluators and communities. Evaluation toolboxes should be provided to evaluate the programs that they often have a great part in managing/delivering. An example of a community intervention evaluation tool is the framework developed in Nunavut with measures for outcomes of programs in the indigenous context. When communities are not aware of what the evidence suggests regarding program evaluations in their context, they are not in a position to be able to improve programs?

Access to the population – Participants noted that vulnerable populations may be hard to access, especially with programs for boys. Accessing and obtaining data on these populations presents several challenges.

Quality of Evidence – Participants raised several issues regarding the availability, quality, timeliness and source of data. Participants felt that research results must be from quality sources and communicated broadly to other researchers, health professionals and other stakeholders, and to the community.

ii. **Plenary Discussion – Next Steps** facilitated by Dr. Joy Johnson

The Plenary Discussion was structured according to the following themes:

Approaches for collaboration and knowledge sharing among researchers and stakeholder groups that may facilitate knowledge uptake and implementation – Participants noted that there is a lot of information about successful interventions in mental health for men and boys in Canada and internationally. However, there is a gap in evidence between what is known and what needs to be done to move forward in terms of knowledge translation and mobilization, especially in regards to implementing this knowledge in programs and policies.

A number of recommendations were made to aid in the facilitation and uptake of knowledge translation. First, programs would need to be given the resources and support to operate and evaluate themselves. Further, an element of effectiveness should be incorporated into the evaluation component of evidence-based programs, thus ensuring that no main points are lost in the translation of knowledge. Second, there should also be further co-creation of program implementation and

evaluation strategies, thus providing opportunities for knowledge dissemination and uptake. Third, researchers should be encouraged and engaged to guide programs and their evaluations so that they may generate evidence that is relevant from an academic standpoint - sharing information and identifying what evidence is valued. For this engagement to occur, there is a need to eliminate the roadblocks for researchers entering into the field of men's mental health research, especially graduate students, for example, (1) Research Ethics Boards, Further efforts should be made to ensure that research funders are educated about suicide research, and (2) Researchers must be mindful of their practices, research outcomes and the responses to the outcomes. Lastly, (3) community involvement in the design, implementation and evaluation of interventions is imperative to their success. Communities should help to determine the language that is used to promote the diverse forms of masculinity and men's mental health needs within their community.

Gaps in knowledge on masculinity and male suicide prevention, and how to build on effective interventions that have been successful in other jurisdictions – There was general agreement among participants that there is a lack of evidence (data) on suicide and self-harm in Canada. There is not a lot of research done in the common academic realm to understand vulnerable sub-populations' mental health, rates of suicide and self-harm, especially in youth. To advance knowledge and grow the field, researchers and academics must be reflexive on these vulnerable populations. Different forms of research and evidence (outside of clinical trials) need to be embraced so that communities can determine what may work best for their context. Strength-based approaches and giving information in transition is also very important and needed in Canada.

Aligning research at the Federal, Provincial, Territorial and regional levels in order to bring coherence to broader research priorities for Canada – There is a need for men-friendly/youth-friendly, gender sensitive tools and resources that can be utilized in diverse settings and tailored for boys and men across the spectrum. These may include resources for researchers to define, and code level of risk and social determinants of male suicide and self-harm, and gender-specific markers and screening. There are four types of resources needed: (1) those that are appropriate for different communities/contexts, (2) tools that support effective implementation, (3) dissemination tools to proactively send out information when risk signals are flagged, and (4) tools to help evaluate these resources. More research needs to be done on the development, application, and intersectionality of these gender-specific tools, and researchers must improve our collective understanding of why they should be used. Existing resources must also be leveraged.

Although the Government of Canada has made data cubes on suicide available to quickly allow users to create tables and graphs using their web browser, there is no single repository to store and share Canadian data on rates of suicide and self-harm. To understand the strengths of effective interventions and take knowledge further at all levels of government, researchers, program and policy-makers, it was recommended to develop a central repository or data bank. It is possible that

platforms currently exist that may be useful to share information and serve as a form to learn from one another.

It was noted that the Federal Framework for Suicide Prevention would be made publically available in the near future, and researchers, health professionals, community leaders and other stakeholders need to think of the programming and resources needed to build on this Framework. Participants stated that the machinery required to get Federal, Provincial and Territorial governments involved in developing policies specific to men's mental health, and designing funding opportunities that are dedicated to men-centred interventions is extremely time consuming and complex, which raises the following questions: How do researchers begin to think of where the policy opportunities are? How do researchers mobilize existing knowledge to reach across Canada at various levels? Is it possible to have a central funding agency dedicated to overseeing this type of research? If this did exist, would this remove barriers to research in men's and boys' mental health, and more rapidly institutionalize things across the country to get research started?

e. Closing Remarks by Dr. Joy Johnson

Dr. Johnson thanked meeting participants for a very fruitful day of presentations and discussions.

The Best Brains Exchange meeting was closed at 16:00.

Appendices

A. Best Brains Exchange Agenda, September 22, 2016
B. Speaker and Presenter Biographies
C. Participant List
D. Best Brains Exchange Objectives Backgrounder
E. List of references/recommended reading

Appendix A

CIHR Best Brains Exchange: ***Masculinity and Male Suicide Prevention***	**Thursday, September 22, 2016** **8:00am – 4:00pm** **The Westin Ottawa** **Governor General III Room – 4th floor** **11 Colonel By Drive, Ottawa, ON K1N 9H4**

Agenda

Objectives:

1. Explore how governments, organizations working in suicide prevention, and health and social care providers can better address the gender-specific needs of men in both universal (population level) and targeted sub-population specific suicide prevention strategies.
2. Consider what key elements community-based suicide prevention interventions need to take into account to reduce suicide rates among men.
3. Begin to explore how to scale up and sustain effective men-centred interventions in diverse settings across Canada.
4. Identify areas for future research on masculinity and male suicide prevention.

Networking Reception
Wednesday September 21, 2016, 5-8pm
Mill Street Pub (555 Wellington St., Ottawa, ON)
Hors d'oeuvres will be served and a cash bar will be available.

Time	Item	Speaker
08:00 – 08:30	*Light Breakfast*	
08:30 – 09:00	**Welcome, Opening Remarks** **Roundtable of Introductions, Overview of the Day and Review of Objectives**	**Joy Johnson,** Vice-President, Research, Simon Fraser University
09:00 – 9:30	**Scene Setting Presentation –** Overview of suicide in Canada and explanation of current policy questions/challenges	**Marie-Pierre Jackson**, Director, Population Health and Innovation Division, Public Health Agency of Canada **Ed Mantler**, Vice President, Programs and Priorities, Mental Health Commission of Canada **Paul Villanti,** Executive Director, Movember Foundation
9:30 – 10:00	**Scene Setting Presentation –** Situating masculinities in male suicide and targeted prevention programs **15 minute presentation followed by 15 min Q&A*	**John Oliffe**, School of Nursing, University of British Columbia & Founder and Lead Investigator, Men's Health Research Program **John Ogrodniczuk**, Department of Psychiatry, University of British Columbia, co-lead Men's Depression and Suicide Network.
10:00 –10:15	*Health Break*	

10:15 – 11:15	**Presentation 1: Group Action Based Therapeutic Approaches for Working with Male Clients** **Presentation 2: The Dudes Club: An Innovative Model for Indigenous Men's Health Promotion** **15 minutes per presentation, followed by 30 minutes of Q&A*	**Presenter 1: Marvin Westwood Counselling Psychology, University of British Columbia** **Presenter 2: Paul Gross Clinical Assistant Professor, Department of Family Practice, Faculty of Medicine, University of British Columbia**
11:15 – 12:15	**Presentation 3: What will it take? New perspectives on suicide prevention for gay and bisexual men** **Presentation 4: Some observations from the Antipodes - men's suicide prevention in Australia** **15 minutes per presentation, followed by 30 minutes of Q&A*	**Presenter 3: Olivier Ferlatte Men's Health Research program, University of British Columbia** **Presenter 4: Susan Beaton Independent Suicide Prevention Consultant, Australia**
12:15 – 1:00	*Networking Lunch*	
1:00 – 2:00	**Break Out Group Exercise / Discussion**	**All**
2:00 – 2:45	**Break Out Group Report Back**	**Facilitated by Joy Johnson**
2:45 – 3:00	*Health Break*	
3:00 – 3:45	**Plenary Discussion – Next Steps**	**Facilitated by Joy Johnson**
3:45 – 4:00	**Closing Remarks & Evaluation**	**Joy Johnson**

Appendix B

Best Brains Exchange – Presenter & Facilitator Biographies

Masculinity and Male Suicide Prevention

Susan Beaton
Independent Suicide Prevention Consultant, **Australia**

Susan is a psychologist with 30 years of experience working in the Suicide Prevention field, currently providing advice to *beyondblue* and other organisations as an independent consultant. Susan worked as national advisor to Lifeline's National Office for 7 years and has been involved with suicide prevention both in Australia and the USA, working mostly for NGO's in: training and education; project management; service innovation, development and implementation; evaluation; standards; policy development and advice; Board representation and various consultancy roles. Susan was elected to the Board of the American Association for Suicide Prevention (2008-2011) and contributed as advisor to the Australian Government's revised Suicide Prevention Framework Living is For Everyone suite of documents.

In 2011 Susan was awarded the Audrey Fagan Churchill Fellowship to study alternative models of suicide crisis support overseas. Susan's expertise covers prevention, intervention and postvention domains and she is interested in ensuring that when suicidal people seek help that they come into contact with a knowledgeable, skilled and compassionate workforce and broader community who do not fear, discriminate or stigmatise them. She also wants to see a paradigm shift where we reduce our focus on risk aversion and service liability and are able to harness the experiences of those who have been suicidal to learn more about this complex behaviour with a view to guiding policy,

Olivier Ferlatte
Men's Health Research program, University of British Columbia

Olivier Ferlatte has over ten years of experience working in gay men's health promotion and research. He recently completed is PhD in Health Sciences from Simon Fraser University. Experienced in mixed-methods and Community-based participatory action research, his ongoing research interests include gay men's sexual and mental health, stigma, syndemics and intersectionality. He is currently a postdoctoral research fellow at the Men's Health Research program at the University of British Columbia, where he leads a photo voice project on gay and bisexual men's suicide.

Paul Gross
Clinical Assistant Professor, Department of Family Practice, Faculty of Medicine, University of British Columbia

Dr. Gross is a family physician with a focus on men's health and HIV primary care. He has a full-time practice at Spectrum Health, a multi-disciplinary primary care clinic in downtown Vancouver. In addition, for the past 7 years, he has worked at Vancouver Native Health Society, which provides a full range of health care services to mainly Indigenous people living in the Downtown Eastside. He is Clinical Assistant Professor in the Department of Family Practice at UBC, where he teaches family practice residents and participates in community-driven research projects focused on men's health. Dr. Gross and his wife have two terrific toddlers and live in North Vancouver.

Joy Johnson
Vice-President, Research, Simon Fraser University

Joy Johnson is SFU's fifth Vice-President, Research. She joined the university in September 2014 after serving as the Scientific Director for the Institute of Gender and Health at the Canadian Institutes of Health Research (CIHR) since January of 2008. She served on the inaugural steering committee for the B.C. Centre of Excellence for Women's Health and was a co-leader on the B.C. Network for Women's Health Research. Dr. Johnson has a highly productive program of research focusing on health promotion and health behavior change. Dr. Johnson's work has been recognized with numerous awards including the UBC Killam Research Prize. In 2010, she was recognized as one of British Columbia's 100 Women of Influence. She received the Queen Elizabeth II Diamond Jubilee Medal in 2012.

Marv Westwood
Professor Emeritus, Counselling Psychology, University of British Columbia

Marv Westwood is Professor Emeritus, Counselling Psychology, UBC. Currently has a post retirement appointment to the Faculty. His major areas of teaching and research focused on development, teaching and delivery of group-based approaches for counselling clients, and men's psychological health. He developed the UBC Veterans Transition Program to help promote recovery from war related stress injuries for which he received both the Queen's Golden and Diamond Jubilee Medals in 2005 and 2013. In 2012 he established the Centre for Group Counselling and Trauma (currently he's Senior Consultant to the Centre).

Appendix C

Best Brains Exchange:
Masculinity and Male Suicide Prevention

September 22, 2016 – Ottawa, Ontario

Participant List

Facilitator

Joy Johnson	Vice-President, Research, Simon Fraser University

Speakers

Susan Beaton	Independent Suicide Prevention Consultant, Australia
Olivier Ferlatte	Post-doctoral Research Fellow, Men's Health Research Program, University of British Columbia
Paul Gross	Clinical Assistant Professor, Department of Family Practice, Faculty of Medicine, University of British Columbia
Marvin Westwood	Professor Emeritus, Counselling Psychology,, University of British Columbia

Participants

Cécile Bardon	Associate Professor in the Department of Psychology, Centre for Research and Intervention on Suicide and Euthanasia, Université du Québec à Montréal
Kathryn Bennett	Professor, Department of Clinical Epidemiology, McMaster University
Joan Bottorff	Director, Institute for Healthy Living and Chronic Disease Prevention, University of British Columbia
Sophie Brière	Psychology Consultant/ Neuropsychologist, Veteran Affairs Canada
Ivy Lim Carter	Men's Health Program Director – Canada, Movember Foundation
Genevieve Creighton	Knowledge Translation Manager, Michael Smith Foundation for Health Research
Sylvanne Daniels	Coordinator, Quebec Network on Suicide, Mood Disorders and Related Disorders, Douglas Mental Health University Institute
Andrew Downes	Director of Mental Health, Canadian Forces Health Services Group, Department of National Defence

Kimberly Fairman	Director, Mental Health Addiction, Northwest Territories Department of Health and Social Services
Therese Fitzpatrick	Global Director, Mental Health, Movember Foundation
Jérôme Gaudreault	Director General, Association Québécoise de prévention de Suicide
Isabel Giardino	Manager, Population Health and Innovation Division, Public Health Agency of Canada
Kiah Hachey	A/Assistant Director, Department of Social and Cultural Development, Nunavut Tunngavik Inc.
Gwen Healey	Executive and Scientific Director, Qaujigiartiit Health Research Centre
Marie-Pierre Jackson	Director, Population Health and Innovation Division, Public Health Agency of Canada
Marc-Etienne Joseph	Senior Policy Analyst, Population Health and Innovation Division, Public Health Agency of Canada
Kerri Tattuinee	Monitoring and Evaluation Analyst with the Quality of Life Secretariat, Government of Nunavut
Nanauq Kusagak	Senior Advisor, Angutiit, Government of Nunavut
Christopher Lalonde	Professor, Department of Psychology, University of Victoria
Tanya Lary	Manager, Health Promotion and Chronic Disease Prevention Branch Public Health Agency of Canada
Ed Mantler	Vice President, Programs and Priorities, Mental Health Commission of Canada
Don McCreary	Independent Scientific Advisor, Movember Foundation
John Ogrodniczuk	Professor of Psychiatry, University of British Columbia
John Oliffe	Professor, School of Nursing, University of British Columbia
Renée Ouimet	President, Canadian Association of Suicide Prevention
Nancy Parker	Provincial Suicide Coordinator, Manitoba Department of Health, Healthy Living and Seniors
Sony Perron	Senior Assistant Deputy Minister, First Nations and Inuit Health Branch, Health Canada
Kathleen Pye	Manager, Research and Policy, Egale Canada Human Rights Trust
Anne Rhodes	Research Scientist, University of Toronto

Philippe Roy	Postdoctoral Research Fellow, University of Moncton
Robin Skinner	Senior Injury Epidemiologist, Public Health Agency of Canada
Paul Vallanti	Executive Director of Programs, Movember Foundation
Krystle van Hoof	Assistant Director, Institute of Gender and Health, Canadian Institute of Health Research
Jennifer Ward	Survivor Network Chair, Canadian Association for Suicide Prevention
Jon Willis	Associate Professor, Aboriginal and Torres Strait Islander Studies Unit, University of Queensland

Observers

Melissa Baker	Report Writer
Britney Dennison	Research Advisor, Men's Depression and Suicide Network
Nadya Hein	Policy Analyst, Population Health and Innovation Division, Public Health Agency of Canada
Joanna Ho	Financial & Operations Manager, Men's Depression and Suicide Network
Kiera Keown	Senior Advisor, Knowledge Translation, Canadian Institute of Health Research
Paige Marshall	Policy Analyst, Northern Region First Nations and Inuit Health Branch/Health Canada
Andrew Munroe	Web Developer, A/V and technical support, Men's Depression and Suicide Network
Megan Schellenberg	Knowledge Broker, Knowledge Exchange Centre, Mental Health Commission of Canada

Appendix D

Best Brains Exchange – Objectives Backgrounder

Masculinity and Male Suicide Prevention

The **Canadian Institutes of Health Research (CIHR)** in collaboration with the **Public Health Agency of Canada (PHAC)** and the **Mental Health Commission of Canada (MHCC)** with support from **Movember's Men's Depression and Suicide Network**

Objectives

The Best Brains Exchange (BBE) will focus on leading research evidence, best practices and lessons learned that address the following objectives:

1) Explore how governments, organisations working in suicide prevention, and health and social care providers can better address the gender-specific needs of men in both universal (population level) and targeted sub-population specific suicide prevention strategies.
2) Consider what key elements community-based suicide prevention interventions need to take into account to reduce suicide rates among men.
3) Begin to explore how to scale up and sustain effective men-centred interventions in diverse settings across Canada.
4) Identify areas for future research on masculinity and male suicide prevention.

Policy Context

On average, more than 10 Canadians die by suicide each day. In 2012, 3,926 Canadians died by suicide. Canadian males die by suicide at three times the rate of females. Within the context of male suicide, sub-groups of men experience disproportionately higher rates of suicide. Suicide is a significant men's health issue; yet it is not often publicly acknowledged or addressed as such. In order to effectively reduce male suicide in Canada, all levels of government, non-governmental organizations, health and social care providers, people with lived experience, and researchers must work together to address this health inequity with suicide prevention strategies that are effective for men.

This BBE is expected to support the Government of Canada's objective of aligning efforts to accelerate the use of research and innovation in suicide prevention through the identification of best practices for suicide prevention, and the promotion of the use of research and evidence-based practices across the suicide prevention continuum. This event will also support continued partnerships, collaboration and innovation in order to prevent suicide in Canada, while respecting the diversity of cultures and communities that are affected by this issue.

Suicide prevention programs can include universal (whole population) and selective strategies for at-risk sub-groups. These strategies need to acknowledge and attend to the unique needs of men generally as well as vulnerable sub-groups of men.

Government of Canada Commitments

The Government of Canada recognizes that suicide is a public health issue that affects people of all ages and backgrounds. It has devastating impacts on families and on communities. To address

this issue, the Public Health Agency of Canada is leading the development of the Federal Framework for Suicide Prevention in collaboration with suicide prevention stakeholders across Canada. This framework will build on existing initiatives implemented by other suicide prevention stakeholders and contribute to the prevention of suicide in Canada.

The Government of Canada provides or funds mental health care services for Canadian Armed Forces personnel, Veterans, current and former members of the Royal Canadian Mounted Police, First Nations and Inuit, as well as federally incarcerated individuals. The federal government is also investing in research and programs that focus on suicide prevention and that enhance mental well-being in communities, especially amongst the more vulnerable populations.

The federal government has also renewed an existing (since 1995) Government of Canada commitment to promote gender equality by formally integrating gender based analysis to all policies, programs and research. As such, the Health Portfolio renewed its Sex and Gender Based Analysis (SGBA) policy in 2015. In addition, the Auditor General recently released a report on GBA implementation, which calls for more comprehensive monitoring of a GBA application by departments; and the Privy Council Office has also committed to the development of a checklist which consolidates policy considerations including gender and other social, economic and demographic priorities.

Identified Need for Evidence

Preventing suicide is a key public health goal. In order to effectively prevent suicide, we must understand how gender, particularly masculinity, affects suicide risk and informs suicide prevention interventions.

While there is a large body of research on risk and protective factors for suicide among men, there is much less evidence about how to effectively intervene at a community level to reduce suicide. Public health interventions need to be based on the best available evidence. This BBE will bring to light some of the existing evidence of what works for men in several Canadian contexts.

A 2013 BBE on gender and suicide prevention among youth was very successful and focused on population based suicide prevention strategies. Building on that, the current BBE will share evidence specific to men and vulnerable sub-groups of men as a means to thoughtfully considering male suicide prevention policy and programs. It is anticipated that this BBE will provide a deeper level of solution-oriented discussion on this important topic and will provide decision-makers, researchers, and those impacted by men's suicide with opportunities to engage in discussions to quickly drive forward such action-oriented solutions.

The results of this BBE will inform PHAC's activities towards supporting community-based male suicide prevention activities. This includes the development of a series of webinars in collaboration with Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States. In addition, research gaps identified during the BBE will inform the suicide prevention research priority setting project being undertaken by PHAC and the MHCC, as well as ongoing activities that support sharing evidence and best practices.

CIHR's Best Brains Exchange Program

The Best Brains Exchange (BBE) program is designed to deliver high-quality, timely, and accessible research evidence that responds to health system policy issues and gaps in knowledge, to inform policy development, planning and program implementation. This program was originally developed by CIHR's Institute of Health Services and Policy Research and Knowledge Translation Branch in an effort to amplify CIHR's capacity to engage with provincial and territorial ministries of health, and the Health Portfolio, and to generate applied and relevant research that is responsive to policy-maker-identified priorities.

Appendix E

Best Brains Exchange – Background Readings
Échange des Meilleurs Cerveaux – Documentation contextuelle

The following background readings are to provide context to the presentations and discussions that will take place at the Best Brains Exchange on September 22, 2016. These articles have been recommended by the researchers who will present at the Best Brains Exchange. We hope that they may prove to be a helpful resource now or in the future. *Please note that it is not required or expected that you will have read all of these articles in advance of the meeting.*

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L'objectif du présent document est de fournir un contexte pour les présentations et les discussions qui auront lieu à l'Échange des meilleurs cerveaux le 22 septembre. Les articles ont été recommandés par les chercheurs qui participeront aux présentations. Nous espérons que ces articles vous seront utiles aujourd'hui et dans le futur. *Veuillez noter que vous n'êtes pas tenu de lire l'ensemble des articles avant la rencontre.*

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