Mental Health Commission of Canada

Commission de la santé mentale du Canada

Mental Health and Suicide Prevention in Men

Evidence Brief

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The head office of the Mental Health Commission of Canada (MHCC) is located on the unceded, traditional territory of the Algonquin Anishinaabe Nation, in what is now called Ottawa, Ontario. We acknowledge that, for thousands of years, the Algonquin people protected these lands, the Ottawa River watershed, and its tributaries. As a national organization, we also acknowledge that we work on the traditional lands of many different nations. Today, a path to truth and reconciliation begins with recognizing both the stewardship and the sacrifices of the original peoples. We are committed to recognizing the errors of the past, acknowledging the challenges of the present, and contributing to a new and equitable relationship with the First Peoples.

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Purpose

This brief offers an overview of emerging research on men's mental health with a particular focus on suicide and its prevention in the Canadian context. It provides statistics on men's mental health and suicidal behaviours, factors that contribute to their increased risk of suicide and suicide deaths, subgroups who are at higher risk of suicide, and the potential and observed impact of the COVID-19 pandemic on men's mental health and suicide. The brief also highlights best and promising suicide prevention practices. It is intended for individuals and organizations working in the health, mental health, and suicide prevention sectors and those developing or delivering supports and resources to men.

Method

This review of emerging Canadian and international academic and grey literature on mental health and suicide in men (with a focus on 2016–21) concentrated on research relating to suicide and effective suicide prevention strategies. Two significant limitations in the reviewed literature include (1) a focus on sex differences rather than gender* differences (along with the interchangeable use of these terms), and (2) a lack of sufficient information to determine how sex and gender were operationalized and measured. As a result, this brief uses the term "men" throughout. Where available, additional information is provided on participants' gender identity.

The brief was reviewed by several experts in mental health and suicide prevention and by people with lived and living experience. To amplify these voices of experience, quotes from the literature are included throughout.

Key Findings

1. Men continue to account for the majority of suicide deaths, both in Canada and internationally. Several notable factors may be contributing to these high rates of suicide:
    - Clear links between adherence to traditionally masculine norms (i.e., strength, stoicism, self-reliance) and reduced mental health literacy, help seeking, and the use of mental health services. Understanding gender biases (held by men and health-care providers) and positively reframing "masculinities" in the plural contexts of mental health are critical for increasing men's help seeking and effectively tailoring the provision of men's mental health services.
    - The growing body of literature about the existence of a male-type depression, characterized by externalizing symptoms such as irritability, anger, and substance use. To increase the detection and treatment of depression among men, externalizing symptoms

* This paper accepts the following distinctions between sex and gender: "Sex: A person's biological status as male, female, or intersex. . . . There are a number of indicators of biological sex, including sex chromosomes, hormones, internal reproductive organs, and external genitalia" versus "Gender: The culturally defined roles, responsibilities, attributes, and entitlements associated with being male or female in a given setting, along with the power relations between and among women and men, and boys and girls" (p. 2375). See Darmstadt, G. L., et al. (2019). Why now for a series on gender equity, norms, and health? [Commentary]. *Lancet*, 393(10189), 2374-2377. https://doi.org/10.1016/S0140-6736(19)30985-7

should be measured alongside typical symptoms and incorporated into the screening tools used for its detection.

- Evidence that substance use, social isolation or loneliness, and depression are among the strongest risk factors for suicidal behaviour in men. Given the strength of these risk factors, prevention efforts should focus on addressing depression and problematic substance use and on targeting and supporting men who are isolated or may be experiencing loneliness (e.g., after being recently separated or divorced).

2. Specific subgroups who identify as men in Canada are at significantly increased risk for suicide (particularly young men). Most notably, the rates of attempted suicide for First Nations, Inuit, and Métis who identify as sexual and/or gender minority men (i.e., gay, bisexual, men who sleep with other men, transmen) are up to 10 times as high as for men in this group who are non-Indigenous. High rates of suicidal behaviours among this subgroup are due in part to unique risk factors related to historical and colonial violence, stigma, discrimination, and the erasure of family structures. Understanding these risk factors as mental health inequities that restrict access to mental health services might encourage the development of suicide prevention initiatives that are tailored to the unique needs and experiences of these subgroups.
3. The COVID-19 pandemic has amplified well-established risk factors for suicide in men, with specific subgroups reporting higher levels of alcohol and cannabis use, depression, self-harm, and suicidal thoughts. Suicide prevention efforts during and after the pandemic should focus on addressing its effect on job loss, financial insecurity, social isolation, and substance use as well as on the barriers to help seeking and accessing social and mental health supports.
4. Though risk factors around men's suicide have been widely researched, prevention approaches remain broad and tailored to men at large, which creates critical gaps in understanding and serving the needs of diverse men. Intersectional and sex- and gender-based plus analyses are required to better understand suicide and suicide risk among men and to guide the development of tailored interventions that respond to and address the unique needs of diverse subgroups, many of which live in marginalizing conditions:
    - To understand the diverse needs of sexual and gender minority groups, it is crucial that research in the field (including formal program evaluation) move beyond the sex binary when collecting, analyzing, and reporting on data and to continue exploring how the intersections between gender, race, and systems of power and oppression impact mental health and suicide.
    - Acknowledging the multiple and diverse identities that exist across the population of men in Canada, interventions should be tailored to geographical and cultural contexts.
    - For suicide prevention programs to be effective and reach those who need them, it is imperative to understand and address the social determinants of health and how they influence mental health literacy, help seeking, and ultimately, access to services.

Background

Of the estimated 4,000 suicide deaths in Canada each year, 75 per cent are men.[1] Suicide is the country's second leading cause of death for men aged 15-39 (after accidental death).[2,3] Research into sex differences in suicidal behaviour has revealed a gender paradox, wherein men are more likely to die by suicide, and women are more like to attempt it.[4-6] Between 1981 and 2017, men consistently had higher mortality rates due to suicide compared to women.[7] During this time, the average "male-to-female ratio" of suicide deaths was 3.4:1, meaning that men died by suicide on average 3.4 times as often as women. These disproportionately high rates have not only been observed across time, but also across the lifespan, where men's rates of suicide are consistently higher than women at all ages.[8]

Rarely is there one "reason" to explain why someone has died by suicide. On the contrary, suicidal behaviour is influenced by a combination of factors — including biological, clinical, environmental, psychological, and socio-cultural — spanning the life course. The factors contributing to and protecting against suicide risk are also fluid and vary across individuals and subgroups, ages, life stages, and circumstances.[9,10] That said, men share several notable factors that increase their risk for suicide.[11] Thus, understanding why men die by suicide at such high rates, and who among them is most at risk, is crucial to developing and implementing effective suicide prevention strategies for this population.

In addition to summarizing the evidence on factors that lead to increased risk of suicide and suicide deaths among men, subgroups that are at higher risk, and the potential and observed impact of COVID-19 on men as it relates to mental health and suicide, this brief will highlight best and promising suicide prevention practices.

Men's mental health and suicide

Men in Canada

Canada is located on the traditional, ancestral, and largely unceded territory of Inuit, Métis, and First Nations people. It is home to just over 38 million inhabitants from diverse cultural and ethnic backgrounds.[12,13] Estimates from 2016 census data indicate that men make up almost half the population (most are aged 25-64), with racialized groups making up nearly a quarter of it.[14] In the same census data, more than 1.67 million people self-identified as Indigenous, of which 813,520 said they were men.[15] Recent estimates from Statistics Canada show that about four per cent of the total population identifies as 2SLGBTQ+, with one quarter identifying as gay and 75,000 (15 and older) as either transgender or non-binary.[16] Due to fear and/or apprehension in self-identifying, this data may underestimate the true number of Indigenous and 2SLGBTQ+ people in Canada and the overall diversity of these populations.

Unfortunately, Canada's incredible diversity is not always captured in the literature on mental health and suicide in men. We therefore acknowledge the limitations of the literature this brief includes in terms of representing the diverse experiences and expressions of men in Canada and considerations of sex and gender identity. The MHCC recognizes this diversity and believes that to improve suicide prevention and life promotion practices for men it is essential to explore and better understand the relationships between gender identity and suicide beyond binary sex statistics.

As Standish (2020) stated in an article anticipating suicide and gender after COVID-19:

> The adoption of binary sex stats to collate incidences of suicide, when they are identified at all, means erasing valuable aspects of both identity and potential interventions. Suicides are attempted and experienced by non-binary, LGTBQI2 and Indigenous persons, particularly youth, at higher rates than cis-gendered Western suicides amplifying the importance of understanding gender in understanding suicide. (p. 114)[17]

Contributing factors

The literature points to several factors that contribute to high rates of suicide deaths among men. The following list was compiled from quantitative and qualitative research[†] on suicide, both in Canada and internationally.

Male-type depression, symptom recognition, and assessment

Research in mental health suggests that men may have different experiences of depression than what is considered "typical" (i.e., according to the *Diagnostic and Statistical Manual of Mental Disorders* [DSM-5]). There is a growing body of evidence supporting the existence of a "male-type" depression, which is characterized by externalizing symptoms,[‡] including irritability, anger, substance use, risk taking, and impulsivity.[18] These symptoms are not outlined in the DSM-5 criteria

[†] Quantitative research is expressed in numbers and graphs and is used to test or confirm theories and assumptions, whereas qualitative research is expressed in words and is used to understand concepts, thoughts, and experiences. See, for example, Streefkerk. R. (2022). *Qualitative vs. quantitative research: Differences, examples, and methods.* https://www.scribbr.com/methodology/qualitative-quantitative-research/

[‡] Externalizing symptoms of depression include escapist behaviour; physical symptoms; alcohol and drug use; controlling, violent, or abusive behaviour; irritability and/or anger; risky behaviours; and impulsivity.

for depression,[§] which largely measures prototypic or internalizing symptoms like depressed mood, fatigue and loss of energy, and loss of interest or pleasure.[19] Meta-analytic research indicates that many men who experience depression report externalizing symptoms.[20,21] Zajac and colleagues (2020), from a sample of 1,000 adult men in Canada, found that, of the 31 per cent demonstrating depressive symptoms (prototypic and externalizing), almost 75 per cent reported externalizing symptoms only or else a mix of externalizing and prototypic symptoms. They also found that men who reported externalizing symptoms were at significantly increased risk of mental health problems and current suicide risk, compared to those reporting prototypic symptoms only.[22] Other evidence suggests that men's conformity and adherence to traditional masculine norms (e.g., stoicism, self-reliance, strength) may impact their experience and expression of depression. Seidler and colleagues (2016) reported that the social conditioning of men to avoid emotion-based communication leaves them with a limited emotional vocabulary to describe their experiences. Men's feelings of shame and weakness or fears of being othered and marginalized (which are associated with depression) were also thought to be capable of worsening the severity of depressive symptoms while making men less likely to seek help.[23]

Several screening tools used to detect depression (e.g., the Patient Health Questionnaire [PHQ-9]) are based on the prototypic depressive symptoms outlined in DSM-5 and do not include the externalizing symptoms many men are thought to exhibit.[24-26] Various researchers have proposed that conventional screening and diagnostic tools that do not measure male-type symptoms may be contributing to the underdetection and undertreatment of depressive symptoms in men.[27-30] In an influential study, Martin and colleagues (2013) found that sex differences in depression rates disappeared when symptoms of male-type depression were measured alongside the prototypic depressive symptoms.[31] When both prototypic and male-type symptoms were measured, men and women met the criteria for depression at similar rates: 30.6 and 33.3 per cent, respectively.[32] Considering the heightened risk for suicide that externalizing symptoms (e.g., substance use, risk taking) pose, detecting male-type depression symptoms is essential for suicide prevention among men.

Rigid alignment with traditional masculine norms

Research has linked masculinity and its conceptualizations to depression and suicide among men. "Traditional" masculine norms represent the "accepted ideal" of masculinity, including stoicism, self-reliance, strength, toughness, success, control, and competitiveness. These norms, which are thought to "stem from dominant models of male socialisation in the Western World (Pleck, 1995)" (p. 107),[33] serve to perpetuate inequalities both within and between genders.[34]

Research shows that adherence to and deviation from these masculine norms can lead to negative consequences.[35-40] While deviation has been shown to have negative results (e.g., social and economic penalties) among some men (including being perceived as weak, less likeable, less hirable), adherence can also have a profoundly negative impact on mental health behaviours and outcomes.[41-47] Studies examining the impact of masculinities on mental health and suicide highlight a range of negative outcomes among men who rigidly adhere to traditional masculine norms. Garfield and colleagues (2008) reported that anxiety, depression, psychological stress, and maladaptive coping patterns were pervasive among men who held more traditional beliefs about masculinity and gender roles.[48] Men who adhere to such norms were also more likely to exhibit externalizing symptoms of depression (e.g., substance use, risk taking, impulsivity), have lower mental health literacy (MHL),

[§] DSM-5 criteria for depression (i.e., prototypic symptoms) are as follows: depressed mood, diminished interest/pleasure, significant weight loss and/or changes to appetite, slowing down of thought or movement, fatigue/loss of energy, feelings of worthlessness/excessive guilt, diminished ability to think/concentrate, recurrent thoughts of death.

and be less likely to engage in help seeking for their mental health concerns.[49-52] The research on masculinity and adherence to masculine norms highlights the elevated risk associated with externalizing symptoms of depression, difficulty recognizing emotions and symptoms (in oneself and others), and having a limited ability and willingness to seek out help when experiencing mental health concerns. It is important to note that, while rigid adherence to masculine norms can lead to negative mental health and suicide outcomes among men, some masculine norms can be protective when applied flexibly.[53,54] For example, Levant and Wimer (2014) found that higher levels of emotional control served as a protective buffer against anger and stress in men.[55]

Stigma (and self-stigma)

According to the Public Health Agency of Canada, stigma

> begins with the labeling of differences and negative stereotyping of people, creating a separation between "us" and "them." . . . Stigma happens in institutions (e.g., healthcare organizations), at a population level (e.g., norms and values), through interpersonal relationships (e.g., mistreatment), and internally (e.g., self-worth and value). (p. 22)[56]

Mental health-related stigma is incredibly harmful and can lead to a range of negative outcomes, including social isolation, reduced help seeking and adherence to treatment, and poorer recovery from mental illness.[57-59] Men can be affected by such stigma and, if they are diagnosed or receive treatment for mental illness, they may avoid seeking help over fear of losing the acceptance of their peers.[60] A systematic review of the literature by Clement and colleagues (2015) found that mental health-related stigma was the fourth highest barrier to help seeking, with men among the groups for whom stigma had a disproportionate effect.[61] In Canada, Oliffe and colleagues (2016) found that men held more stigmatizing attitudes toward male-type depression compared to women. Men were also more likely to report feeling embarrassed about seeking professional help for depression or about others knowing they had done so.[62]

Mental health literacy

MHL refers to a person's awareness of and ability to recognize symptoms of different mental illnesses (in themselves and others), their knowledge of when and how to seek help or information, and their beliefs and attitudes about mental illness and help seeking.[63] Previous research on MHL has shown that, in general, men less often accurately identify symptoms of mental illness such as depression, anxiety, or psychosis than women do.[64] The same study also found that women were more likely to view symptoms as serious compared to men. In Seidler's and colleagues' (2016) systematic review, their analyses revealed that men more often view depressive symptoms (e.g., fatigue, low mood, restlessness, irritability) as potential signs of physical rather than mental illness.[65]

Lower levels of MHL in men may be explained in part by their conformity to certain masculine norms (e.g., self-reliance, emotional control, stoicism), which are thought to be "incompatible with communicative and interactive health literacy" (p. 2).[66] In one study, men who scored higher on a scale measuring conformity to masculine norms were shown to have lower levels of MHL. Specifically, they were less likely to agree that they had the ability to find good health information and to actively engage or be understood by health-care providers. The authors also found an association between moderate-to-severe depressive symptoms and lower MHL.[67] In addition, men may find it more difficult to recognize signs of male-type depression. In a representative survey of Canadians, Oliffe and colleagues (2016) found that women were more likely to correctly identify symptoms of male-type depression, thus demonstrating greater MHL regarding men's depression.[68] As well, poor MHL may contribute to lower levels of help seeking and health-service utilization among men. Research shows that individuals with higher levels of MHL are more likely to seek help, use psychotherapy, and recommend professional help to others.[69,70]

Help seeking

Help seeking encompasses the initial call out for help as well as ongoing consultation and treatment.[71] Research exploring help seeking for mental health-related concerns shows that men are not only less likely to seek out help initially, when they do they are more likely to drop out of treatment and less likely to attend follow up sessions and engage meaningfully with their therapist.[72,73] Men who seek help may also wait to access services until their need for support is serious (e.g., when experiencing severe depression) and they have exhausted their other options (e.g., self-treatment, speaking with their partner).[74,75] In Rice and colleagues' (2020) study of men reporting symptoms of major depression, 60 per cent reported suicidal ideation in the past two weeks, only 8.5 per cent of whom were connected to mental health care.[76] An examination of 52 men by Cleary and colleagues (2017) on the uptake of services following hospital admission for a suicide attempt[77] found that one-third never attended their outpatient appointment; among those who did, one-third attended for less than a month. Men's negative attitudes toward treatment were pervasive, and many were doubtful about the efficacy of psychiatric treatment.[78] Men's experiences with therapy may have a direct impact on their treatment continuity, perceptions about its efficacy, and willingness to disclose their distress in the future.[79,80] Seidler and colleagues (2020) found that lower satisfaction with previous therapy was associated with greater doubt about its effectiveness, which in turn, was associated with greater reluctance to disclose distress to one's physician.[81]

Men may also be less likely to seek out help prior to suicide, compared to women.[82-84] In a qualitative study exploring the experiences of men who had attempted suicide, Oliffe and colleagues (2021) found that, as "struggles (and fatalism) escalated" (p. 420), men experienced growing isolation that further prevented them from seeking out peer and/or professional help.[85] As one participant noted, "Just having the thought of suicide in your mind can take you down a whole new path in life. . . . you're not in my state of mind . . . and when you're going through depression or suicide, you don't want to talk to nobody" (p. 420). This same study highlighted that among those who attempted suicide, professional help was "needed acutely, regularly, and long-term" and that services were "especially valued when they explicitly linked to self-management" (p. 424).[86] Schaffer and colleagues (2016) found that, among those who died by suicide in Toronto without health-care contact in the prior year, almost 85 per cent were male.[87] In a systematic review examining contact with primary and mental health care prior to dying by suicide, women were found to have the highest rates of contact with health and mental health care.[88] That said, in the year prior to their death by suicide, 77 per cent of men were in contact with primary health care, and 26 per cent were in contact with mental health care services.[89] Collectively, these findings suggest that, while professional help is needed and some men are in fact utilizing health and mental health care prior to their death by suicide, their symptoms may be going unnoticed or else the care they are receiving may not be adequately addressing or meeting their needs.

Men who adhere more strongly to masculine ideals (e.g., strength, stoicism, self-reliance) have been shown to be less likely to seek help, drop out from mental health services, experience greater stigma from seeking help, and have less favourable views toward mental health and help seeking.[90-93] Further, men may avoid seeking help because they view therapy as "effeminate" and as relying on behaviours that contradict traditional masculine norms.[94] Hoy and colleagues (2012), in a meta-ethnography of qualitative studies, identified four specific barriers to help seeking among men: (1) social stigma, (2) apprehension about medical professionals and prescription medications, (3) difficulties communicating and sharing emotions and problems, and (4) a preference for managing their own health.[95]

While adherence to certain masculine norms has been shown to undermine men's help-seeking behaviours, research shows that health-care providers' adherence to these same norms may contribute to the low rates of mental health service utilization among men. Affleck and colleagues

(2018) have noted the inevitable influence of gender norms and gender biases on health-care providers when treating patients and how "traditional notions of masculinity are institutionalized in the wider medical system" (p. 586).[96] The authors cited several studies that highlight significant gender biases among health-care providers, including physicians who spend less time with men than with women during health visits (along with fewer and briefer explanations) and those who are less likely to diagnose mental illness among men and act upon it once detected.[97]

Use of more lethal means

One important difference between men and women with respect to suicide death is men's choice and use of means. Compared to women, men are far more likely to choose high-risk methods, make attempts using more lethal and violent means (i.e., suffocation, firearms), and to involve alcohol.[98-101] In Canada, suffocation (53.5%) and firearms (17.6%) accounted for a combined 71.1 per cent of men's suicide deaths in 2018.[102] When compared to other suicide methods, individuals using firearms are up to 140 times as likely to die on their first attempt.[103] Research also suggests that the lethality of suicidal acts may be higher among men than women, even when the same method is used.[104,105] Mergl and colleagues (2015) found that suicidal acts were 3.4 times as lethal in men than in women across all methods examined.[106] Interestingly, aggressivity, impulsivity, and alcohol use (known features of male-type depression) have been associated with more serious suicide attempts.[107-109]

Risk factors

Risk factors are characteristics or conditions that, in combination with other influences, can make a person more vulnerable to suicide.[110] Evidence stemming from academic and scientific literature points to several notable and shared risk factors for suicide among men. The following section outlines these risk factors based on research in Canada and internationally.

Substance use

Alcohol and/or drug use (particularly at high doses) as well as alcohol and other substance use disorders are among the strongest risk factors for suicide attempts and mortality.[111-117] Not only does the consumption of alcohol and/or drugs increase the likelihood of a suicide attempt, deaths that involve them tend to be more violent and lethal (i.e., hanging, shooting, drowning) and thus more fatal.[118,119] Borges and colleagues (2017) found that any acute use of alcohol increases the likelihood of a suicide attempt by almost seven times, whereas high levels of acute drinking increases the likelihood by 37.18 times.[120] People who live with alcohol use disorder (AUD), characterized by an impaired ability to stop or control use, are also more likely to experience suicidal ideation (1.86 times as likely), attempt suicide (1.36), and die by suicide (3.13).[121,122] Compared to women, men are more likely to be diagnosed with AUD[123] and more likely to have elevated blood alcohol levels at the time of death by suicide.[124] Moreover, men who die by suicide are much more likely to have had a diagnosis of AUD than controls.[125] Men living with AUD as well as depression may have a particularly high risk of suicide. Holmstrand and colleagues (2015) found that the increased risk of dying by suicide for men with both AUD and depression was 25 times that of men whose AUD did not include depression.[126]

Studies exploring the relationship between opioid use and suicidal behaviours have reported high rates of suicidal ideation and attempts among individuals who use or are dependent on opioids.[127-129] It has been estimated that people who use heroin are up to 14 times as likely to die by suicide than their peers.[130] The association between opioid use and suicide risk may be explained in part by unemployment, homelessness, childhood trauma, and the lack of social support for those who use opioids.[131] In Canada, opioid-related deaths are responsible for a significant reduction in life expectancy, particularly among young men.[132] In 2017, the country reported 3,987 opioid-related deaths, 76 per cent of them men, with the highest burden of deaths occurring in British Columbia

(B.C.), Alberta, the Northwest Territories, and the Yukon.[133,134] The opioid crisis has affected certain groups at disproportionate rates, notably Indigenous peoples but also incarcerated populations and people experiencing homelessness.[135] In Alberta and B.C., First Nations people were up to five times as likely to experience an opioid-related overdose event and three times as likely to die as a result, compared to non-First Nations people.[136] It is important to acknowledge the significant limitations of available data on unintentional versus intentional overdose among people using opioids.[137] It is believed that the proportion of suicides among opioid-related deaths is underestimated due to misclassification of deaths and the reliance on human judgment to determine the intentionality of the act (i.e., coroners having little chance of knowing a decedent's "intent").[138]

While alcohol and opioid use have been linked to suicidal behaviours among men, the literature on cannabis use is less conclusive. While Borges and colleagues' (2016) literature review and meta-analysis**,[139] found evidence to support a relationship between chronic cannabis use and suicidality, there was a lack of evidence supporting acute cannabis use and suicidality. To address this gap, the authors noted the need for controlled studies with large samples that differentiate between acute and chronic cannabis use.[140] With Canada's legalization of cannabis, more research is required to understand if, how, and to what extent acute and chronic cannabis use might influence mental health and suicidal behaviours, and whether these impacts vary according to sex and/or gender.

Social isolation, loneliness, and loss of connectedness

Social isolation, loneliness, and loss of connectedness are important risk factors for suicidal thoughts and behaviours among men.[141-147] These risks may be heightened among men experiencing relationship breakdown and among those who live alone. Research indicates that men are at higher risk for suicidality following a relationship breakdown[148] and that being single, unmarried, divorced, or widowed significantly increases their risk for suicide.[149-153] In a systematic review conducted by Kazan and colleagues (2016), men were found to be six times as likely to die by suicide following a separation from their partner. While the effects of separation on suicidal behaviour were strongest in the period right after the separation, the risk of suicide remained elevated for up to four years.[154] Similar findings have been observed after divorce, where men have been shown to be up to eight times as likely as women to die by suicide following a divorce.[155] Parenthood (or having children) may have a protective effect on suicide risk among men. Dehara and colleagues (2021) found lower suicide rates in fathers with one (54% lower), two (64%), and three or more (59%) children than in men with no children.[156]

Shaw and colleagues (2021) reported that, compared to those living with a partner, men who were living alone or with non-partners were at greater risk for suicide death, whereas women in similar situations were not. The authors also found that men experiencing loneliness, and those living alone or with a non-partner only, had three times the risk of dying by suicide compared to those who cohabit and are not lonely.[157] These findings suggest that loneliness may be an important factor influencing suicide risk in those living alone or with non-partners.

In a photovoice study examining social isolation among men with a history of suicidality, Oliffe and colleagues (2019) found that the overarching themes were estrangement from family members, marginality in social contexts (e.g., school, work), alienation from mental health services (due to the potential provision of care against their will), increased substance use, and suicidal ideation.[158] These findings underscore the importance of isolation and loneliness, both as potential risk factors for suicidality and as exacerbating factors for those with a history of suicidality.

** Suicidality includes suicidal ideation, intention, plans, and/or behaviours, with the intent of ending one's life.

Depression

Depression is one of the most well studied and established risk factors for suicide (including ideation, attempts, and death).[159-163] For men, a diagnosis of depression is among the strongest predictors of suicidal behaviours.[164] Crump and colleagues (2014) reported that depression increased men's risk of suicide 15-fold, with the highest risk in the post-diagnosis period.[165] Compared to those who were diagnosed with psychiatric and somatic disorders but not depression, the risk of suicide in the 13-week period after a diagnosis of depression was 18-32 times as high.[166] Holmstrand and colleagues (2015) found that the odds of death by suicide was 8.4 times as high in men with depression, whereas the odds for women were less than a third of that at 2.6. The authors also found that suicide risk was particularly high (16.2%) among men who had both AUD and depression.[167] Although depression has emerged as one of the strongest risk factors for suicide among men, other mental health problems and illnesses, including anxiety, bipolar disorder, personality disorder, post-traumatic stress disorder (PTSD), and schizophrenia, have all been linked to increased risk of suicide attempts and death.[168]

Physical comorbidities (e.g., prostate cancer) and a history of adverse childhood experiences (e.g., sexual abuse) substantially increase men's risk of problematic substance use, depression (particularly male-type with externalizing symptoms), and suicide.[169-173] Men who display symptoms of male-type depression may be at even greater risk of suicide than those displaying prototypic (internalizing) symptoms. In a study conducted by Rice and colleagues (2018), men with a marked externalizing profile (including substance use, anger, and risk taking) were more than 14 times as likely to have had a recent suicide plan and 21 times as likely to have attempted suicide in the last four weeks, compared to those who were asymptomatic.[174] These men were also four times as likely to have had a plan and to have attempted suicide than those displaying internalizing symptoms only.[175] Although depression is a well-established risk factor for suicide, it is important to recognize that many men who die by suicide do not have depression or other psychiatric illness prior to their death. For this reason, it is crucial to continue exploring how and to what extent social determinants of health influence suicide risk among men.

Sociodemographic factors.

Among men, research suggests that age, education, work status, and geography are important risk factors.

- **Age.** Age is an important risk factor for suicide attempts and death among men.[176-178] A scoping review by Oliffe and colleagues (2021) reported that young men may have a particularly high risk of suicide.[179] Suicide rates among adolescent males were twice as high as rates among adolescent females, with males less likely to have accessed health and mental health care services.[180] In Canada, suicide is the second leading cause of death among men aged 15-39.[181-183] Depression, bullying, and abuse were strongly associated with suicidal thoughts, behaviours, and death in this age group.[184] Older men (over 65) have also been shown to be at high risk for suicide. One study estimated that older men were nine times as likely to die by suicide as older women.[185] Oliffe and colleagues found that relationship breakdown, work- and finance-related stresses, and substance use were the most consistently reported risk factors for suicide among men (ages 45-54).[186]
- **Education.** Individuals with lower levels of educational attainment may be at higher risk of suicide.[187-190] Some studies report low educational attainment as a stronger risk factor in men (particularly young and older men) than in women.[191-194] Lorant and colleagues (2021) found that rates of suicide were more than two times as high in men with low levels of education, versus 1.3 times as high in women with low education levels.[195] This relationship may be explained in part by a combination of risk factors for suicide that include low levels of education attainment

and other social determinants of health (e.g., income, employment and working conditions, literacy, safe housing, social supports). These factors also include childhood adversity, mental health problems, substance use, and interpersonal or relationship problems, which may be more common among individuals with lower education.[196,197]

- **Unemployment, job loss, and financial difficulties.** Unemployment, job loss, and financial difficulties are strong risk factors for suicide attempts and death among men.[198-209] Mäki and colleagues (2021) reported that, compared to employed men, those with unstable employment were almost three times as likely to die by suicide, a risk almost four times as high among men experiencing long-term unemployment.[210] Work conditions and job stressors may also be important factors influencing men's suicide risk. Milner and colleagues (2017) found that working men who reported low job control, job insecurity, and unfair pay were more likely to report suicidal ideation than men who reported better working conditions.[211] For many men, work is strongly tied to their sense of purpose and worth, since it can provide both structure and routine in their lives.[212] In the absence of employment or financially fulfilling work, men's sense of identity can erode. In Oliffe and colleagues' (2013) qualitative study of men in Canada experiencing depression, men's sense of worth and success were found to be closely tied to their paid work, their financial and material success, and ultimately, their ability to "fill breadwinner and provider roles" (p. 1631).[213] A sense of regret was expressed by those who had not fulfilled their money-making potential, something which negatively impacted their emotional well-being. Among men nearing retirement, there was a strong sense of unfinished business, loss regarding routine and structure, and erosion connected to having an important purpose, which led some to experience a lack of motivation and depression.[214] Physical and mental health problems and problematic alcohol use may in part explain the higher rates of suicide among men who are unemployed or who have lost their jobs, compared to those who are employed.[215-219]
- **Rural and remote.** Men living in rural areas may be more likely to die by suicide (but not more likely to attempt it) compared to those living in urban areas.[220] In Canada, the risk of suicide has been shown to be higher among men living in rural or remote areas, including high rates among sexual minority youth.[221-223] Compared to their urban peers, sexual minority adolescent boys in rural areas were almost twice as likely to have seriously considered or attempted suicide in the last year.[224] During interviews in a small rural Canadian town (2017) with individuals who had lost a male (i.e., son, father, brother, friend, spouse, son-in-law) to suicide,[225] participants identified social stigma around mental health and the fear of being perceived as weak and vulnerable as factors that ultimately led men to hide their depression (and its cause); engage in risk-taking, violence, and aggression; and self-medicate instead of seeking professional help.[226] Compared to other areas, the Prairie provinces (i.e., Alberta, Saskatchewan, Manitoba), known for being the most rural parts of Canada, have the highest rates of suicide.[227] These high rates among men may be due to a stronger alignment with masculine ideals (e.g., strength, invulnerability), greater access and use of firearms, isolation, high-risk occupations (e.g., resource extraction, farming), job instability, economic uncertainty, mental-health stigma (including self- and social stigma), poor access to formal health and mental health services, and high consumption of alcohol and drugs, particularly among young men.[228-233]
- **Homelessness and precarious housing.** Exceptionally high rates of suicidal ideation and suicide attempts have been reported among people experiencing homelessness and precarious housing.[234-236] A recent systematic review and meta-analysis reported a pooled current and lifetime prevalence of suicidal ideation of 17.8 per cent and 41.6 per cent, respectively, and a pooled current and lifetime prevalence of attempts of 9.2 per cent and 28.8 per cent, respectively, among people experiencing homelessness.[237] In Sinyor and colleagues' review of Toronto's coroner records for all suicide deaths between 1998 and 2012,[238] 60 of the 3,319

deaths were people experiencing homelessness, and 230 were precariously housed. Most of these deaths (83%) among the homeless population were men.[239] Temporary homelessness, caused by unstable and unsafe housing, may also increase men's risk for suicide in many populations. The dependence on relationships for stable housing may elevate the risk of suicide, either by increasing the potential for intimate partner violence (IPV) if the partner chooses to stay for the sake of avoiding homelessness[240-244] or, through a lack of stable housing, by (possibly) increasing anxiety, substance use, and unemployment .[245-253] A history of physical and/or sexual abuse, mental health disorders, and problematic substance use are highly prevalent among those experiencing homelessness or precarious housing and may be contributing to the disproportionately high rates of suicide in this population.[254,255]

History of attempted suicide

People who attempt suicide are at greater risk of a subsequent attempt(s) and death, particularly in the first 12 months after an attempt.[256-263] Compared to women, men may be more likely to re-attempt and die by suicide. In Fuller-Thomson and colleagues' (2019) investigation of remission (i.e., absence of suicidal ideation) among individuals reporting a lifetime suicide attempt, the authors found that remission from suicide attempts was almost one-third as likely for men as for women.[264] A study by Bostwick and colleagues (2016) found that 81.8 per cent of individuals who attempted suicide died by suicide within a year; of those, 80 per cent were men.[265] Both older adults and men were associated with a higher risk of dying on a subsequent attempt.[266] This observation about the higher risk among men has been supported in several other studies.[267-270] One study by Finkelstein and colleagues (2015), which examined the risk of suicide and mortality following a first self-poisoning episode, found that "older age," "depression," and "male sex" were among the strongest predictors for eventual death by suicide.[271]

Negative life events and intimate partner violence

Negative life events and adverse childhood experiences are associated with the onset of mental health disorders as well as suicide attempts and deaths.[272-280] In a study examining childhood traumas among men seeking outpatient psychiatric care in Canada, Kealy and colleagues (2016) found that adverse childhood experiences, including emotional neglect and physical or emotional abuse, were highly prevalent. Rates of reported abuse were much higher than what has been observed in general community samples.[281] Afifi and colleagues' (2014) study of different types of child abuse and their association with mental health disorders[282] found that physical abuse, sexual abuse, and exposure to IPV in childhood increased the odds of a suicide attempt by 1.7, 1.5, and 1.2 times, respectively. Turner and colleagues (2017) found that men with a history of childhood sexual abuse (CSA) or of CSA co-occurring with other types of child maltreatment had much higher odds of having a mental health disorder and attempting suicide, compared to those who experienced child maltreatment without CSA.[283]

IPV[284-287] is also associated with suicidal behaviours, including ideation, attempts, and death.[288] In Canada, men account for 95 per cent of murder-suicides, the most common form being murder-suicide involving a man killing his spouse.[289] Some evidence suggests that the level of risk associated with IPV may differ according to whether the person is the perpetrator, victim, or both. Ulloa and Hammette (2016) reported significantly worse mental health outcomes, including depression and suicidality, among those who were both perpetrators and victims, with higher suicidality for perpetrators than victims.[290] Although it is unclear whether men are impacted more by adverse childhood experiences compared to women, many of the well-documented outcomes associated with childhood adversity and trauma are also robust risk factors for suicide among men (e.g., major depression, AUD, and substance use and other mental health disorders, including anxiety and suicide attempts).[291-293]

Subgroups among men who are at higher risk for suicide

Although men collectively account for 75 per cent of suicide deaths in any given year, the risk of suicide varies substantially across different groups.[294] The literature points to several important subgroups (in Canada, specifically) that are at greater risk for suicide. Many factors contribute to and influence this risk, yet the social determinants of health play an especially important role among certain subgroups and may disproportionately impact their rates of suicide. These factors include income, employment and working conditions, education, physical environments, access to health services, sexual orientation, gender expression, culture, race, and others.

The following section outlines notable subgroups from available quantitative and qualitative research on suicide, both in Canada and internationally.

First Nations, Inuit, and Métis men

First Nations, Inuit, and Métis men in Canada have been identified as one of the most disproportionately affected populations in relation to their risk for suicide. Compared to the country's non-Indigenous people, suicide rates are nine times as high among Inuit, three times as high among First Nations, and two times as high among Métis.[295] These disparities in suicide mortality are so stark that suicide prevention has become a public health priority for governments and many Indigenous communities.[296-300] Based on findings collected from the Canadian Census Health and Environment Cohorts (2011-2016), suicide rates among First Nations people living on reserve are higher than those living off reserve and higher among men than women.[301] Relative to men in the general population, Indigenous men exhibit higher rates of suicidal behaviours.[302] Studies have shown that this is particularly so among Inuit men, where suicide attempts are 10 times as high among male Inuit youth, compared to non-Indigenous male youth, and suicidal ideation is higher in Inuit men living off-reserve versus Inuit women living off-reserve.[303]

Researchers have drawn attention to unique suicide risk factors among Indigenous people related to collective trauma. Historical and colonial violence have resulted in intergenerational trauma, abuse, early childhood adversity, the erasure of family structures, a lack of access to health services and education, and increased substance use.[304,305] Colonization led to the forced settlement of nomadic tribes, relocation from traditional settlements, and the removal of children from their homes into residential schools. In the second half of the 20th century, children were also removed from non-Indigenous homes or orphanages into foster homes and child welfare institutions (referred to as the Sixties Scoop).[306-308] The Sixties Scoop engendered cultural dislocation and identity confusion, which is now closely linked to suicide among Indigenous peoples.[309,310] The country's child welfare system continues to be especially traumatic for Indigenous youth. While seven per cent of children in Canada identify as Indigenous, they make up 52 per cent of the those in foster care.[311]

In recent years, researchers have drawn attention to suicide pacts among Indigenous youth in Canada.[312-315] Described as "a specific type of peer pressure involving high-risk and suicidal behaviours in the context of a 'game' or 'pact' that could be planned days or weeks in advance by youth" (p. 21),[316] they have been attributed to the intergenerational trauma and subsequent early childhood adversities experienced by Indigenous youth, especially in rural and remote contexts where services are difficult to access.[317-319] Here, it is important to note the many challenges of obtaining suicide surveillance information for Indigenous populations in Canada, which have been attributed to factors such as under-reporting, low base rates, data access, and geographical access.[320,321]

Sexual and gender minorities

Men in sexual and gender minority (SGM) groups in Canada have been identified as a key population affected by greater suicide risk. In general, they experience high rates of societal stigma, mental health disorders, substance use disorders, and suicidality.[322,323] SGM populations are two to four times as likely to report depression and two to five times as likely to report lifetime suicide attempts, compared to heterosexual and cisgendered people.[324] One in five individuals identifying as a sexual minority (e.g., lesbian, gay, bisexual) and one in two identifying as a gender minority (e.g., transgender, non-binary) have attempted suicide in their lifetime.[325] Rates of suicidal ideation and behaviour are even higher among gender minority groups who (1) report co-occurring mental health and substance use disorders, (2) are from racial minorities, (3) live in poverty, and (4) live with disabilities.[326] Men in same-sex partnerships are at substantially increased risk for suicide mortality, compared to women in same-sex partnerships.[327] Compared to heterosexual men, sexual minority men (e.g., gay, bisexual, queer) experience higher rates of suicidality and/or suicide and are up to six times as likely to experience suicidal ideation.[328] In one study, the likelihood of a suicide attempt was found to be 16 times as high for individuals in this subgroup who had three or more concurrent health problems (e.g., depression, anxiety, drug use, smoking, HIV infection).[329] Gay and bisexual men with annual incomes of less than $30,000 who had no university education were also found to be five times as likely to attempt suicide than those with a university degree and incomes over $30,000.[330,331]

Researchers have drawn attention to the unique risk factors experienced by sexual minority men, such as bullying, victimization, HIV-related social exclusion, stigma, violence due to homophobia, low rates of mental health literacy (MHL), and heightened risk of suicidality following conversion therapy.[332-335] They have also highlighted unique risks for gender minorities (including transmen, transwomen, and non-binary persons), which include constant misgendering by those around them and a lack of access to gender-affirming health services due to protocol restrictions, time delays, and affordability.[336-338]

Occupation groups

Several occupational groups are at increased risk for suicidal behaviour. High rates of suicidal ideation have been observed among people working in industries with greater access to lethal means, exposure to occupational trauma and involvement in hazardous duty, as well as industries that entail high job stress and insecurity.[339,340]

Men in the military (including active and deployed military personnel, regular Armed Forces personnel, and veterans) experience high rates of mental health problems (i.e., depression, anxiety, PTSD) and suicidality.[341] Sareen and colleagues (2016) found that, compared to civilians in Canada, military personnel were 1.3 and 1.7 times as likely to report suicidal ideation and plans in the past year.[342] Whereas suicidal ideation among women in the military decreased over time, among men in the military the prevalence of lifetime and past-year suicidal ideation remained unchanged.[343] Oliffe and colleagues (2021) found that exposure to occupational trauma and deployment-related traumatic events — when combined with physical conditions, a history of childhood abuse, and pre-existing psychiatric disorders — contributed to higher rates of suicidality among these men.[344]

Public safety personnel (i.e., firefighters, police, paramedics) also experience higher lifetime suicidality compared to the general population, with a greater prevalence among paramedics and correctional workers who are single, divorced, separated, or widowed.[345,346]

In addition, occupational groups mainly performing manual labour (e.g., construction, farming, and resource extraction) experience high rates of suicide due to economic uncertainty, mental health stigma, social isolation and loneliness, increased alcohol consumption, poor working conditions, and

a lack of access to mental health services.[347-351] Many of these occupations can be seasonal and sporadic, forcing men to travel greater distances and spend extended periods away from family and other support systems.[352]

Immigrants and refugees

Although the literature does not necessarily point to higher suicide rates among Canada's immigrant (versus non-immigrant) populations, some evidence suggests that the risk of suicide is higher among men than among women.[353,354] Saunders and colleagues (2019), in a population-based study examining suicide among recent immigrants in Ontario, reported that suicide rates were almost twice as high in immigrant men compared to immigrant women (4.4 per 100,000 versus 2.5 per 100,000, respectively).[355] A systematic review and meta-analysis of suicide among immigrants and refugees estimated the prevalence of suicide among refugees at 10 per cent, which is about five times as high as the larger immigrant population.[356] Unlike immigrants who relocated to Canada of their own accord, refugee populations may have an increased risk of suicide due to such factors as stress, the trauma caused by displacement, and the violence suffered before or during the resettlement process.[357] High rates of PTSD and depression have been observed among refugees in Canada, likely because of pre-migratory, migratory, and post-migration stressors related to physical well-being, finances, shelter, education, and health.[358] The literature also points to the under-reporting of mental illness and suicidal behaviour among certain groups of immigrants and refugees due to cultural views that can limit awareness around mental health (e.g., stigma, disgrace, shame, criminality).[359,362] In certain cases, immigrants and refugees may report physical pain instead of psychological symptoms.[363] This is especially true for conflict-affected populations, where psychological pain and suffering have either been normalized into everyday life or be seen as less important than housing and job opportunities.[364-366] Canada's immigrant and refugee populations may also experience barriers related to language, culture, finances, (longer) wait times, and stigma when accessing mental health services, which can make it difficult to access needed support.[367]

Racialized groups

Racialized groups, such as African, Caribbean, and Black (ACB), southeast Asian, and Latin populations, may experience increased risk for suicide. Discrimination among racialized groups has been associated with increased rates of depression and suicidal ideation.[368] Suicide rates among racialized men in North America is significant; for example, African American men are four to six times as likely to die by suicide as African American women.[369,370] Toomey and colleagues (2019) found that Latinx adolescents (ages 11-19) who self-identified as bisexual, lesbian, and/or gay were 1.2-1.4 times as likely to attempt suicide than heterosexual non-Latinx adolescents.[371]

The importance of intersectionality

Although studies on suicidality have focused on subgroups among men, the recent literature draws attention to the importance of the relationship between intersectionality and suicide.[372,373] Intersectionality explores the dynamics between co-existing social identities (e.g., intersections between gender and race) and systems of power or oppression.[374] Ferlatte and colleagues' (2018) study of recent suicide attempts among gay and bisexual men across sociodemographic variables[375] found the highest concentration of attempts among those without a university degree earning annual incomes of less than $30,000.[376] Similarly, research on Indigenous populations indicates that suicide risk among two spirit people is far greater than among the heterosexual Indigenous population.[377] This may be due to experiences of homophobia and isolation, higher rates of substance use, and traumatic experiences.[378] To design appropriate interventions that respond to the unique factors that bring a heightened risk for suicide, it is important to examine and understand the compounding effects of multiple marginalized identities.[379,380]

How has COVID-19 impacted men?

Reports from the early stage of the pandemic revealed significant increases in symptoms of anxiety and depression among people in Canada as well as increases in loneliness, social isolation, and problematic substance use.[381-387] Some reports have also noted increases in suicidal behaviour and self-harm.[388] While many reports suggest that COVID-19 has disproportionately impacted women (both in terms of job loss and mental health), for men it has amplified pre-existing risk factors for suicide, such as job loss, financial insecurity, social isolation, and substance use. Given the strength of these risk factors for influencing suicidal behaviour, the potential and observed impact of the pandemic on men cannot be overlooked. The following section provides an overview of the literature on COVID-19 as it relates to men's mental health and suicide.

Vulnerability to COVID-19

COVID-19 survivors may be at elevated risk for mental health issues and suicide due to the stress associated with a COVID-19 diagnosis, hospitalization and ICU admission, the loss of income, the onset of physical symptoms, and neurological conditions.[389] Research exploring sex differences in relation to COVID-19 suggests that men may have greater vulnerability to infection along with more severe disease and adverse outcomes compared to women. In a population-wide cohort study in Ontario, Stall and colleagues (2020) found that men received less testing for COVID-19 and had higher rates of laboratory-confirmed infection, hospitalization, ICU admission, and death than did women.[390] Higher rates of pre-existing comorbid disease, engagement in high-risk behaviours (e.g., smoking, drinking), and poorer adherence to COVID-19 precautionary behaviours (e.g., hand washing, mask wearing, physical distancing) in men may partially explain these differences.[391]

Mental health decline and psychological distress

National polls and surveys have shown that rates of psychological distress, anxiety, and depression have increased during the pandemic.[392-398] Although a higher proportion of women are reporting deteriorations in mental health, rates of self-reported stress, anxiety, and depression are also high among men. A July 2021 survey by the Centre for Addiction and Mental Health (CAMH) found that 17.6 per cent of men were feeling depressed and 16.2 per cent were experiencing moderate-to-severe anxiety.[399] In Ogrodniczuk and colleagues' (2021) investigation of the psychosocial impact of the pandemic on help seeking among men[400] 79.3 per cent indicated that their mental health was negatively affected by COVID-19, and 42.2 per cent reported experiencing suicidal ideation.[401] In a recent Movember survey, two-thirds of men (aged 18-54) in Canada said they had experienced a mental health challenge since the pandemic began.[402]

Job loss and financial insecurity

Job loss and financial insecurity have been shown to increase vulnerability to both mental illness and suicide.[403-407] Research from past economic recessions shows an association between increased unemployment and higher rates of suicide, particularly among men.[408-412] National surveys conducted during the pandemic show that mental health deterioration and binge drinking have been more pronounced in those who have lost their job, are no longer working due to the pandemic, and are very worried about their finances.[413,414] Statistics Canada's Labour Force Survey (conducted early on in the pandemic) reported that 14.6 per cent of men had lost their jobs as of April 2020, and that a higher proportion of men (versus women) who did so lost full-time employment (92.9% versus 69.9%, respectively).[415] While unemployment rates have decreased significantly since then, the potential impacts of men's losses in employment and finances as the pandemic began should be considered when assessing suicide risk and for continued prevention efforts. Ogrodniczuk and colleagues' (2021) study on help seeking among men also found that, as a result of the pandemic, a

quarter of respondents lost their job, 17 per cent worked fewer hours, and half experienced at least moderate financial stress.[416]

Problematic alcohol and substance use

Alcohol and drug use as well as substance use disorders have been shown to significantly increase the risk of suicide attempts and mortality.[417-419] Data collected during the pandemic, which show increases in the consumption of alcohol and cannabis, have been more pronounced in men.[420-422] In a series of polls conducted by CAMH, significantly more men than women reported engaging in binge drinking[423] — a trend that remained steady from May 2020 to July 2021. A series of polls by the MHCC and the Canadian Centre Substance Use and Addiction (CCSA) during the pandemic revealed that, compared to women, more men reported problematic substance use.[424] Specifically, 28 per cent of men who reported consuming alcohol (before the pandemic), reported problematic alcohol use, and 43 per cent of men who reported consuming cannabis (before the pandemic) reported problematic cannabis use (compared to 16 and 32 per cent of women, respectively).[425]

Social isolation, loneliness, and relationship breakdown

Many of the public health measures adopted during the pandemic (e.g., stay-at-home orders, closure of non-essential businesses) have impacted individuals' ability to access their usual social networks and supports. Unemployment and job loss coupled with stay-at-home orders significantly reduced social integration among people in Canada. Social isolation, loneliness, and relationship breakdown are significant risk factors for suicide, particularly among men.[426-428] There is some anecdotal evidence that rates of separation and divorce have increased in Canada throughout the pandemic.[429,430] Research conducted by Ogrodniczuk and colleagues (2021) on the psychosocial impact of COVID-19 among help-seeking men, found that those living alone felt the greatest impact on their mental health, while 40 per cent indicated that the pandemic had negatively impacted their intimate partner relationship.[431] Of particular concern was that one-third of respondents reported engaging in some form of abuse toward their intimate partner, and that 27.3 per cent had experienced abuse by their intimate partner.[432] Other research suggests that men are feeling lonely, are connecting virtually with family and friends less often, are feeling less connected to their friends, and have been experiencing weakened relationships with friends and colleagues since stay-at-home and physical distancing restrictions were imposed.[433-435]

Help seeking

Men are less likely to seek out help for mental health difficulties[436] and are about half as likely to seek out help from a mental health professional and/or a general practitioner as women.[437] In fall 2020, almost one in five people in Canada reported needing some help with their mental health.[438] Of these, 45 per cent reported that their needs were either unmet or partially met.[439] In the MHCC and CCSA poll on mental health and substance use during COVID-19, men were less likely to have accessed mental health treatment in the past month.[440] National survey data from Canada and the U.S. have shown that many men put off seeing a doctor for non-COVID-19-related health issues early on in the pandemic (particularly among those aged 18-34) and were less likely than women to have sought out help to manage COVID-19 life changes or connect virtually with a mental health worker or counsellor.[441-443] Since the pandemic started, health-care providers have seen an increased demand for mental health services, along with a limited capacity to meet patients' needs due to their own illness and increased anxiety and depression, which have meant longer waits and staff shortages.[444,445] For those without access to a phone, computer, and/or internet (e.g., those living in rural and remote areas, those experiencing homelessness and precarious housing) the virtual delivery of health and mental health services has likely created additional barriers to help seeking.

Subgroups living in marginalized conditions

COVID-19 has amplified known risk factors for suicide, particularly among certain subgroups of the population. National survey data collected during the pandemic shows that Indigenous people and people identifying as 2SLGBTQ+ are reporting greater deteriorations in mental health as well as increased alcohol and cannabis use, self-harm, and suicidal thoughts and feelings, compared to the general population.[446- 449]

Brennan and colleagues (2020) explored how social distancing might impact gay, bisexual, queer, trans, two spirit, and other men who have sex with men (GBT2Q+).[450] In discussing the results of the Community-Based Research Centre's 2019-20 Sex Now Survey, the authors noted that 21 per cent of the GBT2Q+ sample reported depression scores above clinical screening thresholds prior to the pandemic. Almost 60 per cent reported wanting help with a mental health problem they were facing; of those, 19 per cent needed help dealing with suicidal thoughts.[451] Considering the high rates of depression and mental health support needs of GBT2Q+ people prior to the pandemic, and the impact of COVID-19 on their ability to access usual supports and resources (e.g., the loss of social outlets, disruptions to community-based mental and sexual health-related services and resources, delays and cancellations in gender affirming surgeries), focused efforts are required to understand and address the pandemic's potential impacts on mental health and suicidal behaviours in this group.[452,453]

Pre-existing social and health inequities paired with major disruptions to cultural and collective practices, may put Indigenous people and their communities at higher risk of adverse physical and mental health outcomes, both during and after the pandemic.[454] Jenkins and colleagues (2021), who explored the mental health impact of the pandemic in Canada, found that Indigenous respondents were experiencing greater stress related to physical and emotional domestic violence, increased alcohol use, and suicidal thoughts and feelings compared to non-Indigenous respondents.[455] Although COVID-19 has had a negative impact on Indigenous peoples, it is important to acknowledge the limitations of the available data, which has focused more on the negative mental health impact of the pandemic than on community resiliency and resourcefulness in developing and implementing innovative responses to COVID-19.[456] In an editorial exploring issues that the pandemic raises for Indigenous communities, Power and colleagues (2020) highlight the importance of acknowledging the many ways Indigenous peoples have responded and adapted to these challenges:

> Indigenous Peoples are known to survive historical and contemporary adversities, demonstrating resourcefulness and resilience in adversity. Despite the marginalisation of Indigenous Peoples in countries' COVID-19 responses, Indigenous communities are instituting their own measures in the presence of universal approaches to managing not only the spread of COVID-19 but in addressing the needs borne out of poverty, housing and food insecurity. (p. 2739)[457]

Men's suicide prevention practices

Recognizing the high rates of suicide among men in Canada, as well as the observed and potential impacts of COVID-19 on risk factors for suicide, it is imperative that suicide prevention approaches continue to be informed by evidence and be developed and adapted for men. For the purposes of this evidence brief, these approaches were defined as "any specific intervention, program or service which aimed to reduce the incidence of suicide or suicidal behaviour or ideation in males, or strategies employed by men themselves (or those around them) that attempted to address suicidal behaviour and/or promote help-seeking" (p. 81).[458]

The following section outlines best and promising practices in suicide prevention for men at the individual and community levels.

Best practices

This section highlights practices identified in the literature with an emphasis on the Canadian context. The Public Health Agency of Canada's definition[††] was used to guide the search for and identification of best practices in men's suicide prevention.

Mental health literacy for men

As previously mentioned, men exhibit lower levels of mental health literacy (MHL) compared to women [459, 460] and may have difficulty recognizing the signs and symptoms of male-type depression. [461] Suicide prevention approaches, when promoted through language that is accessible, understandable, and inclusive of men from diverse backgrounds, have been shown to advance their MHL.[462-464] Introducing and explaining complex topics (e.g., male-type depression, substance use disorders) to help men learn and apply health promotion strategies is also an important strategy. [465, 466] Studies of men who had previously attempted suicide also underline the importance of expanding MHL education to close friends and family members as a way to improve ongoing supports.[467]

Gatekeeper training

The World Health Organization recommends gatekeeper training as part of a comprehensive suicide prevention strategy.[468] Such interventions are aimed at improving early detection of suicidal ideation and suicidal behaviour by training large numbers of community members to recognize and refer those at risk (e.g., Mental Health First Aid, ASIST, safeTALK). Gatekeeper training programs have been implemented with a focus on populations with elevated risk of suicide, including military personnel, youth, and Indigenous communities.[469-471] Many studies reported decreases in suicide for trainees and those they are socially connected to following various types of gatekeeper training that target whole community populations.[472] Although shown to be a best practice among whole populations, researchers have identified further opportunities to tailor this training to additional at-risk populations, such as sexual and gender minorities (SGMs).[473] From a 2017 survey among the

[††] "A Best Practice is defined as an intervention, program, or initiative that has, through multiple implementations, demonstrated: high impact (positive changes related to the desired goals), high adaptability (successful adaptation and transferability to different settings), and high quality of evidence (excellent quality of research/evaluation methodology, confirming the intervention's high impact and adaptability evidence)." See Public Health Agency of Canada. (n.d.) *Canadian best practices portal: Intervention type — Best practices.* https://cbpp-pcpe.phac-aspc.gc.ca/interventions/search-interventions/

2SLGBTQ+ community in Canada, 95 per cent of respondents indicated an interest in gatekeeper training tailored to risk factors specific to SGM populations (e.g., sex- and gender-based discrimination and exposure to HIV-related stigma and stress).[474] It is recommended that gatekeeper training be assessed in the context of the population it serves and also be informed by the specific risk factors the specific community has experienced.

Awareness campaigns

Suicide prevention awareness campaigns include the use of posters, leaflets, websites, and general communication strategies to increase education among the public. Those that are specifically for men have focused on providing information about symptoms of depression and the local resources available to those seeking help.[475] These campaigns have been especially effective when the information is tailored toward when and how men can get help.[476] Studies have also observed that distributing information specific to male-type depression was also of benefit to men.[477] It is important to note that awareness campaigns tied to broader suicide prevention programs in their local regions have shown promise in reducing suicide rates and suicidal behaviour, compared to those not tied to broader initiatives.[478] It is recommended that awareness campaigns provide information to enhance MHL and continue to break down stigma, misinformation, and stereotypes about therapy and medication.[479]

Means safety

One possible explanation for the gender paradox of suicidal behaviour[480] is the use of more violent and lethal means in male suicide attempts.[481,482] In Canada, men's primary means of suicide is suffocation, followed by firearms, then poisoning.[483] There is substantial evidence that lethal means restriction and means safety activities (which emphasize collaboration with mental health professionals and autonomous decision making) are effective suicide prevention strategies.[484-487] Comprehensive means safety activities can include placing safety barriers on bridges, reporting firearm ownership, using medication lockboxes at home, and implementing safe disposal programs for certain medications, among other strategies.[488-491] Studies have also pointed to the benefits of responsible media reporting and means safety training.[492-497]

Safety plans and ongoing crisis support

The objective of a safety plan is to reduce suicide risk for individuals experiencing suicidal ideation and/or suicidal behaviour. Developed jointly with a health-care provider, safety plans include personalized coping strategies, crisis support resources, and information about restricting access to lethal means.[498] Additional considerations such as including close family and friends when drafting safety plans may be beneficial, given that men's decision making before a suicide attempt may be "affected by impulsiveness and lack of systematic reasoning or insight into other available options" (p. 266).[499] Safety planning has long been considered a best-practice approach for reducing the risk of suicide among individuals experiencing suicidal ideation and behaviour.[500,501] Recent comparison studies demonstrate that patients who received safety planning interventions were half as likely to exhibit suicidal behaviour and more than twice as likely to attend mental health treatment during the six-month follow up period, compared to patients who did not receive such interventions.[502] When drafting a safety plan following a suicide attempt, a case management technique that ensures contact within one week of the attempt, followed by six months of ongoing psychological support, is recommended.[503]

Promising practices

This section highlights several practices for men's suicide prevention in Canada. The Public Health Agency of Canada's definition[⌗] was used to guide the search for and identification of promising practices.

Reframing "masculinity" to encourage help seeking

In recent years, researchers have begun to discuss the concept of a "multiplicity of masculinities," which acknowledges the existence of fluid and dynamic masculinities beyond hegemonic or traditional masculinity.[504,505] Recognizing how traditional masculine norms can limit help seeking, suicide prevention approaches have sought to reframe the way masculinity is conceived so as to facilitate emotional expression.[506,507] Connell's concept of the "plurality of masculinities"[508] has "afforded an important frame to thread gender and other social determinants to men's community-based health promotion programming" (p. 1231).[509] Most recently, researchers have discussed how a positive masculinity model can encourage men and health-care providers to co-construct a concept of masculinity that leans on men's desire for self-development to enhance their mental health.[510,511] Suicide prevention approaches for men have shown the potential to reduce suicide risk by allowing participants to redraw more flexible boundaries around "masculinity" that give room for emotional expression while focusing on recovery to facilitate help-seeking practices.[512,513]

Program evaluation and intersectionality

To be effective suicide prevention approaches for men greatly depend on the extent to which they are informed by (formally evaluated) intersections with social determinants of health on the populations they serve.[514] By evaluating suicide rates and suicidal behaviour through an intersectional lens, researchers and mental health professionals can consider the different identities and experiences of the groups they serve (specifically as they relate to experiences of discrimination and disadvantage) and design suicide prevention approaches that are culturally, racially, geographically, and gender appropriate.

As an example, Salami and colleagues (2019) found that, in Alberta, the most significant barrier to immigrants' and refugees' access to mental health services was language.[515] As a direct response, targeted suicide prevention approaches focused on having language interpreters available to accompany patients.[516] Gross and colleagues (2016) assessed a suicide prevention program for men in the Downtown Eastside community in Vancouver.[517] Due to its innovative model of engaging men in a safe space while honouring Indigenous healing principles (e.g., medicine wheel teachings, regular participation of elders), the authors found that the program effectively addressed a critical gap in health services, particularly for Indigenous men in the community. Participants more often reported higher levels of quality of life, spiritual well-being, mental health benefits, health confidence, physical health, and social and peer support, which corresponded to key elements of the medicine wheel approach.[518]

[⌗] "A Promising Practice is defined as an intervention, program, service, or strategy that shows potential (or 'promise') for developing into a best practice. Promising practices are often in the earlier stages of implementation, and as such, do not show the high level of impact, adaptability, and quality of evidence as best practices. However, their potential is based on a strong theoretical underpinning to the intervention." See Public Health Agency of Canada. (n.d.) *Canadian best practices portal: Intervention type — Promising practices.* https://cbpp-pcpe.phac-aspc.gc.ca/interventions/search-interventions/

Covering a range of social and economic factors, the social determinants of health provide context for a specific person's ability to access health services, including mental health supports such as counselling and medication. Recent studies have begun focusing on at-risk populations such as Indigenous men to inform trauma-oriented practices and sexual minority men (i.e., gay, bisexual, men who have sex with other men) to focus on HIV-related stigma.[519-521] Ferlatte and colleagues (2018) note that, by acknowledging the multiple identities held by men, suicide prevention approaches can "attend to multiple axes of social disadvantage, including those related to income, ethnicity, education, sexual identity, and living environment" (p. 1521).[522] Program evaluation must remain closely tied to the social determinants of health with an intersectional lens while continually assessing its effectiveness at different program milestones and time frames.[523]

Increased awareness and detection of male-type depression symptoms

In addition to assessing prototypic symptoms of depression using scales like the PHQ-9, recent research recommends that health-care professionals administer testing scales to assess symptoms specific to male-type depression.[524] These tools may include the Male Depression Risk Scale (MDRS-22), the Masculine Depression Scale, among others.[525-528] Given that men may wait to access services until their need is serious, early detection of male-type depression symptoms (and subsequent mental health care referral) has the potential to decrease their suicide risk.[529-531] Further, reframing depression as a medical condition, while leaning on action-oriented support that is future- rather than emotion-focused, has improved help-seeking behaviours among men.[532] Although these tailored testing scales have shown to increase the detection of male-type depression symptoms, further research has been recommended for diverse populations of men who are actively experiencing suicidality.[533]

Suicide risk assessment tailored to men

Studies have indicated the potential importance of conducting specialized suicide risk assessment for men in emergency departments, as they are more likely to seek help for non-mental health-related reasons.[534-536] Studies on male suicide decedents have shown that, in the month before their death, about 45 per cent had received health-care services and approximately 20 per cent had received mental health care services.[537,538] It is as important for health-care providers to conduct suicide risk assessments during non-mental health-related visits as it is to refer them when suicide risk is detected.[539,540] Although there are no special instruments recommended for such screening, specialized suicide risk assessments may include closer attention to male-specific risk factors (e.g., male-type depression, substance use, adverse childhood experiences).[541] Researchers also recommend screening those with physical comorbidities (e.g., prostate cancer) for potential suicide risk.[542]

Enhancing physician-patient relationships

Physicians are often men's first point of contact when seeking help.[543] Studies have found a significant positive association between men's perceptions about the quality of their relationship with their physician and the willingness to receive mental health support.[544] Acknowledging the existing research on the limitations that general practitioners' attitudes about men and women may have on the practitioner-patient relationship[545] (e.g., with men, spending less time during health visits, offering fewer and briefer explanations, being less likely to diagnose mental illness), it is important for physicians to be aware of any conscious or unconscious gender biases and how these may affect their interactions with male patients.

Gender competence training may be a useful way to teach physicians how to reflect on their gender socialization and its impact on clinical encounters and, ultimately, enhance the quality of suicide prevention interventions for men.[546] Such training should also include gender-affirming practices to

reduce the misgendering of patients based on their sex assignment at birth.[547- 549] Improved help-seeking behaviours have been observed in health-care relationships based on trust, communication, and collaboration.[550,551]

In keeping with the critical nature of positive physician-patient relationships, suicide prevention approaches that focus on expanding MHL and knowledge among general practitioners have resulted in increased mental health referrals and improved help-seeking behaviours among patients.[552,553] In a photovoice study by Oliffe and colleagues (2021), a gay man in his mid-40s contrasted the help he received after an overdose attempt:

> Someone listened to me, both the psychiatrist at the student health clinic and the doctor. They completely understood what was going on, explained it to me. Like my previous doctor had said, "suck it up," and he had been my doctor forever. So that's what I thought I had to do, and then I just didn't give up and I was like, "I'm going to try and see the people at our clinic here." And I got this doctor who was amazing and made me feel normal and that it was okay, and that there was help, and she set me up with the psychiatrist right away and with medication. (p 424)[554]

Implementing suicide prevention approaches in informal settings

Several studies have focused on the importance of men-friendly community spaces to facilitate recruitment and participation. These approaches include interventions that promote social interaction[555] and encourage connections with confidants in the form of friends, neighbours, and others in the community.[556] Some research indicates that men may prefer environments that involve "shoulder-to-shoulder," action-oriented tasks outside a formal clinic, rather than "face-to-face," talk-focused therapy.[557,558] Men's preference for informal support through spaces of continual learning, where individuals can share knowledge or skills through mentorship (e.g., glass tempering, auto mechanics, camping), has also been emphasized.[559] It is important that programs be place based and provide culturally appropriate supports that consider a community's capacity, socio-economic and cultural landscape, and underlying inequities.[560,561] Equally important are activities that allow participants to reframe and expand the concept of "masculinity."[562,563]

Online resources and supports

The internet is one of the primary places where men seek help when experiencing suicidal ideation and/or behaviours. Rice and colleagues (2014) reported that men are twice as likely to seek online resources than they are to consult a health-care professional.[564] The internet's reach, accessibility, and flexibility for autonomous help seeking make it a promising tool for men's suicide prevention approaches.[565] Online prevention approaches, which have increased exponentially due to the pandemic,[566] have explored skills training, consultation, and MHL education.[567] In studies of various anonymous supports, men tend to prefer communicating via email or through e-mental health platforms that allow for arms-length support.[568,569] These types of supports enable men to disclose suicidal ideation while maintaining confidentiality.[570] Virtual platforms have also been shown to significantly reduce wait times in Canada.[571]

These online resources and supports should be closely monitored by mental health professionals to ensure that safe language and appropriate resources for suicide prevention are being shared. Where appropriate, they should refer individuals to one-on-one supports offered by mental health professionals.[572] In terms of ways to increase their uptake among men, several elements stand out, such as using plain language, amplifying men's testimonials, normalizing help seeking, and utilizing interactive strategies to enhance MHL.[573] Despite the growing accessibility and use of online supports, researchers have noted a lack of specific programs for men with depression.[574]

Group-based supports

Research has explored the ways in which group-based supports facilitate protective factors to prevent suicide among men. Studies have shown a preference among men for programs that encourage social connectedness and emphasize “mates supporting mates.”[575] These peer-to-peer programs have allowed men to connect with those who share similar lived experiences and challenge the notion that "nobody cares.”[576] In certain cases, such as veteran transition programs, these supports provide action-based strategies to process traumatic life events.[577] The opportunity to reflect on social connections and consider consequences for loved ones also appears to exert a strong influence on deterring suicide attempts.[578] Group-based supports designed to equip men with MHL tools through collaborative leadership models have shown a great deal of promise.[579] Instead of merely relying on external forces to prevent men from hurting themselves, embedded notions of leadership and resilience can facilitate decision making and responsibility for choosing to live or change unhelpful behaviours.[580] In a qualitative study by Kivari and colleagues (2018), a military veteran reflected on the benefits of group-based supports as part of a veteran transition program:

> Everyone in the group was able to reflect on the story that was told and say, “Your story was impactful on me because I had a similar experience when such and such a thing happened to me.” We said, “Wow we had the same childhood.” That’s a positive thing. Even if your childhood was horrible, suddenly you’re in a room with four or five different guys saying, “Hey man, I’m just like you,” or “You’re just like me.” That goes a long way towards not feeling so alone anymore. (p. 245)[581]

Building better personal relationships

Personal relationships may be important protective factors for men’s mental health and suicide prevention. In terms of romantic relationships, men have been shown to prefer speaking about mental health concerns with their significant others.[582] Inversely, studies have demonstrated high rates of suicide deaths among men who are separated, pointing to the lack of evidence in existing programming for separated men.[583] Recognizing the risk factors around a history of IPV, studies have focused on prevention programs geared toward men’s roles as fathers and parents.[584-587] These studies found that perceptions of fatherhood as a “provider” and “protector” acted as a protective factor.[588] A strengthened sense of purpose and obligation has motivated men to reconsider suicide.[589] Discussions about gender roles and women’s equality have also been associated with healthier, more equitable relationships.[590] These programs have the potential to facilitate help seeking in men while mitigating adverse childhood experiences in their existing or potential children.

Conclusion

Over the last four decades, men have accounted for most suicide deaths in Canada.[591-593] Experts have suggested that these elevated rates among men are in part due to differences in their experience and expression of depression, poor MHL, lower levels of help seeking and service utilization, and higher levels of mental health stigma, which collectively contribute to high rates of undiagnosed and untreated mental illness.[594-602] Men are also more likely to use lethal means when attempting suicide (i.e., suffocation, firearms) which significantly increase their risk of dying.[603-606] Overwhelmingly, the research on mental health and suicide among men shows that the masculine norms they are “expected” or feel pressured to uphold (e.g., strength, toughness, self-reliance, stoicism) feed into negative attitudes, beliefs, and behaviours related to both mental health and the benefits of help seeking (held by men and health-care providers).[607-610] Given this negative impact, it is recommended that suicide prevention approaches focus on leveraging, reworking, and reframing “masculinity” to allow for greater expression and recognition of emotion as well as help seeking.

This reframing may help de-stigmatize mental illness among men, enhance the quality of health-care provider interactions, and open new pathways for building better personal relationships.

To be effective in preventing suicide among men, it is also crucial to continue researching male-type depression symptoms, particularly among diverse subgroups, and equip health-care providers with the information and tools they need to screen for and treat them accordingly. Equally important is creating and enhancing MHL resources to help men recognize the signs of mental illness in themselves and others, including possible signs of male-type depression.

It is also clear from the literature that suicide risk among men varies substantially across different subgroups.[611] Men who are First Nations, Inuit, and Métis, are part of a sexual and gender minority group, are immigrants or refugees, are part of a racialized group, or have certain occupations are at elevated risk for suicide.[612-620] These groups experience unique and intersecting risk factors related to societal stigma, social exclusion, and exposure to trauma, abuse, and violence, including homophobia, displacement, sexual and physical abuse, and historical and colonial violence.[621-634] High rates of substance use, poor access to health and mental health services and education, as well as financial, cultural, and language barriers may compound existing risk factors in these groups.[635-649] Understanding the impact of the social determinants of health on suicide as well as the diverse risk factors among certain subgroups will facilitate the design of appropriate suicide prevention initiatives that are tailored to the unique needs and experiences of these groups.

The findings from this evidence brief reinforce the notion that suicide is a complex and multi-factorial phenomenon, and that the risk of suicide varies substantially both across individuals and subgroups. Acknowledging that the pandemic has amplified pre-existing risk factors for suicide in men, particularly among certain subgroups, it is now more crucial than ever to actively engage in suicide prevention for men.

These findings also have broader implications on suicide prevention at the community level, knowing that for every death by suicide, up to 135 people are directly and indirectly affected.[650] For every man that dies by suicide in Canada, many people — including family members, friends, and community members — are left behind. Researchers, health-care providers, and mental health professionals must embrace the concept of resilience in a way that enhances men's choice and desire to live. The design and implementation of appropriate suicide prevention strategies for men — such as awareness campaigns, gatekeeper training, and group-based therapies, and those that aim to decrease barriers to accessing mental health supports among men and those impacted by their suicide — are crucial for men's mental well-being and for successful life promotion and suicide prevention efforts made on their behalf.

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