Written evidence submitted by Dr Rob Whitley (McGill University) to the Senate Committee Studying the Federal Framework on Suicide Prevention

Executive Summary

- My name is Dr Rob Whitley and I am an Associate Professor of Psychiatry at McGill University in Canada. I am an expert on male suicide and men's mental health. I recently published the book *Men's Issues and Men's Mental Health* (Springer 2021)
- In this document, I argue that any effective suicide prevention strategy must have a focus on men, given that they account for over 75% of suicides. This must include a focus on men at high risk such as Aboriginal men, Military Veterans and men with mental illness.
- This must involve acknowledging and addressing the **social determinants** affecting male suicide and men's mental health per se. Policy change should be targeted at these social determinants as a form of upstream suicide prevention.
- Loss of **employment** can leave affected men suicidal; bereft of a sense of pride, purpose and meaning in life- all of which are essential to psychological strength and resiliency. Interventions that foster male employment can beneficially affect suicidality.
- Young men are much more likely to be 'not in employment, education or training' (NEETS). This results in high-rates of **'failure to launch'** and is linked to substance abuse and suicidality. Targeted training and educational interventions could help.
- Evidence suggests that **divorce** and romantic breakup are strong risk factors for suicide in men, especially where this involves child custody issues. Reform of the family-law system may help prevent many post-divorce mental health and suicide issues in men.
- **Adverse child experience** such as physical and sexual abuse can have a nefarious impact on suicidality and male mental health. However this is often under-recognized, and resultant issues are not treated as mental health problems, but as character defects.
- Evidence suggests that such abuse was rampant at Indian Residential Schools. Along with forced separation from family and community, this caused substantial trauma. This abuse and trauma both contribute to higher rates of suicide among Aboriginal men.
- I argue that we must recognize that there are **different modalities of healing**, and that men often prefer action-based healing over talk-based healing. Thus, we must create more choice in the mental health system to make it more attractive to men and boys.
- In fact, research shows that men of all backgrounds often respond better to grounded, community-driven supports rather than more formal psychiatric treatments. These community supports should be considered upstream suicide prevention resources.
- Great examples of these programs are peer support groups, physical exercise therapies, outdoor wilderness programs and other activity-based interventions. There is early evidence that peer-based support programs are very effective for veterans. Land-based and culturally appropriate programming has been shown to benefit Indigenous men
- It is particularly important for there to be tailored support for men in male-dominated workplaces, such as law enforcement, the military, construction, and manufacturing. Many of these workplaces have been averse to discussing suicide prevention.
- There are hundreds of civil society organizations that are already out there working effectively on the ground helping men at risk of suicide. This includes Veteran groups, First Nations, Rotarians, Lions, and faith-based organizations. It is important to embrace and better support such organizations to prevent the loss of more men who can be helped.

1. Biographical Details

My name is Dr Rob Whitley and I am an Associate Professor of Psychiatry at McGill University, and a research scientist at the Douglas Research Centre in Montreal. I am submitting this written evidence as I am an expert on male suicide and men's mental health, making many significant contributions to the field. For example, in 2021 I wrote a book entitled Men's Issues and Men's Mental Health (Springer 2021). I guest edited a special issue of the *Canadian Journal of Psychiatry* about men's mental health and male suicide, which was published in September 2018. In April 2017, I gave an invited presentation at the European Parliament on the topic of male suicide and I was a key-note speaker at the 2017 Australian National Male Health Conference in Sydney. I also write a popular monthly column on men's mental health for *Psychology Today* entitled 'Talking About Men', and I have also written articles on male suicide and men's mental health for *the National Post*, *the Globe and Mail* and *CBC Opinion*. All the statistics cited in this testimony are discussed in more detail in my recent book.

2. Introduction

2.1 Publicly-available statistics indicate that men account for around 75% of suicides. This means that one Canadian male is lost to suicide every three hours. The heartbreaking frequency of this loss means that an effective suicide prevention strategy must have a special focus on men.

2.2 Men with the highest risk of suicide include Aboriginal men, middle-aged men between 40-60, Military Veterans, men with a pre-existing mental illness, and men working in predominantly male occupations such as construction, forestry, and mining. These men must be targeted with specific suicide prevention efforts.

2.3 Evidence suggests that men have high rates of substance use disorder and addictions compared to women. Several studies indicate that men are around three times as likely to frequently consume illegal drugs in comparison to women. Similarly, men are over twice as likely to misuse alcohol compared to women. Research indicates that men make up around 80% of drug related overdose deaths. This includes deaths related to fentanyl and opioids. I have argued that such drug abuse could be considered 'slow-motion suicide', as many men partaking in such abuse have lost the will to live, as well as any related meaning and purpose in life. As such, these men must be targeted as part of upstream suicide prevention efforts.

2.4 Numerous epidemiological studies indicate that men have lower rates of depression than women. However many have started to question whether these differences are real or artefactual consequences of measurement and reporting bias. For example, some studies indicate that men commonly experience a form of **'masked depression'** that is not captured by traditional diagnostic instruments and measurement scales. These men are also at high risk of suicide, and are not on the official radar as they have not been officially diagnosed.

2.5 Despite all this, much research indicates that men significantly underutilize health services in comparison to women. Some studies indicate that women are about twice as likely to visit a general practitioner in comparison to men. Likewise, only around 30% of mental health service users are men, with men significantly more likely to avoid visiting a mental health clinician.

3. Beyond Masculinity: Social Factors and Male Suicide

3.1 Many men's mental health and male suicide prevention campaigns focus attention on men's supposed silence and reticence to discuss problems. These often take an accusatory tone, leading to a harmful narrative that blames and berates men for their mental health woes. This approach is known as **victim-blaming** in public health, and is studiously avoided in women's mental health campaigns, where social context is often-acknowledged as a key determinant of mental health. I discuss this victim-blaming approach, and the associated harms in a recent article

3.2 This narrow one-dimensional approach is not based on the latest scientific evidence. This latest evidence suggests that a range of **social factors** heavily influence male suicide and men's mental health. These social factors are often considered in public health research, however they tend to be ignored in current debates and discussion about male suicide and men's mental health. I argue in a recent editorial for the *Canadian Journal of Psychiatry* that we must move beyond victim-blaming to better consider these **social determinants** of men's mental health.

3.3 Myself and colleagues recently published a review paper in the *Canadian Journal of Psychiatry* that summarizes the evidence surrounding these social determinants of men's mental health and male suicide in particular. I discuss the most prominent in separate sub-sections below, namely (i) occupational, employment and educational issues; (ii) family and divorce issues; and (iii) adverse childhood experiences.

Unemployment, Occupational and Educational Issues

3.4 Unemployment, job loss and economic precarity are risk factors for adverse mental health outcomes in adult men including suicide, substance abuse and depression. Interestingly, research indicates that unemployment and job loss can have a greater impact on the mental health of men in comparison to women. This may be because men traditionally link their self-identity, self-esteem and self-worth with their work and bread-winning abilities. Work also provides men with social status, income and resources. As such, loss of employment can leave affected men bereft of a sense of pride, purpose and meaning in life, not to mention loss of income to pay the bills; all of which are essential to psychological strength and resiliency. In short, being a **'failed bread-winner'** is bad for men's mental health and is a risk factor for male suicide. As such, policies and interventions that foster male employment will beneficially affect mental health, and should be an integral part of upstream suicide prevention efforts.

3.5 Men make up the vast majority of people working in dangerous and dirty jobs such as fisheries, agriculture, construction, military and law enforcement. Such dangerous positions frequently lead to disability and injury. This can lead to the development of post-traumatic stress disorder, as well as prescription of pain-killing medications, which can be addictive. Moreover, such employment often involves shift-work, unsocial hours and frequent relocations. This can lead to social isolation and separation from families and friends. All of the above can contribute to suicidal behaviour and substance abuse. As such, micro-level and macro-level **occupational health** policies and interventions should be developed and targeted to support men's mental

health (i) while in the work-place itself and (ii) when transitioning out of the workplace due to injury, disability or discharge from the armed services. This should include suicide prevention.

3.6 Data from Statistics Canada and other organizations indicates that young men are **much more likely to be 'not in employment, education or training'** (NEETs) in comparison to their female counterparts. This contributes to much higher rates of 'failure to launch' in young men compared to young women, which are risk factors for male suicide. As such, myself and other scholars are arguing for reform to the education system, to make it more male friendly and equip male students for the new knowledge economy. Such measures could have a positive impact on suicide prevention and the mental health of men and boys.

Family Issues and Divorce

3.7 Evidence suggests that **divorce and romantic breakup** are strong risk factors for mental illness and suicide in men. Indeed, research indicates that divorced and separated men experience higher rates of depression and suicide in comparison to divorced women. One study indicates that divorced men are roughly twice as likely to report depressive episodes following a divorce than divorced women, while other studies indicate that male suicide increases dramatically after a separation or divorce.

3.8 The negative influence of divorce on suicide and men's mental health has been attributed to numerous factors. A key factor is **the loss of social support and emotional connectivity.** Several studies indicate that divorced or separated men report a significant drop in social support compared to divorced or separated women. This is consistent with sociological research indicating that women tend to have larger circles of family and friends whereas men tend to rely largely on their partner and nuclear family for emotional support. Thus, the loss of a partner can be particularly hard for a man, as can the loss of any children in a custody battle.

3.9 Indeed, evidence suggests that loss of custody and a **negative experience in family court** are some of the most stressful aspects of divorce for men and have been implicated in both substance abuse and suicide. Like employment loss, loss of custody can leave many men feeling bereft of purpose and meaning in life, often navigating a difficult, shocking and surprising transition alone. As such, reform of family law may have a positive impact on male suicide.

Adverse Child Experience

3.10 Much evidence suggests that adverse childhood experiences can lead to short-term and long-term psychological and physical health consequences in males and females alike. Sadly, child abuse is common amongst boys and girls; however, some types of abuse are more prevalent in boys than girls (and vice-versa). While sexual abuse tends to be more prevalent in females, **physical abuse** tends to be higher in males.

3.11 The high rates of suicide among Aboriginal men are due to a variety of factors, but attendance at a residential school and consequent inter-generational trauma appear to play a key role. For example, some reports suggest that physical abuse was rampant at these schools, and the forced separation from family and community caused substantial trauma. This negatively

affected the parenting skills of residential school survivors, meaning that subsequent generations of Aboriginal people are also at higher risk of negative mental health outcomes.

3.12 Research indicates that males and females tend to respond differently to child abuse. Abused girls are more likely to display traditional mental health symptoms such as self-harm and disordered eating. Such symptoms can be identified through conventional mental health assessments, leading to targeted treatments. In contrast, abused boys are more likely to display **a constellation of behaviours** including delinquency, disruption, aggression, binge-drinking and risk-taking. Such 'externalizing' behaviours are often considered character issues rather than mental health issues by parents, educational institutions and society as a whole, meaning that chances for early prevention are missed.

3.13 Interventions that reduce adverse child experience will have a positive impact on boys' mental health, as well as a knock-on effect on men's mental health as these boys grow into men. Such interventions are also an essential part of a comprehensive suicide prevention strategy. Furthermore, trauma-informed support services for adult victims of childhood abuse should be expanded. This may mean more specific services targeted at the mental health of men and boys per se, a point expanded upon below in section 4 below. This must include culturally-appropriate trauma-informed interventions and programs targeted at Aboriginal men.

4. Expanding Services and Diversifying Choice

4.1 The current mental health system offers two main modalities of healing: medication and 'talking therapies'. However, University of Missouri Professor Amanda Rose has conducted considerable research comparing male and female orientations to talking, concluding that males often '**don't see talking about problems to be particularly useful**…men may be more likely to think talking about problems will make the problems feel bigger and engaging in different activities will take their mind off of the problem'.

4.2 Indeed, much research suggests that many men prefer **action-based modalities of healing** over talk-based modalities. This includes regular exercise, which has been shown to effectively reduce depressive symptoms. Likewise religious and traditional healing (including traditional methods of Aboriginal healing) can be effective in improving men's mental health and reducing suicidality. Some action-oriented services specifically target men, including 'men's sheds'. These are places where isolated and lonely men can go to create, repair or make things; finding solace and support in the process. The men's shed motto contains much wisdom: 'men don't heal face-to-face, they heal shoulder-to-shoulder'. Early evaluations indicate that these maybe an effective intervention for both mental health, loneliness and suicide prevention.

4.3 In other words, much research indicates that there is **no one-size-fits-all solution** vis-à-vis men's mental illness and suicide prevention. For some men, face-to-face talking can lead to helpful comfort and support: 'a problem shared is a problem halved'. For others, it can lead to painful brooding and rumination: 'do not reopen old wounds'. For the latter, action-based modalities of healing may be more effective. As such, an inclusive mental health system must offer a variety of modalities of healing in addition to medication and 'talking therapies'. Clinicians can then offer different choices and work with the grain when interacting with

individual male patients. This is especially important for Aboriginal men, who may prefer their traditional modalities of healing over medication and talk-therapy.

4.4 Indeed, tailored support programs will mean doing things differently because of the unique needs of various groups of men (e.g. Veterans, Aboriginal men, etc.). Great examples of these programs are peer support groups, physical exercise therapies, outdoor wilderness programs for young men and other activity-based interventions. There is early evidence that peer-based support programs are very effective for veterans. Land-based and culturally appropriate programming has been shown to benefit Indigenous men in particular.

4.5 It is particularly important for there to be tailored support for men in the aforementioned male-dominated workplaces, such as law enforcement, the military, transport, construction, and manufacturing. While there has been a general reduction in the stigma surrounding mental health in workplaces in recent years, many of these workplaces have been averse to discussing suicide and suicide prevention in particular. This has to change.

4.6 There are dozens of civil society organizations that are already out there working effectively on the ground helping men at risk of suicide. This includes Veteran groups, First Nations, Rotarians, Lions, faith-based organizations, and many other groups that are often leading the way on tailored programming. Research shows that men of all backgrounds often respond better to these grounded, community-driven supports rather than more formal psychiatric treatments. However these community groups often survive on a shoestring budget with few staff or outside support. It is important to embrace and better support these organizations in an effort to prevent the loss of more men who can be helped.

5. Conclusion

To conclude, I repeat that any effective suicide prevention strategy must have a special focus on men. This must include targeted recommendations for men at higher risk, including Aboriginal Men, Military Veterans and men with mental illness. Such a suicide prevention strategy must address the social determinants of men's mental health and male suicide; including occupational, educational and legal factors. Moreover, we must diversify health services to make them more attractive to men. This means offering more choice within the health system, while supporting civil society organizations which are often providing vital programming for at-risk men.

Finally, we have to overcome the well-intentioned but misguided belief that merely talking about suicide encourages suicidal behaviour in others. In fact, several research studies have disproven this antiquated belief, with recent research indicating that open discussion can actually reduce suicide. This is particularly the case if discussion about suicide contains messages of hope, recovery and information about accessing support programs. Such discussion must occur in workplaces, educational institutions and elsewhere. If you require any further information, please do not hesitate to contact me at robert.whitley@mcgill.ca and I would be delighted to assist.

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