

Addressing the Suicide Rate among Gay and Bisexual Men in BC: An Assessment of Policy Solutions

by
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Abstract

Suicide has been identified by the BC Ministry of Health as a key issue in its Mental Health and Substance Use strategies, and gender and sexual minorities have been identified as target populations in regard to this issue. Suicide among gay and bisexual men (GBM) in particular is four times higher than among the general population and as of 2007 has exceeded HIV as a leading cause of death for GBM. This capstone employs qualitative interviews grounded in intersectionality and syndemic theory to understand suicide among GBM, and to generate a multi-pronged policy approach composed of 4 key recommendations supported by specific action items. Using an adapted form of Intersectionality-Based Policy Analysis (Hankivsky et al., 2014), these recommendations are analyzed to identify how they succeed in meeting key policy objectives, while also highlighting key challenges and next steps.

Keywords: gender and sexual minorities; gay and bisexual men; suicide; intersectionality; syndemics; intersectionality-based policy analysis

I would like to dedicate this paper to all the queer people who have taken their lives because they grew up in a society where they were made to feel that their life was worthless because of who they were.

I would also like to dedicate this paper to my teenage self who, at one point believed it might be better to be dead than to be gay. No one, especially not a child, should ever be made to feel that way. I survived and I am still here, however healing those scars is a life-long process and this paper represents one of many steps forward in that journey.

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List of Acronyms

GSM	Gender and Sexual Minorities
GBM	Gay and Bisexual Men
HIM	Health Initiative for Men
MOH	BC Ministry of Health
IBPA	Intersectionality-Based Policy Analysis
MHCC	Mental Health Commission of Canada

Glossary

Health Initiative for Men:	A Vancouver-based community health organization for men who have sex with men (MSM).
Qmunity	A Vancouver-based community health organization for gender and sexual minorities (GSM)
Gender and Sexual Minorities	Refers to members of the Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Two-spirit, and other (LGBTQI2S+) non-heterosexual individuals.
Gay and Bisexual Men	Refers to cis men who identify as either gay or bisexual. For the purpose of this study, this does not include transgender men that identify as gay or bisexual as this was beyond the scope of this study.
Intersectionality:	Refers to the study of intersecting social categories, identities, and social positions with which an individual identifies, and how these factors play a role in social, economic, and health outcomes.
Syndemics:	Refers to the study of how two or more coexisting and interconnected health issues combine to increase the overall health burden of an individual.

Executive Summary

Policy Problem:

Rates of suicide among gay and bisexual men (GBM) are approximately four times higher than the general population in BC, and since 2007, suicide has surpassed HIV as a leading cause of death among this population. The policy problem that needs to be addressed is that the rate of suicide among GBM in BC is too high. This reality has been recognized by the BC Ministry of Health (MOH) which has identified suicide as a key priority in its mental health and substance use strategies and has recognized gender and sexual minorities (GSM) as a priority population. In prioritizing suicide, the MOH has also recognized that, depending on an individual's intersecting social positions and identity, suicide is experienced differently. Based on this reality, the MOH has called for comprehensive multi-strategy approaches based on current research to address suicide that also account for varying and intersecting social positions and identity.

The focus for this study is on GBM. This is based on the recognition that "GSM" covers a vast span of varying identities, experiences, and social positions, and as such, one strategy for this group as a whole may not be appropriate. The purpose of this paper is twofold. First, using qualitative interviews grounded in both intersectionality and syndemics, this paper will add to existing knowledge on suicide among GBM. Second, using these findings, this paper will present a series of recommendations that can be used to guide the development and implementation of a comprehensive multi-strategy approach to suicide among GBM.

To add to existing knowledge on suicide among GBM, and to develop recommendations on a suicide prevention strategy, that addresses the variability in need based on intersecting social positions, this paper is approached primarily from an adapted form of Intersectionality Based Policy Analysis (IBPA) in concert with syndemics as a key consideration. IBPA is a policy analysis framework that attempts to bridge the complexity of intersectionality with the inherent incrementalism, reductionism, and short time horizons of public policy. Syndemic theory comes from research on HIV among GBM, and refers to how "a set of enmeshed and mutually enhancing health problems, that, working together in a context of noxious social and physical conditions, can significantly affect the overall disease burden and health status of a population (Singer,

2009, p. xiv).” Research combining intersectionality and syndemics has shown that the more vulnerable GBM are based on intersecting social positions such as gender, age, ethnicity etc. the more likely they are to experience multiple and concurrent health issues such as STI infection, substance, use or suicide (Ferlatte, Salway, Trussler, Oliffe, & Gilbert, 2017). Together, intersectionality and syndemics are complementary and enable an analysis that accounts for the relationship between intersecting social positions and multiple co-existing health issues, including suicide.

Methods:

A literature review of intersectionality and syndemic-based research on suicide among GBM was conducted to generate a foundational understanding of the issue and to help guide the qualitative interviews. Using findings from the literature review, as well as the guiding questions of IBPA, an interview schedule of six questions was developed. The questions asked respondents to discuss their background and understanding of suicide, promising practices in BC and other jurisdictions, intersectionality-based understanding and approaches, syndemic-based understanding and approaches, interventions in an ideal world, and considerations or resources not already discussed. Using the interview schedule, semi-structured interviews were conducted with 9 respondents with backgrounds in three broad areas: research, policy, and service delivery.

Interview Findings:

The interview period lasted 3 months, and questions related to the 6 key topics generated 34 initial themes. These initial themes were analyzed for similarities and key patterns. These were then re-categorized into six broad conceptual themes: homophobia and discrimination, stigma, syndemics, intersectionality, community, and interventions. These themes are used in the development of four key policy recommendations and accompanying action items.

Policy Recommendations:

The interview findings were used to generate four key policy recommendations that are informed by both literature and interview discussions of syndemics and intersectionality:

Recommendation 1: combat homophobia and discrimination

Recommendation 2: improve mental health and suicide literacy

Recommendation 3: expand the accessibility of mental health services to GBM

Recommendation 4: invest in community-based interventions and services

The recommendations are supported by specific action items. The action items are derived from specific interventions mentioned throughout the interview findings, and where specific interventions were not mentioned, actions were derived from additional research.

The recommendations and action items together are meant to guide the development of a multi-strategy and comprehensive approach to suicide among GBM. Like the MOH, interviewees emphasized that suicide among GBM does not follow a single trajectory but is influenced and interacts with a host of factors, and because of this, a holistic and multi-pronged approach is needed. Therefore, the recommendations should be viewed as a package rather than distinct options to be implemented separately from one another.

Evaluation of Recommendations:

The recommendations and their action items are evaluated based on how they meet key policy objectives which include: reduction in the suicide rate, syndemics, equity, social justice, and feasibility. These policy objectives are derived based on Questions 7-9 of IBPA and syndemic theory. Each objective is described, followed by an analysis of how the recommendations meet this objective. Out of this analysis, four key challenges are identified which include challenges in research, equity, social justice, and stakeholder acceptance.

Implementation:

Key considerations around implementation are discussed beginning with a description of how the recommendations should be prioritized using the principle of centering on the margins. Key challenges are also identified that should be considered in guiding future research and policy development on suicide among GBM. Some of the

ongoing considerations that emerged from these challenges include: increased research on suicide, expanded efforts to reduce inequity of suicide within the GBM population, more efforts towards social justice, consultation with GBM on proposed recommendations, and establishment of evaluation mechanisms for these recommendations.

Conclusion and Next Steps:

To address the suicide rate among GBM in BC and to answer the call by the MOH for a comprehensive multi-strategy approach to suicide, this study aimed to achieve two key goals. First, through qualitative interviews grounded in IBPA and syndemics, this paper has added to existing knowledge on suicide among GBM. Second, the recommendations made in this paper represent a first step in developing a comprehensive multi-strategy approach to addressing suicide among GBM in BC. It is hoped that both this research and the policy recommendations can bring focus to a crucial health issue in the GBM population and help generate policy movement in addressing it.

Chapter 1. Introduction

1.1. Policy Problem

The rates of suicide among gay and bisexual men in BC are too high.

1.2. Purpose

The BC Ministry of Health's (MOH) mental health and substance use strategy *Health Minds, Healthy People* identifies suicide as a key public health priority:

Suicide is a major public health issue that affects everyone across age, gender, ethnic, socioeconomic and cultural groupings. Mental health problems are strongly associated with suicide and suicidal behaviors, and multiple risk factors intersect to influence a person's risk for suicide. There is no "one size fits all" approach to preventing suicide. To address the varying needs of individuals, it is important to develop comprehensive, multi-strategy approaches based on current research (Ministry of Health, Ministry of Children and Family Development, 2010, p. 23)

The MOH's updated strategy, *BC's Mental Health and Substance Use Strategy 2017-2020*, makes specific mention of how some populations, including gender and sexual minorities (GSM), are more at risk of mental health and substance use challenges:

Historical, cultural and socioeconomic factors play a role in the development of mental health and substance use problems. Studies in B.C. and across Canada indicate some groups – notably Indigenous peoples, youth in care, refugees (particularly from countries of conflict), sexual and gender minorities, individuals with special needs, and children with a parent(s) that has a mental health and/or substance use problem – are at higher risk. An effective system of care needs to ensure easy access to supports and services for people in these groups in order to prevent problems, and to intervene early if problems develop (Ministry of Health, 2017, p. 114)

Between these two strategic documents, the provincial government has identified suicide as a key issue of concern, has identified GSM as vulnerable populations, and has articulated the need for a comprehensive and multi-faceted suicide prevention strategy. Importantly, the MOH has explicitly highlighted the need to ensure that services aimed to address suicide are designed in light of the intersecting factors, including race, age, income, ability, and comorbid health issues, that influence an individual's risk for suicide.

Based on these concerns, the purpose of this study is two-fold. First, this study will employ qualitative interviews informed by intersectionality and syndemics to generate new knowledge on suicide among GBM. Second, using these findings, this study will provide guidance on the development of a suicide prevention strategy that addresses suicide among gay and bisexual men (GBM). The focus on GBM is based on the recognition that “GSM” covers a vast span of varying identities, experiences, and social positions, and as such, one strategy for this group as a whole may not be appropriate. However, it is expected that GSM more broadly will experience benefits from the implementation of any of the recommendations of this paper.

To develop recommendations on a suicide prevention strategy for GBM, that addresses the variability in need and intersecting risk factors highlighted by the MOH, this paper is approached primarily from an adapted form of Intersectionality Based Policy Analysis (IBPA) in concert with syndemics as a key consideration. Syndemics has grown out of HIV research on GBM, and has yielded a more sophisticated understanding of HIV and its connection to other key health issues, including suicide (Stall, Friedman, & Catania, 2007). A syndemic lens is included as a key consideration in this paper given that the most recent and innovative research on suicide among GBM has shown that this is a syndemic issue (Dulai, Ferlatte, & Hottes, 2016a; Ferlatte, Dulai, Hottes, Trussler, & Marchand, 2015a; Ferlatte, Hottes, Trussler, & Marchand, 2014; Hottes, Ferlatte, & Gesink, 2015a; Mustanski, Andrews, Herrick, Stall, & Schnarrs, 2013a; Salway et al., 2017; Wang et al., 2018). The importance of syndemics in understanding suicide among GBM is also confirmed through the findings from the qualitative interviews where syndemics emerged as a key theme. Syndemics is paired with intersectionality in this study because there is a connection between an individual’s social position and likelihood to experience a syndemic between two or more related health issues (Ferlatte, Salway, Trussler, et al., 2017). The more vulnerable GBM are based on intersecting social positions such as gender, age, ethnicity etc. the more likely they are to experience multiple and concurrent health issues such as STI infection, substance use, or suicide (Ferlatte, Salway, Trussler, et al., 2017). In this way, syndemics adds to IBPA and intersectionality by providing a clearer picture of the connection between social position and health outcomes, while highlighting how inequity in one health issue can translate into inequity in other health issues. Just as intersectionality rejects the idea of addressing health inequities based on a single social location or identity, syndemics

rejects the idea of addressing health issues in isolation without consideration of interacting and comorbid health issues (Ferlatte, Salway, Trussler, et al., 2017). Intersectionality and syndemics are complementary and enable an analysis that accounts for the relationship between intersecting social positions and multiple co-existing health issues.

This capstone begins with an overview of the policy problem and then goes into existing intersectionality and syndemic literature on suicide among GBM. This is followed by an overview and explanation of the methodology, research design, and research limitations. From here results from qualitative interviews are discussed highlighting the key themes that arose. The interview findings are used to shape four key recommendations that are supported by key action items. The recommendations and their accompanying actions are evaluated based on how they meet key policy objectives that are developed based on interview findings, syndemics, and IBPA. Based on the policy objectives and analysis some key challenges are identified. The paper concludes with a summary of recommendations and next steps.

1.3. Background

According to 2015 data from the BC Coroners Service, the suicide rate among the general population of BC is 13.1 deaths per 100,000 population (“BC Coroners Service - Suicide Deaths in BC (2006 - 2015),” n.d., p. 1). The average annual number of deaths per year due to suicide between 2006 and 2015 was 527.5 per year (“BC Coroners Service - Suicide Deaths in BC (2006 - 2015),” n.d., p. 1). According to WHO, for every one adult that dies by suicide, there are as many as 20 or more who have attempted suicide (World Health Organization, 2014, p. 9).

These are alarming numbers on their own, however certain groups experience the burden of suicide at higher rates than others. For instance, a 2015 study by Hottes, Ferlatte, and Gesink found that in 2011, suicide resulted in approximately 46 deaths per 100,000 population among GBM (Hottes, Ferlatte, & Gesink, 2015b, p. 513). This means that GBM die from suicide at nearly four times the rate of the general population. While much of the focus in terms of research and policy pertaining to GBM’s health has been focused on HIV, based on the same study, as of 2007 suicide surpassed HIV as a leading cause of death among GBM (Hottes et al., 2015b, p. 513). This is largely the

result of a concentrated and sustained effort to address the HIV rate among GBM, while at the same time suicide as a health issue has been left unattended. Therefore, policy and practices aimed specifically at GBM have been instrumental in addressing the HIV epidemic in BC, and given that suicide takes at least as many lives – if not more – than HIV in this population, similar strategies are needed.

1.4. Literature Review

1.4.1. Overview of Suicide

Suicide, put simply, is the taking one one's own life. More specifically, suicide is "death from injury, poisoning, or suffocation where there is evidence (either implicit or explicit) that the injury was self-inflicted, and the person intended to kill him/herself (Monk & Samra, 2007, p. 6)". What is not simple is how an individual reaches this decision. Suicide can be described as a "crescendo phenomenon" where an individual moves from "sporadic thoughts of death to more frequent suicide wishes or from diffuse suicide plans to schemes that include detailed choices of method and place (Wasserman, 2016, p. 232)".

The MOH has developed a guide for treating suicidal individuals that outlines an extensive list of factors that can increase the risk of suicide in an individual. These include: age, sex, history of mental illness, hopelessness, previous suicidal behavior, experiences of abuse and trauma, substance use, periods of conflict or stress, family history of mental illness and suicidality, isolation and loneliness, lack of quality relationships, access to lethal means, and physical disorders or disabilities. According to the Centre for Addiction and Mental Health (CAMH), individuals with multiple risk factors occurring concurrently are at a higher risk of suicide (Centre for Addiction and Mental Health, 2015).

Both CAMH and the MOH identify protective factors that help to reduce suicide risk. These include individual, family, work, and community factors. Individual factors can include problem solving skills, self-understanding, optimistic outlook, interpersonal skills, and adaptive coping skills. Family factors include a sense of family responsibility and family relationships characterized by warmth and belonging. Work factors include sense of accomplishment, positive peer and colleague relationships, supportive work

environment, positive core values in the workplace, access to employee assistance, and opportunities for professional development. Finally, community factors include opportunities to participate, affordable and accessible supportive resources, hope for the future, and a community that foster self-determination and solidarity.

The CAMH handbook on suicide specifically mentions key populations that are at risk for suicide, including GSM. Risk factors most relevant to GSM include higher rates of depression, substance use, social and family rejection. GSM youth in particular are more likely to experience homelessness or drop out of school. Understanding these factors and the way they are experienced by GBM can help explain why the suicide rate is higher among this population and helps to inform strategies to address this issue.

In the next section an intersectionality and syndemic analysis is used to generate an in depth understanding of suicide among GBM. This includes a focus on explaining how GBM are differentially affected, and the interacting factors and health issues that contribute to suicide among GBM. Examining this issue from these two theoretical approaches provides critical background information and helps to establish a foundational understanding of this problem. This provides the platform off which to launch an investigation into interventions that might address the underlying factors that contribute to suicide among GBM.

1.4.2. Intersectionality

Intersectionality refers to the study of intersecting social categories – such as race, gender, and social class – with which an individual identifies. Intersectionality uniquely addresses a holistic understanding of the lived experiences of an individual within a society. It is the recognition that social outcomes cannot be properly explained by investigating independent social categories and treating them as stand-alone variables (Guittar & Guittar, 2015, p. 657).

Intersectionality was largely pioneered by black feminist scholars who deployed it in explaining the position of black women within larger civil rights and feminist movements (Lisa Disch, Mary Hawkesworth, & Brittney Cooper, 2016). These scholars argued that to understand the position of black women within the feminist or civil rights movement, the intersecting systems of power to which they were subject, must be examined. Kimberlè Crenshaw, a black feminist and legal scholar, applied an intersectional critique to the feminist movement which she argued needed to consider the unique and

intersecting systems of oppression faced by black women and women of colour (Lisa Disch et al., 2016). Like class based movements, she argued that feminism largely ignored racial dynamics, which meant the feminist movement replicated the patterns of racial inequality that exist in society at large (Lisa Disch et al., 2016). In a similar way, the civil rights movement focused on the issue of race with minimal consideration of gender inequality within the movement. Crenshaw argued that social or legal interventions aimed to address only racism, sexism, or poverty would be insufficient as these interventions fail to account for how all three forms of oppression are inter-related and contribute to compounded oppression (Lisa Disch et al., 2016).

Intersectionality applies to explanations of the experiences of GSM individuals. For instance, the GSM population tends to be treated as a single bloc, and the vastly different experiences between the sexual identities within GSM community are glossed over. Moreover, the lived experiences of each identity within the GSM population varies considerably, which further complicates efforts to treat the GSM population as a homogenous group. For instance, Fredriksen-Goldsen et al. argue that within the GSM community, transgender and bisexual individuals emerge as experiencing different systemic barriers than lesbian and gay individuals and remain chronically underserved and at risk (Fredriksen-Goldsen et al., 2014). The singular focus on sexual identity as the primary locus of oppression fails to see how barriers and inequities faced by the GSM population are the result of a combination of intersecting identities and systems of power.

Intersectionality is especially applicable to health disparities faced by the GSM community. Fredriksen-Goldsen et al. (2014), in their research on what they call the “health equity promotion model”, explain that health disparities that exist within the LGBT community differ based on a multitude of factors including, sexual identity, gender, age, race, class etc. They go on to argue that “a consideration of social positions and health must include attention to the complex nature of intersecting social positions including diverse sexual and gender identities and how social locations interact and the potential for synergistic disadvantage or advantage based on multiple statuses (Fredriksen-Goldsen et al., 2014, p. 656).”

Like other health issues facing GBM, the risk for suicide varies across GBM sub-groups based on differing and intersecting social positions such as ethnicity, income,

education, geographic location, and marital status. Studies on suicide among adult GBM have been sparse, however a 2016 study by Dulai et al. showed that GBM that identified as Aboriginal reported that they had attempted to end their life in the last year at a rate double that of the general population of the survey (Dulai, Ferlatte, & Hottes, 2016b, p. 3). Additionally, twice as many GBM with a combination of low education and income reported attempting suicide in the previous year (Dulai et al., 2016b, p. 3). Ferlatte et al. (2017) examined the interaction of different social identities within the GB population and how this affected suicide risk. The study showed interactions between education, income, and geography. Specifically, low education, income, and residing in urban environment independently had an effect on the odds of reporting a suicide attempt, but when low education and low income intersected, the odds of reporting a suicide attempt were even higher (Ferlatte, Salway, Hankivsky, et al., 2017, pp. 9–11). The study also showed that there were interactions between being bisexual and one's relationship status, where bisexual men partnered with a woman were less likely to report a suicide attempt compared to those partnered with a man. The paper concluded by stating that "by applying an intersectionality framework, this article demonstrated that the prevalence of recent suicide attempts depends critically on multiple, intersecting social identities" (Ferlatte, Salway, Hankivsky, et al., 2017, p. 11).

1.4.3. Syndemic Theory

Syndemic theory is an analytical framework first developed by Merrill Singer that describes how "a set of enmeshed and mutually enhancing health problems, that, working together in a context of noxious social and physical conditions, can significantly affect the overall disease burden and health status of a population (Singer, 2009, p. xiv)." The concept emerged out of Singer's extensive research on the HIV epidemic within low-income Black and Latino neighborhoods in the US where he found that HIV was only one part of a whole of multiple interacting and reinforcing health and social problems (Singer, 2009, p. xiv). Syndemic analysis has since been applied to a myriad of public health issues such as SARS, asthma, influenza, hepatitis, tuberculosis, and other STIs.

The application of syndemics in analyzing health disparities among GBM has been almost exclusively focused on HIV. Stall et al. performed one of the first studies of HIV/AIDS among GBM in 2003 using a syndemic framework which tested the

relationship between a set of psychosocial variables and increased risk of HIV infection (Stall et al., 2003, pp. 939–940). The outcome of the study was that there was in fact a syndemic among the MSM studied and that the interconnectedness of psychosocial factors magnified the impact of HIV/AIDS in this group (Stall et al., 2003, p. 941). The study concluded that research and interventions aimed at HIV/AIDS among GBM must go beyond sexual risk alone (Stall et al., 2003, p. 941). Since Stall et al., many studies have continued to apply a syndemic lens to HIV/AIDS among GBM. In 2013, Mustanski et al. used syndemics to study an ethnically diverse sample of youth in Chicago and found an independent association between substance use; psychological distress; intimate partner violence; sexual assault and the likelihood to have multiple anal partners; unprotected anal sex; and HIV infection (Mustanski, Andrews, Herrick, Stall, & Schnarrs, 2013b, p. 42). Another study in Latin America of 24,274 online respondents showed that syndemic factors such as drug use during sex; childhood sexual abuse; intimate partner violence; and sexual compulsivity were associated with increased self-reported HIV prevalence and high risk sexual behavior (Mimiaga et al., 2015, p. 1874).

While prominent in research on HIV/AIDS, syndemic research hasn't been applied to nearly the same extent for suicide among GBM. In a study that compared the research on HIV to the research on suicide for GBM, Hottes, Ferlatte, and Gesink found that research on suicide had 10 times fewer citations than for HIV between 2003 and 2012 (Hottes et al., 2015b, p. 513). Even within these studies, the number that use a syndemic analysis are sparse, however recent research has suggested that this problem is a syndemic issue. Two separate studies found that individual marginalization and psychosocial indicators were positively associated with an increase in prevalence of suicide related ideation and attempts for GBM (Dulai et al., 2016b; Ferlatte, Dulai, Hottes, Trussler, & Marchand, 2015b). Marginalization indicators included physical violence, anti-gay bullying, sexual violence, and workplace discrimination (Ferlatte et al., 2015b). Psychosocial factors included substance use, tobacco use, use of anxiety or depression medication, being diagnosed with one or more STI's, HIV status, and episodes of condomless intercourse with a partner whose HIV status was unknown or discordant (Dulai et al., 2016b, p. 7; Ferlatte et al., 2015b, p. 605). The study by Ferlatte et al. argued that because "many of the health disparities experienced by gay and bisexual men (such as HIV, depression, anxiety, polydrug use, suicide) happen

synergistically, it is unlikely that any of these conditions would improve without attending to the others (Ferlatte et al., 2015b, p. 604).”

1.4.4. Combining Intersectionality and Syndemics

Bringing intersectionality and syndemics together provides a more comprehensive understanding of suicide among GBM by explaining the relationship between intersecting social positions and interacting health issues among GBM, and how interventions must account for this relationship. A 2017 study by Ferlatte et al. combined both an intersectionality-based and syndemic analysis to understand the health inequities faced by Canadian GBM. The study demonstrated that there was a relationship between the dependent syndemic variables and independent demographic variables such as ethnicity, education, income, and age (Ferlatte, Salway, Trussler, et al., 2017, p. 6). More specifically, the study found that independent variables such as identifying as gay, being aged 45 or younger, not having a university degree, earning under \$60,000 annually, being single, and identifying as Indigenous were associated with an increased likelihood to report two or more psychosocial issues (Ferlatte, Salway, Trussler, et al., 2017, pp. 6–8).

The studies reviewed here show that approaching the problem of suicide among GBM in BC through the lens of intersectionality and syndemics can lead to a more holistic understanding of the issue. The research and analysis conducted in the remainder of this paper is informed by the findings of these studies. The goal of this approach is to reach a policy recommendation, or combination of recommendations, that accounts for the complex interaction of factors, including identity and concurrent health issues, that contribute to this problem.

Chapter 2. Methodology

2.1. Background of Theoretical Approach

To address suicide, particularly among diverse priority populations, the MOH has emphasized the importance of developing “comprehensive, multi-strategy approaches based on current research.” The current research on intersectionality and syndemics, in relation to suicide among GBM, points to the need for holistic and multi-faceted solutions that account for both intersecting social identities and positions of power as well as co-morbid interacting health issues. The literature clearly indicates that one-size-fits-all approaches are unlikely to have a significant impact on suicide among GBM. Given these realities, policy making on this issue must be adjusted to avoid a single-factor or single-issue focus and must be more holistic in both analysis and implementation.

Based on this need, traditional approaches to policy analysis, may not be effective. As Manuel (2006) argues, “[p]ublic policy, by its very nature, is reductionistic and incremental. Public policy analysts try hard to simplify policy solutions as much as possible, and simplicity often comes at the expense of comprehensiveness. That is, to simplify policy solutions and avoid conflict, public policy scholars often try to “boil down” the range of people’s experiences down to a single, “treatable” issue that can be resolved inexpensively (MANUEL, 2006, p. 195).” As the literature has demonstrated, suicide among GBM is complex and cannot be reduced to a single treatable factor, and people’s unique experiences and identity critically affect how they are affected by suicide. Another key feature of policy analysis, particularly in the realm of decision making, is that there is an assumption of a “best collective decision, the public interest, that can be rationally and analytically determined if the correct neutral procedure is followed (Bacchi, 1999).” However, this approach largely ignores the reality that policy is not neutral, does not affect all people in the same way, tends to benefit some groups over others, and often perpetuates inequality that leads to the policy problem in question (Hankivsky & Cormier, 2011). Health policy analysis can also take a similarly reductionist approach where attempts are made to develop neutral policies or interventions aimed at making broad improvements in the health of populations, however because of this reductionism they “may not effect meaningful change in the health of those situated at intersecting axes of disadvantage (*An Intersectionality-Based Policy Analysis*

Framework, 2012, p. 11).” Therefore, in approaching this problem, policy analysis models that attempt to reduce complex problems to single factors and in doing so lead to simplified solutions, are inappropriate for addressing suicide among GBM. Typically, these models, such as multi-criteria-decision-making models, are designed to reduce a field of options to a single recommendation rather than to generate a series of recommendations needed to achieve the goals of the MOH in creating a comprehensive and multi-strategy response.

To avoid the pitfalls of reductionist policy analysis, to achieve the goals of the MOH, and to develop recommendations based on intersectionality and syndemics, this paper uses a policy analysis approach based on IBPA. IBPA is used in an attempt to bridge the complexity of intersectionality with the incrementalism, reductionism, and short time horizons of public policy (*An Intersectionality-Based Policy Analysis Framework*, 2012). Rather than reducing the complexity of suicide among GBM to a single factor or a field of strategies to a single recommendation, IBPA is used to account for complexity and to generate a series of recommendations that can be implemented in concert with one another as a comprehensive strategy.

While the use of IBPA in this manner is relatively unique (there have been several case studies using IBPA to analyze existing policies), the approach of generating multiple recommendations as part of an overall strategy is not. In fact, this approach reflects the format adopted by the MOH and other key public health stakeholders and can be seen in a multitude of strategic reports and policies including the MOH substance use and mental health action plans: *B.C.'s Mental Health and Substance Use Strategy* and *Healthy Minds, Healthy People*. The Provincial Health Officer also released a similarly formatted policy document for addressing HIV stigma and related health issues: *HIV, Stigma and Society*. Other key reports referenced in this paper, and that follow a similar format include: *Moving together towards social equality: Quebec Policy against homophobia* and *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*. What these reports have in common is the recognition that health issues are complex, intertwined, and connected to social identity and positions of power, and as such, require multi-pronged approaches that account for this complexity rather than single-factor single-strategy responses.

It is also important to reiterate that the purpose of this paper is not to make a decision for government on what should be done but rather to present a series of potential recommendations that can be used to guide the development and implementation of a comprehensive multi-strategy approach to suicide among GBM. Because of the nascent stage of research in suicide among GBM and GSM more broadly, the voices of those with lived experience and from wide ranging intersecting identities have not been sufficiently accounted for. Therefore, it would be irresponsible to present these findings as definitive, objective, or neutral recommendations that fully represent the needs or interests of all GBM. In particular, as an urban, cis, white, educated, middle-class, gay man, as an analyst, I am approaching this problem from a relatively privileged state and cannot claim to speak on behalf of the entire GBM community. Further, given that all the interview respondents are urban, highly educated, white, and cis, their views, while important and valuable, also cannot be seen to represent the views of GBM or GSM more generally. Therefore, this study is meant to provide a starting point for the development of a comprehensive strategy, and to provide recommendations that should be subjected to further research and consultation with GBM from varying intersecting backgrounds and identities to ensure that implementation truly achieves the desired objective of reducing suicide among GBM.

2.2. Intersectionality Based Policy Analysis

The Intersectionality Based Policy Analysis (IBPA) Framework developed by Hankivsky et al. (2014) is an analytical framework designed to integrate the benefits of intersectionality theory into a coherent, methodical, and flexible policy analysis tool. Being rooted in intersectionality, the IBPA rejects the notion of focusing on singular identities or social positions when developing policy, but rather encourages an analysis that examines “the complex relationship between mutually constituting factors of social location and structural disadvantage so as to more accurately map and conceptualize determinants of equity and inequity in and beyond health” (Hankivsky et al., 2014, p. 121).

IBPA consists of two key components, a set of guiding principles and a set of 12 guiding questions. The principles guide the ways in which the questions are answered. The 12 questions are categorized as either *descriptive* or *transformative*. The descriptive questions are designed to provide critical background information including how different

groups are influenced by the problem, policies that exist in relation to this problem, and how different groups are affected by these policies (Hankivsky et al., 2014). The descriptive questions also ask the analyst or policy maker to identify their own knowledge, perspectives, experiences and background and how this comes to play in relation to this problem.



Figure 1: Descriptive & transformative overarching questions of IBPA

Image: Hankivsky et al., 2014, p. 123. Licensed under CC BY 4.0.

The transformative questions are designed to draw out inequities in relation to the problem, potential interventions, how they will address inequities, and how these will be implemented and evaluated. The final question challenges the analyst to reflect on the process and examine how their thinking has changed, and what the process has taught them about the problem, and the role of varying social positions and power structures.

IBPA is meant to be flexible and adaptable to differing policy contexts, and therefore not all the questions need to be used or used in exactly the same way. The questions also act as guide posts and can be implemented implicitly and explicitly in the analysis. However, the principles of IBPA should be used to ground any use of the IBPA in policy analysis.

The descriptive questions of IBPA have been incorporated in this study at several junctures in implicit and explicit ways. First, a combined intersectionality and syndemic based literature review was used to explain the policy problem under consideration, and to identify how identity and health status are related. Qualitative interviews were guided implicitly by IBPA with questions that aimed to uncover the knowledge, values, and experience of the interview respondent; generate understanding of the problem; highlight different representations of the problem; identify current policy responses; and explain how groups are differentially affected.

Because of the nascent stage of research and policy development in relation to the issue of suicide among GBM, and the limited scope of this paper, only questions 6-9 of the transformative questions were used to guide this analysis. First, both in the literature review and in the interviews, a key inquiry was what inequities exist in relation to this problem. Second, respondents were asked to discuss potential interventions both in terms of feasibility and in how interventions might address inequities. Finally, the policy recommendations are analyzed in light of the transformative questions which are used to develop five key policy objectives focused on improving the problem, reducing inequities, and feasibility.

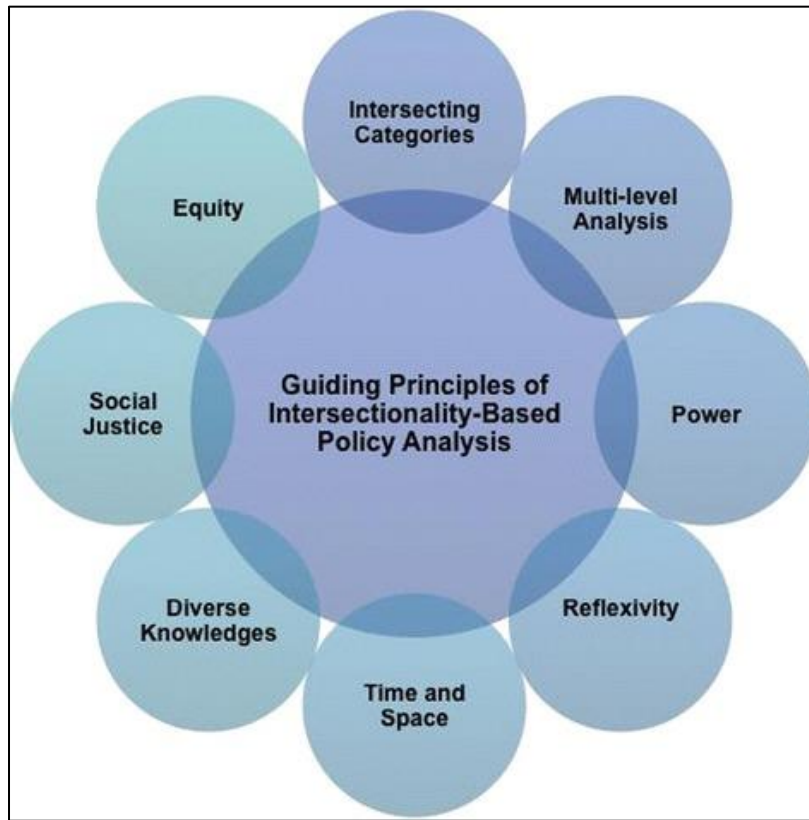


Figure 2: Guiding principles of Intersectionality-Based Policy Analysis

Image: Hankivsky et al., 2014, p. 122. Licensed under CC BY 4.0.

This study is guided by the principles of IBPA, primarily the principles of equity, social justice, intersecting categories, multi-level analysis, power, and reflexivity. Equity and social justice play a role in this paper as the purpose of this study is to propose recommendations that both reduce inequity but also work to undo the structures or ways of thinking that lead to these inequities in the first place. Intersecting categories is a key principle of this analysis as the goal is to go beyond sexual orientation as a factor in suicide and look at how members of the GBM population experience suicide differently based on a wide array of intersecting social positions and power. Multi-level analysis was incorporated by implementing both syndemics and intersectionality to investigate the relationship between social position, identity, and health status. Power is implicit in this analysis through secondary and primary research that highlight ways in which this problem affects individuals differently based on social positions. Reflexivity is reflected in how interview respondents were asked to identify their own experience and knowledge in relation to this issue.

2.3. Primary Research Methods

2.3.1. Purpose

Primary research data gathered for this study comes from semi-structured qualitative interviews. This research methodology was chosen because qualitative methods are more conducive to the purpose of this study as the goal is not to test or prove a hypothesis (Corbin & Strauss, 2017), but rather to gather ideas for potential policy interventions and key considerations. Interviews were conducted with stakeholders involved in research, policymaking, and service delivery. Additionally, because this study represents a relatively new area of research – in terms of identifying solutions – it is as much a fact-finding endeavor as a policy recommendation. Thus, the flexibility and fluidity of qualitative research methods lends itself more usefully to this study than a more rigid quantitative study.

2.3.2. Research Design

Semi-structured interviews were conducted with 9 respondents with backgrounds in three broad areas: research, policy, and service delivery. The interview guide was informed by IBPA and was composed of six core questions that covered the following topics of discussion: the respondent's background and understanding of the issue, promising practices in BC and other jurisdictions, intersectionality-based understanding and approaches, syndemic-based understanding and approaches, interventions in an ideal world, and considerations or resources not already discussed. While these six topics guided the discussion, unstructured questions were asked to prompt further discussion or explore concepts or ideas that emerged from the primary questions. Additionally, while the topics of the six questions remained the same, the questions evolved or were adjusted based on the respondent's area of knowledge.

Interviews lasted from 45 to 75 minutes and were audio recorded and transcribed. Respondents were recruited through two means. The first was a search of organizations representing the three target categories to find publicly available contact information for relevant individuals. In addition to this, some respondents were recruited through snowball sampling where respondents that were interested, or had participated, referred colleagues and other relevant individuals to the study. Interview transcriptions

were analyzed for key themes including potential policy interventions and considerations.

2.3.3. Limitations

While the advantages to using qualitative methods for this study have been identified, there are some limits that should be considered. First, because of the time-consuming nature of gathering the data, only a limited number of respondents were contacted. This means that this study cannot be considered representative of all stakeholders. Because of this, the findings cannot be considered conclusive, and further quantitative or mixed-methods analysis may need to be applied to test the research findings, which is beyond the scope of this study. Additionally, using snow-ball sampling may lead to a singular voice from respondents because it is likely that colleagues of respondents have similar thoughts or viewpoints on this issue. This may mean that dissenting or less known views of equal importance and consideration may have been missed.

Chapter 3. Interview Results

The interview period lasted 3 months, and questions related to the 6 key topics generated 34 initial themes. These initial themes were analyzed for similarities and key patterns. These were then re-categorized into six broad conceptual themes: homophobia and discrimination, stigma, syndemics, intersectionality, community, and interventions. These themes are used in the development of the policy recommendations and their accompanying action items. The six themes are summarized below.

3.1. Homophobia and Discrimination

Respondents agreed that suicide can and does affect anyone. However, to explain why GBM may face higher rates of suicide than the general population, many respondents explained that homophobia and oppression had a role to play. The consensus was that many GBM experience homophobia, either directly or indirectly, over the course of their lives. Respondents discussed how homophobia and oppression have the largest impact in childhood, where these adverse experiences of violence and trauma disrupt key developmental stages, especially if this violence and trauma is being perpetrated by family or peers. The program manager for the gay men's mental health program at the Health Initiative for Men (HIM), explained that throughout their life, GBM tend to experience a

strange kind of mix of long, long term anxiety in coping with a system in a world that's very oppressive to them, and that anxiety eventually seems to turn into a rather serious depression.

A researcher from the BC Centre for Disease Control (BCCDC) described this process using the concept of minority stress theory. The theory explains that GBM experience accumulated stressors from both enacted stigma and anticipated prejudice that can lead to negative thoughts, hopelessness, and emotional isolation.

While homophobia and discrimination are of key importance respondents cautioned that the path to suicide is more nuanced, and in fact minority stress theory and homophobia are only part of the explanation. Another researcher at the BCCDC explained that there is a misconception that

all of these health conditions have their defined paths, but these things are often complex and intertwined.

In fact, researcher explained that while many GBM experience the effects of minority stress, in some cases they attribute suicide to other issues including those within the gay community itself. These intra-community issues include racism, ageism, body shaming, and other forms of discrimination.

A researcher at UBC and director of a research project on suicide among GSM individuals, explained that the path to suicide sometimes follows a pattern of cascading events and experiences that bring an individual to a place of hopelessness. Based on his interviews of GBM who have attempted suicide, he explained that

it's very complicated. There's a lot of factor[s]. I lost my boyfriend. Then I had to move in a tiny apartment where I didn't want to live. I was on disability. I couldn't pay my bill[s]. Then all my friend[s] left me. It's pretty rare that people have a very simple answer.

These cascading events can start with childhood trauma, which leads to mental illness, which leads to poor education and employment outcomes, which can lead to poverty, and eventually a sense of hopelessness. The pathway doesn't always follow the same trajectory, but the stories of cascading experiences and obstacles were common in this researcher's findings.

Homophobia and oppression can also act as a barrier to accessing care. For instance a staff member at the Crisis Centre in BC explained from his lived experience that

part of what was blocking me to getting help was that I'd have to admit to being gay before I could admit to being [...] depressed and suicidal, they'd have to ask me why and then I'd have to admit to being gay.

Essentially, the fear of being outed or the potential for homophobia can act as an additional barrier to accessing needed care. A respondent from the Community Based Research Centre (CBRC) explained that for some GBM there is still a generational memory of

historic oppression and the use of the mental health industry to essentially make us sick and considered like in general, like our sexuality was considered a mental illness.

This history of homophobia may leave many GBM, especially older GBM, afraid to access mental health services.

3.2. Stigma

Collectively, the interviewees expressed that there is stigma in every level of addressing suicide: among the general population, politicians, policymakers, public health workers, and healthcare service providers. Stigma is manifested through several inaccurate ideas or attitudes in society, the first being that suicide is hopeless and that those who are at the point of committing suicide are beyond help. In regards to the stigmatizing attitudes she hears from service providers and other individuals, a program director from the Crisis Centre explained that

I think there is a lot of hopelessness when thinking of suicide, it is like we can't really do anything. If someone is seriously thinking about suicide, that person is seen as a write off.

Interviewees who worked in service provision explained that there is a fear among the public that talking about suicide may trigger someone to actually commit suicide, and so it is better not to bring it up. For instance, one respondent explained that one of the main reasons people are afraid to talk about suicide is the cultural and historical fear that

if we talk about it and somebody starts thinking about it, or somebody does it, or somebody ... or I'm the reason, or what if I make it worse, or what if something bad is gonna happen.

There is also the idea that suicide is a small problem that only affects the severely depressed or mentally ill. Essentially, there is a fundamental lack of understanding or accurate knowledge around suicide that extends across society including the healthcare system and among policymakers.

Suicide and mental health stigma can also lead to the provision of inappropriate or harmful care. One of the respondents from the Crisis Centre explained that many of the individuals who seek suicide prevention training are those that may have been suicidal before or know someone who was, and that many have had traumatic experiences with the healthcare system. She explained that

It is not uncommon for participants in our two-day suicide intervention training to be triggered, and feel challenged because the model we teach

is so different from how they were treated when they were struggling with suicide. For some, they are so triggered by it that they cannot finish the training. They reflect back on how poorly they were treated. Some say they felt they were treated like a criminal, an “insane” person, like someone who had no capacity to manage their own life.

3.3. Syndemics

Syndemics came up both in terms of explaining suicide, and in terms of describing the kinds of interventions needed. First, suicide was described as often coexisting with other health issues such as HIV, STIs, violence, substance use, and of course mental illness. Respondents explained that GBM, and sexual minorities in general are susceptible to these issues, and in many cases, they interact and contribute to one another.

Respondents explained that a syndemic approach is not reflected in the current health system. Instead, approaches to suicide or co-related issues tend to be a siloed and disease-specific. As the respondent from CBRC explained

you can't effectively reduce one of these many epidemics without taking on all of them at the same time.

This was echoed by a respondent from the BCCDC who explained that

it's pretty clear when you look at the literature that people often don't experience health conditions in isolation, and really looking at those social and structural inequities that drive health inequalities is really key if you want to have a meaningful and sustainable impact.

One of the practical ways that this approach could be articulated, raised initially by one public health researcher, but echoed by several other respondents, was the idea to use existing STI clinics, specifically those targeted to GBM, as potential avenue for suicide prevention. This would involve training STI nurses on mental health and suicide screening, offering suicide resources at the STI clinic, and providing funding for these sites to offer more mental health and wellness services. Two respondents explained that that for many GBM, their primary, and sometimes only, interaction with the health system is through these community clinics. Because of STI testing protocols, many GBM visit these clinics multiple times throughout the year, and so STI clinics provide an existing infrastructure to deliver a combination of sexual health, mental health, and suicide prevention services.

3.4. Intersectionality

Discussions around intersectionality focused both on how it explains different experiences of suicide, and how it should inform approaches to address it. First, almost all respondents acknowledged that while GBM commit suicide at a higher rate than the general population, there is variation in suicide rates within this community. This variation is based on other social identities and positions in society. For instance, many respondents explained that GBM that identify as Indigenous have higher suicide rates in comparison to more privileged individuals in the GBM. Because of this, many respondents emphasized that a single approach to suicide for GBM would not be effective, and instead an approach that considered the health inequities within this population would be more effective.

When asked to describe how intersectionality should inform an approach to suicide among GBM, there was a consensus around the idea of reducing barriers to access. A key theme that emerged explicitly and implicitly in the interviews was the idea of "centering on the margins". In discussing this concept, one respondent explained that

there is a tendency for new interventions or even improvements in interventions to differentially benefit the people who have historically benefited from those services.

So, in the instance of GBM, an approach targeted at GBM as a whole, without consideration of intersectionality would likely benefit wealthier, urban, white men while leaving the inequity between members of this population relatively intact.

This concept was echoed implicitly in different ways by the other respondents. For instance, two respondents suggested that rural and First Nations communities need more resources than urban centers, while the respondent from HIM explained how counselling services at HIM are designed to prioritize the most at risk and marginalized individuals so that they get quicker access and more resources. The respondent from the MOH brought up a similar approach to centering on the margins referred to as proportional universality. He explained that proportional universality

suggests that change in health status on the population level relies on effective universal interventions as well as interventions that layer on intensity to meet the needs of other population groups that are experiencing greater disadvantage or a greater burden of health problems as a result of a variety of socioeconomic factors.

3.5. Community

When asked what preventative measures might look like, a general consensus emerged from the interviews that community plays an integral role in preventing suicide. For instance, the respondent from the MOH explained that

some of the more promising practices that really are still fairly nascent in terms of research evidence to support them but are starting to emerge as promising are ones that look at how we reinforce that community of identity. How we reinforce that community of commonality that that is defined pretty subjectively by people within the queer and the transgender community but is such a strong influence in terms of mental well-being and such a strong protective factor for potential mental health problems and ultimately, for suicidal ideation.

Respondents approached the concept of community in different ways, but what emerged is that community essentially refers to the social networks that an individual is found in. Community could be a high school, a workplace, a neighborhood, an identity group, social groups etc. Regardless of the specific form of community being referred to, respondents generally agreed that prevention efforts should be community-based. This was often linked to two factors: first, that suicide is often associated with social isolation, and second, that communities know more than anyone else what they need, and more localized or specific interventions are more effective. A respondent from the Canadian Mental Health Association (CMHA) explained that community-based programs, in contrast to traditional public health or government programs,

[are] not programs and supports and services that someone from on high in some agency or another has simply decided this is what we're going to do, and this is going to work.

Instead, community-based programs should be run by and for communities and could be supported by government through overarching strategic policy and funding.

Respondents felt that the primary benefit of community was that it serves as a protective factor. The respondent from CMHA explained that investing in communities, and focusing interventions there, is a form of strength building. She listed specific community building interventions such as Men's Sheds as a program that isn't suicide specific but that can prevent against many factors that contribute to suicide such as social isolation and lack of purpose. Two researchers and a policy director mentioned

Mpowerment, a community-based HIV prevention program, which is partially syndemic and non-suicide specific.

Gay Straight Alliances (GSAs) (sometimes called Gender and Sexuality Alliances) were brought up by two researchers and the respondent from the MOH as an ideal upstream and preventative program that can build GBM communities within schools. The MOH respondent explained that in school communities, GSAs are

a hugely important and really easy to implement approach to improving the mental health and well-being of queer and gender minority students, and also as it turns out heterosexual male students.

Finally, three service providers from the Crisis Centre and CMHA explained that suicide prevention training in workplaces, social spaces, schools, and other "communities" could help increase the capacity of these communities to recognize, intervene, and prevent suicide. These programs target so called "community gatekeepers" which are individuals that many members of a given community would have regular interaction with.

3.6. Interventions

One of the primary goals of the interview process was to generate a repository of potential policy options. All the questions, either directly or indirectly, prompted respondents to list interventions, policy options, or programs that might address suicide among GBM. Responses range from specific and existing programs, to highly ambitious interventions that respondents would implement in an ideal world. The list of possible interventions is extensive, however some of the key interventions will be listed here.

Some key reoccurring interventions, that could be classified as "easy wins" are suicide awareness campaigns, anti-stigma campaigns, and increasing visibility of suicide resources. More ambitious interventions that were common among respondents increasing the number of GSAs in BC schools, providing queer competency training to frontline service providers, targeting suicide prevention and awareness training to GBM, improving mental health literacy, and increasing means-preventing initiatives.

The most ambitious interventions stemmed from a question where respondents were asked what downstream and upstream interventions they would like to see happen

in an ideal world. In terms of downstream interventions, most respondents explained that mental health services should be covered or be made more accessible, with some suggesting that it be included as an essential service under the Canada Health Act. The program manager from HIM imagined a world where psychotherapy could be prescribed like medication:

I have this dream of a physician being able to prescribe eight sessions of counselling. And that prescription can be taken to a dispenser of service, and that might be a counselor, a psychologist, a private psychiatrist, who then could do the thing and follow up with that person.

Respondents collectively expressed the importance of bringing down silos to achieve truly integrated care where mental health services, physical health, and other health services were accessible in the same place. Other downstream services included enhanced funding of existing programs to deliver suicide and mental health services, such as funding organizations like HIM and Qmunity to expand mental health services and incorporate them with sexual health services.

Ideal upstream solutions centered around a common idea: making the world a better place. Specifically, if stigma, homophobia, violence, poverty, and other forms of oppression could be eliminated, this would have a significant impact on reducing suicide. Some concrete ideas of how to achieve this goal included targeted and persistent social marketing designed to attack stigma and homophobia in our society. When asked what was meant by social marketing, one respondent answered

if you can teach people that an iPhone is the coolest phone, you can teach people that being nice is the coolest phone.

The MOH respondent explained that what is needed is a multi-pronged approach incorporating all of these initiatives that is funded and sustained over time. The CMHA respondent expressed the importance for a coherent strategy incorporating anti-stigma efforts, mental health services, community building, and anti-homophobia campaigns, as opposed to the one-off pilot projects that are common-place in Canadian public health. She expressed that

we're really good at saying, 'Well, let's do this, we'll do this and this will work,' without the notion that what we do needs to be a brick in a wall and has a lot of bricks and most programs are only one brick.

Essentially, what emerged from these intervention ideas was that suicide is a vastly complex issue that requires more than a one-off intervention. Instead, addressing suicide among GBM requires a multi-pronged approach based on an acknowledgement of the importance of syndemics and intersectionality.

Chapter 4. Policy Recommendations

The themes of the interview findings are used to develop four key policy recommendations, that are supported by specific action items. The action items are meant to incorporate some of the more specific interventions mentioned by the interview respondents. In cases where respondents didn't mention specific interventions that could support a recommendation, actions were drawn from additional research on best or promising practices being implemented in other jurisdictions or by other key stakeholders. For example, under Recommendation 1 respondents discussed GSAs as a means to combat homophobia and discrimination, however they did not discuss specific recommendations for addressing homophobia and discrimination among adults, despite identifying this as a key issue. In this case, additional research was done to identify interventions being done in Quebec to provide an action that addresses homophobia among both children and adults. A similar process was used to generate the actions for Recommendations 2 and 3. Finally, the recommendations together, as an approach, are meant to be informed by both literature and interview discussions of syndemics and intersectionality. The details of each recommendation and its accompanying action items are outline in Figure 3.

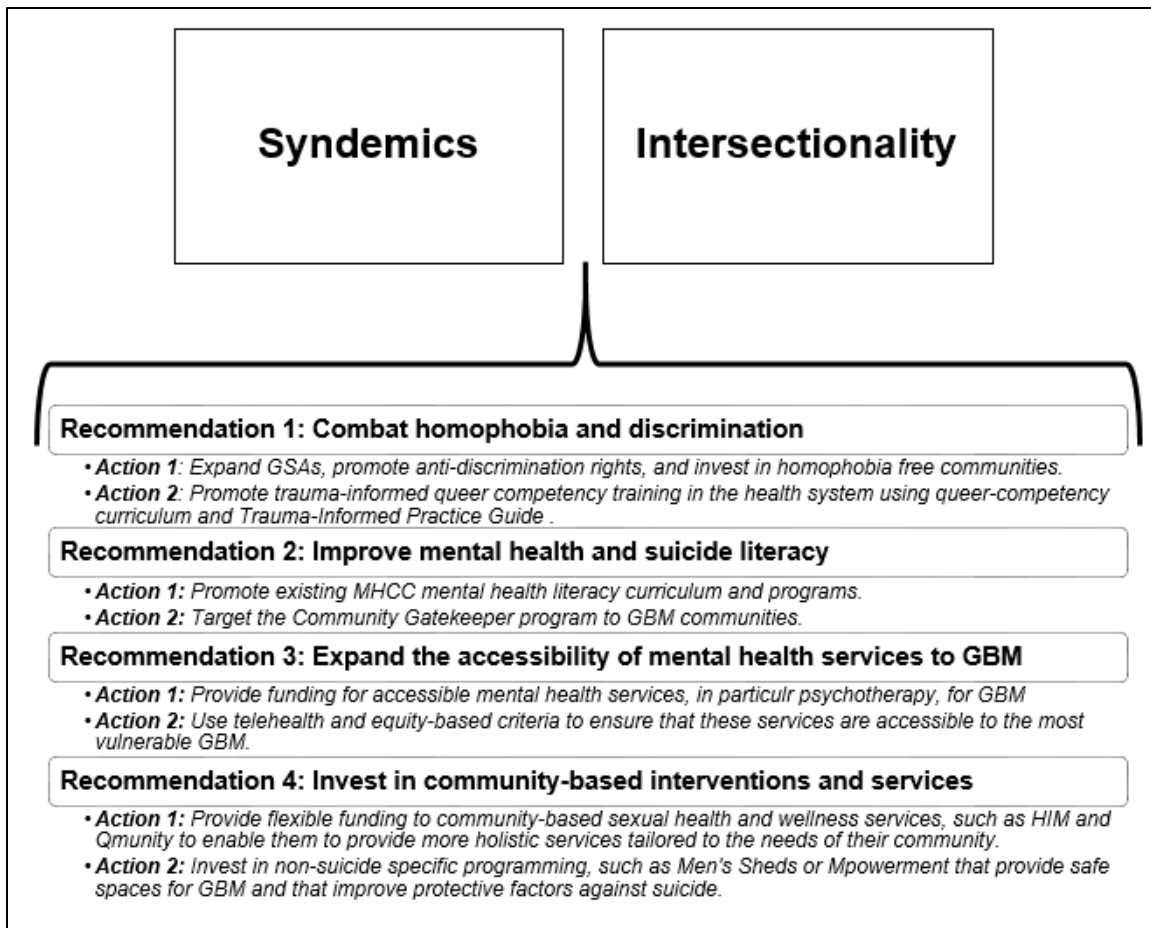


Figure 3: Summary of Recommendations and Action Items

4.1. Recommendation 1: Combat homophobia and discrimination

4.1.1. Overview

As a risk factor for suicide, homophobia and discrimination is experienced in childhood during key developmental stages such as adolescence and can have significant impacts on GBM throughout the rest of their lives (Carrie Lee, John L. Oliffe, Mary T. Kelly, & Olivier Ferlatte, 2017; Plöderl et al., 2014; Saewyc, Konishi, Rose, & Homma, 2014; Salway et al., 2017). For instance, the 2014/15 Sex Now survey showed that depending on age category, 33-63% of respondents had been called homophobic names over the course of their life, 10-13% had attributed a missed career opportunity to homophobia, and 12-45% of respondents had experienced hate talk or verbal violence before the age of 18 (Trussler & Ham, 2016, pp. 28–30). Those with lower instances of homophobia were those over 60 years old while those with the highest instances of homophobia tended to be younger with some of the highest rates of homophobia being experienced by GBM under the age of 25 (Trussler & Ham, 2016). This data, and the issues raised by the interview respondents demonstrate that homophobia and discrimination still play a significant role in the lives of GBM, which can be a contributing factor to higher rates of suicidality among this population.

The second impact of homophobia and discrimination discussed by interview respondents was a fear by many GBM in approaching healthcare providers, particularly outside of more tolerant urban environments. There is some evidence from the 2015/16 Sex Now survey that supports these concerns. Depending on age, 33-50% of respondents were not out to their healthcare provider (Trussler & Ham, 2016). This may be for a host of reasons including fear of homophobia from the provider, fear that the provider will out them, or just not feeling that it was necessary to tell their provider. The gap of knowledge by the provider of a significant aspect of their patient's identity means they may not be as informed of key health issues these patients could face including suicide, substance use, STI's, or mental illness. Additionally, the Sex Now Survey was lacking in responses from MSM of visible minority backgrounds (Trussler & Ham, 2016, p. 12). GBM of colour, in particular Indigenous GBM, experience both homophobia and racism induced trauma and discrimination. The combination of experiences of

homophobia and racism may make these individuals less likely than their white GBM peers to feel safe or comfortable accessing services, particularly those related to suicide.

Based on these key concerns, two potential actions can be taken to achieve Recommendation 1:

Action 1: *address homophobia and discrimination in children and adults through the promotion and expansion of GSAs and through promoting anti-discrimination rights and investing in homophobia-free communities.*

Action 2: *promote trauma-informed queer competency the health system through mandatory training involving existing queer-competency curriculum and the Trauma-Informed Practice Guide.*

Action 1

GSA traditionally refers to Gay Straight Alliance more recently these are being referred to as Gender and Sexuality Alliances. (For the purpose of this study these will be collectively be referred to as Gender and Sexuality Alliances using the acronym GSA). GSA's are one of the most promising initiatives that can be used to combat homophobia among children and youth. According to the BC Teachers Federation (2017), a GSA is a

school based group organized to end antigay bias and homophobia in schools, and create positive change, making schools a welcoming and safe place for all students, regardless of sexual orientation or gender identity.

GSAs are student run initiatives sponsored by one or more teachers with membership from GSM students as well as heterosexual allies ("MyGSA," 2018). The purpose is to connect GSM students with one another and any like-minded heterosexual students not only to create a safe space but to advocate for social change in schools. GSAs in schools are often, but not always, supported by explicit anti-homophobia school policies (Saewyc et al., 2014). The goal of both GSA's and anti-homophobia policies is to improve the wellbeing of sexual minority students by combating stigma, homophobia (both physical and verbal), and by building resilience in GSM students (Saewyc et al., 2014). As part of addressing homophobia and discrimination among children, BC should provide funding, support, and training for all schools in BC to establish a GSA.

BC can look to Quebec for inspiration on combating homophobia among adults. As part of its overarching strategy to reduce homophobia and discrimination, Quebec has taken specific action to promote the existing anti-discrimination rights for GBM in employment, schools, social and sport organizations, and when receiving public services (Gouvernement du Québec, 2009). GBM in BC should be made more aware of these rights, and employers, schools, and organizations should be made aware of their duty to uphold these rights (Gouvernement du Québec, 2009). Part of the anti-homophobia strategy also calls for Quebec to provide funding and provide policy direction to municipalities to develop homophobia-free communities. BC should consider a similar strategy by supporting regional and local governments in combatting homophobia through funding, legislation, and policy.

Action 2

Queer competency training essentially involves understanding the history and unique experiences of GSM and how that relates to their health including past experiences, and better enable providers to “develop the understanding, language, and skills” to engage with and support GSM clients (“Training,” 2018). Curriculum exists already in BC for queer competency training that could be scaled up and expanded. In particular Qmunity, a Vancouver-based GSM health centre, offers workshops to organizations and service providers from varying backgrounds.

Trauma informed care is an approach to service provision “based on an understanding of the prevalence of many forms of violence and trauma among children and adults [...] and the wide range of adaptations people make to cope (Government of Nova Scotia, 2015, p. 5).” The purpose of trauma informed care is to create “safety and trustworthiness in the course of health – and social-care interactions (Government of Nova Scotia, 2015, p. 5).” The BC Provincial Mental Health and Substance Use Planning Council has developed an extensive Trauma-Informed Practice Guide that can be used to shape queer competency training (BC Provincial Mental Health and Substance Use Planning Council, 2013).

Trauma-informed queer competency training should be made mandatory where possible with all healthcare providers. It can be encouraged in areas where the province doesn’t have direct control such as among practicing physicians, psychologists, or existing mental health organizations. Whether new curriculum is developed, or if existing

curriculum is used as a foundation, extensive consultation is necessary to ensure that the curriculum is relevant particularly to the most vulnerable groups, and where needed made culturally relevant. In particular, trauma informed queer competency training should be delivered alongside the Indigenous Cultural Safety (ICS) training that is already provided across the health system by the Provincial Health Services Authority.

4.2. Recommendation 2: Improve mental health and suicide literacy in the public and the health system

4.2.1. Overview

According to the Mental Health Commission of Canada (MHCC), more than 60% of people with mental health issues don't seek help ("Stigma and Discrimination | Mental Health Commission of Canada," n.d.) In the case of GBM, a study of American LGB adults showed that of those that attempted suicide, only 23% sought out help (Meyer, Teylan, & Schwartz, 2015). A report by the CBRC on Health Literacy among GBM found that a lack of mental health literacy or knowledge of how to navigate mental health services was identified as a key gap in the overall health literacy of GBM (Gilbert, Dulai, Wexel, & Ferlatte, 2014).

MHCC attributes the hesitancy to seek help, and negative experiences when doing so, to three key forms of stigma: self-stigma, public stigma, and structural stigma (Mental Health Commission of Canada, 2013). Self-stigma refers to the internalization of cultural stereotypes towards mental illness or suicide, where they believe that they are weak or that mental illness is their fault. Public stigma refers to the prejudice or stereotypes held by broader society against mental illness, and commonly include the ideas that people with a mental illness or who are suicidal cannot be helped and that these issues are the fault of the sufferer. Structural stigma is the manifestation of stereotypes and prejudice through institutions, policies and laws where individuals suffering from mental illness or suicide are treated in negative ways, ignored, or not prioritized (Mental Health Commission of Canada, 2013).

Efforts should be made to address stigma at the individual level for GBM, at the public level through media and broad training for society, and the structural level with health and social service providers. Improving mental health and suicide literacy can

enable GBM to reach out for help, enable peers to identify and assist suicidal GBM, and improve GBM experiences when reaching out for help. Two key actions that can be taken to achieve this:

Action 1: *Promote existing MHCC mental health literacy and mental health first aid curriculum.*

Action 2: *Target the Community Gatekeeper program to GBM communities.*

Action 1

To address stigma, the MHCC has identified mental health literacy as a key area for improvement. MHCC has developed several programs to improve mental health literacy designed for specific target groups including journalists, healthcare providers, youth, workplaces, and a mental health first aid curriculum for the general population. The target groups were chosen because of their impact on mental health stigma. Journalists and news media are shown to be the primary source for the public on information regarding mental health and mental illness (Mental Health Commission of Canada, 2013). Overly negative stories regarding mental health can foster stigma, while positive stories of recovery can reduce it. Healthcare providers are one of the sources of the most deeply felt stigma for people with mental health issues, and this can be attributed to lack of training and insufficient skills (Mental Health Commission of Canada, 2013). Workplaces are where most adults, including GBM, spend the majority of their day, and stigma in the workplace can prevent individuals from seeking help for fear of being viewed as unreliable or lazy. Finally, youth are a target group because, MHCC findings show that nearly 60% of youth 25 years of age or younger reported experiences of stigma when seeking treatment for mental illness (Mental Health Commission of Canada, 2013). This is of particular concern for GBM as younger respondents to the Sex Now survey reported higher instances of homophobia than older GBM.

The programs MHCC has developed for these groups are based on a large-scale systematic evaluation of existing community-based anti-stigma campaigns across Canada (Mental Health Commission of Canada, 2013). BC should take the findings of the MHCC report and provide wide scale mental health literacy training either by replicating the MHCC programs or providing investment for anti-stigma programs that meet the same criteria as those the MHCC found to be most effective. This training

should be made mandatory in the same manner as queer competency training where possible and encouraged with incentives where this isn't possible.

Action 2

BC is already involved in implementing a program designed to improve suicide competency and create suicide safe communities through Community Gatekeeper Training provided by the Canadian Mental Health Association (CMHA). The CMHA has been mandated by the BC MOH to provide suicide first aid training to 20,000 BC residents by December 2018 (BC Gov News, 2015). The training is provided to “community gatekeepers” which are individuals that hold positions of trust and responsibility in communities and who regularly come in contact with a wide array of adults or youth (“Suicide Prevention Training | CMHA British Columbia,” 2018). Gatekeepers can include teachers, coaches, healthcare workers, community volunteers, elders, spiritual leaders, first responders etc. The training is comprised of two courses developed by LivingWorks: a one day course on basic suicide skills called safeTALK, and a two day course with more advanced training called ASIST (“Home » LivingWorks Education,” n.d.) This program should include GBM, or GSM more generally, as one of the target populations. To do this, consultation with the GBM communities should be done to ensure that the training is relevant, appropriate, and reaches the most effected individuals. For instance, many GBM come in contact with bartenders, drag queens, or bathhouse attendants, and STI nurses. These would be key individuals to connect to the community gatekeeper training program. Additionally, this training should be free for GBM to reduce financial barriers and should be made available online for those living in rural communities.

4.3. Recommendation 3: Expand accessibility of mental health services

4.3.1. Overview

A common theme among several of the interview respondents was the need for more accessible mental health services. As the respondent from HIM expressed, mental health services are typically only available at the point of crisis, are difficult to access, or the only help available is prescription medication from a physician but not appropriate psychological interventions. This is a concern shared by the MHCC which explained in

its 2012 mental health strategic plan that the “fragmented and underfunded mental health systems across the country are far from able to meet the mental health needs of Canadians” and that “people living with mental health problems and illnesses – whatever their age and however severe their mental health problem or illness – and their families should be able to count on timely access to the full range of options for mental health services, treatments, and supports, just as they would expect if they were confronting heart disease or cancer (Mental Health Commission of Canada, 2012, p. 52).” Currently, for most individuals, mental health services, in particular psychotherapy, is not publicly available and must be paid for out of pocket. There is a significant cost to these services, and given that low-income, indigenous, and rural GBM are the most vulnerable to suicide, it is unlikely that these individuals could get access to these services.

Two specific actions can be taken to improve the accessibility of mental health services both broadly and specifically:

Action 1: *Provide funding for mental health services, in particular psychotherapy, for GBM.*

Action 2: *Use telehealth and equity-based criteria to ensure that these services are accessible to the most vulnerable GBM.*

Action 1

Cognitive behavioural therapy (CBT) and related psychotherapy techniques were found in an extensive review by the Suicide Prevention, Intervention, and Postvention Initiative for BC Suicide PIP BC to be best practices for preventing suicide among vulnerable and high-risk populations while being beneficial to the general population as well. These services should be made available to GBM, in particular those GBM most vulnerable to suicidality (Joshi, Damstrom-Albach, Ross, & Hummel, 2009). Such an initiative falls in line with what statements by interview respondents who wanted to see psychotherapy and other upstream mental health services be made more available, particularly for GBM. The respondent from HIM explained that in an ideal world, psychotherapy should be as available as prescription drugs in treating mental illness and addressing suicidal thoughts.

Action 2

Two measures can be taken to ensure that those GBM that most need psychotherapy services get them. Services could be provided using an equity criteria, such as those used at HIM, where key criteria such as income, ethnicity, location, age, ability etc. are used to determine the need of the patient and prioritize services for those who are least privileged and at the highest risk. A systematic review of internet delivered CBT versus traditional CBT demonstrated that therapy delivered through an online means can be just as effective as traditional in-person therapy (Andersson, Cuijpers, Carlbring, Riper, & Hedman, 2014). Therefore, publicly funded internet-based psychotherapy offers another means of improving accessibility of mental health services.

4.4. Recommendation 4: Invest in and expand community-based interventions and services

4.4.1. Overview

A common theme throughout the interviews was the importance of community, and community-based interventions for addressing suicide in among GBM. These recommendations are supported by the literature which shows that isolation and lack of community connection are contributing factors to suicidality (“CAMH: What are the potential protective factors against mental health problems?,” 2017; Centre for Addiction and Mental Health, 2015; Monk & Samra, 2007).

Interview respondents emphasized the importance of identifying existing community-based programs or services that could be invested in to address suicide. They discussed how existing health service providers for GBM might be a key location to implement a syndemic approach to suicide that incorporates mental health and suicide services alongside traditional sexual health services. There was also an emphasis on creating or investing in more general community spaces, that are not suicide specific, that would help reduce isolation and build relationships that act as a protective factor against suicide.

Two actions can be taken to expand community-based interventions and services:

Action 1: *Provide flexible funding to community-based sexual health and wellness services, such as HIM and Qmunity to enable them to provide more holistic services tailored to the needs of their community.*

Action 2: *Invest in non-suicide specific programming, such as Men's Sheds or Mpowerment that provide safe spaces for GBM and that improve protective factors against suicide.*

Action 1

While both HIM and Qmunity offer mental health services to communities, these services are supported through HIV funding. Two interview respondents explained that these organizations are only able to offer these by being creative with this funding, but that devoted mental health or suicide funding does not exist. Interview respondents emphasized the need for localized and community developed programs, and so flexible funding should be offered to these organization to allow them to design their programming based on the specific health and wellness needs of the communities they serve.

Action 2

Mpowerment is a peer led HIV prevention program that is primarily designed to cater to the specific needs of gay and bisexual men, but in Vancouver includes all young males including “trans, non-binary, and cis guys who identify as gay, bisexual, pansexual, asexual, or queer, and two-spirit (“Mpowerment,” 2018)” The program is based on an empowerment model where young gay and bisexual men, ages 18-29, form a core group of members facilitated by one or more paid coordinators (“High Impact Prevention: Mpowerment,” 2017). The program usually includes a physical space where young men can drop-in and socialize with one another in addition to more structured events focused on safe sex education (“High Impact Prevention: Mpowerment,” 2017). The primary objective of the program is HIV prevention, but an equally important and necessary objective is community building where Mpowerment helps members form friendships and build resilience through social support networks (Hays, Rebchook, & Kegeles, 2003). Mpowerment seeks to create “settings where young gay/bisexual men can express their identities, form positive linkages with similar others, draw support, and band together to take action on issues of importance to them (Hays et al., 2003, p. 303).”

Mpowerment is meant to serve the community in which it is implemented, and therefore each Mpowerment group is “tailored to the unique culture and social environment of whatever community implements it (Hays et al., 2003, p. 308).”

The respondent from the CMHA emphasized that Men’s Sheds could also serve as another model of non-suicide specified community intervention. According to the Men’s Sheds Association of Canada (MSAC), Men’s Sheds are spaces where men of all ages can meet and engage in activities including woodwork, car repairs, music, discussions etc. (“About Men’s Sheds – Men’s Sheds Canada,” 2018) Men’s Sheds can be found in Australia, the UK, New Zealand, Ireland, and Canada. The spaces are designed to give men a purpose and a place to gather in order to engage in meaningful social activity and tasks such as repairs, maintenance, or projects for community members and organizations (“About Men’s Sheds - Australian Men’s Shed Association,” 2018). Men’s Sheds are not always comprised of only men and are sometimes called “community sheds” which serve the same purpose but are inclusive of both men and women (“About Men’s Sheds - Australian Men’s Shed Association,” 2018). Typically, Men’s Sheds are peer created and run. Men’s Sheds are not designed for GBM specifically and tend to be spaces that cater to heterosexual males and traditional notions of masculinity (Corey S. Mackenzie et al., 2017). Therefore, Men’s Sheds in their current form may not be welcoming spaces for GBM. However, they can serve as a model for a community space where GBM can engage with their peers, openly discuss issues relevant to them, and engage in meaningful activities that contribute to their communities.

While Mpowerment and Men’s Sheds were models that were mentioned specifically by participants and have been evaluated and shown to improve mental health and well-being, there are other community-based programs that could potentially yield similar results including GBM or GSM sports leagues and social groups. Regardless of the specific form, funding should be allocated for community-based programs and interventions that are specific to GBM and other sexual minorities. It is important that this funding be flexible and that communities be able to apply for and adapt this funding to their specific needs. It is also important that these resources be made as accessible as possible to rural communities, low-income communities, GBM of colour, and communities of GBM with disabilities.

4.5. Multi-Strategy Approach

The recommendations and action items together are meant to guide the development of a multi-strategy and comprehensive approach to suicide among GBM. Interviewees emphasized that suicide among GBM does not follow a single trajectory but is influenced and interacts with a host of factors, and because of this, a holistic and multi-pronged approach is needed. Therefore, the recommendations should be viewed as a package rather than distinct options to be implemented separately from one another.

The recommendations work with one another in various ways. For instance, Recommendation 1 focuses on preventing the negative mental health outcomes that can result from homophobia and discrimination particularly in GBM youth, while also making the health system more friendly to GBM which could help them in accessing services earlier on. Recommendation 2 works with Recommendation 1 by ensuring that not only do GBM get queer-competent care, they also get care that is free from stigma around suicide and mental illness. By improving mental health and suicide literacy, Recommendation 2 gives GBM the tools to articulate experiences of mental illness or suicidal thoughts, and ensures that their health care providers might have the knowledge to intervene before GBM reach the point of attempting suicide. Recommendation 2 also helps to ensure that when GBM are getting treatment for suicide that those in their community have the knowledge and awareness to be supportive. Recommendation 3 compliments Recommendation 2 by ensuring that when GBM recognize that they need help, that they actually have access to affordable and effective mental health services. Recommendation 4 encompasses Recommendations 1-3. Community-based service organizations designed for GBM compliment Recommendation 1 by providing a safe queer-friendly space to seek health care, and ensures that GBM have homophobia-free spaces to socialize and build community. Recommendation 4 also works alongside Recommendation 2 by ensuring that the community based health services that many GBM access are able to provide mental health and suicide competent care when needed. Additionally, community spaces like Mpowerment or Men's Sheds are excellent environments in which to introduce mental health and suicide literacy training. Recommendation 4 works with Recommendation 3 because community based

organizations are key avenues to deliver or refer mental health services to GBM, as the relationships between these organizations and many GBM is already well established.

Together, the recommendations are interconnected and complement one another. While each recommendation on its own would certainly have an impact, the collective impact of the recommendations together is more significant. It is important to reiterate that these recommendations together represent the beginning of a comprehensive multi-strategy approach to addressing suicide among GBM. As will be discussed in the analysis section, additional research, consultation, and evaluation are needed to build on these recommendations and expand the field of interventions to address this issue. Therefore, these recommendations are a first step in addressing this policy problem.

Chapter 5. Evaluation Criteria and Analysis

In this section, the recommendations and their action items will be evaluated based on how they meet key policy objectives. These policy objectives have been derived based on Questions 7-9 of IBPA and syndemic theory. The first and primary policy objective is to reduce the suicide rate among GBM in BC. This is the overall objective of this entire study, but also stems from Question 7 from IBPA which asks where and how interventions can be made to improve the problem. This is a continuation of the interview findings where respondents were asked to identify potential solutions and vantage points for intervention. Syndemics is used as a policy objective under IBPA Question 7 because this study has shown that suicide exists alongside coexisting health issues. This means that to improve the problem of suicide, the recommendations must lead to improvements in related health issues as well.

Equity and social justice are key principles of IBPA and intersectionality more broadly, which is why Question 9 of IBPA challenges the analyst to demonstrate how policies and interventions will reduce inequity. This requires analyzing how the recommendations will reduce inequity between GBM and society, but also how they will reduce inequity within the population of GBM as well. In terms of social justice, Question 9 also presses for an analysis of how interventions might also address power structures, stereotypes, and biases that reinforce and maintain health inequities in the first place. With this framework in mind, equity and social justice are key policy objectives.

Finally, feasibility is a key consideration across policy, particularly from a government perspective. This reality is recognized explicitly in IBPA through Question 8, which challenges the analyst to consider government priorities, time frames, and cost of proposed interventions. To account for these factors, feasibility has been included as a key policy objective.

Each policy objective is laid out in more detail below, followed by an analysis of how the recommendations meet that policy objective. Because the recommendations are meant to be implemented in concert with one another as a single approach, the purpose of this analysis is not to compare the recommendations against one another, but rather to demonstrate how they address the problem of suicide among GBM. In

concluding the analysis of the recommendations, some key policy challenges are identified in Section 5.4 which will shape ongoing considerations.

5.1. Where and how can interventions be made to improve the problem?

5.1.1. Reduction in Suicide Rate

The primary purpose of this study is to develop a comprehensive multi-strategy approach to reduce suicide among GBM in BC. Therefore, the primary policy objective for the recommendations is reduction in suicide rate. Ideally, this would be measurable in a quantifiable way, however, due to methodological restrictions, measuring the effect of any intervention on suicide reduction is extremely difficult. Due to this reality, the effectiveness of programs is largely based on surrogate or indirect measures. In its systematic evidenced-informed practice review of suicide prevention methods, the Suicide PIP Initiative of BC used surrogate measures that included: reduction in suicide risk and behaviors, increased knowledge/awareness around suicide, reduction of impacts of suicide risk or behavior on family and friends, reduction in risk factors of comorbid issues for suicide, and increase in any protective factors (Joshi et al., 2009). Some of these measures will be used here to assess how the recommendations will meet the objective of reducing suicide among GBM.

Analysis

Recommendation 1 is expected to reduce the suicide rate by preventing the negative effects of homophobia and discrimination both in childhood and in adulthood. It will also ensure that when GBM reach out for services that they are not re-traumatized and are less likely to experience homophobia and discrimination from health providers. A study by Saewyc et al (2014) of grade 8-12 students showed that in schools with GSAs, particularly those where they had been in place for three years or more, there was a reduction in the odds of sexual orientation-based discrimination, suicidal thoughts, and suicide attempts for LGB students as well as heterosexual boys. In relation to the promotion of anti-discrimination laws and homophobia-free communities, research in the US has shown that in states that lacked specific protections against sexual orientation-based discrimination, GBM were almost five times more likely to have more than two mental or mood disorders in comparison to states that had extended and specific

protections for GSM (Haas et al., 2010). This demonstrates that creating or promoting anti-discrimination laws and policies at the provincial and community level could have an impact on improving the mental health and wellbeing of GBM. Because mental illness is also a risk factor for suicide, this should also reduce the likelihood of suicide among GBM. Finally, as the data from the Sex Now survey demonstrated, a significant portion of GBM in Canada are not open about their sexual orientation to their primary healthcare provider. This could be indicative of homophobia, either perceived or real, from their healthcare provider. A systematic review of cultural competency training, and the effect on patient outcomes, indicated that training can lead to improvements in patient outcomes for those receiving care from trainees (Lie, Lee-Rey, Gomez, Bereknyei, & Braddock, 2011). The Suicide PIP Initiative for BC identified culturally relevant and appropriate training as a best practice for vulnerable or high risk populations in a systematic evaluation of suicide reduction strategies (Joshi et al., 2009). Queer-competency training, like cultural competency training, should enable GBM to feel more comfortable approaching their healthcare providers, and also make these providers more aware of their client's needs and experiences, thus increasing the likelihood for suicide and mental health issues to be identified and addressed.

Recommendation 2 will reduce suicide among GBM by providing them with the mental health and suicide literacy skills to identify when they might need help, and will also ensure that communities, service providers, workplaces, and society at large will be more responsive to their needs. Action 1 points to the promotion of MHCC based mental health literacy training and material, which the MHCC has already shown to have positive learning outcomes for respondents (Mental Health Commission of Canada, 2013). In terms of a more direct effect on suicide, the Suicide PIP systematic review demonstrated that stigma reduction, suicide awareness, and mental health education were promising practices in addressing suicide (Joshi et al., 2009). The community gatekeeper program referenced in Action 2, particularly safeTALK and ASIST training included in the program, have been extensively evaluated. Both safeTALK and ASIST have been shown in multiple studies to improve suicide awareness and competency among training recipients (Ashwood, Briscoe, Ramchand, May, & Burnam, 2015; Bailey, Spittal, Pirkis, Gould, & Robinson, 2017; Burnette, Ramchand, & Ayer, 2015; Mellanby et al., 2010). ASIST has been shown in a randomized control trial to reduce the likelihood that crisis line callers would feel depressed, suicidal, or overwhelmed in

comparison to callers to crisis lines without ASIST training (Gould, Cross, Pisani, Munfakh, & Kleinman, 2013). Gatekeeper training was also shown to be a promising practice for addressing suicide among high-risk or vulnerable populations by the Suicide PIP Initiative review (Joshi et al., 2009). Both Action 1 and 2 can increase the ability of GBM, healthcare providers, and key GBM community members to identify mental health issues and suicidality. This increases the likelihood that GBM will receive treatment before or at the point of suicide (Helen Jones & Andrea Cipriani, 2016).

Recommendation 3 focuses on the expansion of the accessibility of mental health services. Psychotherapy, in particular CBT based therapies were shown in the Suicide PIP Initiative systematic evaluation to be best practices in suicide prevention for all target groups including high-risk and vulnerable groups (Joshi et al., 2009). This conclusion was corroborated by an analysis of RCTs that tested the effect of psychotherapy, particularly CBT, which showed that it was effective in reducing the likelihood of a suicide attempt (Calati & Courtet, 2016). Another systematic review and meta-analysis of CBT and suicide by Tarrier, Taylor, and Gooding (2008) showed that CBT had a highly significant effect in reducing suicide behaviour. Vulnerable or higher risk populations, particularly those in geographic areas without psychotherapy services present, could experience the same suicide reducing benefits through internet-delivered psychotherapy. There is evidence that internet-delivered psychotherapy, in particular CBT, can yield the same benefits as in-person sessions (Andersson et al., 2014; David Gratzer & David Goldbloom, 2017). Therefore, targeting psychotherapy services to GBM has potential to reduce suicide among this population.

Recommendation 4 is expected to address the suicide rate by increasing knowledge, awareness, screening, and identification of suicide. It is also expected to increase protective factors such as social support and self-esteem that can be provided through programs such as Mpowerment or Men's Sheds style programs. Depending on Health Authority, 53-71% of MSM in BC were tested for STI's and 53-68% were tested for HIV in 2014/15 (Trussler & Ham, 2017). For those in Vancouver, community-based sexual health centers like HIM and Qmunity are one of the primary places for this service. While there is certainly a large portion of GBM who are clearly not being tested, this data also demonstrates an opportunity to use existing sexual health resources to reach GBM with suicide and mental health services as well. Providing flexible funding to existing community health programs such as HIM and Qmunity to provide expanded

services for suicide and mental health, would increase the capacity of these organizations to screen and identify suicidal behaviour and mental health issues.

Investing in non-suicide specific community initiatives, particularly those modeled after Mpowerment or Men's Sheds, have potential to reduce suicide by promoting protective factors. In the case of Men's Sheds, academic research has shown that Men's Sheds can be beneficial to the overall health of participants, including improving mental health and reducing suicidality. For instance, a 2013 study by Milligan et al., using data from the UK Men's Sheds pilot project program, showed that Men's Sheds can act as a therapeutic space, can promote health, and reduce social isolation. Mpowerment has also been shown to improve self-acceptance for MSM and improve conditions comorbid with suicide such as HIV or STI risk, and reduce stigma associated with these issues (Shelley et al., 2017). Mpowerment also enables participants "to become actively involved, develop their competencies, help their community, and develop a sense of mastery and personal empowerment (Hays et al., 2003)." Protective factors mentioned in the literature that have the potential to be improved by these or similar initiatives include improving interpersonal skills, sense of accomplishment, positive peer relationships, opportunities to participate, and self-determination.

5.1.2. Syndemics

As the literature and primary research shows, suicide can be understood as a syndemic issue that exists alongside and interacts with other health issues such as substance use, HIV status, STIs, and mental illness. Additionally, both literature and interviews demonstrate that addressing suicide among GBM requires a holistic approach rather than a typical disease-specific approach. Interventions that go beyond suicide to address related health issues are expected to be more effective than those that focus on a singular health issue. Syndemics will be discussed based on how the recommendations directly or indirectly meet the policy objective of addressing other comorbid health issues.

Analysis

Recommendation 1 addresses related health issues in much the same way as it addresses suicide. Like suicide, homophobia and oppression are shown to play a significant role in increasing the risk of GBM in experiencing other health issues such as

substance use, HIV, STI's or mental illness (Ferlatte et al., 2015a). Work by Stall, Friedman, and Catania (2007) shows that marginalization and discrimination experienced in adolescence, and migration to so called "gay ghettos" contributes to a syndemic of poor sexual health, substance use, and mental health issues among GBM. Therefore, by reducing discrimination and homophobia in schools, GSA's could have a positive effect on other health issues experienced by GBM that are associated with homophobia and discrimination. Trauma-informed queer competency training is also likely to have the same effect on other syndemic issues as it does on suicide in that GBM may feel more comfortable talking to service providers about more than just suicide, and service providers will be more aware of the key health issues faced by their GBM clients.

Recommendation 2 and **Recommendation 3** could improve other health issues indirectly. A study examining mental health and sexual risk behaviour showed that emotional dysregulation and maladaptive cognitions, influenced by homophobia and discrimination, were associated with symptoms of anxiety and depression, sexual compulsivity, and higher risk sexual activities (Rendina et al., 2017). Therefore improvements in mental health literacy will enable GBM to identify their mental health needs and have them met appropriately by healthcare providers, which may reduce their sexual risk behaviour and likelihood to contract STIs or HIV. CBT-based psychotherapy focuses on addressing emotional dysregulation and maladaptive cognitions, and therefore could be beneficial in addressing mental health, suicide, and sexual health issues. For instance, a study on the use of emotional regulation therapy on HIV-positive men, based on principles of CBT, showed that there was evidence to suggest that therapy improved mental health outcomes, decrease drug use, and decrease STI transmission risk-behaviour (Parsons et al., 2017).

Recommendation 4 will address other health issues both directly and indirectly. Investing in community-based health services such as HIM and Qmunity to offer suicide and mental health services will address multiple health issues directly by incorporating sexual health, mental health, and suicide treatment into one service centre. By providing flexible funding and making these services community based, GBM health organizations will be able to offer services that are relevant to the syndemics faced in their unique communities. Investing in programs similar to Mpowerment or Men's Sheds could address other health issues indirectly as many of the protective factors that these

community programs promote are also protective factors for other health issues. For instance, community engagement, interpersonal connection, sense of purpose, sense of connectedness, and community safety are protective factors for substance use and mental health (“CAMH: What are the potential protective factors against mental health problems?,” 2017)(Representative for Children and Youth, 2016). Substance use and mental health issues are risk factors for HIV, and therefore by protecting against these, these community initiatives can indirectly prevent against HIV (Ferlatte, Salway, Trussler, et al., 2017).

5.2. How will proposed policy responses reduce inequities?

5.2.1. Equity

A key principle of IBPA, and intersectionality more broadly, is equity. As a policy objective for this study, equity will refer to the way in which the recommendations will reduce inequity faced by GBM as well as within the population of GBM. Equity will be discussed in terms of how accessible each recommendation is to GBM and the most vulnerable within the GBM population, and will include suggestions of how each recommendation can be made more equitable.

Analysis

Recommendation 1 addresses inequity primarily between GBM and dominant society by reducing homophobia and discrimination faced by GBM, early in life, as adults, and when seeking healthcare services. The focus of these actions is on sexual orientation, and not on other intersecting forms of social position or identity. However, each of the action items can be made more equitable. For instance, GSAs, while commonly known as Gay-Straight Alliances, should be encouraged to take on a more holistic model of Gender-Sexuality Alliances which would take the emphasis off solely gay men and encompass more diverse GSM identities. Furthermore, funding and promotion of these spaces should allow, where possible, for GSAs to be set up for GSM from particular backgrounds such as an Indigenous GSA, a GSA for people of colour, or a GSA for people with disabilities. Additionally, more all-encompassing GSAs should include a focus on education and promotion of inclusivity based on other intersecting identities such as race, class, ability, and gender. The promotion of GBM rights and the

encouragement of homophobia-free communities should be done alongside efforts to promote all anti-discrimination rights and efforts to build communities free of other forms of discrimination as well. Finally, given that the term “queer” is encompassing of sexual and gender identities beyond GBM, trauma informed queer competency training will help to address inequities faced by those from varying GSM identities. Furthermore, trauma is experienced by individuals from varying social positions and identities, in particular Indigenous individuals, and so GBM from varying backgrounds and experiences of trauma stand to benefit. Additionally, trauma-informed queer competency training could be provided in concert with other cultural sensitivity training such as the ICS delivered by PHSA.

Recommendation 2 will have a mixed impact on inequity faced by GBM and within the GBM population. Action 1 is not addressed to GBM specifically, but rather is aimed at improving mental health literacy across BC. The curriculum is not designed specifically for either GBM, other GSM, or other vulnerable populations and so could be less relevant to them than more targeted curriculum. However, because these recommendations are meant to be implemented as a whole, providing mental health literacy training alongside trauma-informed queer competency training will provide context in which to understand GBM mental health issues.

Under Action 2, the Community Gatekeeper curriculum is standardized and hasn't been made specific to an audience of GBM, GSM, or other vulnerable populations. As with Action 1, this may mean the training is less applicable to these groups than if it was made more specific. However, Action 2 can be made more equitable by prioritizing the delivery of training to higher risk populations within the GBM population such as Indigenous, disabled, rural, or low-income GBM.

Recommendation 3 addresses inequity faced by GBM by providing them greater access to psychotherapy. Given the higher rate of suicide among GBM, increasing access to these services will potentially reduce suicide among this population while also leading to other benefits in related syndemic issues. Action 2 ensures that inequity within this population is addressed as well; using internet or telehealth technology to deliver psychotherapy services to GBM ensures that those with challenges in accessing face-to-face psychotherapy can still benefit. This could include those with disabilities, those living in rural areas, those in First Nations communities, and those

lacking transportation. Additionally, by using an equity-based model of delivery, similar to that used at HIM, which prioritizes services for individuals based on key social indicators such as income, age, disability, or ethnicity, can help to ensure that those GBM who would most benefit from mental health services are the most likely to get timely access to it.

Recommendation 4 addresses inequity in several ways. First, providing additional funding and resources to community-based GBM health service providers will allow them to deliver added services that are needed to reduce health inequities in terms of suicide and other health issues faced by GBM. Also, by providing flexible funding, these organizations can tailor their services to the unique needs and inequities faced by the specific populations they service. On the other hand, many rural or remote communities might not have a large enough GBM population or the capacity to deliver these kinds of services and so Action 1 may benefit urban GBM populations more than those in rural or First Nations communities. Another consideration is that much of the services provided by these organizations can only be accessed by an individual physically going to the community health organization. This represents a barrier to access for individuals who lack transportation or those with disabilities. Finally, many of these services are designed for GBM as a whole and aren't tailored to GBM from differing identities or social positions, which may make these services both less accessible and less appealing to these groups.

Action 2 helps to address inequity faced by GBM by providing more programs and space similar to Mpowerment or Men's Sheds where GBM can meet, interact, and build skills with GBM peers. Action 2 faces some of the same equity challenges as Action 1 in that programs like Mpowerment and Men's Sheds require participants to go to a physical location. However, Action 2 is more feasible in smaller communities as these programs don't require the same level of expertise or capacity to implement. Additionally, it is more feasible to tailor Action 2 to different populations, where possible, within the GBM such as an Mpowerment or Men's Sheds for GBM of colour, GBM with disabilities, or GBM from varying age groups.

5.2.2. Social Justice

In addition to equity, social justice is a key principle of IBPA and of intersectionality. In particular, an intersectionality framework argues that it is not enough to address health inequities through services and provision alone. Instead, interventions must also address the power structures or stereotypes and bias that create and sustain these inequities. Power structures or systems can include discriminatory laws and policies or lack of visibility or voice in decision-making and positions of power. This can also represent disparities in access to certain services or resources such as housing, jobs, or social and health services. Damaging stereotypes and bias include perpetuation of discriminatory views and rhetoric around certain groups. Therefore, in adhering to principles of intersectionality, social justice is a key policy objective and will be discussed in terms of the degree to which the policy recommendations address power structures and stereotypes or bias.

Analysis

Recommendation 1 contributes to social justice primarily through addressing damaging stereotypes and bias but also through changes in structures of power. GSAs provide a way to combat homophobic attitudes in schools and can help with the well-being of GBM and other GSM, but they can also prevent discrimination and combat homophobic attitudes at an early age among non-GBM students (Poteat & Russell, 2013). Promotion of anti-discrimination rights and homophobia-free communities are structural changes that can weaken homophobia by providing legal protection to GBM in their communities, workplaces, and when receiving services. Trauma-informed queer competency training can also reduce homophobic attitudes and discrimination within the health system and other social services.

Recommendation 2 and **Recommendation 3** address stereotypes and bias in relation to mental illness more than in relation to sexual orientation. For instance, improving mental health and suicide literacy helps to reduce prevailing bias and stereotypes that those with mental illness face in society and when accessing health services. Recommendation 3 addresses power structures to a certain extent by ensuring that GBM have access to extremely beneficial mental health services that they may otherwise not be able to access due to financial barriers or social barriers such as discrimination.

Recommendation 4 addresses structures of power in two ways. First, by providing funding to GBM community-based service providers, and by providing this funding on a flexible basis, these organizations are empowered to build programming and services for their own communities. This devolves more power and self-determination for these communities as they are able to make decisions on service provision as opposed to having these decisions dictated by higher levels of government. Action 2 also helps address power structures by expanding the availability of GBM-specific community spaces. Community spaces and activities are predominantly designed by and for heterosexual individuals and so the needs and safety of GBM may not be accounted for. Providing funding and support for interventions like Mpowerment or Men's Sheds helps to create spaces designed by and for GBM where they may feel safe to partake in community activities.

5.3. What are feasible short, medium and long-term solutions?

5.3.1. Feasibility

Feasibility is a key objective in policy development and is a key consideration in IBPA. For the purpose of this study, feasibility will be discussed in terms of expected complexity, cost considerations, and potential timeframes. Each of the recommendations will be analyzed based on these considerations to determine how they meet this policy objective.

Analysis

Recommendation 1 is relatively low in complexity. The promotion of GSA's is a short-term action that is relatively simple in terms of administration, as it requires mostly an increase in funding to train teachers and support staff to help facilitate GSAs, and funding for promotional and capacity-building materials. Promoting anti-discrimination rights requires funding for promotional materials and advertising but could be more complex in the development of these campaigns to ensure that they are effective. Developing homophobia free communities is a medium to long-term action that requires funding and the development of initiatives or materials to achieve this goal. The development of trauma-informed queer competency training is a short to medium term action that requires consultation and curriculum development. Making this training

mandatory would require coordination and engagement with employee groups such as nurses or Health Authority staff. Getting partners in health delivery such as physicians, to do this training will require advocacy and consultation.

Recommendation 2 is relatively simple in terms of ease of implementation and can be done in the short term. Most of the Mental Health literacy programming has already been developed and evaluated by the MHCC and would only require adaptation to the BC context, planning for delivery to target groups, and funding to provide the training. The Community Gatekeeper program is already underway and being delivered by CMHA. To deliver and target this program to GBM will require consultation with GBM communities and additional funding to deliver training to this population.

Recommendation 3 is a medium-term action that is higher in complexity. Providing publicly funded psychotherapy to GBM requires the development of a means of delivery: either hiring psychotherapists or providing reimbursement for psychotherapy services. Determining eligibility and adopting an equity-based model may also require extensive planning and consultation. There will also have to be systems of oversight established to ensure that GBM are receiving quality care. Delivery of psychotherapy via internet, or other virtual means, may also require the development of a delivery system or interface which could require significant financial resources and IT expertise.

Recommendation 4 is mixed in terms of complexity and time frame. Action 1 can be done in the short term and will require a readjustment of the funding model for existing GBM health organizations and may require the establishment of oversight mechanisms to ensure that funding is achieving desired improvements. Obviously, empowering these organizations to expand the range of services to adopt a more syndemic approach will require increases in funding. Action 2 is complex in the sense that there should be a strategy developed in how to foster more community programming like Mpowerment and Men's Sheds. Criteria will need to be developed to determine which community programs would be eligible to receive funding in order to meet key goals of suicide reduction and overall health improvement. Additionally, financial resources will be required to help support these organizations with finding space, administrative costs, and promotional or group materials.

5.4. Implementation

5.4.1. Prioritizing Implementation

The recommendations complement one another and are expected to have the greatest impact when implemented collectively. However, in a world of strained resources implementation may need to be done in phases. There is no obvious path that should be taken in terms of prioritizing one recommendation over the other. However, the principle of “centring on the margins”, which emerged throughout the qualitative interviews, could serve as a potential means to prioritize interventions. Centring on the margins essentially refers to focusing interventions on those who most need it and then building out. Therefore, instead of prioritizing recommendations over one another, specific GBM populations could be prioritized first. The realities of these populations can be used to guide how and what recommendations can be best applied. One priority population could include Indigenous GBM facing a combination of low education and low income. The recommendations and action items could be tailored for this population and lessons learned could be incorporated as the recommendations are expanded over time. Therefore, as opposed to choosing one recommendation over the other, implementation can be guided by a focus on where there is the greatest need.

5.4.2. Key Challenges

While the recommendations over all meet the five key policy objectives, there are still significant challenges that need to be considered in further policy development on addressing suicide among GBM. These challenges are outlined below.

Research

The four recommendations were shown to be promising in reducing the suicide rate among GBM, however this was assessed using indirect and surrogate measures. To reiterate, this is due to methodological challenges in assessing the impact of interventions on the suicide rate. This also speaks to a common theme identified by interview respondents and the literature which shows that there is a lack of research on suicide and the efficacy of interventions. In comparison to HIV, the research on suicide is sparse (Hottes et al., 2015a). Based on this gap in knowledge, while the

recommendations have potential to reduce the suicide rate, the certainty of success isn't clear.

Equity

Equity is a key policy objective in this study, and while the recommendations make progress on this front, there are still gaps. For instance, much of the focus of these recommendations is still on reducing health inequity between GBM and the general population, but the recommendations are weaker on reducing inequity within the GBM population. Some key groups that are less likely to benefit from these recommendations include new immigrants, those in rural and remote communities, closeted GBM, and GBM with certain disabilities. New immigrants, specifically those who don't speak English, may not benefit from the recommendations due to a significant language barrier. Additionally, some recommendations may not be culturally relevant, such as mental health literacy or GSAs. While some of the recommendations will benefit rural individuals, those in the most remote and isolated communities are unlikely to benefit. For instance, those in small communities without internet access won't benefit from internet-delivered psychotherapy and are unlikely to benefit from investments in community-based interventions as the GSM population in these communities is too small to support them. They may also not benefit from improvements in mental health literacy as these communities are unlikely to have mental health services, if they even have primary health services at all. Closeted GBM, those who are not open about their sexuality, are also unlikely to benefit from these recommendations as accessing them will result in GBM outing themselves. Finally, GBM with certain disabilities may not benefit from all the recommendations. For instance, those with mobility issues are unlikely to be able to access community-based health services non-suicide specific community interventions. Those GBM with challenges, such as being deaf, may also not be able to benefit from some of the recommendations, in particular psychotherapy or community-based health services unless these services offer interpretation. And those whose identity is composed of an intersection of these social categories are likely to face an even greater risk for suicide yet may face the biggest barriers in accessing these interventions.

Social Justice

While the recommendations do make some progress on meeting the policy objective of social justice, this is done primarily through addressing harmful stereotypes and bias rather than through changing power structures. Programming, policy, and legislation is often designed by and for dominant society and may have unintended consequences in adding to the burden of suicide among GBM. Additionally, because of their history of homophobia and discrimination, GBM may need more help in accessing things like well-paying jobs, higher education, suitable housing, or getting other services. Based on the literature, low-income and low-education GBM are at a higher risk for suicide, and addressing barriers or disparities that prevent these GBM from accessing employment or education could help reduce this risk. These recommendations, while making some notable progress on social justice, still leave gaps that should be explored further and addressed.

Stakeholder Acceptance

A major challenge with the recommendations may be stakeholder acceptance, primarily acceptance of the recommendations by GBM themselves. The research to support these recommendations comes from literature and qualitative interviews but does not incorporate the voices of GBM individuals. Therefore, these recommendations may not accurately reflect the needs and priorities of GBM. More specifically, because of the homogeneity of the respondents in terms of class, ethnicity, education, and geographic location, the study is lacking the perspective of more marginalized GBM such as GBM that are low-income, disabled, rural, immigrants, GBM of colour, or a combination of these.

There are other stakeholders that may pose a challenge to these recommendations including healthcare providers. Physicians in particular who may resist further training or education requirements in terms of mental health literacy or trauma informed queer competency. These and other providers may see this as a burden rather than a necessity. The expansion of support for GSA's in schools may also face backlash in more conservative regions of BC similar to the backlash that is occurring as a result of sexual orientation and gender identity curriculum included as part of school anti-bullying policies in BC (Jeong, 2017).

5.4.3. Ongoing Considerations

The challenges identified should be used to guide future research and policy development on suicide among GBM by including them as ongoing considerations. In light of the challenges, some key ongoing considerations include the following:

Research

An indirect finding of this paper has been that there is a significant lack of knowledge on suicide among GBM, and suicide more generally. Further research is needed to generate more robust knowledge of suicide. Specifically, research should be done to determine further how populations are differentially affected, particularly when identities and social positions intersect. Further research to refine knowledge around the efficacy of suicide interventions is also crucial in guiding appropriate and effective actions on addressing suicide.

Equity and Social Justice

There needs to be ongoing efforts at examining how the recommendations can be more effective in reducing inequity within the GBM community. Direction on how this can be done could come from further consultation with GBM of differing backgrounds and identities. This may also require additional and innovative recommendations targeted at specific GBM such as those in rural and remote communities, immigrants, closeted GBM, and those with specific disabilities. Additional efforts need to be made to address how legislation, policies, or programs might be perpetuating health inequities faced by GBM to ensure that social justice objectives are also being achieved.

Consultation

The lived experience of actual GBM has not been taken into account in this study, and so before implementing any of the recommendations, further consultation with GBM communities is required. In particular, efforts should focus on consulting with the most vulnerable GBM populations. To ensure success of implementation, other key stakeholders such as healthcare providers, parents, and school administrators should be consulted. This may help avoid backlash and generate buy-in.

Evaluation

Upon implementing these recommendations, efforts should be made to evaluate their effectiveness. This will ensure that resources are being used effectively, that outcomes are actually being achieved, and will generate further knowledge on what interventions work, and which don't. Specifically, evaluation is needed to measure success, which in the broadest sense should mean a reduction in the rate of suicide among GBM. However, the five policy objectives can also help guide evaluation. For instance, based on the objective of equity, it is not enough just to reduce the overall GBM suicide rate, but should also include a reduction in the impact of suicide on certain populations within the broader GBM population. In other words, disparities in the suicide rate between GBM of differing identities should be reduced. Similarly, evaluation can include measurements of interventions in addressing syndemics or improving social justice. Finally, evaluation should involve GBM communities to ensure that evaluation criteria are reflective of their priorities and needs, and to ensure that there is a shared definition of success.

5.4.4. Transferability to Other Populations

As outlined in the beginning of this study, GSM should not be thought of as a single homogenous population. "GSM" is an umbrella term that covers a wide range of non-heterosexual identities. The lived experiences, barriers, health inequities, and forms of marginalization are not the same across the entire GSM population. Therefore, the focus of this study on GBM is based on the recognition that "GSM" covers a vast span of varying identities, experiences, and social positions, and as such, one strategy for this group as a whole may not be appropriate.

This recognition does not mean that the findings and recommendations in this study are not applicable to other GSM, rather the approach, findings, and recommendations should be seen as a potential starting point to guide research on suicide among other GSM. It is also expected that some of these recommendations, particularly addressing homophobia and discrimination, would have positive impacts for GSM more broadly. Finally, as has been identified as an ongoing consideration for this study, any interventions or policy development for addressing suicide among other GSM must always include the voices of actual GSM with lived experience.

Chapter 6. Conclusion

Suicide among GBM is four times higher than the general population and is a higher leading cause of death among GBM than HIV. The MOH has also acknowledged that vulnerable populations, including GBM face higher rates of suicide. To address this, the MOH has stated the importance of comprehensive multi-strategy approaches that are designed in light of the intersecting factors that influence an individual's risk for suicide. However, the MOH and other key public health stakeholders have yet to develop such a strategy targeted to GBM, and research on this issue is lacking. Therefore, through qualitative interviews grounded in IBPA and syndemics, this paper has aimed to achieve two goals. First, this study has helped to add to the existing knowledge of suicide among GBM. Second, this paper has used these findings to generate four key recommendations that represent a first step in developing a comprehensive multi-strategy approach to addressing suicide among GBM in BC.

To ensure that these findings and recommendations have an impact, I will identify opportunities for knowledge translation and transmission such as sharing the findings with stakeholders, conference presentations, and media publications. It is my hope that this research will help raise awareness in the GBM community about the significance of suicide, while encouraging policymakers to recognize that HIV is not the only health issue GBM face, and that prioritizing HIV at the expense of addressing equally as concerning health issues is no longer appropriate.

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Appendix

Interview Guide:

1. Can you tell me first a bit about yourself: your background and experience, how you came to be involved in this issue?
 - a. What is your understanding of this issue?
 - b. Who is affected?
 - c. Why is this a problem?
2. What promising programs, policies, or initiatives do you know of that are being done in BC, in Canada, or abroad to address suicide among gay and bisexual men, or LGBTQ people in general?
 - a. Are there actions being taken to address suicide among other marginalized populations that you think could be adapted for gay and bisexual men?
 - b. Why do you think that there hasn't been a provincial response to this problem yet, what barriers do you think there are to this issue getting on the agenda?
3. Research shows that there appears to be an interaction between suicide and other health issues such as mental illness, HIV, violence, substance use, and marginalization. What do you think of this idea? How do you think this should affect interventions or policy to address suicide among gay and bisexual men?
4. The GBM population is diverse, and suicide affects GBM men of different identities and backgrounds differently: for instance a GBM man who identifies as Indigenous, is low income, lives in a rural community, or has lower education may have a higher likelihood of reporting suicide attempt or ideation. How do you think we make sure that the policies, programs, or interventions reach the most vulnerable populations within the larger GBM population?

5. If there was unlimited money and resources, and you could enact any policy or intervention you wanted, what would be the first thing you would take?
 - a. What do you think needs to be done in the short term, and long term?
6. Is there anything that we haven't covered in this discussion that you think I should know, or that should be considered when addressing this issue? Are there any resources I should access or individuals I should connect with to inform this study?