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Submission to the Department of Health and Social Care Mental Health and Wellbeing Plan: discussion paper and call for evidence

Executive summary

A. Male suicide
B. Men's overall health and wellbeing
C. Role of public and policy narratives around men's mental health
D. Barriers to men's wellbeing and help seeking
E. Key social determinants affecting the mental and physical wellbeing of men and boys
F. Policy recommendations
G. Examples of best practice

Precis

The Men and Boys Coalition represents more than 100 leading academics, charities, practitioners and professionals, who all work to address gendered health and wellbeing issues disproportionately affecting men and boys – these range from educational underachievement and fatherlessness, to suicide and male victims of domestic abuse. We have a deep understanding of the structural issues and barriers impacting on the physical and mental health and wellbeing of men and boys in the UK.

The core message that we hear from our members and the men and boys' sector as a whole, is that it is not enough to say "men must talk" – it is imperative that society and policy makers take action to address the gendered issues that impact on men's mental health and wellbeing. We would like to make three central points in our submission below.

1) Men are willing to talk, however forums and spaces must be created that are 'male friendly' and tailored to meet men 'where they are', not where society thinks they should be. The public and public policy discourse (characterised by the highly damaging phrase "Toxic Masculinity") is shifting the blame for health problems that men and boys face -- framing them as primarily down to out-dated forms of masculinity and/or the health problems they develop are the fault of men and boys themselves due to poor lifestyle choices. This is a form of victim-blaming and must change.

2) Society and policy makers must listen when men express their distress over issues that may be hard to hear, such as due to lack of post-separation contact with children, or as a result of being victims of domestic abuse.

3) Policy action is needed to address the structural wellbeing issues such as those mentioned above, along with numerous other grave issues of social exclusion including homelessness and educational underachievement – that are disproportionately experienced by men and boys and are the key drivers of male mental ill-health.

A public discourse that places the overwhelming onus and responsibility on men and boys to address their own health problems is an avoidance of social, statutory service and Governmental responsibility. It is an excuse for society and policy makers to not address the structural causes of men and boys' health problems and also for service providers to not create male friendly health services.

The Men and Boys Coalition is acutely aware of the intersectional issues affecting, and addressed by, our members and the men and boys they work with. This submission is intended as an overview of key issues affecting the mental health of men and boys from all backgrounds and demographics – we hope colleagues will also contribute from their own perspectives and expertise. Sources for the information and data included below are available on request.

About the Men and Boys Coalition

The Men and Boys Coalition is a registered charity which is a network of more than 100 leading academics, charities, practitioners and professionals committed to highlighting gender-specific issues affecting the well-being of men and boys.

A number of its members are experts in this field such as the founders of the Men's Section of the British Psychology Association (Dr John Barry and Martin Seagar), leading UK men's well-being organisations such as UK Men's Sheds, and a range of charities that deal with the effects on the physical and mental health of men and boys. The charity also supports organisations such as the Men's Health Forum and the Fatherhood Institute in their work.

The trustees of the Coalition are also the team behind International Men's Day in the UK (www.ukmensday.org.uk). The UK has more events marking the day than anywhere else in the world and men and boys' health is a significant feature in those events – especially those run by employers, education providers (schools, colleges and universities) and health bodies. International Men's Day in the UK has become a vitally important national vehicle for conversations about men's physical and mental health.

The views expressed here do not necessarily represent the views of all the Coalition's members but are representative of a broad range of views held by members of the Coalition.

The issues that the Coalition focuses on all have a negative impact on the mental health of men and boys ins one shape or form. These issues are:

- The high male suicide rate
- The challenges faced by boys and men at all stages of education including attainment
- Men's health, shorter life expectancy and workplace deaths
- The challenges faced by the most marginalised men and boys in society (for instance, homeless men, boys in care and the high rate of male deaths in custody)
- Male victims of violence, including sexual violence
- The challenges faced by men as parents, particularly new fathers and separated fathers
- Male victims and survivors of sexual abuse, rape, sexual exploitation, domestic abuse, forced marriage, honour-based crime, stalking and slavery
- The negative portrayal of men, boys and fathers

A) MALE SUICIDE

Male suicide continues to be a significant problem in the UK. Over 4,500 men in the UK took their own lives in 2020. With 2019 figures from Northern Ireland (157) , this is the equivalent of 13 per day.

Men make up 75% of all death by suicide and it is the biggest cause of male death under 50. Whilst female suicide has halved since 1981, male suicide rates have only reduced by 20%.

While the suicide rate (deaths per 100,000) has gone down since 1981, the actual number of men (England and Wales) who have died by suicide has risen due to population growth: from 3,562 in 1981 to 3,925 in 2020. (The peak was 4,303 in 2019.)

There are also subsets within the male group:

- Males aged 45 to 49 years had the highest age-specific suicide rate at 24.1 per 100,000 male deaths (457 registered deaths) – 7.1 women (138)
- 124 male full time students died by suicide in 2019 (England and Wales) as did 58 female students. Between 2012-2107 the rates were 5% and 2.1% respectively.
- Men in the building trades are three times more likely to take their own lives than the average UK man, with almost nine tragedies a week
- Rates of suicide for men in prison are three times higher than men not in prison

The Government's approach through a national suicide strategy (alongside approaches from others) focuses on suicide prevention: stopping men going through with their suicide ideation.

There is less research / agreement on preventing suicide ideation in the first place.

This needs to be better understanding of the actual underlying causes of these high rates and demographic differences and to draw policies from that understanding.

B) MEN'S OVERALL PHYSICAL AND MENTAL WELLBEING

The statistics on male suicide are set in a context of broader health wellbeing issues affecting men and boys.

The following is a (non-exhaustive) list of key statistics about men's wellbeing which have long been known, but with little male-focused action by Government or the NHS. (References for women's health are solely provided for context and understanding).

Many of the issues of male physical ill-health and social exclusion outlined below are both drivers of, and caused by, poor mental health creating a "negative feedback loop". While both men's and women's life expectancy are reduced by poverty, poverty has a greater negative impact on men's life expectancy than on women's.

- 5,957 men suffered alcohol-related deaths in 2020 across the UK (3,017 women) and the rates are increasing (19 per 100,000 men and 9.2 per 100,000 women);
- Men are nearly three times more likely than women to become alcohol dependent (8.7% of men are alcohol dependent compared to 3.3% of women, more likely to use (and die from) illegal drugs yet are less likely to access psychological therapies than women;
- 676,000 years of life lost every year in the working age male population in England and Wales (16-64), mostly through avoidable premature mortality and 19% of UK male deaths – around one in five –were before the age of 65;
- Men in the London Borough of Kensington and Chelsea now live 27 years longer than those in Blackpool: a seven-year increase on the life expectancy age gap calculated two years earlier;
- In September 2021, the ONS reported the first decline in male life expectancy since the 1980s;
- Among adults 16 and over, 68% of men and 60% of women were overweight or obese, with only 34% of men aged 25-34 years normal weight, compared to 44% of females
- In 2019, 32,304 men in England die prematurely from heart disease (18,837 women);
- Between March 2020 and November 2021, 93,665 men died due to Covid-19 (77,990 women). Men made up a higher portion of Covid mortality rates. For

working age men there were 31 deaths per 100,000 compared with equivalent female death rates of 17 per 100,000, respectively;
- Boys lag behind girls at every stage of education and boys are around 3 times more likely to be excluded from school;
- An estimated 13.2% of men aged 16 to 24 years were NEETS (Not in Education, Employment or Training) and for women the proportion was 10%;
- Among rough sleepers 83% are male;
- Men make up 96% of the prison population.

C) THE ROLE OF PUBLIC AND POLICY NARRATIVES ON MEN'S MENTAL HEALTH AND SERVICE PROVISION

It is crucial that any solution-focused response to the issues and statistics outlined above recognises the structural barriers to men's wellbeing and help seeking.

The 2012 Big Lottery report, Invisible Men conclude that "one of the biggest barriers in engaging men into social projects is this overall resistance to engage with gender as an issue from a male perspective. Despite evidence that tells us that that male engagement is an issue, we do not rethink our approach. This needs to be tackled so that engagement can happen effectively."

The public discourse around men and boys' health tends to take a negative view of men, presenting a gender stereotype of stubbornly refusing to get help in order to maintain a strong and silent façade. While there may be some truth in this stereotype, there is general agreement among practitioners who specialise in working with men, that focusing on this deficit is unhelpful and the way forward is to develop male-friendly services that respond to men's strengths.

In short, men do talk, but it is imperative that services are tailored to offer approaches that work for men – for example, UK Men's Sheds "shoulder to shoulder" rather than "face to face" approach has been found to be effective for engaging men.

The public and public policy discourse (characterised by the highly damaging phrase "Toxic Masculinity") is shifting the blame for health problems that men and boys face as being primarily down to innate masculinity and/or the health problems they develop are the fault of men and boys. We believe it is vital that this phrase is not used in public discourse as it is a shaming phrase. When you front load the noun "masculinity" with a term like "toxic", what implicit message does this drip feed to boys? We know that self-esteem has a big role to play in mental health, so how is this slow drip-feed of discourse about toxic masculinity helpful for boys?

A public discourse that places the overwhelming onus and responsibility on men and boys to address their own health problems is an avoidance of social, statutory service and Governmental responsibility. It is an excuse for society and policy

makers to not address the structural causes of men and boys' health problems and also for service providers to not create male friendly health services.

In his evidence to the APPG on Men and Boys hearing on male suicide, Glen Poole, CEO of the Australian Men's Health Forum, said:

"The general cultural view of male suicide is usually quite simply that suicide is a mental health issue and that men aren't as good as women at talking about their feelings, their mental health, and that's why more men kill themselves …men don't get help, that's why they kill themselves."

"But that really does a great disservice to men in distress who end up taking their own lives and actually when you look at the data, it's a complete mis-analysis of the problem of suicide. The fact is, apart from the fact men are 3-times more likely to kill themselves in countries like the UK and Australia, there are some really clear distinctions between male suicide and female suicide that we need to understand before we start to seek solutions.

"The first one, is that generally, while the majority of women who die by suicide have a diagnosed mental health issue, the majority of men who suicide don't.

"In fact depending in the data you use, in up to as many as 98% of cases, there is at least one other serious social or psychological distressor that's going on in a man's life, and that will be things like: relationship issues; money issues; legal issues; alcohol problems; trauma at any time in life – often unresolved trauma from childhood – so a whole range of other issues that put men on the path to suicide, other than mental health.

"It's important to actually note that the vast majority of people who have mental health issues like depression or anxiety, don't attempt suicide and don't kill themselves. There's not this straight from depression and anxiety through to suicide. It's much more commonly a response to a mix and it's very rarely just one issue.

"In the vast majority of cases of cases of [male] suicide, it's men coping with a combination of stressors that makes them feel like life is unbearable – and yet if you help them solve those distressors, the suicidality goes away. That's not true of all male suicide, but that's a very common feature of male suicide that we completely miss in all our policy and interventions."

D) BARRIERS TO MEN ACCESS HELP FOR HEALTH

There are a range of barriers that prevent men and boys from accessing help with respect to their health needs. These include:

Social determinants:

- Boys' educational attainment;
- The impact of poverty on men's life expectancy;
- Vulnerable employment, such as risk-related occupations,

redundant skills/industries and shift-based work patterns;
- Availability of social housing for single men;
- Marital status, the growth in single men (including those still living at their parent's home) and relationships (including fatherhood and family breakdown/child contact).

Intersectional factors:

The impact of race, ethnicity, sexual orientation, age, and disability alongside broader notions of 'class', 'poverty' and 'place'.

Gender Norms:

The way society responds to men and their needs, including:

- It is 'up to men' to use the health service as it is and if they do not use it, it is their fault;
- In empathy gap on male vulnerability and disadvantage;
- Strategies and initiatives that look at the symptoms causing adverse health outcomes for men rather than looking at or taking significant enough or successful action on the causes (suicide);
- Men are expected to live with their problems. For example: Men with a bad back feeling they need to turn up to a construction site for fear of 'letting the team down.';
- Men fear being ridiculed or not taken seriously. They worry about the consequences of disclosure, especially employment;
- Lack of health literacy from an early age where teenage boys are not given support on how their bodies/minds work, how to deal with emotions/anger and how to 'use' the health system (such as how to register/book an appointment with a GP without parental involvement).

A public health system that is not male-friendly:

A health system that is not built on patient needs first means health services engage men, especially working age men, less effectively. As set out in the Men's Health Forum policy document 'Levelling up men's health: The case for a men's health strategy', this lack of engagement not only means that men's all-round wellbeing is under-supported by regular health check-ups, it can result in much more serious issues going untreated for longer, sometimes until it is too late. Some of the statistics cited in the policy document include:

- Men are 32% less likely than women to visit the doctor – particularly during working age;
- Despite making up 75% of suicides, men make up 34% of those referred to IAPT therapy;
- Men make up 76% of premature deaths from heart disease and the

majority of those with Type 2 Diabetes, but are a minority of those undertaking NHS Health Checks, despite its effectiveness in detecting both conditions;

A lack of understanding or focus on actual male help-seeking and communications

This leads to one-size-fits-all campaigns rather than gender-informed campaigns which include male orientated messaging, identity, placement (based on where men go rather than a view on where men should go) and often initial anonymised help-seeking.

E) KEY SOCIAL DETERMINANTS AFFECTING THE MENTAL AND PHYSICAL WELLBEING OF MEN AND BOYS

The Outcome and Impact of Fatherlessness

In the UK, 92% of lone-parent households are headed by mothers and about one million children in the UK are growing up without any contact with their fathers

In recent evidence to the APPG on Men and Boys, the male mentoring charity, Lads Need Dads, stated that young boys whose father is absent or who have no appropriate male role model at home have a higher risk of:

- low self-esteem;
- mental health issues;
- under-achieving at school
- dropping out of education;
- antisocial behaviour;
- substance misuse, and,
- being engaged in criminal activity.

The charity further described the emotional and behavioural impact of absent fathers on boys which they see every day with the boys that present to LND:

- a sense of rejection which can lead to unworthiness, self-doubt/hatred;
- a feeling of being adrift, rudderless and lost;
- a crisis of identity because they do not have not have a male at home to identify with (in the school system this is compounded as it is a "man desert" particularly in the early years/nursery and primary sector);
- they are susceptible to anger, bouts of rage, a lack of motivation and have difficulties in forming relationships;
- they are at higher risk of joining gangs because boys have a natural, innate sense of wanting to belong;

- they develop a poor judge of character;
- they are more likely to underachieve in their studies, and,
- they are at risk of developing addictions (in an attempt to fill voids in their life).

Impact of family separation and lack of contact with children

- Kpsowa (2000): Divorced and separated men were found to be nearly 2.4 times more likely to die by suicide than their married counterparts
- Kpsowa (2003): When comparing gender differences, divorced men were nearly 9.7 times more likely to die by suicide than divorced women. In other words, for every divorced woman that dies by suicide, more than nine divorced men died by suicide.
- Evans et al. (2016) reviewed 29 studies comparing gender differences in suicide risk following relationship breakdown. 17 studies found that men were at greater risk of suicide following relationship breakdown (while 6 suggested women were at greater risk and 6 found no gender difference).

Educational underachievement

Boys are behind girls at every level of education, with young men 35% less likely to attend university than young women.

A very common problem for some boys, which often starts in primary school, is that they fall behind with literacy and numeracy skills and they then lose hope of catching up. They can become despondent and so give up trying. This problem particularly affects poor working-class boys, who also have the lowest attainment outcomes.

If this is not attended to early enough it is carried forward into secondary schools. It becomes a downward spiral and highlights three critical issues that need to be resourced:

- Early detection systems to spot barriers to learning;
- Effective and individually-tailored interventions to address these barriers, and,
- Programmes and initiatives to develop and sustain higher levels of boys' resilience ("Bouncebackability") in terms of educational development – to handle bumps in the road in their learning.

Some schools involved in the University of Belfast's Taking Boys Seriously 2 (TBS2) boys' education research project, have looked at the communication between feeder primary and secondary schools to ensure early learning issues are detected and resolved. This is to make sure they do not become deep seated and intractable. In addition, mentoring for Year 8 boys has played a crucial role in this.

Community interventions are really important. One example cited by TBS2 is the

'Box Clever' project in Monkstown, County Antrim. This reaches out to the most hard-to-reach and disengaged boys: Year 11 school refusers. Boys turn up twice a week and receive life coaching in areas of improvement from specially trained youth workers. The 'deal' is they can only join if they go to school for the other three days and do not get into trouble. Boys routinely exit with 5 GCSEs and successfully go onto post-16 education or employment.

Imprisonment

Men make up 96% of the prison population.

Dr Naomi Murphy, is a Consultant Clinical & Forensic Psychologist and the Clinical Director of the Fens Offender Personality Disorder Pathway Service based in the high secure prison, HMP Whitemoor. In her evidence to the APPG on Men and Boys for the 'A Boy Today' report, Dr Murphy stated that while we are very familiar with the idea that women in prison are a traumatised population and that prison may not be not the right solution to how we deal with and support women who have offended, the same is very often true for male inmates.

Her team has collected data in the prison service on what is known about the history of men referred to her service, which is perhaps the 'last chance saloon' for men in prison.

By the time men get to her they have typically all been assessed on multiple occasions by a probation officer and by a psychologist and many of them have multiple reports. However, Professor Murphy states:

> "We have an idea about what their history is when they come to us, yet six months after they've been with us we see a statistically significant increase in the kind of disclosures that men talk about. These are typically disclosures of vulnerability. The men are highly resistant to sharing stories about their vulnerability, about trauma early on in life and mostly men take much longer to talk about that than they talk about their offending. We also know that some men take much longer than six months to disclose."

Of those being supported by Dr Murphy, she stated that at least:

- 73% have experienced abuse;
- 81% have been physically or emotionally neglected;
- 81% have been subjected to emotional abuse such as active denigration by their parents.
- 66% have been sexually abused; often been sexually abused by multiple perpetrators not just one individual (at multiple points during their childhood) and of those 52% have been sexually abused by a

woman, or women, during that time;
- 44% of men have witnessed domestic violence;
- 53% were spent periods in local authority care;
- 77% were bullied during childhood;
- 16% identified themselves as being raised in poverty by not having enough food, not having adequate clothing and not having things like washing machines, and,
- 20% were pressurised by older peers to engage in violence or crime.

Dr Murphy stated that the stories that she hears in prison from men relating to child abuse are not dissimilar to the kinds of accounts that were heard from the girls in the Rochdale and Rotherham child abuse scandals. This includes where child abuse took place where older peers were befriending them and were offering money and incentives to engage in criminal activity.

F) POLICY RECOMMENDATIONS: THE CASE FOR A UK MEN'S HEALTH STRATEGY

In the UK there is little in the way of proactively planning for or reacting to emerging issues facing men's mental and physical health.

For example, Covid mortality rates for working age men and women were respectively 31 and 17 per 100,000. Unfortunately, we have had minimal discussion, either public, political or in the health community on the causes and how to address this gender-related issue.

In 2019 the Women and Equalities Committee inquiry into the mental health of men and boys recommended the development and roll out of a dedicated national Men's Health Strategy.

A Men's Health Strategy will be a more effective way of improving the mental and physical health of all men and boys throughout their life course.

Some examples showing why this is a better solution:

- If we simply address the problems of suicide, alcoholism or obesity as separate issues, we will fail to see that they often result from similar circumstances;

- If we treat differences in life expectancy, work-related deaths/injuries and prostate cancer deaths separately, and do not take into account intersectional matters such as poverty, class, occupations and place then we may fail to address the real causes

There has been a growing awareness of the health and wellbeing needs of men and how these should be best met by service providers, community action and through research – but this has not been fed through into national or local health policies,

plans and actions.

Much of the recent positive development in men’s health has been ad hoc and delivered by community organisations starting from scratch. These include organisations such as UK Men’s Sheds, Andy Man’s Club, the Lions Barber Collective, Movember and Save Dave (Domestic Abuse). This grassroots activity is welcomed but it is unfortunate that they are operating in a health system with no overall men’s health strategy that supports and underpins their work.

In addition, no one is accountable for men’s mental or physical health at a national level from a ministerial perspective through to divisions within the Department of Health and Social Care, Office for Health Improvement and Disparities or the Government Equalities Office. The same can be broadly said at a regional /local level with no known people/roles with specific accountability with Clinical Commissioning Groups, Mental Health Trust’s and within local authorities.

It is noted and very welcome, that the Government’s new Women's Health Strategy proposed the appointment of a Women’s Health Ambassador. The Government should also propose a Men’s Health Ambassador as one of the key components of a Men's Health Strategy.

A Men’s Health Strategy would pull these threads together through creating a holistic and gender-informed approach to men’s health across their life course.

Some claim existing policies cover the need, that we should just improve healthcare for all. However, as the evidence here shows, men and women each have specific health needs and challenges.

Professor Alan White, Founder and Co-director of the Centre for Men’s Health at Leeds Beckett University, now Emeritus Professor of Men's Health at the University, responded to these claims: “*It is true that there have been many areas of women’s health that have been under-researched and poorly managed, especially around their reproductive health. It is also the case that there are many aspects of men’s lives that have been historically overlooked and show similar gender inequities and inequalities, which suggest that a more targeted approach is needed because current policy is not working. This has not been helped by a lack of any formal statement on men’s health by the government since a chapter on men’s health in the 1992 Chief Medical Officer’s annual report.”*

G) EXAMPLES OF RECENT AND EFFECTIVE COMMUNITY ACTIONS ON MEN’S HEALTH

In any men’s health strategy, community-based projects and organisations must always be included and the lessons from their work learnt. Much of the recent and welcome development in men’s heath has been ad hoc and delivered by community organisations starting from scratch. These include successful

organisations such as:

- UK Men's Sheds
- Andy's Man Club
- The Lions Barber Collective
- Save Dave (Domestic Abuse)
- Male Survivors Partnership
- Male Domestic Abuse Network
- Black Men's Health UK
- Mental health 'First-aiders'
- Football Fans in Training (weight loss initiative)
- Men's Health Unlocked in Leeds

It is vital they have the opportunity of being included in any development of a mental health plan that meets the needs of men and also that there are places for them on any longer term official advisory/expert roles.

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