



Delivering male

Effective practice in male mental health

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For better
mental health

Commissioned by



National Mental Health
Development Unit

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About the partner organisations

The Men's Health Forum

The Men's Health Forum (MHF) aims to be the centre of excellence for men's health policy and practice. The MHF provides an independent and authoritative voice for male health in England and Wales, and tackles the issues and inequalities affecting the health and well-being of men and boys. The MHF's vision is a future in which all boys and men have an equal opportunity to attain the highest possible level of health and well-being.

Mind

Mind is the leading mental health charity in England and Wales. Mind works to create a better life for everyone with experience of mental distress by:

- Campaigning for people's rights
- Challenging poor practice in mental health
- Informing and supporting thousands of people on a daily basis

A fundamental part of Mind's work is provided through its network of over 180 local Mind associations who last year worked with over 220,000 people running around 1,600 services locally. Services on offer include supported housing, crisis helplines, drop-in centres, counselling, befriending, advocacy, and employment and training schemes.

For further information about Mind and how you can get involved, please visit www.mind.org.uk.

The National Mental Health Development Unit

The National Mental Health Development Unit was set up in April 2009 to support the effective implementation of key policy goals in mental health and wellbeing. It aims to ensure an effective link between policy and practice to deliver real change and achieve measurable outcomes. It disseminates best practice and ensure the co-ordination of national activity to effectively support regional and local delivery. The NMH DU is funded by the Department of Health and the NHS. It develops its work in partnership with key external organisations, including the NHS Confederation, the Association of Directors of Adult Social Services (ADASS), mental health voluntary organisations and service user and carer representatives.

Acknowledgements

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We also acknowledge the encouragement and guidance of Cathy Freese, National Project Lead for Gender at the National Mental Health Development Unit.

We thank our colleagues at the Men's Health Forum and Mind for their support and advice while the document was in progress. We are especially grateful to Colin Walker, Policy and Campaigns Manager at Mind, who facilitated all the focus groups for us.

Finally, we thank those people who responded to our online requests for comments and suggestions, and those men who took part in our focus groups. We also thank several individuals and organisations who helped with those specific sections of the report where we lacked specialist knowledge. All these contributions are acknowledged where they appear in the document.

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Executive Summary

Introduction

“... men often have mental health needs that are distinct from those of women and which are particularly associated with the lived experience of being male. Some of these needs are not being met as effectively as they might.”

Untold Problems: published by the Men’s Health Forum, 2010

Delivering Male was commissioned by the National Mental Health Development Unit, and written and published as a partnership between the Men’s Health Forum and Mind. It addresses the following question in relation to service delivery and professional practice:

What can be done to make sure we meet the mental health needs of men and boys more effectively in the future?

Because the issue of good practice in male mental health is relatively under-researched, a detailed consultation process was established in order to ensure that the document drew on the widest range of expertise. This process included:

- An expert advisory panel which advised on the developing content of the report and reviewed the various drafts
- Open access online “Have Your Say” pages which encouraged service users, carers, mental health professionals and interested members of the public to express their views on male mental health
- A series of focus groups in various parts of the country which sought the views of men with personal experience of mental health problems
- A free conference held at Reading University which invited a mixed audience of service users, carers, representatives from voluntary organisations, and mental health professionals to make suggestions for improved future practice

The particular findings of this process in relation to the views of men with personal experience are effectively a piece of original research and are reported in chapter 2 as a prologue to the substantive content. Chapter 2 is not covered in this Executive Summary.

Chapter 8 reflects on the particular needs of some specific groups of men. This chapter is also not included in this Executive Summary. The specific groups covered in Chapter 8 are:

- Men in the criminal justice system
- Older men
- Men living in rural areas
- Black and minority ethnic men
- Men with eating disorders
- Ex-servicemen
- Gay men
- Men who have been sexually abused in childhood or sexually assaulted as adults

The substantive content of the document is contained in chapters 3 – 7 and is organised along a “continuum” of men’s engagement with mental health services. The essential points along this continuum are numbered 1 – 5 below.

1. Male views and experiences

There is an on-going scientific debate about the extent to which men’s attitudes and behaviours are “hard wired” into their genetic make-up. There is no serious dispute however, that social influences and life experiences are crucial to men’s view of mental health, and their likelihood of seeking advice, help and support. Cultural expectations of men – particularly the belief that men and boys should not express vulnerability – are believed to militate against many men’s ability to give priority to their personal mental wellbeing.

If men’s mental health is to be improved, then it is important to take this cultural background into account. It may be particularly important to find ways of supporting the early development of boys. Health, education and community service providers all have a part to play. Similarly, there is scope for schools to review the way they support and encourage boys – not least, because boys consistently experience poorer educational outcomes than girls. Support for fathers and recognition of the importance of fatherhood is also important. Children (male and female) who have supportive and loving fathers often enjoy better social functioning.

There is a perception that men and boys are often portrayed negatively in the media and advertising. This is said to make it difficult for boys to find positive role models. Similarly, the stigmatising of mental health problems, which is damaging for both sexes, may present some particular problems for men. These may include public and professional assumptions that men with mental health problems are invariably threatening and even violent. Men may find that their mental health difficulties are viewed less sympathetically, perhaps particularly by male friends and employers. These kinds of attitudes need to be challenged.

In general terms, men tend to lead less healthy lives than women. Unhealthy lifestyles are detrimental to mental health as well as physical health. It might be that male mental health could usefully be made the focus of some campaigns promoting healthier lifestyles.

2. Helping men and boys to maintain and improve mental health

There is significant potential for programmes targeting the improvement of the mental health of men and boys. There is also increasing evidence from the field of physical health that male-specific marketing approaches can help close the gap between the sexes in the appetite for advice and information.

Existing mental health promotion campaigns often focus on the importance of recognising the signs of emotional distress and on the value of seeking support. Such campaigns may assume a level of self-awareness and a willingness to seek help that many men may not possess.

This does not mean that mental health promotion campaigns are doomed to fail with the male audience. There is some evidence that messages that draw on “traditional” male sensibilities (e.g. “facing up to things”; “having the courage” to act etc.) may be effective. It may also be necessary to work to change some men’s perception that to care about one’s

mental health is “un-masculine” (and the associated belief that mental health services are designed to the needs of women).

In some cases – for example, after bereavement, relationship breakdown, or redundancy – it is important to recognise that the male “brave face” may be concealing mental distress. Mental health promotion campaigns that focus on the role of friends and relatives in providing encouragement and emotional support may have something to offer here.

3. Identifying and supporting men in mental distress

Sometimes ensuring that advice, support and information are available is not enough. It is probable that some men who are in need of professional help remain unknown to mental health agencies and other service providers. It is important to find ways of reaching out to these men to ensure that they at least have the opportunity to consider using services.

Primary care has a crucial role to play. Men – especially younger men – use primary care services less frequently than women. Men therefore need to be treated encouragingly and with respect when they do attend primary care and try to raise the concerns about their mental health. Primary care staff may sometimes need to look beyond an ostensible physical problem, especially if they happen to know that a male patient has suffered a recent adverse life experience. There is some anecdotal evidence that the encouragement of a third party (a friend or relative, or other trusted adviser) may provide the necessary “permission” for men to seek help for themselves. Health professionals may be able to take advantage of this by being directive about onward referrals – for example referrals for psychological therapies about which a male patient may be hesitant.

Outreach services for men are finding increasing favour in relation to physical health. Outreach programmes allow basic health checks to be performed in a non-clinical setting (such as a workplace or social setting). Men who are found to have potential health problems can then be encouraged to refer themselves for further help if necessary. Although it may be somewhat less straightforward, there is scope for developing this approach in relation to mental health.

Male behaviour that is self-damaging or which involves aggression towards others, can sometimes be a symptom of underlying mental distress. This is a particularly challenging issue but it is important to try and ensure that men are not denied the offer of support if they come to the attention of public agencies as a result of this kind of behaviour. There may be some potential in developing “signposting” strategies within other public bodies and among organisations that have significant male memberships. The use of local mental health “ambassadors” - men who have experienced mental distress and are willing to speak about their experiences – may be helpful.

4. Supporting men and boys with diagnosed mental health problems living in the community

Diagnosis of a mental health problem does not always guarantee that men will be offered the help that they need, or that they will engage with services in an effective way. In some ways, the crucial issue here is that service users should always be treated by consideration of their individual needs. Such an approach should ensure that the service users “gendered needs” (whether as a man or a woman) are taken into account among their other needs.

The existing moves towards the “personalisation” of care are very welcome here. There are however, some more general principles that can be applied that might benefit male service users in particular.

Giving accurate information and advice is very important. Diagnosis with mental health problems is likely to be distressing and, for men in particular, may feel threatening and disempowering. Clear and thorough explanations of the implications of the diagnosis, possible side effects of medication and so on may help reassure male patients.

Non-verbal interventions can also be appealing to men, especially shared activities that place service-users “shoulder-to-shoulder” (rather than “face-to-face”) with service providers and other men who have mental health problems. These might include physical exercise, social activities and “meaningful occupation” (activity with an end product). Training courses focused on their future work prospects will be seen as valuable by many men.

All-male support groups can provide peer support and may work well for some men. Similarly, some men welcome hearing the personal stories of others who have experienced mental distress and made progress towards recovery. Allowing men to choose a practitioner of either sex may also be helpful.

5. Supporting male inpatients

The inpatient environment presents a unique opportunity for mental health services to work productively with men. Unlike other settings, the initial challenge is not about getting men to approach the services. The men are already there. Even so, men may remain less likely than women to engage with the services that are available. Service providers may need to develop an approach that is proactive, persuasive and persistent if they are to be effective.

It is important that male inpatients are assessed and treated as individuals. An inpatient stay not only provides the crucial opportunity for men to be offered the clinical and therapeutic support that they need, it may also provide a breathing space to allow them to sort out some of the wider problems in their lives (for example, housing and benefit problems). Men will often need professional support to do this, perhaps from organisations outside the NHS who are prepared to visit men in inpatient units. Suicide is more common among male than female inpatients, so it is also vital that service providers aim to provide a safe, caring environment in which men feel able to express their vulnerability.

Boredom is a problem for many inpatients of both sexes and may be a particular trigger for self-damaging or aggressive behaviours in men. Providing useful, constructive and supportive activities for men is as important for inpatients as it is for men living in the community. The national “Star Wards” programme has much to offer here. It is crucial that male inpatients are afforded the same degree of understanding as female inpatients. Although violence and aggression are more common among male than female inpatients that does not mean that all men are potentially aggressive and is no reason for routinely treating men defensively.

It is important not to lose sight of the goal of recovery. When men are well enough to return to the community it is absolutely vital that the transition is handled smoothly and effectively and, again, with the focus on the specific needs of the individual.

The big ideas

The final chapter of the document (Chapter 9) highlights a group of seven themes that run through the many of the groups of “Ideas for Practice” that are contained in earlier chapters. These seven “big ideas” are:

Treating men as individuals

Gender is perhaps the most fundamental determinant of an individual’s sense of self. Ensuring that mental health service users are treated as individuals will therefore greatly increase the likelihood that their gendered needs as men (or women) are taken into account. If all service users are treated as individuals that should also lead to a greater recognition of the shared needs and experiences of groups and communities in general. The existing moves towards greater personalisation of care and support (for example direct payments and personal budgets) are already giving some people with diagnosed mental health problems greater control over the way their support needs are met. This approach is to be welcomed and has the potential to contribute significantly to the better recognition of male mental health needs.

Inter-agency working in the early years

Many of the attitudes and beliefs that underpin people’s mental health behaviours are established in childhood – arguably during early childhood in particular. There is much more that could be done to support boys during childhood, especially those boys whose circumstances may increase their potential lifetime vulnerability to mental health difficulties and may reduce their capacity for seeking help. Supporting the development of good mental health is not currently a shared objective for health, education and social service providers in any organised way. There is significant scope to prioritise the development of happy, well-adjusted children, and a very strong case to be made for taking the gendered needs of boys into particular account.

Stigma

Few dispute that mental ill health is much more more stigmatised than most forms of physical ill health. The damaging experience of stigma is commonly reported by mental health service users of both sexes. There has been little work to examine whether stigma affects men and women in different ways and/or in different degree. Nor is there much detailed knowledge about whether prejudicial beliefs among the general public are more marked in relation to one sex or the other. We believe that it is at least possible that, in general, men may feel stigma more strongly than women, and that public attitudes may be more prejudiced against men with mental health problems than women. A greater understanding of the relationship between stigma and gender is needed.

Promoting services

The evidence suggests that men tend to under-use mental health services. There is probably no single explanation for why this should be. Structural reasons probably play a part, as probably do stigma and “traditional” male attitudes, which can make the acknowledgement of vulnerability extremely difficult for many men. It is probable that a more sophisticated and nuanced approach to the promotion and delivery of services could improve male uptake. Men who find help-seeking difficult are not going to change in the short term – but mental health services can.

The role of third parties

We make the point in several places, that third parties may have a very particular role in encouraging men to seek help for mental health problems. It is possible to argue that the focus should be on moving men towards taking greater responsibility for their own health but other people, particularly life partners, are likely to remain a crucial element in the decision-making process for many individual men. Because even married men tend to have fewer, and less intimate, social and family contacts than women, there may also be a place for other people who are in contact with a man in mental distress to support him in the process of seeking help. Male friendship groups may have a particular part to play here, as may men prepared to talk about their personal experience of mental health problems. There may be ways to facilitate and support the role of these third parties.

Joined-up approach

Men in mental distress often exhibit difficulties in other areas of their life and functioning. Alcohol and drug misuse – which may have been used as a coping mechanism – are common. Relationship problems, social disengagement, offending behaviour, and difficulties with work (chronic unemployment or work-related stress) also occur. “Whole-life” problems need whole-life solutions. Joined-up approaches which include the involvement of social care, employment, and housing providers may be of particular value for men, who sometimes lack supportive networks of their own.

Professional training and an improved knowledge-base

Professional training is an important element in making progress on all equality issues. Training in relation to the most important issues in male mental health may be particularly useful, given the range of the issues that have been identified. Beyond developing practitioner expertise however, we believe that there is a good case to be made for the development of a much greater professional and academic knowledge base. There is little history of the dissemination of good practice, and the academic literature is sparse. At the very least we would encourage the professional mental health bodies to develop an internal focus on male mental health. We would also like to see a national focus on the issue, for example in the establishment of an inter-disciplinary network with a conference or seminar programme. Ultimately, perhaps an academic centre for research on the issue might be established.

Foreword

This report is a valuable outcome from the work of the Mental Health Equalities Programme, which has been one of the six strands of activity undertaken by the National Mental Health Development Unit.

Gender is one of the most fundamental determinants of an individual's sense of self. It is therefore crucial that services are provided in a way that is sensitive to this. We have had some success in ensuring that we do so for women but this report addresses the same issue in relation to men and boys. Actions of the kind recommended in this document should also make a significant contribution to the overall goal of treating all mental health service users as individuals and greatly increase our ability to deliver personalised mental health care and recovery.

This report should be of value to commissioners (including those working within new and evolving commissioning arrangements), especially in helping to coordinate mental health commissioning across local government and the NHS. It should also be helpful to a wide range of others including teachers and others working in education, the police, prison officers and others working in the criminal justice system, social workers and youth workers, employers, voluntary sector organisations and individual users of services, their carers and families

It focuses on the roles of men and boys in the family and includes the engagement of fathers through service provision. The report also emphasises the vital role of the voluntary and community sector in improving the engagement and responsiveness of services for men and boys.

The Government's White Paper *Equity and Excellence: Liberating the NHS* sets out how the improvement of healthcare outcomes will become the primary purpose of the NHS. Now that the National Health Service as a whole is changing, the way that we think about mental health needs to change with it. This report makes an important contribution to the debate about how to meet the needs of individual service users and the population at large more successfully. I hope this report will help stimulate further discussion.



A handwritten signature in black ink, appearing to read 'Hugh Griffiths'.

Dr Hugh Griffiths
Acting National Clinical Director for Mental Health

1: Background and context

Introduction

... men often have mental health needs that are distinct from those of women and which are particularly associated with the lived experience of being male. Some of these needs are not being met as effectively as they might.

The words in the box above are from *Untold Problems: a review of the key issues in the mental health of men and boys*, published in 2010 by the Men's Health Forum. The present document has been commissioned as a follow-up to that review. It addresses the review's implicit question with reference to service delivery and professional practice:

What can be done to make sure we meet the mental health needs of men and boys more effectively in the future?

In offering guidance and ideas for practice, we will not revisit the premise highlighted in the text box. *Untold Problems* identified the most important issues and readers are encouraged to refer to that document for relevant evidence. There are a small number of footnotes in the present document but these are limited to places where we discuss evidence or other background information not included in *Untold Problems*. Apart from this, the present document is entirely written as a guide to effective practice.

It is not possible however, to make best use of this document without setting it in context. This introductory section outlines the rationale for the document and describes the extensive consultation process that – together with the evidence from *Untold Problems* – forms the basis of its content. The subsequent chapters have as sharp a focus on practice as we have been able to achieve within the state of current knowledge.

Commissioning of this document

This document was commissioned by the National Mental Health Development Unit (NMHDU) which had previously commissioned *Untold Problems*. Among NMHDU's responsibilities is that of helping NHS service providers ensure that principles of equality underpin mental health service provision.

In recent years the mental health of women has been paid increasing attention within mainstream services. This has been a consequence of national policy thinking in relation to women's health in general. Developments in women's mental health have been supported by NMHDU and its predecessor organisations, and implemented by many provider organisations. The interest in women's needs has been founded on the recognition that a woman's "gendered experience" is often a significant determinant of her mental health status. It is generally accepted that where women's needs have been accounted for in the planning and delivery of services, those services have become more responsive and potentially more effective.

We strongly support this approach in respect of women. NMHDU's purpose in commissioning this document and *Untold Problems* is to encourage a parallel development in meeting the mental health needs of men and boys. This is important not just for the obvious professional reasons and in order to ensure the most effective use of public funds, but also because there are now legislative imperatives to do so. Details of the legislative position are given in the box below.

The Equality Duty

The Equality Act 2006 prohibited sex discrimination in the exercise of public functions. It also placed a duty on public authorities, including the NHS, to promote equality of opportunity between men and women (the "Gender Equality Duty", or GED). The intention of the Act was that public bodies should seek to achieve equality of outcome between men and women using public services, wherever that was possible. Similar duties already existed in respect of people of different racial origins and disabled people.

The Equality Act 2010 brought together all the existing provisions of previous legislation in one unified Equality Duty. This new overall duty includes additional responsibilities in relation to age, sexuality and religious belief but otherwise has precisely the same effect as its predecessor in relation to gender equality. These additional duties will also contribute to addressing the diverse needs of men and boys.

Further information is available from the Government Equalities Office.

The present document has been commissioned from the Men's Health Forum in partnership with Mind. Mind has a significant track record of its own in recognising that male mental health deserves particular attention. The content of this document draws much of its strength from Mind's ability to engage directly with people who have experience of mental distress. Information about NMHDU, Mind and the Men's Health Forum is given inside the front cover. Information about the two individual authors of the document is given at Appendix 3.

Untold Problems is downloadable from the website of the Men's Health Forum. Mind's 2009 campaign report on male mental health, *Get it off your chest*, is downloadable from the Mind website.

Who is this document for?

NMHDU commissioned this document for a broad audience:

- Planners and commissioners of mental health and wellbeing services
- Staff in primary care settings
- Public health and health improvement staff
- Mental health staff working in both community and inpatient settings
- Social care staff
- Mental health trainers, educators and students
- Families and carers of men with mental health problems

We hope that the document will also be of interest to a wider range of people who work in settings in which male mental health may be a relevant factor. These people might include,

for example: teachers; social workers; youth workers; social care staff; housing staff; police officers, prison officers and others working in the criminal justice system; independent counsellors; employers; and voluntary and community sector organisations working with local communities.

Format of the document

The substantive content in relation to effective practice is contained in chapters 3 – 7. There were a number of ways in which we could have presented this content but, after consultation with our Advisory Panel, we have opted to organise it along a “continuum” of professional involvement with men and boys. This continuum begins with issues related to the behaviours and attitudes of the male population as a whole and ends with issues related to male psychiatric inpatients.

This structure should enable practitioners and commissioners to home in easily on the area that is most relevant to their work if that is the way they prefer to use the document. Each sub-section of each chapter has a box giving “Ideas for practice”. We hope that the discussion of the issues will inspire further ideas from readers of the document.

In Chapter 8 we address the needs of particular communities of men, and the relevance of maleness to some specific mental health conditions. In the final chapter we summarise seven important “big ideas” that have emerged from the document as a whole.

Please note that for the sake of simpler sentence construction, we often use the word “men” to mean males of all ages. Unless the context suggests otherwise therefore, the word “men” should generally be taken to mean “men and boys”.

Consultation process

Because there is relatively little published information about effective practice in male mental health, we decided to establish as comprehensive a consultation process as possible. Although the consultation process encouraged a wide-ranging debate, its primary purpose was to collect information and ideas in relation to practice with men. The consultation process had several components:

Expert Advisory Panel: The Expert Advisory Panel was made up of mental health professionals, other health professionals, academics, and representatives of voluntary organisations. Among this group were people with personal experience of mental health problems and those who had used mental health services. Members joined the panel by invitation and were mostly chosen because of their pre-existing interest in male mental health. Panel members took part in on-going e-mail discussions about the content of this document and were involved in reviewing the draft versions (the final draft version was also reviewed at NMH DU). Around two thirds of panel members also took part in a one-day meeting in February 2010. Membership of the Expert Advisory Panel is given at Appendix 1.

A one day consultative conference: The consultative conference was held at Reading University on March 29th 2010. The conference was widely publicised on mental health networks and was open to mental health professionals, service users and other interested parties. Places were allocated on a first-come-first-served basis and the conference was free to attend. The conference was structured solely around the objective of generating ideas for inclusion in this report. Names and designations of conference delegates are given at Appendix 2. We are grateful to the Charlie Waller Institute at Reading University for hosting this event for us free of charge.

Workshops and seminars: During the spring of 2010, we gave seminars or workshops at three conferences: The NMH DU Annual Conference on Mental Health Equalities; The Annual Conference of the UK Public Health Association and a regional conference on men's health in the east of England. Participants in these seminars and workshops were invited to contribute their ideas for inclusion in this document.

Meetings with specialist organisations: Where we felt that we needed more detailed guidance on particular issues and that guidance was not available via the Expert Advisory Panel, we arranged meetings or teleconferences with specialist organisations working in the particular field. Four of these meetings were held, covering: the mental health of children and young people; the mental health needs of older men; the mental health of adult male survivors of sexual abuse; and the mental health of ex-servicemen. We are grateful to the Mental Health Foundation; Age UK; the Children and Young People's Mental Health Coalition; the Royal British Legion; and Survivors UK for their advice and expertise in this context. We have also had informal meetings and phone conversations with specialists from a number of other organisations.

Focus groups of male users of mental health services: We took the view that learning from the personal experiences of male service users was crucial to constructing guidance for good practice. For this reason we conducted a series of focus groups with male service users in various locations around the country. As we consider this element of the consultation process to be particularly important and it is effectively a piece of original research in the field, we have decided to dedicate a specific chapter – Chapter 2 – to an analysis of our findings.

Previous focus groups of men in minority ethnic communities: In 2008, as part of a project commissioned by the Department of Health, the Men's Health Forum conducted a series of focus groups about mental health with men from minority ethnic communities (African-Caribbean, African, Indian, Bangladeshi, Pakistani, and Chinese communities). The outcomes from this project have been published separately but it seemed worthwhile to re-visit the project's findings to help ensure that we have incorporated a diversity of opinion into our own recommendations. Our analysis of the work from this project has been incorporated into Chapter 2 alongside the findings from our own focus groups.

"Have Your Say" pages: Open pages were available for several months on both the Mind and Men's Health Forum websites. These pages invited anyone, whether mental health professional, service user or interested members of the public, to post observations, ideas or suggestions. These web pages generated 74 responses, many of which drew on respondents' personal experiences of mental health problems and mental health services. As most of the respondents were service-users (or carers), we have incorporated their comments into the report of our own focus groups in Chapter 2.

Value of the consultation process

We used the consultation process for a variety of purposes which will become evident later in the document. The most important of these are as follows:

- To learn about "what works" from the point of view of practitioners and service planners
- To learn about "what works" from the point of view of service users
- To gather examples of existing (and past) good practice and invite workable ideas for future practice
- To discuss the relationship between maleness and mental health



“ I used to really enjoy playing football and I didn't think I'd get another chance to play. The opportunity to play again has made me feel much better about myself. ”

Tim, Croydon

- To improve our understanding of the kinds of support that men want and need
- To look at what might be done more broadly to promote and maintain good male mental health

At this point we should draw attention to one particular outcome of the consultation process. Many mental health professionals that we heard from had developed a clear professional sense of the differences between working with men and working with women. As a consequence they had advice about the key issues for men, and advice about effective practice with men, that they felt strongly was validated by their own day-to-day experience.

Some of this “learned-through-experience” advice was consistent between individual practitioners, even where they were from different disciplines. Furthermore, some of these professional beliefs were confirmed by male service users. To take one example among several, many professionals believe that men may need “permission” to seek help for mental health problems. In other words, men may find it easier to seek help when a third party (a friend, relative or other trusted advisor) has urged them to do so, rather than “admit” directly that they may be experiencing difficulties with their mental health.

It is of course reasonable to point out that commonly held professional beliefs of this kind sometimes turn out, despite their ubiquity, to be incorrect when tested by empirical research. In the absence of a strong research base however, we have given weight to some of these ideas where they have been widely represented across our consultation process - and we have felt justified in using them to form the basis of some of our own recommendations.

Note that, for the sake of simplicity, we have decided to refer to our entire body of consultees as our “advisors”. From this point forward, opinions or ideas credited to our advisors should be understood as those opinions or ideas that achieved significant consensus across the consultation process as a whole.

Case studies and *Viewpoint* boxes

In addition to the general text we have included 21 case studies of successful projects which have focused on male mental health. The case studies have been chosen because they seem to us to have risen well to the specific challenges of male concerns. We do not claim that they are the only examples of their kind. We have sought examples of good practice as widely as we could but there is no doubt that we will have missed many. We hope that the continuing focus on this issue will gradually begin to pull together networks of interested people and that a body of known good practice will emerge and be disseminated.

We have also included a series of twelve “Viewpoint” text boxes in which practitioners from various mental health disciplines comment freely on their own experiences of working with men and boys. Again, we do not claim that these contributors are the only people with knowledge of this subject. They are people known to us as having an interest in the field and who were willing to contribute to this document.

Photographs

We are fortunate to have had the services of a professional photographer, Dave Atkinson, who has given his time free of charge. Dave’s portraits of men who have experienced mental health problems appear throughout the document. Each photograph is captioned with a personal comment from the subject, except in a couple of cases where the subject has chosen to add no information about himself. We are very grateful to Dave for his contribution to this document and to the men who agreed to be photographed.

Framework for the content*

In commissioning this document NMH DU specified three guiding conditions:

- Ideas for practice should be realistic, practical and achievable
- Ideas for practice should be aligned with existing and emerging national mental health and wellbeing policy
- Suggestions for new ways of working should be capable of implementation at local or national level without requiring funding greater than is already available for the provision of services

These conditions have provided a useful discipline in framing the various debates that we have had during the process of writing this document. We have adhered to them throughout the document and they undoubtedly contribute to the usefulness of the content, even though they have meant that we have not been able to include some of the interesting ideas that were put to us in the consultation process.

Authors' observations

We are privileged to have been given the opportunity to write this document. In writing it we have spoken to, or heard from, large numbers of service planners, mental health practitioners and service users. No-one has disputed the basic premise that there is a case for considering the mental health needs of men and boys within the context of male culture, attitudes and behaviours. The majority view indeed has been that this document and its recent predecessor documents are long overdue. "It is so obvious that we need to do this – I don't know why it hasn't been done before" has been the most common response from the people with whom we have had contact.

Notwithstanding this level of enthusiasm, we are aware that there may be concerns in relation to this piece of work. Some will argue that since health services already aim to be both universally available and consistent in quality, it is up to the people who use them to do so effectively. In other words, that the onus to change is on men, not on services.

To this, we say that it has long been recognised that just because services are universally available it does not mean that they are universally effective. Virtually no-one engaged with health service provision now disputes, for example, that services need to adapt to ensure that they better meet the needs of the least well off. Much recent health policy has been built around this very principle. Similarly it is not controversial to adapt health services to the needs of people from minority ethnic communities or – as we have seen – to the needs of women. In this document we merely advocate extending this approach to the needs of men. We will argue that such an approach has the potential not just to improve the lives of individual men but also to help address some wider social problems in relation to – for example – family breakdown, anti-social behaviour and substance misuse.

The question then arises of whether, in advocating that services should take greater account of male attitudes and behaviour, we are "condoning" those behaviours and attitudes – even when they may be part of the problem.

* Since this document was commissioned, the Minister for Care Services, Paul Burstow, has signalled his intention to publish a revised national mental health strategy following the publication of the Public Health White Paper in late 2010. We hope that the ideas in this document, in conjunction with the evidence in its predecessor document, *Untold Problems*, will help to inform the development process for the revised strategy.

To this, we say that, quite apart from the complex matter of whether or not those behaviours and attitudes actually can be changed, they are certainly not going to change in the immediate future. In the meantime, there may very well be large numbers of men who could benefit from help and support but who are not receiving it. In this document we argue for early years intervention approaches which might allow boys yet-to-come to grow into men who are better able to understand their own mental health, and more willing to seek help when they need it. This does not, however, excuse us from the responsibility to provide the most effective support to men whose mental health is poor now.

Another criticism sometimes levelled at the debate about how to improve male health is that it relies heavily on generalisation. Readers may ask whether, in writing about “men and boys” in this way, we might be generalising to too great an extent. This is a fair question. Some generalisation is inevitable in a document like this one but *Untold Problems* demonstrated that there are a significant number of mental health problems that are markedly more common in men - and that “simply being male could be seen as a primary risk factor” for some particular problems (e.g. death by suicide; alcohol dependence). Furthermore *Untold Problems* pointed out that:

... in some circumstances some of the familiar cultural markers of masculinity are also potential symptoms of, or predisposing factors for, poor mental health. Many of these behaviours are so familiar that they seem indisputably “normal” even though it is easy to see that they are sometimes simultaneously damaging.

To recognise that some attitudes, behaviours and symptoms are commonly “male” is however, not the equivalent of asserting that all men are the same. Bearing this point in mind when reading this document should help minimise the sense that the document over-generalises its subject, or stereotypes men.

A final point associated with the one above is the importance of recognising that maleness is often directly linked to some of the other markers of inequity that we are more familiar with taking into account in planning services. For example, the greater likelihood of black people being compulsorily detained in psychiatric hospitals that has caused much social and political anxiety in recent years is largely a greater likelihood of black *men* being compulsorily detained; the greater risk of suicide in the most disadvantaged communities is largely the greater risk of the most disadvantaged *men* taking their own lives. Unless we take account of the gendered nature of some of these problems, we will not succeed in tackling them as effectively as we might.

This document has some limitations. We have already drawn attention to the absence of a research base into good practice with men. We have sought to address this as far as possible by basing our approach on the evidence about need from *Untold Problems* and by seeking a wide range of expert opinion. As we have already noted however, we know we will not have identified everyone who has a contribution to make and we will not, by any means, have found all the existing examples of good practice. Inevitably, we have also been restricted in terms of time and resources. The content reflects the amount of time available to write the document and the amount of space available to contain it.

The greatest value of the document will be to help planners and practitioners identify guiding principles for practical new initiatives at a local level. We concur with the analysis that mental health – in this case male mental health – can be improved most effectively by cross-cutting

policies and inter-agency co-operation. We therefore hope also that this document will make a useful contribution to this approach, influencing planning, not just in the NHS and social care but also in other areas of public service provision, and in the private sector and the third sector.

Finally, we hope most of all that this document will help establish a professional area of interest. Ideally, we would like to see the development of a national network of people interested in male mental health that is capable of making judgements about effective practice and of disseminating information and expertise. We believe also that there is room for a specialist academic initiative dedicated to exploring the relationship between maleness (or perhaps gender) and mental health, with a particular emphasis on developing effective practice. We return to this point in the summary of key principles in Chapter 9.

It will be clear by now that we want to see interest and expertise grow to the point that male mental health needs are met with maximum effectiveness. More than that, we would like to see a climate created in which the highest level of mental wellbeing for the whole population becomes a reasonable goal. This cannot be achieved without finding ways to support men and boys to maintain and improve their own mental health.

Menzone

CASE STUDY

Jack Smith

Menzone drop-in support worker

Menzone is the men-only drop-in session held every Wednesday evening (5pm to 9pm) at Mind-in-Bradford, which caters for men of all backgrounds facing mental health difficulties. Our aim has been to create a warm and caring atmosphere to enable men to share experiences and coping strategies, thus allowing them to explore alternative ways of improving their mental well-being. We find that our service helps to reduce social isolation, increase self-confidence, encourage friendships and generally improve the quality of members' lives.

On the whole, the drop-in is fairly unstructured. However, we do host various activities, such as a presentation by Roger King of "Love the Miracle You Are" – a series of discussions focussing on improving self-esteem and developing a positive mental attitude. This proved a great success with much openness, honesty and mutual-support being expressed. It also attests to the value of Menzone's men-only environment, which allows

Menzone's men-only environment allows men to escape the pressures exerted by the social norms of male invulnerability

men to let their guards down and escape the pressures exerted by the social norms of male invulnerability.

Menzone also has weekly meditation sessions. These help to combat the stress and anxiety felt by many of the men. We are also looking at the possibility of expanding this into an anxiety support group.

However, it's not all touchy-feely emotional openness at Menzone as indicated by the increasing popularity of Menzone's weekly football sessions (attendance has grown to the extent that we can't accurately describe it as 5-a-side anymore!). Last season, Menzone entered a team into the Yorkshire and Humberside Positive Mental Attitude Football League. We had mixed success (we have the oldest players in the league by far!) but the experience has helped the men to develop teamwork skills and a sense of camaraderie.

Other activities are chosen according to democratic principles. These have included: day trips to the seaside and countryside; various museums; and indoor sporting pursuits such as snooker and ten-pin-bowling.

An academic's perspective

VIEWPOINT

Peter Branney PhD CPsychol CSci

Senior Research Fellow in Men's Health

Centre for Men's Health, Leeds Metropolitan University

As an academic, I am interested in understanding what historical, political and social conditions make possible (and impossible) particular forms of mental health and illness in groups of men. Feminists have arguably been the most influential in creating the conditions where it is possible for men's health to be a subject of activism, research and policy. As Paul Crawshaw, a sociologist studying masculinities, argues, feminists politicised gender, pushing it into the social consciousness, which resulted in an epistemic shift where men and women started to recognise men (among others) as gendered beings.

Global statistics collated by the World Health Organisation show that men spend many more years of their lives living in disability than women for behavioural mental health

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conditions

conditions (alcohol misuse; self-inflicted injury).

This is in contrast to psychological conditions (depression; bipolar disorder; schizophrenia).

I would argue that distinctions between behavioural (drinking too much) and psychological (feeling depressed) conditions have largely emerged through the ways that gender is enacted on a daily basis by the medical establishment. Diagnostic procedures are more likely to deal with and tackle the emotional (self-esteem; self-confidence; feelings of unworthiness); nevertheless, society treats masculinity and emotional difficulties as mutually exclusive, constructing men presenting with such concerns as deviant.

In contrast, men predominate in groups defined by the problems they present (rather than their emotions) such as people with mental health difficulties who are held under compulsory detainment or those found guilty of violent crimes. Indeed, men are largely absent in the recognition, mild and moderate steps of mental health care but they are treated much more seriously when they present a risk to others or themselves. This gives us two dichotomies (psychological/behavioural; emotion-focused/problem-focused), which are mapped onto ways of being gendered (female/male). Given these conditions, what remains is to challenge these divisions of sex. Susan Brownhill points the way with her 'Big Build' model, which shows that we could align the inner emotional world with outward signs of antisocial behaviour. For example, we could challenge the status quo for a successful professional worker by seeing overworking or binge drinking as ways in which inner emotional difficulties are held at bay (however unsuccessfully).

Peter Branney develops articles and teaching resources about how research on mental health can be applied to areas of clinical practice.

Best practice in psychology

CASE
STUDY

Andrew White

As a practicing psychologist currently researching “Best Practice with Male Clients” for a PhD, I have been able to assimilate some contemporary theories relating to men’s psychological health into my work both in the NHS and private practice (www.counsellingformen.com).

During the recent economic downturn, one area of men’s vulnerability has come to the fore – the ability to work. As current definitions of masculine social norms typically include items like “winning”, “status” and “the primacy of work”, then a loss of employment may have a disproportionate effect upon a man’s self-esteem.

Many men adhere to this rigid masculine code despite the very severe detrimental effects that such automatic thinking has on their health. Shame, associated with the inability to live up to expectations, often compels men to hide redundancy or business decline from spouses, friends and neighbours. Indeed, men frequently exaggerate success in order to avoid “losing face” or to negate any depletion to their masculine standing.

I have encountered men who have lost their sexual functionality when the ability to fulfil the roles of “worker” or “provider” becomes impaired

I have encountered men who have lost their sexual functionality when the ability to fulfil the roles of “worker” or “provider” becomes impaired; whilst others suffer depression and even contemplate suicide.

Recently, I assessed a married father who found himself on a station platform contemplating a violent suicide after his IT role was relocated abroad. Fortunately, he soon found alternative employment as a door-to-door salesman and, miraculously, his depression and suicidal ideation disappeared. Many men become vulnerable when faced with major losses due to the absence of

protective factors like a good social network that can be utilised to provide emotional support; a coping strategy that may be more socially available for women. Although my client is now symptom-free (and therefore less willing to continue in therapy), my purpose was clear; to encourage the development of a more balanced lifestyle so that feelings of self-worth and role-identity could be engendered by other facets of his life, i.e. friends, hobbies and a more active and emotional involvement with his family. This process has been described as the redefinition of a healthy manhood and may be achieved through the humanisation of men through a normalizing and educative process. Moderate self-disclosure to engender trust and to model shamelessness when help-seeking can facilitate this.

It has been suggested that “collective denial” is responsible for the lack of awareness in men to seek out a more holistic and emotionally involved life. Responsibility for raising such awareness may rest upon the wider society, rather than psychological services alone, if men are to mitigate against the effects of psychological stress more effectively into the future.

Young male suicide


 VIEWPOINT

Jane Powell

Director, CALM, campaign against living miserably

Suicide is currently the biggest killer of men under 35 in the UK. Our role as a charity is to encourage men to seek help, and foster a wider acceptance of men seeking help. The challenge for CALM isn't about encouraging men to open up. We know with the right service and approach they will ask for help. CALM's difficulty is finding the resources to take their calls.

I worry, though, about those men who we persuade to seek medical help.

Suicide is no different from heart disease or AIDS. We need to treat the illness, as an illness, not stand in judgement and write the guy off

For a young man to visit a GP – or A&E – he almost needs to be seen to be bleeding to death for him to still be seen as a “man”. So, for him to admit to mental health problems must surely indicate that something is very badly wrong. From here, the pear-shaped options are 1) save his dignity and agree he's really okay (to the point where professionals may even ignore the risk assessment findings in front of them) or 2) get him to stop wasting NHS resources and send him home to pull himself together, with a appointment in six months time with someone further up the food chain. Obviously, if he's just “weak”, then he will kill himself and nothing can be done.

Why is an overwhelming desire to kill yourself NOW not considered to be an acute medical problem?

Suicidal feelings ARE a health issue. We make no moral judgements about people with weak hearts; we expect them to receive medical help. If someone kills himself, and has sought medical help, then frankly we should look to see where he was failed by the health service, rather than pick at why he felt so low. Suicide is no different from heart disease or AIDS. We need to treat the illness, as an illness, not stand in judgement and write the guy off for, say, being in debt.

I've the words of a father ringing in my ears. Everything suddenly went wrong for his son regarding his career. The GP reassured his son that he didn't have mental health problems, he just had a life crisis. His son killed himself shortly thereafter. If it had been a young woman crying in front of the GP, wanting to self harm, would she have received a different response?

2: Male views and experiences

Online responses

Introduction

Between February and April 2010, the websites of both Mind and Men's Health Forum hosted a feedback form enabling members of the public to submit their ideas on what should be included in this document. We are grateful to the 74 people who took the time and trouble to respond to this part of the consultation process.

Socialisation and public perceptions of men

Many of the responses acknowledged the effect of socialisation on male behaviour. Linked to this, the media's portrayal of men in general, as well as of men experiencing mental distress, was criticised for creating an unhelpful male stereotype.

Men also expect to be the one that others can go to, to be looked after, and have their problems solved.

I believe there is still a lot of prejudice against men with mental health problems. They are either seen as crazy or a danger to the public.

I object to being typecast by society as a beer-swilling, football crazed, woman beating paedophile.

A number of respondents also stated that society's narrow perception of how men should behave has restricted the way in which mental health services view and engage with male service users. As a result of this, it was argued that services can often appear feminised and that mental health professionals can lack understanding of men's complex needs.

Counselling from several different sources was so tailored to meet women's needs as to be ludicrous.

I think services could be more male friendly by people within services having an understanding that men have a high degree of sensitivity and complex emotional needs.

The environment of the doctor's surgery tends to be both female and judgmental. Most of the patients in the daytime surgery are women; there are posters and other resources about "women's issues", kids and toys about etc. Not a bloke friendly place. Add to that the posters screaming at you about smoking, drinking, obesity and other causes de jour and it's a place I'd rather not be.

I think it's less to do with men not being able to articulate and more to do with how men are viewed...I've also been refused help for being angry despite the fact I was only venting anger out of frustration...As a man, even if you DO articulate your problems and how you feel, completely explicitly, there is STILL no help available...I had the crisis team of the local mental health services tell me "You just need to go out and get drunk and you'll be fine".

Promoting better mental health to men

Respondents identified a need for better promotion of mental health messages to men through a wide variety of media. It was felt that men needed to be educated about the signs of mental distress and how to seek help. One respondent advocated the introduction of a "Men and Mental Health Day" to publicise the issue.

Press notices, adverts on radio, on TV, in magazines highlighting the fact that, yes, men do suffer from depression and other forms of mental health difficulties, that it is not their fault.

Often an individual will present to a GP with a symptom of depression which is treated as an illness in itself and not a symptom. For a major mood disorder such as clinical depression in men, sexual dysfunction is a key indication, this should be mentioned.

Advertisements on the television showing case studies of men that he can relate to...showing men that there is light at the end of the tunnel would have encouraged my husband to get help earlier.

Teach parents that saying "act like a man", "boys don't cry" etc. are not helpful and very dangerous messages.

The Department of Health should create a "Men and Mental Health Day" so that every man who thinks they have a mental, alcohol and addiction problem can automatically go to a GP.

In order to combat the stigma surrounding help-seeking among men, some respondents suggested that sports personalities and men who have recovered from mental health problems be used to demonstrate that accessing treatment does not mean you are weak and that full recovery is possible. One respondent advised that mental health promotion messages should emphasise the privacy available to men seeking help in order encourage more men to come forward.

Young men who encounter mental health problems for the first time can benefit immensely from speaking to people who have had problems for some time.

Use sport icons to break down male ego barriers.

They need to know that it is possible to get fully well. Publish accounts of men who make full recovery.

Emphasise the privacy angle, this takes away the fear of work finding out, which in my experience is the biggest drawback for men seeking help.

Effective interventions

The dominant theme among the responses regarding treatment was that mental health services need to be flexible. Services should be made more proactive and easily available for those in full-time work, help should be made accessible through a variety of means beyond face-to-face interaction, a range of interventions should be offered that include options other than medication and service users should have the option of seeing a male or female mental health professional.

Services need to be flexible and offer a range of choices... some men may find art and horticultural based therapy less threatening than having direct therapy where their feelings are discussed openly.

Men are not encouraged to take time off to seek help. I think opening hours for GPs need to be extended to weekends and evenings.

The psychologist could not give him an appointment after 5 p.m. Part of his self-support was to be at work.

Services should be proactive... not waiting till men contact them... it won't happen.

It's not easy for men to talk about these issues, even on the phone let alone face-to-face, so schemes where they can text from their mobile phones about problems or e-mail or even

just go to a website and find out about specific men's mental health issues... I believe it's important to get men step by step to a point where they can talk about their problems.

[With helplines men] benefit from being able to access [support] in their preferred way (remotely by telephone and increasingly having options such as text, e-mail and web forum chats) from any location, 24/7 and being able to remain anonymous if they choose.

I always found talking to a woman (usually not a family member) the best way forward. The fear of being judged by the same sex disappears when this happens.

One of the main issues is the lack of male professionals in the sector.

Offer support [so that] they will be able to keep their employment while they are managing their mental health problems...being able to keep their employment is a significant boost for men's mental wellbeing.

Other issues

In addition to the above, other issues outlined by the respondents included loss and middle age, homophobia in mental health services and support for men during key life events.

The issue of loss is central to the mental health needs of middle-aged men.

I experienced homophobia when an inpatient at a mental health hospital. Perhaps there should be men only groups and having a set male worker for males to be able to approach.

I think services should consider some intensive support during the initial stages of a life event... buddying up, phone contact, risk register of those who are isolated.

Focus groups

Introduction

In February and March 2010, we carried out five focus groups on the issue of men and mental health. Four of the groups were made up of male mental health service users¹ and were organised via local Mind associations. One group was made up of male members of the public, randomly recruited via a market research company. In total, 36 men took part in the focus groups.

We decided to hold focus groups in different parts of England, in both urban and rural areas. The service user focus groups took place at: Dorset Mind (in Bournemouth); Tameside, Oldham and Glossop Mind; Southend Mind; and Carrick Mind (in rural Cornwall). Participants in the Dorset group were members of Dorset Mind's 'Men in Mind' support group and participants in the Southend group were members of Southend Mind's 'SOS' men's support group for foreign-born men (including asylum seekers and refugees). Participants in the other two service user groups were regular visitors to their local Mind associations but did not belong to a particular men's support group. The general public group took place in Nottingham.

The focus groups described above were held specifically to inform the writing of this document. We have also incorporated into our own findings some of the findings from another series of focus groups held as part of a Men's Health Forum project on the mental health of men from minority ethnic communities. These focus groups, twelve in total, took place in 2008 and were held in various locations across London and the West Midlands. The groups were stratified by age and ethnicity: African-Caribbean; African; Indian; Pakistani;

¹ This chapter (and the document generally) uses the term "service user" to refer to a person who has had formal experience of mental health services. The term "member of the general public" is used in this chapter for a person who has not had such formal experience.

Bangladeshi; and Chinese. Some groups consisted mainly of men with direct experience of mental distress and others did not.

We acknowledge with gratitude the contribution of all the men who took part in the focus groups and were willing to discuss their personal experiences so openly, even when those experiences had been painful for them.

Male attitudes to mental health

All the focus groups agreed that socialisation plays a large role in determining the kinds of mental health risks that men are exposed to, as well as the ways that men try and cope with the psychological difficulties that inevitably arise during their lifetimes.

Men have been classed as workhorses and if you're a sick workhorse the last thing you want to do is complain about it.

(Dorset Mind)

Women are a bit more understanding, they speak to each other about these things. The guy won't sit down and talk about how they're feeling.

(Nottingham group)

Men are brought up completely differently from girls. If you fall over and you're a boy you're told to get up, "it's only a scratch, get on with it"...that's gone all the way through my life, there can't be anything wrong with me because I'm a bloke, I'm being a big baby. It's very difficult. I get so angry because I was taught not to show any emotion and so I direct the anger at myself'.

(Carrick Mind)

For the younger participants of the BME focus groups, and particularly those from African-Caribbean backgrounds who described living in a competitive street culture, these socialised attitudes were especially dominant.

It's a survival of the fittest thing because the environment has certain standards and certain ways of living up to that. Everyone wants to get to a certain place.

(African-Caribbean 18-25)

Keep it locked up – if you tell one guy and you think you can trust him, he'll probably go and tell another mate and he'll tell everyone.

(Pakistani 18-25)

Many of the participants described the act of admitting that they needed help as fearful and explained that they had only received help for their mental health problems as a result of a crisis or through the process of receiving treatment for a physical problem.

Going to the doctor is a sign of weakness and you don't want to appear like that. It's like a caveman mentality.

(Nottingham group)

I was loathe to ask for support...my pride gets in the way about opening up with my feelings and asking for help and getting support. Fear and pride means I haven't been as honest as I should be.

(Tameside, Oldham and Glossop Mind)

I think that would help – a lot more publicity aimed at men so that they can recognise various things about mental health problems and stress related problems because, like me with the stress that I had, I thought it was a physical thing.

(Carrick Mind)

Stigma was discussed in the BME groups and thought to be a significant barrier to help seeking. Participants explained that their local communities viewed mental health problems in a negative way and that the reputation of an entire family could be affected if one family member was known to have experienced mental distress.

The word “mad”, when it is translated, that’s the end of the line. When someone is mad, that’s hopeless, you forget about the person.

(Bangladeshi 26-55)

Nobody will admit they have mental illness, if they speak out [they] will be discriminated.

(Chinese 26-55)

The stigma is on the whole family.

(Indian 26-55)

Participants agreed that, in being less willing to seek help for mental distress, men were at particular risk of isolation and engaging in potentially damaging coping mechanisms. One particular focus group member explained that these coping mechanisms resulted in society labelling men as aggressive perpetrators.

Boys have nightmares about being a man, becoming a man. If you tell people they’re bad from day one, that they have nothing to contribute, [and] then give them antidepressants and cheap alcohol...

(Dorset Mind)

I’ve worked a lot with young men and usually find that, particularly with young boys, they just seem so lost. Nowhere to go and nothing to do and they tend to go to drugs, drink and violence. I think it’s the playing tough, not knowing where to go with it.

(Carrick Mind)

Whenever you try to access things the first thing they do when they look at a man with mental health problems is to draw the conclusion immediately that you’re drugs, drink or violent. Even if they’ve never met you.

(Dorset Mind)

The impact of racism and acculturation² on a man’s identity were identified by the BME participants as contributory factors towards mental health problems in their communities.

All the white people have moved out to posh areas, and all that’s left is black people, Chinese people, Kurdish people. It’s all foreigners. So as you are developing, you are not getting anything out of it because it’s changing, and that’s a lot of stress.

(African-Caribbean 26-55)

Now on top of that we have terrorism issue as well.

(Pakistani 26-55)

² “Acculturation” is a term used to describe the exchange of cultural features when groups of individuals from different cultures come into continuous contact for the first time.



“ For me, work is very important. It helps add structure to my week and improves my self-esteem. ”

Merrick, Dorchester

My parents were foreign to this country, and had foreign ways and attitudes to things and it fed down to me. As an English-born person I have to go into the mainstream with foreign attitudes...it brought up a lot of stress.

(African-Caribbean 26-55)

You're living here now but you've still got your traditional values. I think it could break you down over a period of time, it could hit you. You're trying to be two people.

(Pakistani 26-55)

Access to services

Almost all focus groups stated that there was a real need for education about mental health problems and better information about what services were available, how to access them and what your rights were within these services. Participants from the BME groups also called for information to be provided in their own community language and for more resources to be tailored to family members (many of the BME participants, particularly those from South Asian backgrounds, described having close and extended family).

I was utterly unaware of what services were out there, what were available. When I needed help quite urgently there was no clear pathway for myself or those who loved me or those who tried to help me.

(Tameside, Oldham and Glossop Mind)

When you do get information, it's a year and a half out of date.

(Dorset Mind)

I don't know why they diagnosed me, I don't know where they got it from, but I would have liked the doctors to have given a better diagnosis and also information on it. They never did.

(African-Caribbean 26-55)

Perhaps what we really really need is a form of re-education of how people perceive mental health problems, how men must be honest with themselves and admit that they aren't right and pluck up the courage to ask for help...it's about publicity, that there's nothing shameful.

(Carrick Mind)

There should be a mental health bible, how the doctors treat you, a code of conduct in the hospitals and how doctors are supposed to assess you and nurses are supposed to treat you, your rights.

(African-Caribbean 26-55)

If the information could be provided both in Bengali and English it would be very good.

(Bangladeshi 26-55)

It would be good if we had leaflets for our parents.

(Bangladeshi 18-25)

Information so the older generation will be able to know. As a user and a carer, from both angles.

(Bangladeshi 18-25)

All focus groups discussed the importance of primary care staff. Participants wanted the flexibility of having longer appointments with their GP in order to talk through emotional

problems properly and for surgeries to advertise which GPs had a particular interest in mental health.

I talked to my GP, it's difficult to find a GP who takes it seriously... You need to know which GP is sympathetic to mental health problems. Having details of a GP who would listen to my complaint would help me.

(Dorset Mind)

Something so important [having an understanding GP] really is a matter of chance as to who you see, there really is that disparity of approaches and you can't have that when people are in a really delicate stage.

(Tameside, Oldham and Glossop Mind)

I think the doctors these days, if you had issues like mental health issues, they don't give you enough time to go through everything and get it off your chest.

(Nottingham group)

A number of participants highlighted the importance of being assured confidentiality when seeking help for mental distress.

It's important that all that's said in the room stays in the room.

(Dorset Mind)

I'd be alright initially contacting a doctor but when it comes to the nitty gritty I wouldn't want to break down in front of them. That's the same doctor my wife sees, my mum sees.

(Nottingham group)

[I would like online forums] because they don't know me and I don't know them, just to have somebody else to listen to me.

(Nottingham group)

A couple of participants from different focus groups stated that they had been unfairly rejected by services in the past because they were thought of as aggressive. Many participants in the BME groups distrusted services because they had concerns about discrimination and overly-aggressive treatment as a result of institutionalised racism.

Because I was trying to articulate myself and was becoming passionate about things, he thought I was going to hit him [counsellor].

(Tameside, Oldham and Glossop Mind)

If a man's being emotional it's thought of as being aggressive.

(Dorset Mind)

I would tread carefully before I seek help in the system, because of what might happen and the authorities, they are enemies to us.

(African 26-55)

They could be aggressive with you. I have been in the ward before and they have pinned me down.

(Indian 26-55)

The men from the BME groups also wanted services to take better account of their cultural backgrounds.

[Services have] no compassion or sympathy to your background.

(African-Caribbean 26-55)

The main fear is that the service is not correlated, and they do not fulfil the cultural needs of the people.

(Pakistani 26-55)

Other suggestions for making it easier for men to access services included: opening drop-in services that enable men to seek help according to their availability; an increase in male staff; and more joined up services.

Little groups... I've always thought are the best, and drop-in groups. You'd have tea and biscuits and you'd just talk about what had happened to you that week. And through that somebody would have heard "oh you're hearing voices" and say "oh, there's a hearing voices group".

(Tameside, Oldham and Glossop Mind)

I felt I could have done with the doors [to support] being open all week so I had a safety net.

(Carrick Mind)

If you've got male staff it's easier to talk to a bloke, but with women staff you worry if you look quite wimpy.

(Carrick Mind)

The NHS didn't know what to do with me, we had exhausted the options. So they banged me around from pillar to post.

(Tameside, Oldham and Glossop Mind)

When asked about the particular issues facing a rural community, Carrick Mind participants identified travel, isolation and the lack of specialists in their area as key concerns.

Travel is the main thing. The distances involved.

(Carrick Mind)

Where I used to live you do feel detached...I was just sort of left. Knowing that I was two miles up made it difficult mentally. Two miles felt like twenty.

(Carrick Mind)

One problem I found with the rural areas is that you don't get specialists... In the rural areas you're not going to have good quality trained medical staff. You've got to rely on second best.

(Carrick Mind)

"What works"

All of the focus groups emphasised that men needed to be provided with a safe space in which to address mental health problems. Confidentiality and/or anonymity were often referred to as key components for creating safe spaces. Being given legitimacy to talk about emotional issues was also thought to be vital. Every focus group identified peer support, such as male support groups and peer-to-peer mentoring, as the most effective way to provide such legitimacy. Some members of the BME groups also identified a need for more mental health practitioners from their ethnic and language peer group.

I got a lot from the peer group, people in the same situation. They experienced similar things, similar situations. Their experiences in a way were my experiences. It didn't feel so weird, didn't feel like you were the odd one out.

(Tameside, Oldham and Glossop Mind)

It's good to talk about what you're going through and having it verified by other people.

(Dorset Mind)

If you are able to talk to somebody and get reassurance that you're not weird.

Reassurance that it happens to a lot of people.

(Nottingham group)

You want to feel like no one is being judgmental or analysing what you say.

(Nottingham group)

It is difficult for us to tell our symptom when seeing an English speaking GP.

(Chinese 26-55)

More Asian workers who speak languages like Punjabi and Gujarat.

(Indian 26-55)

Most participants felt that it was important to be offered a form of male-only peer support. In addition, the Southend Mind group stated that they found being able to access a group solely for foreign born men particularly beneficial.

I'm in supported accommodation and it's just men and that sort of helped, none of this sort of manly business. And we sort of get close and we share emotions and we talk things out... If women were there then I guess you would have to perform again.

(Carrick Mind)

People get shy – they don't want to talk about problems, especially in front of women.

(Southend Mind)

[In] other groups... we were foreigners. Here we respect each other.

(Southend Mind)

We come from similar backgrounds, we understand each other. Other groups can be mean. Here, we're all on the same level.

(Southend Mind)

Almost all participants agreed that talking through problems was effective. Many said that they had found counselling, both one to one or in groups, helpful and wanted to be able to access these services more easily.

In they run a DBT group for women but not for men. Dialectical behaviour therapy works just as well with men as it does for women. It's not very fair.

(Carrick Mind)

It was only when I reached a voluntary organisation pretty much as a last resort that I found somebody who would sit in a room with me and talk to me, [that's] what I needed years ago.

(Tameside, Oldham and Glossop Mind)

A number of participants had taken part in courses designed to address mental health problems. Most of these participants had found the courses helpful and liked the sense of control over their condition that their newfound skills gave them.

They taught me ways to recognise triggers and how to cope with it, in a way reprogrammed my mind. But I had control of the reprogramming.

(Tameside, Oldham and Glossop Mind)

He [GP] gave me a prescription but I didn't want chemical help... I just didn't like not being in control.

(Nottingham group)

Several participants in each focus group stated that they found exercise helpful in dealing with mental distress. Related to this, getting involved in social activities and meaningful occupations was also described by some as an effective way to address mental health problems.

The best thing is not to get medication but to send us to the gym. I went to the swimming pool but had to pay myself. Five minutes in the sauna and steam room and I felt very different.

(Southend Mind)

I bought a punch-bag. It's phenomenal. It was just the right thing for me.

(Tameside, Oldham and Glossop Mind)

The creative side is good for me. You want to do something that improves your sense of self-worth.

(Dorset Mind)

Allow men to volunteer. Boys would see men contributing in a positive way, instead of being criminalised.

(Dorset Mind)

The general public group discussed ways in which the workplace could tackle mental distress. It was agreed that managers have a crucial role to play in looking after the mental wellbeing of their employees but that most managers simply do not have the skills to do so.

There should be more onus at work to provide someone for you to talk to.

(Nottingham group)

If managers were more aware of this kind of thing, then that would be useful.

(Nottingham group)

If there is more access to health facilities or they'll part fund things like gym memberships, do more things outside of work to help people socialise.

(Nottingham group)

Other suggestions for improving the help offered to men in mental distress included: services for men who have experienced sexual abuse; support for fathers; and avoiding the use of the word "mental" when promoting services.

I don't have any statutory help. I was in care and abused. There is no legal redress for our group... have no language for it. Boys aren't "raped".

(Dorset Mind)

Fathers have problems. It's just like single mothers [in the past] having children taken away from them. They [fathers] are treated as "bad" because the group are thought of as "bad".
(Dorset Mind)

Some people come a few times but say "I don't like mental groups" – it's the stigma... the word "mental" is a block. Using the words "depression and anxiety group" would help, people would understand that – they'll have an aunt or a friend who has had depression.
(Dorset Mind)

Gender training

VIEWPOINT

Jennie Williams

Clinical Psychologist

Director, Inequality Agenda

www.inequalityagenda.co.uk

Inequality Agenda provides courses that support gender-informed practice in mental health services; work which offers many valuable insights. For example, when we ask participants to explain why women are usually centre stage in discussions about gender and mental health, they consistently say it is because men are supposed to be strong and not have mental health problems.

It is startling that this unhelpful belief persists in services where large numbers of men are visibly distressed. It seems that the private constraint many men experience when it comes to talking about their difficulties is paralleled by public and professional reticence

In short, male patients are both less likely to make their needs known and to have them met.

to acknowledge their mental health needs. This is particularly evident in the assumptions and practices of in-patient mental health services. For example, a common problem for service managers is that the majority of in-patient staff would rather work with men than women. This is not a bias that works in men's interest: the common reason given is that men are less demanding to work with than women. In short, male patients are both less likely to make their needs known

and to have them met. Furthermore, whilst mental health staff are typically poorly prepared and reluctant to talk with patients about their troubled past and present lives, "To take the lid off the can of worms" they readily say that it is especially difficult to take the initiative with men. There is a collusion of silence.

These are important reminders that gender inequality is not only a determinant of men's mental health, but also of the ways that services respond, or fail to respond to these needs. However, most people in the field are unable to address these problems constructively; they lack training, supervision and support. This is despite the huge body of knowledge that has been garnered about the mental health implications of gender and other inequalities. The challenge now is to make this knowledge accessible to the mental health workforce: the quality of care depends on it. Fundamental changes to pre-qualification and post qualification training are the key to making this happen and to ensuring that people working throughout the mental health workforce are gender informed in their thinking and practice. At present 70% of the mental health budget is spent on staff costs, it is imperative that this money is spent more wisely.

Relate *Live Chat* service

CASE
STUDY

www.relateforparents.org.uk

In July 2009, Relate launched a Live Chat service (real time text talk) from their website for Parents and Families.

One year on, the service is dealing with approximately 800 Live Chats per month. Statistics are showing that 44% of those contacting the service are men. This compares to 31% of men who call our telephone enquiry line, Relate Response 0300 100 1234.

Not all the male users of the service are Dads, however the feedback and themes of the enquiries show that immediate and direct contact with a trained counsellor can provide:

- an opportunity to get good information
- check out whether something is reasonable or usual
- gain another perspective on a current dilemma
- get ideas on how to tackle difficult communication

All of these are therapeutic and accessible in the moment. The counsellors working on the service are intensely trained to deliver interventions in text and considerable attention is paid to the use of language and gender.

The immediacy of being able to contact someone when it suits them, anonymously, without the effort and cost of a full counselling experience, are all attractive considerations.

We know that if a Mum is asked how she feels about being a Mum, she will be able to verbally describe this without too much difficulty. However, to ask a Dad how he feels about being a Dad, he will not always be able to respond so easily. However, asking a Dad “what do you do with your kids” or “what do you think is good about being a Dad” usually results in the reflexive response that helps to enable an observer position.

Feedback from men who have used the service is showing clearly that the immediacy of being able to contact someone when it suits them, anonymously, without the effort and cost of a full counselling experience, are all attractive considerations. Men

have also reported that they have been given the space to explain their situation without interruption and having the time to read and consider the responses has helped them too.

The mental health of boys

VIEWPOINT

Paula Lavis

Policy and Knowledge Manager, YoungMinds

There are a number of different risk factors for mental health problems in early childhood and - although it may appear strange – being a boy is one of them. 7.7% of children aged 5-10 years have a mental disorder but boys are twice as likely to experience these problems as girls. Boys are more likely to have ADHD, conduct disorders, and autistic spectrum disorders. Girls are more likely to suffer from eating disorders and self harm. As children get older, this gender difference balances out with the prevalence of mental health problems in teenagers being roughly equal.

Quite why so many more younger boys have mental disorders is debatable. Some professionals believe that boys are more likely to be wrongly diagnosed because

All children need to be securely attached to their parents/carers to ensure that they get off to a good start in life. It seems that, for boys, being insecurely attached may be more likely to result in behavioural problems.

they are boisterous and just “being boys”, and that we as a society are intolerant of that. In reality, it is probable that both biological and environmental factors contribute to gender differences.

All children need to be securely attached to their parents/carers to ensure that they get off to a good start in life and develop mentally, emotionally and socially as well as physically. It seems that, for boys, being insecurely attached may be more likely to result in behavioural problems. Boys are twice as likely as girls to have conduct problems. The number of young people with a conduct disorder has increased during the last twenty years, and the cost to the individual, their family and society is very high. Children with conduct disorders go

on to commit 30% of crime, at a cost to society of over £22 billion a year. The number of young men in the justice system has increased by 25% in the last fifteen years. Ensuring that boys are given the right support is crucial to tackling these problems.

Services need to be designed so that they are appropriate and accessible to boys and their families. However, there are wider societal issues that need to be addressed such as boys feeling that they cannot talk about their feelings and seek help. This is connected to the way that society sees boys, but also to the stigma associated with mental health. There is also a crisis of male role models in some communities with thousands of young men growing up without fathers. Parenting programmes have been shown to be effective in helping children who have conduct disorders.

MAC-UK

CASE STUDY

www.musicandchange.com

MAC-UK was founded in September 2008 to engage some of the UK's most challenging young men through an innovative "street therapy" approach and promote wellbeing amongst this socioeconomically deprived group. MAC-UK works with 14-30 year olds with complex mental health and social care needs, many of whom are involved in youth crime, and acts as a bridge to access appropriate mainstream services when the time is right for them. It also trains existing services (e.g. youth clubs and the police) in a youth-led approach and builds their understanding of young men's mental health needs.

The pilot project, Music and Change, was funded by the Paul Hamlyn Foundation Social Justice Programme and took place on Camden's Rowley Way Estate (NW8), recognised by the government as in desperate need of regeneration. MAC-UK aims to empower its young men to re-engage themselves with the community and realise positive aspirations for their future, and success stories on the Rowley Way Estate show that the approach works.

How MAC-UK works and what MAC-UK offers

1. Works with young men in their own environment and gives them a strong stake in the development and implementation of project activities
2. Provides training to other service providers to help them respond to the needs and aspirations of young adults
3. Shares its findings and approach with key stakeholders in order to influence practice more widely
4. Monitors and evaluates its work with the support of University College London

Each project is youth-led, with all decisions made and activities co-led by the young men, thus instilling within them a sense of pride and purpose. Each project lasts for two years and is framed around activities chosen by the young men such as music, gigs, football, street art and gym. The aim of these activities is to build rapport with staff in an informal, youth-led

Each project is youth-led, with all decisions made and activities co-led by the young men, thus instilling within them a sense of pride and purpose.

environment so that subsequent mental health work can take place. Activities are held three days per week and "life skills" workshops take place twice a month. The activity times and days change on a regular basis to fit around the needs of the young men, as do the activities themselves in order to keep the project fresh and prevent boredom and drop-out.

One-to-one "street therapy" sessions are offered on a daily basis to support young men to attend the main activities. These enable young men to interact with a therapist in whichever environment and at whatever pace they feel comfortable. MAC-UK staff spoke to one anxious young person through his letterbox for three months until he was ready to meet in Starbucks. He recently began a placement at a city-based architects' firm.

3: Male beliefs, attitudes and behaviours

Introduction

The relationship between masculinity, male culture and mental health is considered in *Untold Problems*. The key observations, for which there is some evidence or academic support, are as follows:

... there are often significant tensions between conventional masculine behaviour and the idea of nurturing good mental health. Admitting the need for support with emotional and psychological problems may be a particular challenge for some [men] and may account for some of the more destructive behaviours seen more commonly in men.

... some of the accepted cultural markers of masculinity – for example (and among others): the willingness to “soldier on” when under emotional stress; the consumption of large amounts of alcohol; the greater propensity to physical aggression; the greater tendency of boys to misbehave in school – are also potential symptoms of, or predisposing factors for, poor mental health. Many of these behaviours are so familiar that they seem indisputably “normal” even though it is easy to see that they are sometimes simultaneously damaging.

Untold Problems also notes that there is an on-going, unresolved debate about the extent to which gendered attitudes and behaviours are “learned” by reference to pre-existing social norms or are “hard-wired” by human biology.

There are two crucial issues in thinking about how we can take into account men’s beliefs, attitudes and behaviours. The first is the need to recognise the existence of the context highlighted above and to acknowledge its impact on the mental health of individual men. The second is to realise that it is not necessary to come down on one side or other of the “nature/nurture” debate. There is no serious dispute that social influences are extremely important, even if one agrees that some elements of the male world view are biologically pre-determined.

This means that there is value in seeking to change those beliefs, attitudes and behaviours that are not conducive to good mental health. More importantly perhaps for later chapters of this document, it also means that we should try to avoid judging those men who find it difficult to seek and accept help. Crucially it means that we should try to shape services that reach out to men “as they are” and not assume them to be the receptive audience and motivated service-users that we might wish for in an ideal world.

Early years interventions

There was a very strong feeling among both male service users and mental health professionals that many of the barriers to good mental health are formed in childhood. Growing boys are often discouraged from expressing “softer” emotions and more frequently expected to “stand on their own two feet”. This may make it more difficult for men to seek support and help in adulthood, whether that is within personal relationships or from formal services.

This analysis is borne out, albeit from a relatively limited evidence-base and at the further end of this spectrum, in some of the studies reported in *Untold Problems*. These studies report that very damaging childhood experiences may result in serious mental health difficulties in adulthood. In men, these damaging experiences may be more likely to manifest as self-destructive and/or anti-social behaviours.

There is good evidence for the value of early years interventions targeted at children in the most challenging circumstances. Some of our advisors argued for what is effectively an extension of that approach; an early years intervention programme aimed at parents and pre-school children that specifically supports the development of emotional intelligence in boys.

Interestingly this idea finds clear parallels in the very first group of “Priority Objectives” in *Fair Society, Healthy Lives*³ (the report of the Marmot Review) which – on the basis of detailed collection of the evidence from a wide range of sources – recommends action intended to “reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic and social skills”. Examples of the kinds of actions that Marmot would like to see prioritised towards this end include “high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient.”

Our own view is that there are good arguments for looking at the particular needs of boys within all early years interventions. We believe especially that there is a case for developing specific approaches that encourage families and carers to support the emotional development of boys.

Early years interventions: *ideas for practice*

There is scope for the development, within local partnerships, between health, social services, education providers and the voluntary sector, of initiatives intended specifically to support the early emotional development of boys, especially those living in the most challenging circumstances.

In practical terms, this might involve, for example, health visitors discussing the differing needs of boys and girls with new parents. It might also involve pre-school providers consciously ensuring that their day-to-day practice allows and encourages boys as well as girls the freedom to express their feelings. These kinds of ideas could be developed at a local level and incorporated into practice development and staff training initiatives.

Boys in school

Among other evidence, *Untold Problems* points out that boys are four times more likely to be identified as having a behavioural, emotional or social difficulty in school and make up 80% of children excluded for conduct problems. Boys and young men are also doing less well at all levels in terms of educational outcome. This is important because, as the Marmot Review also strongly emphasises, improving educational achievement across the whole population will ultimately improve physical and mental health.

³ Prof. Sir Michael Marmot. *Strategic Review of Health Inequalities in England post-2010*. London: The Marmot Review; 2010.

Against this educational background, our advisors highlighted the common belief that boys in general are “a problem”. In other words, that boys are a population group for which society lacks tolerance. This view of boys was said to militate against the provision of sensitive care and support for boys, and to be a negative experience for boys themselves. It is also clear that peer pressure and other experiences in boyhood and school can continue to contribute to the formation of those potentially damaging attitudes, beliefs and behaviours that we highlighted earlier.

Within this rather unpromising context, growing boys must learn to cope with the challenges that inevitably accompany their physical and emotional development. It is important for boys to learn that periods of emotional difficulty are to be expected in everyone’s life and that, like physical illness, mental ill health cannot always be avoided. In other words, we should aim to help “normalise” the idea of emotional difficulties and mental health concerns in the minds of boys and young men. This means moving beyond generalised “anti-stigma” work towards a process that takes specific account of boys’ attitudes and needs.

Detailed recommendations about educational provision are beyond the scope and expertise of this document. There is, in any event, on-going debate among educationalists about how best to support those groups, including boys, who are doing less well educationally. The challenge is to make sure that those boys who are not reaching their full potential, especially white and African-Caribbean boys from poorer backgrounds, begin to do better.

We therefore lend our support to the work that is already in hand to improve the educational performance of boys from poorer backgrounds. It is important however to emphasise that the increasing gap between girls and boys in educational attainment should not be a matter of concern only for educationalists. Because of the link between educational outcome and health outcome, it is important that other agencies also support work that will help boys engage better at school.

Boys in school: *ideas for practice*

The development of local initiatives in relation to the poorer educational attainment of boys is important. Where they can, schools might also usefully look at the way boys are supported and engaged “as boys” across the whole range of school life. Since African-Caribbean boys are one of the groups particularly affected, there is also a need to look at these boys’ needs in a way that is sensitive to the cultural and community context. Additionally, other agencies which have regular and less formal contact with boys e.g. youth organisations and sports clubs could examine whether their practice supports the emotional needs of boys effectively.

We recognise that schools cannot be expected to address boys’ emotional needs at the expense of the school’s educational priorities. At the same time, it should be noted that there is already substantial provision in national PHSE guidance for the coverage of mental health issues. Schools could consider developing elements within the PHSE programmes specifically for boys (for example, discussion of how to deal with emotional difficulties within a masculine context).

It is our view that there is greater potential for partnerships between schools and local NHS providers. It is also worth schools considering working with local service user groups (see later recommendation about mental health “ambassadors”).



“Taking part in things is important for me to change my life and look after my wellbeing. It is important for me to keep myself going, and I enjoy the gym, football, and volunteering on the allotment.”

Roy, Croydon

Fatherhood

Fatherhood is important for three reasons. First, there is evidence that having a loving and supportive father improves the chances of children growing up healthy, happy and well-adjusted. This observation applies to children of both sexes but in the context of this report it is of particular importance in relation to the wellbeing of boys and young men. In this context, it is also important to take account of issues associated with relationship breakdown. Nine out of ten lone parent families are headed by the mother and a significant minority of children brought up in these circumstances have no contact with their father. Where separated fathers are in regular contact with their children, those children tend to do better in terms of their development.

Second, it was observed by our advisors on a number of occasions that becoming a father is a life-changing experience for almost all men. It is also, for obvious reasons, a time during which a man is very likely to have significantly greater contact than usual with health services and other agencies. This led our advisors to suggest that this period is one in which a man might be open to reflection on his own attitudes and his own health choices, and to advice in relation to his approach to the care of his children.

Third, the transition to fatherhood is also a time when a man's own mental health may be at greater risk. Poorer mental health in a new father may carry the additional risk of impairing the wellbeing of his partner and children. *Untold Problems* points out that there is increasing evidence that not all men cope well psychologically with the transition to fatherhood, and that depression and low mood in new fathers are probably under-diagnosed. Since the publication of *Untold Problems*, a large-scale longitudinal study funded by the Medical Research Council has confirmed that diagnosed depression is more common in new fathers than previously believed; 3% of fathers have depression in the first year after the birth of a new child, and 10% before the child is four.⁴

Fatherhood: *ideas for practice*

Much greater recognition is needed in national and local policy of the needs of fathers, and of the value of fathers to families. At the national policy level we strongly endorse the Fatherhood Institute's Six Signposts for Fatherhood and we would like to see proper consideration in the work of the Childhood Task Force of the role of fathers in families. At the practical local level, we recommend the development of protocols for the routine engagement of fathers by health professionals and other family support services, especially in the perinatal period. This is a particular opportunity for helping fathers to think about their influence on the attitudes and behaviours of their children, especially – as we have already noted – their sons.

Role models

There was widespread criticism among our advisors of the perceived stereotyping of men in the popular media. It was suggested that the idea of men as irresponsible, insensitive and generally rather “useless” has become a commonplace public portrayal. It was also pointed out by some that men are often routinely regarded as suspicious or potentially threatening, particularly in relation to children.

⁴ Davé S, Petersen I, Sherr L, Nazareth I. *Incidence of Maternal and Paternal Depression in Primary Care : A Cohort Study Using a Primary Care Database*. 2010: Archives of Pediatrics and Adolescent Medicine.

These negative views of men were argued both to be damaging to men in general and to reduce the likelihood of men with mental health problems receiving a sympathetic response either from public services or the general public. It was suggested that negative views of maleness are particularly unhelpful for growing boys, especially for those who may lack positive male role models in their own day-to-day lives. In this respect it is perceived to be a particular problem that there is a known shortage of men in caring or nurturing roles in relation to boys – for example nursery staff and primary school teachers.

Role models: *ideas for practice*

We acknowledge the efforts that have been made by some agencies to attract more men into those professions that are traditionally largely female. We strongly encourage the adoption of recruitment policies that actively encourage men to apply for these kinds of jobs. It may also be helpful for public agencies and other organisations to be mindful of the value of using positive images of men in material aimed at the media or the general public. We think it is entirely appropriate for public agencies concerned with mental health to challenge negative or derogatory portrayals of men where such portrayals appear both gratuitous and potentially damaging.

Stigma

Another view held by many of our advisors was that the stigma associated with mental health problems is more strongly felt by men. This was said to be because men are more concerned than women about appearing capable and “in control”, and may fear that emotional distress will be seen as a personal weakness. This stigma is believed to add a further barrier to help-seeking by men.

Our advisors, particularly men who have used mental health services, also suggested that men with mental health problems are far more likely than women with mental health problems to be seen by the general public as physically threatening and potentially violent. Some believed that this attitude extended to some health professionals and directly affected the way they were treated.

There is a well-established general evidence base which confirms stigma to be both a deterrent to seeking treatment and an important factor inhibiting people’s ability to gain support during their recovery. There is also evidence suggesting a foundation for men’s anxieties about being stigmatised; there are known to be generalised prejudices among the wider public which might lead, for example, to a man with mental health problems being seen as an unsuitable workmate.

In the particular case of perceptions of physical threat, it is of course true that men (with or without mental health problems) are much more likely in general than women to commit acts of violence. This issue is explored in some detail in *Untold Problems*. If, however, there is a commonplace assumption that all, or most, men with mental health problems are potentially violent as a consequence of their mental health problems, then that is not only incorrect, it clearly has the potential significantly to impair men’s willingness to seek help and their ability to cope with their diagnosis.

Little of the evidence about stigma, however, considers gender differences in the way people feel about their own mental health problems. Similarly, there has been little work on whether the public view of people with mental health problems differs according to whether men or women are being considered.

Stigma: *ideas for practice*

National and local organisations concerned with tackling stigma could usefully investigate whether there really are gender differences in individual and public attitudes. If so, then gender-specific anti-stigma campaigns should be initiated. We believe that the hypothesis is already plausible enough that there is scope for testing male-specific approaches in some existing campaigns.

We further believe that other organisations beyond the NHS and social care are in a position to address the problem of stigma and we call particularly on organisations with significant male constituencies to promote the normalisation of mental health problems. Examples of organisations which have the capacity to do this include trade unions, business organisations, sports organisations and student organisations.

Male lifestyles

There is good evidence that, in general, men lead unhealthier lives than women. Men are more likely to drink alcohol to excess, more likely to misuse drugs, more likely to work very long hours, more likely to be involved in accidents, less likely to take part in health improvement programmes, less likely to eat a healthy diet and more likely to be overweight. The only healthy lifestyle measure on which men do better than women is physical activity and, even here, at least 60% of men are not physically active enough to derive a health benefit.

These lifestyle issues are important because there are known correlations between physical health and mental health. Alcohol and drug misuse are, for example, directly linked with an increase in mental health problems, as is work-related stress. Being overweight is strongly associated with a greater likelihood of chronic ill health, which, in turn, is associated with an increased risk of mental health problems.

Healthier lifestyles promote good mental health in a variety of ways. A regular, balanced diet coupled with reduced alcohol intake will help increase the sense of wellbeing. Regular exercise is associated with improvements in mood both for those who are mentally well and those with diagnosed mental health problems. There are believed to be particular benefits to exercise in green space (sometimes known as “ecotherapy”).

Numerous local and national programmes promote healthier lifestyles with the broad intention of improving population health. Very few of these programmes target men specifically and most use exactly the same approach for men and women. Many such programmes emphasise only the benefits to physical health.

Male lifestyles: *ideas for practice*

Even where it is not the explicit intention, successful healthy lifestyle campaigns have the potential to benefit mental health. There is however, good evidence that men are less likely to become involved in such campaigns, even though they are often at greater risk of the health condition being addressed. It is therefore important to take active steps to encourage male participation. Apart from anything else, and as we have already seen, there is a statutory duty on health providers to ensure equitable uptake of services between men and women. We recommend that uptake by gender should be a routine element in the evaluation of all such campaigns and that where male uptake is disproportionately low, service providers should take action to rectify the problem.

The Brave Project

CASE
STUDY

(Bradford Reducing Anger and Violent Emotions)

Sue Dominey

Counsellor / Manager

www.brave-project.org

In 2001 I was a Primary care counsellor. My MA (Violence, Abuse and Gender Relations) research covered the health consequences of domestic abuse and violence prevention programmes for men, most of the research at that time was very negative. Kath Grogan, founder of Leeds STOP Project (a domestic abuse prevention project www.stoponline.org), invited me to sit in at the men's group. I was so impressed that I stayed a year, learning how the group worked and how the men were supported to change their behaviour, attitudes and beliefs – I was inspired to set up The Brave Project.

I travelled Australia and New Zealand on a Churchill Fellowship; researching violence prevention work with boys and young men. I came back with a clear idea about a gender specific, male focussed, strengths and resilience model for Brave. Working with men throughout the last nine years, I have learnt that heart-centred therapeutic interventions are most effective!

We offer one-to-one counselling, open and rolling therapeutic group work and Health MOTs for men. We use a male-focussed, strengths and resilience based approach:

- We extend an invitation to responsibility without shaming
- Dignity and respect – see the man not just the behaviour
- Identify (together) a man's needs – one-to-one counselling/group/signposting
- Work "relationally"; building trust and supportive relationships
- Educate: recognising anger/rage signals, time outs, ability to self-soothe
- "Heart listening" - validate men's histories
- Continuity – "holding and containing" men – mix of therapeutic, educative, solution-focused and CBT interventions
- Emphasis on the importance of the "Check-in" – therapy, recovery and healing
- A solid core of "old timers" are welcome and mentor new men
- Wealth of resources but no fixed programme – all men must get the basics
- A solid belief and faith in the ability of the men to change
- Professional clinical responsibility to work with risk to self and others and suicide.

The benefits of our project: help to change abusive/risky behaviour attitudes and beliefs; healthier relationships (with family, partners, children and friends); improved emotional health and wellbeing; reduced self harm, risky behaviour and suicidal intentions; improved self esteem; confidence, resilience and "recovery and healing" from past experiences; and learning how to regulate powerful emotions such as rage, sadness and fear and recognise it is a sign of strength to ask for help and that it really is okay for big boys to cry.

A psychological perspective 2


 A purple speech bubble containing the word 'VIEWPOINT' in white, slanted capital letters.

Luke Sullivan

Clinical Psychologist in Training

Salomons Clinical Psychology Doctoral Programme, Canterbury Christ Church University

Many men and boys are not receiving appropriate psychological services when they really need them. Traditional psychiatric diagnoses, such as depression, may not fit the experiences of men in psychological distress that well. Men are more likely than women to express psychological distress through behaviours such as aggression and substance misuse. Historically, statutory mental health services would often exclude people presenting with anger and substance misuse. Men can also present a degree of risk and from very early on they can attract more reactive and punitive interventions from services. This is often at the expense of addressing any underlying psychological distress.

If rigidly adhered to, traditional westernised ideas of maleness may have significant implications for men who experience psychological problems. Psychological therapy itself may be perceived by some men as unmanly, involving discussions about emotions

and feelings, dependency on another, psychological weakness and a close intimate relationship with a therapist. Common assumptions about men, such as their poor emotional literacy, may also be somewhat misguided.

It needs to become
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sense of maleness.

Men may struggle more with intimacy than women throughout life. This can lead to greater social isolation and fewer relationships to fall back on if things do become difficult. The individualised and competitive nature of western capitalism has meant men are less likely to support other men and traditional community networks have disappeared with little to replace them.

Historically, I think that men's mental health has been overlooked and a lot is required to get up to speed with the pioneering work into the psychological wellbeing of women. Clinical psychology needs to look in greater depth at the impact of its work on men and women as distinct groups. Before this can happen there needs to be more openness to discussion of both genders. In my experience as a clinical psychologist in training, even raising men's mental health as an important issue can feel controversial.

Collectively, it needs to become okay for men to access the right help when they need to without it compromising their sense of maleness. A more empathic approach to men's psychological distress is required with greater acknowledgement from services of the underlying causes of distress rather than just a shallow interpretation of observable behaviour.

Boston *Daddy Day Care*

CASE
STUDY

Mark McRae

Boston's Children's Services Team Management identified a need to increase the engagement of all male carers with their children who are under 5. A Father's Engagement Worker from Lincolnshire YMCA was therefore commissioned to work with all male carers through Sure Start's Children's Centres.

The Dad's Support Service has become a vibrant and positive service for all male carers and family men in the surrounding community.

Being a new service, uptake of the Dad's Support Service was initially slow. However, the introduction of a six week pilot Daddy Day Care Saturday Club (10.00am and 12.00pm) led to the service gaining a higher profile within the Boston community. This resulted in the generation of a higher number of referrals from the multi-agencies involved with safeguarding and an increase in parents' positive engagement with their children.

The service offers support to all male carers on accommodation, mental health, parenting, behavioural, employment and childcare issues in their homes or via the Children's Centres.

Upon evaluation, it was extremely obvious that the service has positively benefited male carers. It has enabled participants to develop their father/child relationship by providing an opportunity for them to engage with their children on a one-to-one basis through the activities on offer at the club. It has also allowed them to socialise with other dads.

The Daddy Day Care Club has now restarted and is busier than ever with many new dads attending with babies who are just weeks old in an effort to engage with their child as well as giving mum a break from early year's child care. The Dad's Support Service has become a vibrant and positive service for all male carers and family men in the surrounding Boston community.

4: Helping men and boys to maintain and improve mental health

Introduction

This chapter looks at the specific needs of the male audience for the promotion of mental wellbeing. It is largely concerned with men and boys who do not currently have mental health problems. The underlying premise is one now commonly accepted by health service providers; that it is possible for individuals to take action to support and improve their mental health in the same way that they can change their lifestyles for the benefit of their physical health.

There is now good evidence that male-sensitive approaches increase the likelihood of male engagement with physical health improvement programmes. The evidence-base is less developed in relation to mental health improvement initiatives but *Untold Problems* does demonstrate that services are not currently engaging men as well as they might. There was consensus among our advisors that there is a case for developing male-specific approaches to mental health improvement programmes.

Although there is more to mental health improvement initiatives than simple marketing, it is also worth noting that gender-specific approaches have been commonplace in the commercial world for almost as long as the modern concept of the consumer has existed. There are established principles about how to engage differentially with the sexes and how most effectively to reach different groups within the male (and female) population. These principles exist in relation to product design as well as to the final process of marketing.

In the main, this chapter is intended to provide guidance for public health departments planning local campaigns. We are however, as convinced here as we are elsewhere, that there is significant scope for joint-working between public health departments, other health service providers, and a wide range of other public and private sector organisations. We also believe that many non-health organisations could undertake activities to improve male mental health, perhaps by initiating contact with local public health agencies.

Mental health improvement messages

Mental health promotion campaigns often focus on the importance of recognising the signs of emotional distress and on the value of seeking support, whether that is from formal helping agencies, or from friends and relatives. This approach is entirely sensible. As we have already seen however, the barriers to recognising symptoms and seeking help may be greater for men. This means that messages of this kind may not always chime with men as well as they do with women.

Furthermore, as our advisors pointed out, being frank about symptoms may genuinely involve greater risk for men. This may be particularly so when men are worried about the potential threat to their employability. Men remain much more likely than women to be the primary breadwinner in families headed by a male/female couple and may therefore feel constrained

by their financial responsibilities. Arguably, men are also more likely to work in settings where there is less likelihood of their difficulties meeting with understanding or sympathy.

Another potential problem identified by our advisors, and borne out to some extent where there is relevant research, is that male friendships may be less likely than female friendships to offer a supportive environment for the discussion of emotional problems. As *Untold Problems* reported, evidence suggests that men tend to have fewer close emotional relationships than women in any event. Men are therefore less likely to have anyone to turn to in the event of experiencing emotional distress and are less likely to receive encouragement to seek professional help when that is needed. This problem may be exacerbated for some older men in particular, as male social networks are known to contract after retirement from work.

Overall then, campaigns that encourage people to act on symptoms and to seek support for themselves may work less well for a male audience. This does not mean that there is nothing that can be done. There has been little work in this field but it seems at least probable that, by taking the relevant background into account, mental health messages for men can be made more effective.

Mental health improvement messages: *ideas for practice*

There are good arguments for developing male-specific approaches to mental health improvement. There is evidence that men are under-represented in help-seeking services, and that unaddressed emotional problems in men may result in damaging outcomes for both the man himself and those around him. There is some evidence – and a strong sense from those familiar with the issues – that messages couched in terms that appeal to traditional male sensibilities could be effective. We recommend that all future mental health improvement campaigns should consider using male-specific (and female-specific) materials instead of, or in addition to, materials aimed at the whole population.

Changing male perceptions of services

Another barrier to the improvement of male mental health identified by our advisors is the perception among men that concern for emotional health is a “women’s issue”. This perception is associated with the issues highlighted immediately above but differs in the sense that, as well as being reflected in the way a man might think about his own mental health, it may also affect the way he perceives services. Services may seem unduly feminised. There is some existing evidence of a similar belief among some men that primary care services are primarily constructed to meet the needs of women and children.

We have not included any specific ideas for practice in respect of this idea. We do believe however, that there is a case for local services to try and establish whether a significant proportion of men really do perceive mental health as a “women’s issue” and mental health services as being “for women”. If this does prove to be a common view among men then that would indicate another important component for mental health improvement strategies; the need to describe and publicise support services in a way that counteracts the view that services are more in tune with women’s needs than those of men.



“Family and friends mean a great deal to me. They define me as a man and make it worth carrying on with life.”

Richard, Poole

Looking beyond the brave face

A point raised numerous times in our discussions is that men may sometimes want help – even want help desperately – without being able to find a way of asking for it. If help, or encouragement to seek help, is offered at this point, they may be willing to accept it.

We believe that finding effective ways of offering this help is a crucial part of any strategy to improve male mental health. In the following chapter, we deal with the relevance of this key point for primary care staff and the linked issue of “legitimacy”. In the present context of considering mental health improvement campaigns, the most important point to make is that there may be opportunities for friends, relatives and colleagues, and for professional workers, to identify men who might need help and to offer support at a time when the man may be willing to accept it.

In some circumstances, the man’s probable need might be clear even if he appears outwardly to be coping well, for example if he has recently experienced a bereavement, relationship breakdown or redundancy. Alternatively, it might be signalled by changes in his behaviour. (*Untold Problems* suggests that, in men, these behaviour changes may include irritability, aggression and substance misuse, as well as, or instead of, the more familiar symptoms of depression and anxiety, such as low mood, tearfulness and social withdrawal).

Looking beyond the brave face: *ideas for practice*

Mental health improvement campaigns that focus on the role of friends and relatives in helping men to prioritise their mental health may be more effective in reaching men than campaigns that target men themselves.

Physical activity, team sports, football and mental health

In Chapter 3, we highlighted the relationship between “healthy lifestyle” campaigns and better mental health, and stressed the importance of such campaigns aiming to reach as many men as possible.

There is strong evidence about the specific relationship between regular physical activity, participation in team sports, and mental wellbeing. This connection is not covered in detail in *Untold Problems* but is important because men are more likely to choose to engage in physical activity than women and make up the great majority of participants in team sports. The huge participation rate for football is particularly important. Almost two million (largely younger) adult men participate in some form of football at least once a week. Importantly, football also has proportionately greater participation among BME men than among the white population (as does cricket).⁵

Arguably, the connection between football and men is already the most familiar component in male-specific health improvement initiatives where those exist – indeed, some examples are given in the good practice boxes in this document.

⁵ All data from Sport England

Physical activity, team sports and football: *ideas for practice*

We believe there are benefits in local partnerships between health, education and voluntary sector providers aimed at encouraging participation in team sports for all ability levels, in both competitive and non-competitive settings. We further believe that there is scope to develop mental health improvement materials for distribution via local sports clubs. It is important to recognise that football is not a motivator for all men - but it will be for some. Connections with football are therefore potentially of particular value both in the promotion of physical activity and the dissemination of mental health improvement messages.

Older and/or disabled men, may have more limited capacity for strenuous physical activity but the psychological benefits of regular exercise still apply and their needs should not be forgotten. There is good advice available for men in older age groups – for example, Age UK's *Fit as a Fiddle* programme.

Topaz Wellbeing Centre

CASE
STUDY

www.topaz-ashton.org

Following a review of day services across Tameside and Glossop in 2006, Tameside, Oldham and Glossop Mind changed from a traditional day centre and opened as a well-being centre in April 2008.

The model of the well-being centre focuses on prevention, recovery, social inclusion and holistic intervention. The mission statement is “to be an organisation of excellence with an ever-changing and diverse range of activities and services that promote psychological and physical wellbeing, stimulate recovery and lead to social inclusion within mainstream society”.

The Topaz Wellbeing Centre consists of the following services:

- Café
- Courses
- Drop-ins run by external agencies
- Counselling
- Problem Solving Service
- Information centre
- One-to-one service
- Allotment
- Community Access
(run by an external agency)

The whole project is based on the fact that everyone has mental health and wellbeing and all the services are open to anyone living in Tameside and Glossop over the age of 16. The services are self-referral and do not require an “assessment”. Any issue that someone feels is affecting their wellbeing can be catered for through the services.

The building is a relaxing and open access environment, allowing men to access the services in an easy way.

The building is a relaxing and open access environment, allowing men to access the services in an easy way. The centre’s door is unlocked between 10am and 4pm each weekday, so anyone can walk off the street to ask advice. One of the roles of the café is to be a “neutral normal” space where men can come and have a coffee, without anyone asking about their problems nor feeling that they have to use the other services. A “normal” space is created by the café, therefore breaking down the stigma involved with doing something about your wellbeing.

There are a variety of one-to-one, problem solving and counselling services at the centre that men access. There are also a variety of taster courses, ranging from art, physical activity, complementary, lifestyles and skill-based courses – anything that improves someone’s wellbeing can be run at the centre. The variety of courses, as well as the other services, allows people, particularly men, to find something that works for them rather than fitting men to services.

Finally, volunteering is central to the centre and would not run without volunteers. This allows people to give back their skills, to improve their own skills and feel valued – it allows people not just to be the receiver of services but also the giver of services.

It's a Goal!

CASE STUDY

Pete Sayers

***It's a Goal!* began in 2004 in response to Government and World Health Organisation statistics stating that men between the ages of 16-35 were four times more likely to kill themselves than any other group in society. Men in general, and younger men in particular, are poor at accessing services, particularly to talk about emotional issues. We have made this process easier by basing our programme in football stadiums, somewhere that many men feel comfortable. We removed the issue of stigma and, judging by the feedback we have received, men have found our non-clinical, non-judgemental and non-critical approach extremely empowering.**

The results so far are encouraging... high percentages of participants find or return to employment and the overwhelming majority report an increase in confidence and self-esteem.

The programme consists of eleven two hourly sessions ("matches") which concentrate on motivation, stress management, assertiveness, confidence building, problem solving, self esteem etc. The project users ("players") sign contracts (as footballers would) that set out basic ground rules covering attendance, behaviour, confidentiality etc. They then set short and long term goals for themselves, and address their issues using analogy and metaphor drawn from football scenarios. Alongside the programme (the "season") is an unstructured drop-in group called the "Supporters Club". Many players who require ongoing support have found this a useful facility.

Encouraging the football clubs to participate is theoretically the easiest part. All that is required is a nice room (preferably overlooking the pitch) two afternoons a week with some tea and coffee thrown in. In return, they get positive publicity, as does the Health Trust. Both are seen as forward thinking innovators doing their bit for men's mental health and the local community. Thus far, we have run successful programmes at: Macclesfield Town; Manchester United; Stockport County; Plymouth Argyle; Burnley; and Stoke City. In May 2010, the programme was launched in the Scottish Borders and we are currently planning launches at nine further clubs in the North West of England.

The results so far are encouraging. Around two thirds of those who start the programme complete it. High percentages of participants find or return to employment and the overwhelming majority report an increase in confidence and self-esteem. What is seen by the players as crucial is being able to work on their issues in a relaxing atmosphere, using language and behaviour they feel comfortable with, the lack of which has turned significant numbers away from seeking help in the past.

The Grouchy Old Men? Project

CASE
STUDY

Toby Williamson

Head of Development & Later Life
Mental Health Foundation

The *Grouchy Old Men?* project was a two year service improvement project in England, managed by the Mental Health Foundation and funded by the Department of Health, which came to an end in 2010. The Mental Health Foundation is a UK research and development charity that undertakes work on mental health and wellbeing issues as well as issues affecting people with mental health problems.

Older men's mental health issues are significantly under-reported, particularly regarding chronic loneliness and depression, and the suicide rate for men in later life remains high.

The aims of the Grouchy Old Men? project were to raise awareness of the mental health needs of older men within health and social care services, including mental health services, housing and non-statutory organisations, and to support service improvements in order to better meet those needs. There is significant evidence to indicate that older men's mental health issues are significantly under-reported, particularly regarding chronic loneliness and depression, and the suicide rate for men in later life remains high. A particular focus of the project therefore was to identify and promote real life community-based examples or approaches that could help address this.

The project developed and piloted a one day training workshop for staff and service users on mental health issues for older men and has produced a simple "How To" guide for services and organisations seeking advice and information on how they can develop their services to better meet the mental health needs of older men.

Important themes that emerged from the work include:

- Being careful when using the language of "mental health" with older men – it may carry a particular stigma, especially for the generation of older men who grew up during World War II and the years of austerity that followed, and in more traditional male settings where admitting to having mental health problems may simply be seen to be a sign of being weak, or not a "real" man
- Recognising that for many older men their lives, including their social networks, have been shaped by work, and the experience of retirement may bring with it a sense of loss of role, identity, status, income and friendships
- Activities or services that seem most successful in engaging older men and helping to reduce isolation are those related men's to hobbies, interests and previous working lives (often with the banter that goes with it!) – and what men can continue to offer and do, rather than the help or support they are perceived to need

Men in Sheds

CASE
STUDY

Malcolm Bird

Men In Sheds Co-ordinator

Age Concern Cheshire, working across Cheshire East and Cheshire West & Chester

I wanted to provide a recreational activity (originally mainly woodworking) for men that would also help their physical and mental wellbeing. We opened for two days a week, soon to be four. Officially launched by Sir Trevor Baylis OBE on January 30th 2009, Men in Sheds is open to men over 55.

What's inside the Shed is freedom from having to be or do anything other than what men want for themselves. Once there, men are free from "work" restraints, can sit and read the newspaper and have a drink for as long as they want (between 10am and 4pm).

What's inside the Shed is freedom from having to be or do anything other than what men want for themselves.

It offers peace, though it is often noisy, and relaxation, but keeps you busy.

Every man who enters is welcomed and shaken by the hand before being shown round. I feel individual welcome is really important and understand just coming through the door can be a huge hurdle. I let the men know they can share how they feel with me in complete confidence.

If the man is disabled, me and my volunteers do all we can to accommodate his needs. I promote inclusivity and equality.

Having suffered depression in the past has given me some understanding. I found that engaging in activity which kept me physically and mentally engrossed helped me recover. I found purpose and reason to be. I watched my father lose his identity when he was made redundant.

These are quotes from men or their close family about what the Shed is to them:

"I feel better once I am here."

"It was just what I needed."

"I don't have to DO anything here."

"The look on my lad's face when I gave him that car I made was amazing, I'll never forget it."

"It's given Dad a new lease of life."

"The Shed gives Dad something to talk to us about, something for him to look forward to, it "anchors" his week."

"I wish you'd opened 30 years ago."

"I think I'd probably be dead now if it wasn't for the Shed."

"We are Men in Sheds."

5: Identifying and supporting men in mental distress

Introduction

We have seen that some familiar aspects of “male culture” are not always conducive to good mental health. We have also seen that there are obstacles to engaging men in mental health improvement programmes.

We believe that – given the will – some of these problems can be tackled. At the same time, it is almost certainly true in general terms that men are less likely than women to recognise symptoms in themselves and more likely to perceive obstacles to seeking support and treatment. This does not mean that all men who need help will fail to seek it – but it does mean that those who do not take the initiative themselves present a significant challenge. Service providers need to ensure that services are as capable as possible of identifying this group of men and of offering and delivering support in such a way that uptake is encouraged.

The rest of this chapter deals with the general principles involved in reaching out to men at the local level. As *Untold Problems* points out:

[There may be]... a potentially sizeable group of men who cope less well than they might. These men may fail to recognise or act on warning signs, and may be unable or unwilling to seek help from support services. At the further end of the spectrum they may rely on unwise, unsustainable self-management strategies that are damaging not only to themselves but also to those around them.

In this particular context it is especially important to recognise the needs of men who are fathers. In Chapter 3, we pointed out the potential value to the mental health of future individuals of a loving and supportive father. It shouldn't be denied, however, that some fathers sometimes have a negative impact on the health and wellbeing of their children and this may be especially so where the father is in psychological distress, or is abusing alcohol or drugs.

There is reasonably good evidence from some areas of physical health that male-specific approaches to service design can improve uptake. The rest of this chapter looks at aspects of mental health where men may not be using services as effectively as they might, and outlines some of the solutions proposed by our advisors.

Male patients in primary care

The way men are dealt with at the primary care level is absolutely crucial to improving male mental health. In general, men use primary care less often than women and tend to present later after the onset of symptoms (potentially resulting in a worse prognosis). Research has also suggested that men may worry more about “wasting the doctor's time”. It is therefore extremely important that when men do appear in primary care, they are encouraged to talk about their mental health whenever that seems appropriate.

It is also important that primary care staff try to look beyond an ostensible physical presentation, especially when they know, or suspect, that a male patient may have emotional difficulties. Our advisors frequently suggested that an ostensible physical problem may

provide the “cover” for a primary care appointment during the course of which a man may be hoping for an opportunity to raise concerns about his mental health. Our advisors pointed out too, that poor physical health may sometimes be a manifestation of underlying psychological problems. Additionally, a number of physical problems may be direct indicators of a potential mental health problem – for example, obesity may be an indicator of excess alcohol intake or “comfort eating”; erectile dysfunction may be an indicator of stress or anxiety.

In the previous chapter, we looked at the potential role of friends and relatives in identifying men in emotional distress. Essentially, the same principles apply in primary care. The difference here is that there may be one, very brief, opportunity to encourage male patients to describe their symptoms. A man invited to do so may welcome the opportunity to talk. It is particularly important that, if a man does express a mental health need, his concerns are not dismissed; he may not come back a second time.

Male patients in primary care: *ideas for practice*

There are obvious problems with seeking to give all male patients in primary care sufficient encouragement and time to raise mental health concerns. It is not realistic to suggest that every appointment could be so flexible. At the same time, there may well be opportunities that are currently missed – not least if the GP (or other primary care practitioner) is relying on patients candidly to volunteer their mental health concerns. We urge the development of protocols that will help GPs to identify circumstances when raising mental health issues with men would be relevant. We also believe that in-service training programmes for primary care staff might usefully look at the questions that would be most effective in allowing male patients to express mental health concerns.

“Legitimacy”

There is some evidence from other areas of health that men may be more likely to seek help if they are encouraged to do so, either by a friend or relative (perhaps especially a female partner) or by someone who has offered advice in an formal capacity (for example, an occupational health nurse who suggests a visit to the GP).

The theory is that this third party confers “legitimacy” on the help-seeking behaviour when the man would otherwise have found it difficult, for the cultural reasons that we have already discussed, to “give himself permission” to seek help. In other words, a man can say – for example - “I am only here because my wife insisted” and his sense of himself as not conceding the need for help remains uncompromised. It was also suggested by our advisors that legitimacy may be conferred by male peer groups where those peer groups share a collective belief that asking for help does not compromise an individual’s “maleness”.

Mental health professionals among our advisors were familiar with this idea both as it is used by male patients and as a tactic they can themselves use to encourage men to accept an onward referral. It was further suggested by the service users to whom we spoke that similar legitimacy can perhaps be conferred by other men who are prepared to speak about their own experiences. Such men might be public figures prepared to speak openly about their own mental health problems or simply local men who have life experiences in common with the

men being addressed. (See our later recommendation on mental health “ambassadors” for more thinking on this point).

In the previous chapter we suggested that health improvement campaigns might usefully focus on the role of friends and relatives in helping men to prioritise their mental health. To some extent that recommendation encompasses the idea of legitimacy. We believe however that the idea has specific value in encouraging men to take action when they may need professional help.

“Legitimacy”: ideas for practice

We suggest that there are ways that this concept of “legitimacy” can be used to promote active help-seeking by men. There may be benefit in approaches that encourage men to discuss with friends and relatives, not their “feelings”, but the question of whether or not they need to take any action (perhaps, for example, in relation to their drinking or problems at work). Likewise, there might be value in leaflets or web pages which act as a kind of “ticket” to help-seeking by highlighting specific symptoms and including a direct call to action. Similarly, GPs or other primary care staff could consider making a firm suggestion that a man who is experiencing emotional difficulty might accept at least an initial appointment with a mental health practitioner, with processes to allow the appointment to be made there and then.

Outreach

Another lesson to be learned from work with men on physical health problems is the value of outreach services – particularly in relation to initial “check ups” which might lead to a referral for a primary care appointment. Increasing interest in improving male health has led in recent years to these kind of physical health checks being offered in pubs and clubs, barber’s shops, supermarkets, railway stations, workplaces, and at football and rugby stadia on match-days.

These services have evaluated reasonably well in general and eliminate some of the known problems for men in using primary care, which include difficulty in getting time off work, the perception that primary care is a “female-oriented” service, reluctance to make appointments or queue, and simple inertia. Of course, the identification of mental health problems requires a more sensitive engagement than taking a blood pressure reading or calculating a man’s BMI. Some outreach programmes have used basic questionnaire-style approaches to the identification of stress, anxiety or depression as a means of raising psychological issues with men.

Outreach need not be confined to the idea of NHS and social care staff delivering services at informal venues. There is good evidence that very large numbers of both men and women now routinely use the internet to seek health information. One of the most common reasons for going online is to help decision-making about whether a primary care appointment is necessary. Men are more likely than women to use the internet interactively (e.g. game-playing, downloading software) and evidence from the Men’s Health Forum’s own malehealth



“ I’m now working in partnership with NHS staff and service users to promote the concept and understanding of Recovery within Mental Health Services. ”

Bob, Portland

website suggests that many men would like to be able to use their computers to communicate directly with medical professionals. This is a service that the site does not actually offer and is clearly not viable on a large scale but it does suggest that interactive online services may have a particular value for men who may not otherwise seek out face-to-face services.

Outreach: *ideas for practice*

There is an increasing evidence-base for the effectiveness of “male outreach” – taking services out to men. The approach is particularly useful as a first stage in encouraging men to attend primary care for a more in-depth appointment and may have specific value in reaching those men who are least likely to attend primary care of their own volition.

Outreach services do not necessarily involve NHS staff attending at non-NHS venues. It may be possible for present mental health services to become more flexible or there may be opportunities for co-operation between statutory and non-statutory service providers. There may well also be significant potential in developing online services. Outreach is still a novel approach and there is plenty of scope for developing new ideas. The sensitive nature of mental health problems may present a challenge but the problems are not insurmountable. It may be helpful to combine basic psychological health-checks with physical health-checks in these kinds of initiatives.

Depression and anger

There is some evidence and a body of academic opinion that depression may be under-diagnosed in men, not only because men are less likely to seek help, but because the conventional diagnostic approach is more likely to identify depression in women than in men.

This issue is explored in more detail in *Untold Problems* but, in simple terms, it is suggested that men may often exhibit different symptoms of depression from those seen in women. Among the more important ideas, is the suggestion that the externalising of psychological distress (“acting out”, risk-taking, aggression) is more common in men. It is suggested that these more “typically male” symptoms are often not recognised as symptoms of depression and, furthermore, that they may militate against a sympathetic response from health professionals and other agencies – or even from family and friends. Indeed, these symptoms have the potential to prevent the individual getting any help at all (for example, if they mean that a man’s behaviour brings him in the first instance to the attention of the police rather than to a health professional). The situation is further complicated by the fact that the symptoms of depression in men may be more likely to be masked by the use of alcohol or other drugs.

In this context, it is also worth reporting a common feeling among some of the service users that we spoke to – that some people, including some mental health professionals, routinely assume a threat of violence from men in psychological distress. This damages the relationship with the man and may lead to limitations on the support that he receives. (See “Aggression and other challenging behaviours” in Chapter 7 for more on this point).

We include no ideas for practice in relation to the possible under-diagnosis of depression in men. This is partly because the debate about the issue is on-going and currently inconclusive,

but largely because we believe that the previous recommendations in this chapter are an important part of the solution. If service providers seek to ensure that the mental health needs of men are taken into account in the widest range of presenting circumstances then there is much greater likelihood that depression that would otherwise be missed will be identified and treated.

Active promotion of services and help-seeking

In recent years several men, well known in public life, have openly discussed their own mental health difficulties. Clearly the impact of this kind of intervention on public opinion is difficult to evaluate, although it seems at least possible that it will have helped to break down barriers to help-seeking for some men. Our advisors made the point however, that the best way to reach “ordinary men” is via existing social networks whether these are face-to-face or online. Such networks might include workplaces, professional organisations and trade unions, social clubs and hobby groups, faith organisations, sports organisations, housing providers and social networking systems.

There are two issues here. The first is the capacity of these organisations to identify men who may be experiencing mental health problems and encourage them to seek help. The second is whether there are ways of working with these groups to make them more helpful to men with mental health needs.

On the first point we think there is some potential to explore the provision of training for people active in community organisations which have large male memberships. Such people might include leaders of faith groups, trade union officials, people responsible for managing staff, and officers of community organisations. In the case of groups of older men, the people who have contact with them might include wardens of sheltered housing and others working in the field of social care. The training could include basic recognition of signs of poor mental health and strategies for encouraging men to seek help.

On the second point, we are convinced of the potential value of “mental health ambassadors”. These would be men who have had mental health problems and who, having been trained to do so and provided with on-going support, are prepared to speak publicly in group settings about their personal experiences.

In thinking about these two potential interventions, the particular approach that was believed by our advisors to be useful would be to aim to normalise the idea of mental health difficulties. In other words, to emphasise that these problems do sometimes happen to “men like me”. Our advisors frequently referred to the untapped potential of male groups to “look after their own”. The intention of the two models outlined below would be to engage with that sense of camaraderie in male communities.

Active promotion of services and help-seeking: *ideas for practice*

We encourage the establishment of local programmes in respect of the ideas highlighted above. The first to train people in positions of influence to help identify men who might need psychological support and to signpost them to appropriate services. The second to establish local networks of trained male mental health ambassadors willing to speak in group settings about their personal experiences.

Service providers themselves could aim to work with existing programmes that offer consultancy and solutions on mental health in particular settings, such as the Mind Workplace programme that works with employers.

Family and relationship problems

Problems in maintaining relationships with their children may be a particular cause of distress for men whose relationship with the children's mother has broken down. *Untold Problems* draws attention to the higher rate of diagnosed mental health problems among this population group. There is also often a lingering sense of unjust treatment by the family courts among many separated and divorced men. These problems have been recognised in Australia where a dedicated national help-line for men, "MensLine", uses a specifically male-centred approach and focuses particularly on problems arising from family breakdown.⁶ MensLine receives 60,000 calls a year.

Family breakdown is also important in relation to the wellbeing of children. As we pointed out in Chapter 1, children who maintain a good relationship with their father, even when he no longer lives with them, are less likely to experience a range of social, educational and psychological problems. Family breakdown also arguably has the potential to harm the mental health of other family members such as grandparents.

We do not recommend dedicated centrally funded helplines for England, partly for reasons of cost but also because some national third sector organisations already offer at least some of this kind of support (e.g. Samaritans, Relate, Families Need Fathers). This does not mean that we do not advocate paying particular attention to the needs of men who have experienced, or are experiencing, problems in their relationships with the mother of their children, or relationship problems more generally. We have already made a number of recommendations intended to develop a better range of advice and support services and we think it is important that these services actively concentrate on engaging men who are believed to be at higher risk of mental health problems. This will, of course, include men experiencing relationship difficulties. Other groups of men with known mental health needs are discussed in Chapter 8.

⁶ www.crisissupport.org.au

First Time: A guide for prisoners, by prisoners

CASE
STUDY

Stephen Sibbald

Prisoner Health Resource Project and The Men's Health Forum

In 2009, the Men's Health Forum (MHF) was commissioned by Warrington Primary Care Trust to develop a health resource suitable for men in two prisons – HMP Risley and HMYOI Thorn Cross.

Although there were plenty of existing health resources in both prisons, there were very few that reflected life within a prison context. Indeed, the large percentage of existing resources suggested lifestyle changes in a way that is not practical in a prison environment e.g. take your dog for a walk, change your diet etc.

From the outset, the objective was to involve the male prisoners themselves in the production of the resource to ensure it was relevant to offenders whilst in custody; that it was ultimately useful; and, importantly, that the "tone of voice" was correct. It was also an aim of the project to leave behind the skills and expertise among the education teams at

both prisons to be able to run similar projects themselves in future.

The objective was to involve the male prisoners themselves in the production of the resource to ensure it was relevant, useful, and, importantly, that the "tone of voice" was correct.

While it had always been the original intention to produce a resource which would encompass issues around mental health, healthy eating and physical activity, the challenge was to present this in a way which took into account the prison environment. Further discussion led to the idea of using the experience of surviving the first night in prison as a unifying theme to link these issues together.

More discussion and surveys amongst the prisoners elicited some startlingly frank and open reports of their first night experiences as well as suggestions for coping mechanisms for those early few weeks. Many spoke of their fear and desperation and the inability to express these powerful emotions within an overtly masculine environment and one in which they felt that vulnerability

and weakness had to be positively disguised. The voices of these prisoners were used to generate the content of the resource which, it was decided, would be a leaflet to be included in the "bed packs" for all prisoners arriving through the prison reception process.

A designer was commissioned to produce sample designs for the resource for discussion with the prisoners and their feedback and comments were used to arrive at the final version. In their view, it was important that the information be seriously delivered but that the language was accessible and the tone lightened by the use of cartoon illustrations throughout. A short glossary of prisoner slang language was also included in the resource.

A GP's perspective

VIEWPOINT

Dr Liz Miller

General Practitioner

My experience suggests that men are more likely to receive antidepressants than counselling when they seek help from their general practitioner. Men either don't want to talk about how they feel or are not offered the opportunity. It is far from clear whether this is because society expects men to be the strong silent types, or whether men have a largely non-verbal biological blueprint.

Nonetheless the verbal nature of our extrovert society demands that people talk about their most intimate life details. Not everyone feels comfortable with this approach. Because of widespread influence of drugs, antidepressants and other medications are often the basis of treatments for mood disorders, such as depression, bipolar disorder, ADHD and anxiety disorders.

No one would deny it is helpful to encourage men to talk, nonetheless, those of us who wish to help men improve their mental health need to consider non-verbal ways of managing moods.

This approach goes against common sense. For thousands of years people have managed their moods, felt happy and comfortable despite unspeakable misery. Even language only evolved in the last 70,000 years! We have managed our moods and emotions long before the drug industry got under way.

Many male mental health problems come from the Western cultural assumptions. For example, divorce can produce a life crisis for men, leaving men emotionally vulnerable, perhaps because of the unspoken social assumption of women as victims and men as perpetrators. Western society assumes that men do not talk about feelings. No one would deny

it is helpful to encourage men to talk, nonetheless, those of us who wish to help men improve their mental health need to consider non-verbal ways of managing moods.

It is well proven that exercise improves mood. In some areas GPs can prescribe the gym, and all doctors can recommend exercise. Encouraging hobbies, such as fishing, football, music and activity holidays provides "men" time, as opposed to "me" time. This time can help men understand and usefully resolve their experiences.

Mood mapping is a non-verbal way of managing mood where a person can track their mood without needing to put words to how they feel. Mood mapping both explains mood, and allows people to self-manage their mood and take control of their own mental health.

Medication is not the answer to poor mental health, although there are times when it is helpful to put on a sticking plaster. It is good to talk but we also need to find more non-verbal ways to come through bad experiences.

Back on Track 2 Study

CASE
STUDY

Annie Lau, MD FRCPsych

North East London Foundation Trust

This partnership project was led by the Learning and Skills Council/National Institute of Adult Continuing Education in partnership with the National Mental Health Development Unit. Between July 2009 and March 2010, eight regional pairings of Early Intervention in Psychosis (EIP) teams and matched further education colleges worked together to improve working relationships across the inter-organisational divide in order to support service users with a first episode psychosis back into training and further education. It is known that education is an important step on the pathway to employment.

Activities included three whole group meetings in which health and education providers came together to share learning and resolve issues (such as managing risk). This included flexibility in course provision and named contacts across teams.

By March 2010, data received from the eight teams covered a total of 1,010 service users. This was a predominantly male group (70% males; 30% females) with an average age of 24.

It is known that education is an important step on the pathway to employment.

They were young people in early adulthood for whom vocational recovery is crucial in setting the stage for eventual longer term outcomes. The EIP teams involved included: Nottingham City and South County; Hull and East Riding; Worcestershire; North Devon; West Sussex; Great Yarmouth; Sunderland; and Wirral.

For the wider population, the average percentage of service users in contact with Community Mental Health Teams that are in education, employment or training (EET) is 15%. In comparison, an average of 51% of the project participants were in various forms of employment and an average of 46% were in school, further or higher education.

All participating EIP teams, further education colleges and learner focus groups reported benefits from taking part in the study. For some EIP teams it was their first real engagement with the further education provider. This involved learning a different language, and engaging with a different culture. All saw the benefits for their clients of engaging in learning, in terms of increases in social confidence.

"How To" Guide can be found at: www.niace.org.uk/current-work/back-on-track-2

6: Supporting men and boys with diagnosed mental health problems living in the community

Introduction

Under-diagnosis of mental health problems in men is one of the important issues that this document aims to address. However, the diagnosis of a mental health problem does not necessarily mean that men will get the help that they need. Assumptions about the types of treatment that men will want, perhaps due to socialised attitudes within society, can narrow the options that men are presented with. For example, the view that men are unlikely to open up about their feelings may result in services not routinely referring men for psychological therapy.

Diagnosis also does not mean that men with mental health needs will suddenly engage with services. Instead, services need to earn men's trust in order to ensure an ongoing and effective relationship. In this sense, formal diagnosis may sometimes be less important than developing a focus on engaging and supporting men with psychological needs.

Ultimately, mental health services should listen and respond to the needs of an individual. What works for one man may not necessarily work for another and services must be willing to personalise their approach. However, throughout our research, key principles of delivery and types of intervention have been recurrent in the advice we have received. The following chapter describes these principles and interventions.

Information and advice

One of the main complaints we heard from service users was that mental health professionals do not always provide adequate information and advice about diagnoses or the help that is available. Being diagnosed with a mental health problem is likely to be distressing and, for men particularly, may feel disempowering. With little understanding of mental health, many will suddenly find themselves in a situation that they feel they cannot control – this feeling may be further compounded by potential fears around job security, financial issues and stigma. To counteract this, services need to ensure that men understand their situation – by knowing what is going on and how things may progress, men can be helped to attain some sense of control over their circumstances.

Information and advice: *ideas for practice*

Services should provide men with a full explanation of their diagnosis and the options available to them. This explanation should be given face-to-face and include an outline of the range of available interventions for their presenting problems and comprehensive information about any medication that may be prescribed, including potential side effects (such as erection problems). Service users should be given time to ask any questions they may have. Further information to take away should also be provided in a format that is accessible to the service user. This may include information in different languages or using audio-visual media. It may also be important to provide information tailored to family members of male service users, particularly those from black and minority ethnic communities.

Creating a safe space

Our advisors argued that a fundamental element of any service seeking to work with men should be the creation of a “safe space”. The concept of safe space is important and it may be that there are gender differences in what precisely constitutes a safe space for given individuals. Certainly, as we have seen in the previous chapters, seeking help for a mental health problem can be fearful for many men. This does not automatically mean that men will not be willing to open up and engage with services. It simply means that it may be particularly characteristic of men that they are less likely to engage until they feel secure – knowing that no one will make a value judgement about them for discussing their problems. To help overcome their reticence to ask for support, men may also need to be specifically reassured that what they say is confidential.

It is probable that we do not know for sure what are the most important components of a male safe space. It is possible to speculate that there may be other elements, including those relating to the balance of power and the man’s sense of having some control of his circumstances.

Creating a safe place: *ideas for practice*

Services should aim to provide a non-threatening and familiar environment. For example, treatment sessions could be held in community settings. Mechanisms for peer support should be encouraged, confidentiality should be emphasised and the possibility of anonymity offered where appropriate.

Language and verbal development

As Chapter 5 explains, it is important that services are marketed in “male-friendly” language. There may be benefits in adopting a similar approach to the language used during mental health interventions. Some of our advisors suggested, for example, that men may be more receptive to “action based” language that emphasises productivity, outcomes and goals. Some research has also suggested that characterising the process of recovery from mental health problems within a framework of traditional masculine qualities can also be effective

– for example, conceptualising the process of recovery as a “heroic struggle”. The broad aim is to acknowledge the risk that some men feel emasculated by accessing mental health services and that this may hinder their ability to engage. Language undoubtedly plays a large part in this. It seems probable that, by describing help-seeking and treatment processes in a way that calls attention to independence, strength and action, some men will feel more positive about the contribution they can make to their own recovery.

As well as addressing the language used with men, it will sometimes be necessary for services to consider the way in which language is used by men. Women generally score higher than men on tests of verbal ability. Obviously this does not mean that all men lack verbal skills. It does suggest however, that it cannot always be assumed that men can express themselves in a way that is adequate for making the most of the treatment that is offered to them. Whilst it is important that services adapt in light of this by providing non-verbal interventions (see below), services might also aim to give individual men the opportunity to develop their verbal skills where that would be welcomed by the service user and where it has the potential to enhance the treatment process. This might, for example, help some men become better able to express thoughts and feelings and allow them to gain more benefit from verbal interventions such as psychological therapy.

Language and verbal development: *ideas for practice*

Services should be willing to adapt the language used with men in a way that focuses on traditional masculine qualities and encourages men to feel empowered by engaging with treatment. Where appropriate, services might consider looking for ways to help some individual men develop improved verbal skills.

Psychological therapy

Although some men will prefer non-verbal interventions, the assumption that all men do not want to talk through their problems is unfounded. The men we spoke to throughout our research often said that they wanted to access psychological therapy but had found it difficult to do so, either because they lacked information or because of long waiting lists. It should also be remembered that because, as we have seen, men tend to find it harder to seek help for mental health problems, they are also less likely to request referral or self-refer to psychological therapy services. As a result, it is probable that not enough men are accessing these services.

The Improving Access to Psychological Therapies (IAPT) programme is well placed to increase the uptake of psychological therapy among men. Although not suitable for everyone, the programme’s focus on cognitive behavioural therapy (CBT) could be particularly effective for men. Some of our advisors argued that CBT is capable of being interpreted as a “masculine” approach to tackling psychological difficulties, in the sense that it involves facing up to problematic thinking and applying a practical solution. The IAPT model also uses a time-limited methodology, suggestive of achieving a personal target within a given timescale, and this may be another aspect of the approach that commends itself to men. It is clear however, that more needs to be done to increase the uptake of IAPT among men; women were twice as likely as men to access IAPT services in the first year of roll-out.⁷

⁷ Glover, G., Webb, M., Evison, F. *Improving Access to Psychological Therapies: A review of the progress made by sites in the first roll-out year*. Stockton on Tees: North East Public Health Observatory; 2010



Psychological therapy: *ideas for practice*

Health professionals should proactively suggest psychological therapy to men experiencing mental distress as men may not consider accessing services themselves or even recognise that they might benefit from them.

The IAPT programme, based on a range of talking therapies, appears well-placed to increase the uptake of its services among men. There is potential to market the service to men and even to target particular sub-groups of men who may be even less likely to use the service. As part of this, the programme should be monitored both locally and nationally to ensure it delivers gender-equitable services.

Non-verbal interventions

Another idea raised several times by our advisors was that, as men are thought to be “doers” not “talkers”, they may respond better when engaging “shoulder-to-shoulder” rather than “face-to-face”. Although this will not be true for all, non-verbal interventions will definitely be preferred by some men. Such interventions can also act as a first step – enabling men to develop a relationship with services before they move on to other therapies.

This document has already described the benefits of providing interventions through physical activity, either with individual exercise or team sports. Social activities outside of sport, such as group trips and film nights, can also be effective. The activities need not be billed or planned as mental health interventions – in fact, they may be more popular if they are not. However, the social engagement is likely to lead to mental health benefits. These include the opening up of new social networks (stigma can result in men losing friendships), the provision of a non-threatening and non-pressured environment for men to share their problems with others if they choose and simply the enjoyment of a fun activity (which in itself has benefits for wellbeing).

Participants in our focus groups felt that it was also important to present men with the chance to engage in meaningful activity. This may be especially beneficial for men who have lost employment due to mental distress. *Untold Problems* suggests that the cultural importance of the role of men as “providers” means that unemployment often has a particularly damaging psychological effect for men. Meaningful activity can help combat the loss of purpose that can be a consequence of unemployment. There is also good evidence about the value of meaningful activity for the wellbeing of older men who have retired from paid work. Art and music classes were popular options for the men that we spoke to. Volunteering was also discussed as a good way to help men develop their skills and provide the stability of a routine.

Non-verbal interventions: *ideas for practice*

Non-verbal treatment options should be made available and widely publicised to men. These options should go beyond exercise and team sports to include social activities and meaningful occupations.

Peer support

As already discussed in Chapter 5, it is important to provide men with the legitimacy to seek help. Peer support has been repeatedly suggested as an effective way to provide such legitimacy – showing men that they are not alone and allowing men to feel that will be understood, supported and not judged.

Male support groups can be very successful at giving men a platform to be helped by their peers. With the group structure enabling men to help others as well as receiving support themselves, men can feel like active participants as opposed to passive beneficiaries. Such reciprocity can allow men to regain control and a sense of pride. Publicising support groups in a way that explicitly mentions mental health can be off-putting. Instead, providers should think about advertising such groups as drop-in services or men's clubs.

Although support groups have great potential, they will not suit everyone. In fact, our focus group research suggests that young men, in particular, may not feel able to get involved in group interaction due to the strong stigma around mental health in this age group. Young men may however, be enthusiastic about the opportunity to learn from male service users who have experienced the mental health system. "Mental health ambassadors" (see Chapter 5) could therefore be an effective way to provide peer support for those who do not wish to join a men's group.

For some men, it will also be important that the health professional they see is considered to be a peer. This might mean a peer through gender, ethnicity or both. For example, some of our focus groups called for more male Asian counsellors. Although it will not always be possible, services should aim to give men a choice of practitioner if they can. The option to choose the sex of the practitioner may be particularly welcome where that choice can be offered. In some cases – although this is likely to present difficulties for a variety of reasons – it may be appropriate to offer the opportunity to choose a practitioner from the same ethnic background.

Peer support: *ideas for practice*

Commissioners should ensure that men are provided with options for peer support in their area. Men's support groups should be encouraged and developed and services should aim to provide training for service user champions who, where appropriate, are sourced from the communities they will be working with.

Where possible, male service users should be given the choice to work with a health professional of either sex. Where the gender diversity of a workforce is limited (for example, counsellors are predominantly female), steps should be taken to address the balance, such as recruitment campaigns profiling men as positive professional role models.

Training courses

It was suggested by our advisors that many men are "goal-oriented" and this suggests that taking a solutions-based approach to dealing with mental distress has the potential for greater effectiveness in some cases. This type of approach aims to be straightforward, focusing on

what can be achieved and identifying the means to make progress. Usually, a solutions-based approach will endeavour to provide the tools for men to manage their own condition – something that can be particularly welcome for men who may be keen to regain control over their lives.

Training courses, such as anger-management and confidence building, are well placed to provide this type of approach. Courses may also be easier to promote to men as they need not advertise as “mental health” interventions but can instead emphasise skills-building and traditionally “masculine” qualities such as facing a challenge and empowering oneself.

Training courses: *ideas for practice*

Mental health services should make links with local training providers in order to make appropriate training courses available to male service users. Such courses should be widely promoted using solutions-focused language designed to engage men.

Joined-up services

In many cases an individual man’s mental health will be additionally affected by wider social difficulties he may be facing or by the experience of chronic physical ill health – an experience which becomes more likely with increasing age. Although mental health service users are often in touch with a number of different services, such as employment support and social care, these wider issues may not be addressed as part of their mental health support. In particular, male service users will frequently be given a “dual diagnosis”⁸ that will involve them needing to seek help from different services. Consequently, it is very common to hear that service users feel they are being thrown from “pillar to post” between the different agencies that they are told to deal with.

An effective, personalised mental health service should work with mental health in a holistic way. To achieve this, mental health services need to develop good communications between other teams – such as housing benefit or drug and alcohol services – and gather up-to-date and comprehensive information on all local support available so that service users can be provided with effective signposting.

A good way to deliver more joined-up services is to provide non-mental health support as part of mental health interventions. For example, job support advice and training could be delivered to a men’s support group or a service user champion could invite the local housing benefit team to present at a community event.

⁸ The term “dual diagnosis” refers to people diagnosed with mental health problems who also misuse alcohol or street drugs (illegally produced drugs or illegally obtained prescription medicines).

Joined-up services: *ideas for practice*

Mental health services should be proactive in creating a joined-up approach to local service delivery. Services should develop better communication between teams and aim to provide wider social services through mental health interventions where relevant. This is particularly important for men who, as we have seen from the evidence relating to health services, may, in general terms, be less likely to seek out additional support services for themselves.

The “Making Every Adult Matter” coalition (made up of Mind, Drugscope, Homeless Link and Clinks) is currently running service pilots aimed at better co-ordinating services across mental health, addiction, homelessness and criminal justice to improve support for those with complex and multiple needs.⁹

⁹ www.meam.org.uk

STRIDE

CASE STUDY

Deb Ashby

www.digm.org

STRIDE is a Greater Manchester young men's (11-19 years) dance project, developed by Dance Initiative Greater Manchester (DiGM), in partnership with professional dance company Company Chamelon.

Via evidence gathered across 2009 and 2010 projects, we believe STRIDE improves:

- Physical fitness and wellbeing – through regular dance sessions that challenge strength, stamina, cardiovascular health, agility and flexibility;
- Mental health – through opportunities to develop creative ideas, for self-expression, and engagement with others in a positive environment;
- Confidence and self-esteem – through challenging participants to step out of their comfort zone and supporting achievement through performance;
- Life skills – through providing opportunities to value the importance of team work, goal setting, commitment and time management.

Hayden (19 yrs) feels better when he dances, he'd rather be doing this than sitting at home feeling sorry for himself. Javan (14yrs) feels happy when he dances. Javan has made friends with people he thought he wouldn't hang around with... It's given him more confidence.

DiGM, a charity increasing access to high quality dance activity to underrepresented communities, works across Greater Manchester's ten boroughs in partnership with local authorities, communities, educators and artists. STRIDE is a free activity with its participants coming from diverse socio-economic and cultural backgrounds. STRIDE challenges stereotypes around young men and dance and promotes positive role models in communities.

STRIDE is artistically directed by Company Chameleon and supported by six professional dance artists. The professionals at Company Chameleon are artists of international reputation and act as positive male role models for the boys. Creativity is at the centre of the project. For example, the pilot project ('Rites') asked participants to explore the stepping stones of a man's life, with themes including growth, peer pressure and support.

District Arts Officers have provided some funding towards the project and support identifying outreach settings. Initially, extensive outreach is undertaken with 24 hours of high quality dance being offered over four or more locations in each participating district. District based groups are formed following "Try Outs" where young men can demonstrate their openness and commitment to the project. Through regular sessions, the groups prepare for high-profile performances, including:

- Sited performances in The Lowry foyers;
- The international showcase "British Dance Edition 2010";
- An international event in Germany;
- Outdoor performances in Manchester's Urban Moves International Dance Festival.

Some STRIDE participants now look to pursue further opportunities in their dance development, such as entering pre-vocational professional training and taking on supported facilitation roles with younger community groups.

A psychiatrist's perspective



VIEWPOINT

Dr Richard Laugharne

Consultant Psychiatrist, Cornwall Partnership NHS Trust
Hon. Clinical Lecturer, Peninsula Medical School

Psychiatrists are very aware in our day to day work that men are more prone to severe psychosis and alcohol problems. Most of us have seen patients in prisons and police cells and are aware of the mental health problems in the male-dominated offender populations. Men often respond to mental stress by drinking too much, and liaison with alcohol services is crucial. More men are socially isolated which may explain why the rate of suicide is much higher in men, even though we see many more depressed women than men.

Men feel more embarrassed to see me in my clinic, and seem less open to talking therapies. This is consistent with this report, and overcoming barriers to help seeking behaviour is crucial. Shared decision-making would help to empower patients in their

I do believe public health measures to reduce alcohol consumption would have direct benefits for men's and women's mental health, more so for men

care. Talking therapies and medication can help men when appropriate. Non-talking social interventions are a particularly good idea for many men, such as physical exercise in team sports and making music together. These increase social networks through doing something together, which men often prefer. I do hope the allotment movement continues its renaissance – I believe allotments are very good for men's health. Helping men with mental health problems back into work has a strong evidence base for improving all mental health problems, whether mild or severe. Employment workers need to be embedded in mental health teams.

I do believe public health measures to reduce alcohol consumption would have direct benefits for men's and women's mental health, more so for men. Support for veterans returning from war needs to be accessible through service charities and NHS agencies. We still need to improve on the treatment of mental illness in prisoners with follow up on discharge.

Finally, patients suffering from severe psychosis must not be forgotten. They are small in number but predominantly male, often not vocal and sometimes have no advocates. Any equitable health service should prioritise their recovery. Rehabilitation services are often the first to be cut. However, providing the most unwell with recovery focussed care is a moral imperative.

CALM

CASE STUDY

Jane Powell, Director

www.thecalmzone.net

CALM is a campaign targeted at young men aged between 15-35. The campaign offers help, information and advice via a free, anonymous and confidential phonenumber and web service.

It was set up because suicide was, and is again, the biggest killer of men aged under 35 in the UK (ONS 2008). However, this group are reluctant to access services and are not using the traditional support helpline services available. Research found this was due to their perceptions of these services; they saw them as something that other, more desperate men may turn to but not relevant to them and their lives.

CALM, which stands for “the campaign against living miserably”, was launched as a pilot by the Department of Health (DH) in December 1997. In 2004, the DH announced the end of the pilot. However, those involved on the ground felt it was important the line was continued and CALM, the charity, was launched in 2006 with adverts on MTV and posters

and billboards provided by JCDecaux, Clear Channel and Viacom across England.

CALM passionately believes that the way services are shaped, packaged, and the methods used to promote them are as important as how good they are when it comes to successfully engaging with men.

Currently, there are two local areas that CALM actively promotes in, Merseyside and East Lancashire, with the support of the regions’ Primary Care Trusts. Callers from within these “CALMzones” are able to get signposting information to local agencies that could offer additional specialist support on a range of lifestyle issues.

CALM passionately believes that the way services are shaped, packaged, and the methods used to promote them are as important as how good they are when it comes to successfully engaging with men. We receive over 80% of our calls from men; clearly we are getting something right.

The campaign is now firmly established as a credible brand that young men relate to. We are promoted by nightclubs, festivals and musicians; we have the backing of big male brands such as TOPMAN and support from artists like Dizzee Rascal.

In the Merseyside CALMzone, which celebrates its tenth anniversary this year, we have seen a sustained reduction in the suicide rate amongst men aged 15 – 34, measuring 39% over the eight years of figures available.

Any service that wants to reach men needs to put men and their viewpoints and preferences at the heart of what they do. It has to be on men’s terms, or they will simply vote with their feet...

Boxercise

CASE STUDY

Michel Thizzy

Boxercise is a partnership between Mind in Croydon and the former world champion boxer, Duke McKenzie. Under Duke's instruction, people with mental distress learn boxing techniques to help improve both their physical and mental wellbeing. The scheme can help people recover their confidence and self-belief in a different way to the usual mental health support. Although Boxercise is designed for both men and women, it has particularly good outcomes for men.

Feeling good about yourself is inextricably linked to having good mental health, and many of the men the project works with have been made to feel that their mental health makes them somehow "weak" or "less of a man". Rather than addressing just the thoughts and emotions that go with mental distress, Boxercise helps people to recover the most basic of things – a feeling of self-worth. It can also be a positive way to manage emotions; a form

"All men have egos and men with mental health problems aren't any different. Everyone needs encouragement to build up their confidence. That's what keeps men going".

of anger management. It's not about aggression. As Duke says, "How many fights do you think I've got into outside the ring? None. It's about discipline and management".

The project has four main aims: to improve health and fitness; to improve self-esteem and mental wellbeing; to improve social inclusion; and to help people lead healthier lives. Isolation can be a persistent problem for people with mental health problems, and bringing people together to train can go a long way in helping people feel more included. The project brings the group together; people bond and make friends. Quite a few have joined a gym as a full-time member, on reduced fees. No one

at the gym has noticed they have mental health problems, and this makes them feel better about themselves – they don't feel like they're just "the nutcase off the street". They feel the same as anyone else; it's a step towards integration.

Duke adds: "Through boxing, I've learnt to understand people and I feel I can identify with others. All men have egos and men with mental health problems aren't any different. Everyone needs encouragement to build up their confidence. That's what keeps men going".

7: Supporting male inpatients

Introduction

The inpatient environment presents a unique opportunity for mental health services to work productively with men. Unlike other settings, the initial challenge is not about getting men to approach the services. The men are already there. This does not necessarily mean however, that male inpatients will automatically be fully engaged in their treatment. As with men in the community, male inpatients may still be less willing to seek an active part in the management of their mental health. Inpatient services may need to be proactive, persuasive and persistent if they are to be as effective as possible with men. African-Caribbean men make up a disproportionately high percentage of inpatients by comparison with the population as a whole. In some hospitals, the majority of men on inpatient wards are black. There is therefore a need, in respect of all the fields of activity that we highlight below, to plan and deliver services in a way that is culturally sensitive.

For the majority of men in inpatient settings, the contributory factors to poor mental health will have already taken hold. Many male inpatients will have had some or all of the adverse life experiences that we have already highlighted. Some will have had difficult childhoods or will have experienced relationship problems in adulthood. Others may have been through the criminal justice system, have little or no employment history or have long-established substance misuse problems. This means that early intervention and prevention techniques will not be appropriate for most male inpatients but it is vital that services do not take a defeatist attitude when working with such men. Instead, a recovery and relapse prevention approach should be taken that emphasises positive solutions and enables men to retake control of their lives.

In this context it should be noted that an inpatient stay may provide a valuable breathing space to help those men who have previously had difficult living circumstances to sort out some of their practical problems. For example, the inpatient stay will provide an opportunity to attend to physical health problems which may have been neglected. It may also be an opportunity to encourage GP registration, to give health promotion advice and to sort out financial problems, including difficulties with welfare benefits.

Inpatient settings also play a part in suicide prevention by providing a safe, well-managed environment for the relatively small number of men who are in acute distress and at immediate risk of self harm. Suicides among inpatients have been reduced in recent years, largely as a result of physical changes (removal of potential ligature points) and improved vigilance by staff. Staff training may be helpful to enhance awareness of the patterns which sometimes surround suicide – for example, the most common locations for suicide attempts and the times of day at which suicides most often occur. One of the recurring themes of this document is the difficulty that some men experience in acknowledging their own vulnerability; it is crucial therefore to try and create an inpatient environment in which potentially suicidal men feel safe and cared-for, and able to ask for help.

Mention should be made here too of the on-going programme of activity to reduce the number of mixed sex wards in the NHS. This work has recently been given fresh impetus by the election of a new government. Mixed sex wards in psychiatric hospitals have been a particular focus of criticism by mental health service user groups. Generally, and

understandably, the emphasis has tended to be on the important issue of safety for female patients but our advisors suggested that the concentration on the needs of women can lead to an incidental neglect of the needs of men – for example, the creation of women-only day areas may take place without any detailed consideration of what the consequences for male patients.

Finally, we acknowledge that there can be very serious challenges in providing appropriate care for some men who present with complex problems – for example some men who have substance misuse problems and/or personality disorders in addition to their mental health problems. Personality disorders and substance misuse problems are both known to be more common in men so it is inevitable that this group of patients will number more men than women. Some of these men will have unstable personalities, difficult social relationships and propensity for impulsive behaviours, all of which can have a negative impact on staff and other inpatients.

We are grateful to colleagues at NMH DU and to Nick McMaster for their expert advice on this section and their suggestions for specific content.

Information provision

Entering an inpatient setting may be felt by patients to be an inevitably disempowering experience. For reasons that we have discussed in earlier chapters, this may be particularly so for men – especially those who conform strongly to a conventional masculine stereotype. These feelings may be even stronger in men who have been sectioned.

As we discussed in the previous chapter in relation to male service users living in the community, the provision of comprehensive information can both reassure and empower. Inpatient services should therefore ensure that men receive clear information on their situation in an accessible format. Information should include details on how the ward is run, service user rights and the side effects of any medication that may be given. This information needs to be provided as soon as possible following a service user's initial arrival.

Information provision: *ideas for practice*

Service users should be provided with information on their situation as soon as they are in a position to receive it after arrival. The information should be presented in person as well as in an accessible written format (or audio format for those who need it). Service users should also be given time to ask questions following the presentation of information.

Activities for male inpatients

Boredom is a significant problem for both male and female service users on inpatient wards. Our advisors felt that this might be a particularly important issue in relation to men, with boredom potentially acting as a trigger for damaging coping strategies that are known to be more common in men.

To counter boredom in men, inpatient services could consider developing activities that specifically reflect male interests. As well as providing direct benefits, ward activities have the potential to develop men's trust and engagement in services. Activities can therefore become

a pathway to further interventions such as group work or one-to-one therapy. “Star Wards”, a national, user-led, largely third sector-funded initiative aimed at improving the mental health inpatient experience, has been instrumental in encouraging creative, co-operative, innovative work on inpatient wards.¹⁰ Among other elements, Star Wards encompasses recreational activities, including: physical activity; community-building involving patients, staff and visitors; and the encouragement of talking therapies. In some places, male-focused activities have emerged and clearly, the emphasis on patient involvement has the potential to ensure that local initiatives do reflect the felt needs of service-users whether male or female.

Activities for male inpatients: *ideas for practice*

We encourage wards to consider developing activities that are directed at men. Services could look to work developed within Star Wards to gather ideas for inpatient groups and activities with a male bias (“Doing Stuff” mentioned in the “Working with male inpatient service users” Viewpoint is a good example). Developing such activities in consultation with male inpatients increases the likelihood that the activities will meet men’s needs well and that male patients will participate.

An environment to talk

As this document has already explained, it is important for mental health services to provide and promote a safe space for men to talk about their problems. This will be no different in inpatient settings. It is generally acknowledged that many inpatient wards do not provide adequate access to a range of psychological therapies. Although disadvantaging all service users, this lack of provision prevents men from accessing psychological therapy at a time when they may feel most ready to open up (our advisors noted that men often seem more emotionally available following a mental health breakdown). Services should therefore aim to improve access to psychological therapies on inpatient wards, develop non-threatening environments for male inpatients to access this support and encourage staff to seek out male participants.

Experience suggests that male inpatients may prefer one-to-one therapy and effort should be made to ensure that men not only have opportunities to access this treatment but also that the therapy provided adapts to meet the needs of men. This might include giving men the option to see a male practitioner or framing the therapy in “goal-oriented” language (see “Language and verbal development”, Chapter 6). Particularly suited for this approach are cognitive behavioural therapy and solution focused therapy. Both can facilitate effective problem solving in time-limited circumstances, whilst still allowing a client space to talk about their distress.

Men’s perceived preference for one-to-one support does not mean that men’s support groups will not be successful on wards. Although attendance may fluctuate, group work can be extremely beneficial for some male service users and should be made accessible. Meetings need to be regular, continued even when there is poor turnout and make it possible for men to dip in and out of sessions. If groups become a regular and well-publicised element of inpatient life, taking part will be normalised and may make it easier for men to feel able to attend sessions or engage in other therapies.

¹⁰ www.starwards.org.uk



“Stay in the gym!”

Michael, Croydon

An environment to talk: *ideas for practice*

Male inpatients should have the opportunity to access both one-to-one therapy and men's support groups in a safe space that gives them the legitimacy to open up. Staff should aim to be both proactive, persuasive and persistent when encouraging men to engage in these therapies.

Aggression and other challenging behaviours

There is often a perception among inpatient staff that male service users have the potential to be violent. This may be especially so in respect of men from particular communities or certain local geographical areas. Of course, some patients are potentially violent but a generalised perception can lead to all men being treated defensively even when there is no risk present. Defensive behaviour from staff reduces the likelihood of positive engagement from male service users which, in turn, may reduce the effectiveness of treatment. Staff should be encouraged to address defensive behaviour and be supported to foster relationships with service users founded on mutual trust.

With service users who are known to be aggressive, it is not only more likely that staff will act defensively but that they will also mirror body language and communication style. For men who display violent behaviour, it may be all the more important for services to develop a safe and calm environment. If staff mirror aggressive behaviour, a tense atmosphere will be created that is not conducive to the treatment process. It is essential that all inpatient staff are given the confidence and capability to recognise and defuse potentially violent situations in a non-aggressive manner. Guidance specifies that comprehensive training on anticipating and de-escalating violent behaviour should be provided to staff on a regular basis; the Healthcare Commission's 2008 review of NHS acute inpatient mental health services found however, that only two thirds of clinical and administrative staff had received such training and the proportion of staff who had received this training within the previous twelve months varied markedly across the country, from 39% to 85%.

Finally, although services tend to focus their attention on male inpatients as potential aggressors, little consideration is given to male inpatients as potential victims of aggression. Interventions that seek to protect service users from violence on wards generally concentrate on the risks to women. The Healthcare Commission's review also found that sexual vulnerability risk assessments were more likely to be carried out for women than men. This is understandable given women's greater physical vulnerability but services do nevertheless need to recognise that male inpatients may also experience violence and that their mental distress may worsen as a result. Wards must take violence and the threat of violence against male service users seriously, and take measures to provide safety for all.

Aggression and other challenging behaviours: *ideas for practice*

Mental health trusts should ensure that they provide routine and comprehensive training for all staff in the recognition and non-aggressive de-escalation of violent behaviour. Appropriate care planning, anticipation of risky circumstances or situations, and learning from previous incidents also have a part to play in reducing the incidence and seriousness of aggressive behaviour.

In the case of men with personality disorders it is vital that staff understand the function of the behaviours exhibited and how they link to the characteristics of personality disorders. A non-judgemental approach to service user behaviour is likely to be helpful, as is having the space to explore differences within staff teams that might otherwise cause rifts. Good strategies, good training and good staff support systems are crucial to the delivery of an effective service.

Interventions preventing and addressing violence against service users on the ward, such as risk assessments for physical and sexual vulnerability, must address the needs of men as well as women. Male inpatients should be given the opportunity to talk to staff about any fears they may have. In particular, they should be encouraged to report violent incidents or threats, and be allowed to request changes that would improve the situation.

Taking a recovery-based approach

The stigma surrounding mental health sometimes leads to the erroneous assumption that it is not possible for a person who has experienced severe mental health problems to reintegrate into the “normal” activities of daily life. It is important to be aware of these attitudes and to challenge them when they are expressed. It is vital that inpatient services build service user expectations around the possibility of recovery.

It is believed that men are particularly receptive to solution-focused interventions and so a recovery-based approach has the potential to be very effective with male inpatients. This may be particularly so if the concept of recovery is presented as drawing upon those personal attributes traditionally perceived by men as masculine, such as bravery, fortitude and strength.

Taking a recovery-based approach: *ideas for practice*

When working with male inpatients, services should build interventions on a recovery-based approach that enables service users to identify personal goals and develop strategies for achievement. These interventions should be clear and directional and provide a way for male service users to feel that they are able to regain control of their future. The National Mental Health Development Unit is currently piloting an approach designed to support recovery-focused organisations and services. It may be that this work will have useful learning in respect of how to work effectively with men.

Transition from inpatient settings to the community

The transition from inpatient settings back into the community needs to be well-managed. Readjustment to society can be difficult for many service users, particularly in situations where there may be problems accessing housing, addressing financial difficulties and reconnecting with, or developing, social networks. These extra stressors can make the transitional period more difficult. Male service users may be vulnerable to mental distress during this time, and also potentially prone to disengaging from mental health services. A good transition should aim to take proactive steps to prevent this.

Inpatient settings can help prepare men for transition back into the community by providing access, before discharge, to information, advice and advocacy on social issues such as debt and social housing. This could include inviting experts on these topics, such as Citizens Advice workers, to talk to inpatients on the ward.

Effective transition requires comprehensive communication between inpatient staff and community mental health teams (CMHTs). These teams should be enabled to work together to identify the particular needs of male service users ahead of discharge. Similarly, where they are involved, staff from Crisis Resolution Home Treatment (CRHT) and Assertive Outreach teams (AOTs) need to be in regular liaison with inpatient staff in relation to care plans and discharge arrangements for individual service-users. AOTs, in particular, are likely to have a higher concentration of male service-users on their caseloads. The named CPA (Care Programme Approach) care co-ordinator is pivotal. The role of the care co-ordinator is to ensure that service user needs are met by influencing, supporting and negotiating across boundaries within the care pathway.

A successful strategy would aim to develop a support network that proactively supported men to continue behaviour change in the community. For example, CMHTs may choose to find service providers who are willing to proactively contact men once they have been discharged, such as gym trainers or group support workers. These providers would volunteer to contact the service user and encourage them to access their service.

Transition from inpatient settings to the community: *ideas for practice*

Services should aim to provide men with a smooth transition between inpatient and community settings. Inpatient services should provide men with the knowledge and skills to address the practical concerns of moving back into the community. Inpatient staff and community-based mental health staff should be encouraged to develop good communication links and work together to assess the needs of male service users before discharge. CMHTs should aim to create a support network for discharged men that proactively seeks their continued engagement with services.

The mental health of BME men

VIEWPOINT

Dr Frank Keating

Senior Lecturer in Health and Social Care
Royal Holloway University

The mental health needs of BME* men are an area for public concern. These groups are disproportionately represented in mental health statistics. Common concerns include the high rates of schizophrenia and psychotic disorders and the fact that these men normally find themselves at the harsher end of mental health services. What is disturbing is that this situation persists despite the fact that the needs, issues and concerns for BME men with mental health problems have been pushed to the fore of the policy agenda.

There are also particular issues for BME men in relation to mental health. They often find themselves in conditions and situations that are considered as risk factors for mental illness, such as exclusion from school, social deprivation as a result of unemployment,

Prior to improving aspects of mental health service delivery, we need a critical understanding of connections between culture, ethnicity, "race", racism and mental illness

prevalence of crime and drug cultures, and over-representation in prison populations. It has to be acknowledged that these experiences are all underpinned or informed by their experiences of racism.

In relation to seeking help, men are in general less able to identify themselves as experiencing mental health problems, lack awareness of available sources of help and are therefore reluctant to seek help. The range of problems is even greater for BME men based on their perceptions of mental health services and a belief that these services will discriminate against them. More importantly, there exists a real and potent fear that engagement with mental health services will lead to their death.

I therefore argue that prior to improving aspects of mental health service delivery such as access to care, appropriate treatment, etc., we need a critical understanding of connections between culture, ethnicity, "race", racism and mental illness, which in turn may help us to understand the disparities for BME men in mental health services.

BME men need "safe" points of entry to mental health services which can be achieved through building relationships of trust.

* Black and minority ethnic (BME) is an umbrella term referring to men who belong to a minority group with shared ethnicity, language and culture.

The mental health of military veterans

VIEWPOINT

Tony Letford
Clinical Nurse Specialist, CBT
Combat Stress

**“I was a marine commando”; “I was a paratrooper”; “I was invincible”.
Now I am weak, I have failed, I am ashamed and am without worth.**

On average it takes about fourteen years for an ex-serviceman, suffering attributable or aggravated psychological injury, to access help via our service.

Untold Problems identifies many factors that conspire to provide barriers to seeking help amongst men and boys in general. Research suggests that there is no significant difference in help-seeking behaviours between the general male population and military

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veterans. Given the higher risk of occupational psychiatric injury however, it could be argued that they should be even more prepared to seek help. Currently-serving personnel tend to opt for support from family, friends or chaplain. It may be that entrenched military custom has to shift before our service sees a change in veterans readily seeking help or earlier intervention.

Some theorists view Post Traumatic Stress Disorder as an attachment disorder. Our aim is to initially re-create a sense of connectedness, security and social support.

We use a phase-orientated approach, setting a firm foundation of coping skills, self-care strategies and building the therapeutic alliance, before exploring trauma. Some would argue however, that the peer group itself is as important in encouraging acceptance, breaking down barriers, empowerment, normalisation, often via the “male” medium of sport, outward-bound, humour and sense of worth from supporting others.

Implications for the future?

- Greater provision of specialist treatments such as CBT and Group Therapy, which is already patchy and difficult to access for the general population, let alone returning troops.
- Accepting that, for many, there is no satisfactory conclusion to their experiences. Progress is slow and punctuated with relapse and setbacks.

We need to continue to be available and accessible, to maintain a hope and to hold a space for the “Band of Brothers”.

Lifting the Lid: men who survive sexual abuse as children

CASE
STUDY

Sue Hampson

Sarah Nelson's 2001 research into the mental health care needs of survivors of childhood sexual abuse established that there was a pattern of poor care responses and a fear by staff of opening the can of worms. In response, the Safe to Say National Training for Trainers Programme in Scotland was developed.

Training was devised as a result of the research and its aims were to:

- Build self-confidence in staff
- Develop safe, sensitive ways of exploring a sexual abuse history
- Encourage safe, helpful responses to disclosure
- Enable managers to effectively support staff working with adult disclosures
- Prevent survivors being passed from agency to agency

What became very obvious in the training was that men were consistently missed. For workers, sexual abuse doesn't happen to men, or if it does then not often. Coupled with this is the difficulty men have with being seen as vulnerable; to be a man is to be strong and take care of yourself. There is a great deal of shame and confusion involved which prevents men from coming forward to disclose or means that it takes them longer than women to do so.

All of these factors are very powerful. As a result, workers do not have this issue in their awareness. What we don't look for we don't see and this is in turn reflected in the dearth of services specifically for male survivors. It was therefore felt crucial to raise awareness of the experience of male survivors.

What we don't look for we don't see and this is in turn reflected in the dearth of services specifically for male survivors.

As part of the project, a film, 'Lifting the Lid', was developed where three men describe the abuse their experienced, the impact it had on them and what helped or discouraged them on their road to recovery. Their bravery and honesty throughout cuts through the myths and enables us to understand how to respond sensitively to each unique individual. The film is used as part of the training and gains very positive and moving feedback whenever it is shown.

The ethos of both the film and the training is about listening and hearing the voices of survivors as the experts of their own experience, ensuring that they are in control and are not disempowered in any way. Giving them space and time to tell us what they need and want from us as workers, rather than feeling we have to jump into action, fill in the silences and fix the situation.

Working with male inpatients

VIEWPOINT

Nick McMaster

Lead Activities Facilitator – Star Wards Lead
Sussex Partnership NHS Foundation Trust, Brighton

Recent improvements in community care and psychiatric medication has meant that the average inpatient stay has been reduced. The knock-on effect is a decrease in the number of hospital beds and a higher threshold for admission; leaving the inpatient population being one of increased acuity. Now, services catering for this more traumatised client population have a tendency to become risk averse. This has resulted in the majority of daily duties for ward staff being about stopping people rather than starting people.

This exacerbates two important inpatient issues, regardless of gender: boredom and limited opportunity to have a conversation with staff and share stories. The most effective answers can be found in two very different initiatives. For the former, Star Wards is an ever developing online resource of practical ideas. With the laudable aim of improving the mental health inpatient experience, it is mainly centred on facilitating groups and activity.

The client group which has most invested in inpatient care is the one least likely to engage in and therefore benefit from these opportunities: the male PICU (Psychiatric Intensive Care Unit) patient.

For the latter, Productive Wards aims to find and increase staff/client contact by identifying and problem solving an individual ward's often unique time wasting practices.

Yet the client group which has most invested in inpatient care is the one least likely to engage in and therefore benefit from these opportunities: the male PICU (Psychiatric Intensive Care Unit) patient.

Usually living with a psychotic illness, they are often "revolving door" patients who have experienced many of the contributory factors to poor male mental health. This creates a client group that needs care but will often (sometimes literally) fight against receiving it.

Some answers lie in adapting the aforementioned improvements. For boredom, it is about finding activities that appeal to men and can be done both in groups and one to one. For example, my own project "Doing Stuff!" is an ideas file for male-orientated activity that links what is created on the ward with a community resource, providing a potential socially inclusive interest upon discharge from hospital.

For time to talk, it is about access to non judgemental recovery orientated conversation, where behaviour is linked to personal values and goals rather than symptoms. The current system perhaps pushes clients with psychosis into either denial or unhealthy symptom suppression. "Third wave" behaviour therapies such as Acceptance and Commitment Therapy (ACT) are being adapted for the inpatient setting, giving those with seemingly no hope the increased opportunity to avoid rehospitalisation and therefore a chance to live a life of independence within their chosen community.

Nick has been working in the NHS for twenty years. He has a particular interest in recovery and relapse prevention practice for the male service user.

8: Particular groups of men and boys, and particular mental health concerns

Introduction

The preceding chapters have discussed the generality of men's mental health needs and of men's engagement with services. We noted in Chapter 1 that some degree of generalisation is inevitable in a document of this kind. We also pointed out that, while generalisation has its drawbacks, it is an essential component in viewing the bigger picture and potentially very useful in providing a background to practice with individual men.

Untold Problems observed that, among other things, the mental health needs of any one man need to be considered within the context of the community or communities to which he belongs, and the life experiences that he has had. His needs will also vary according to the specific mental health problem with which he may be diagnosed. The fact of an individual's maleness will have greater relevance in some circumstances than in others.

This chapter draws attention to specific communities, specific life experiences and specific conditions where the interaction with maleness may be important. We do not, by any means, claim that this chapter is exhaustive but in the sections below we are reflecting concerns that were particularly highlighted during our consultation process. We are grateful to Sam Thomas, Michael May, Tony Letford, Marcel Vige, Toby Williamson and Philip Hurst who gave advice and supplied content for some of the specific sections which follow.

Men in the criminal justice system

Mental health problems are markedly more common among offenders and prisoners. 95% of the prison population is male and there is little dispute in either the criminal justice service or among other service providers that these men often do not receive the help that they need with their psychological difficulties. Men with chronic alcohol or drug misuse problems are also significantly over-represented among those who come to the notice of the police or who cause problems for agencies providing public services.

Lord Bradley's report into the needs of men and women with mental health problems in the criminal justice system addresses many of the most important issues.¹¹ There is however, no direct equivalent for men of Baroness Corston's review of the needs of "women with particular vulnerabilities" in the criminal justice system which, by connecting adverse life experiences with the increased likelihood of offending, makes the case for a more supportive and empathetic approach to the rehabilitation of female offenders.¹² Baroness Corston's review also advocates an approach that takes specific account of gender – a "woman-centred approach".

It is hard to imagine an approach to male offenders based on the acknowledgement that many male offenders suffer vulnerabilities arising from adverse life experiences, even though this

¹¹ Rt Hon Lord Bradley. *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health; 2009.

¹² Baroness Jean Corston. *The Corston Report: The need for a distinct, radically different, visibly-led, proportionate, holistic, woman-centred, integrated approach*. London: Home Office; 2007.

concept is relatively easily understood in relation to female offenders. This is perhaps because the number of male offenders massively exceeds the number of female offenders and/or because men are more likely to commit offences of violence. The consequence may be that policy-makers and service providers view the needs of mentally disordered male offenders as less deserving of recognition or treatment, or perhaps view them as so challenging that they cannot be addressed.

Men in the criminal justice system: *ideas for practice*

We recommend greater co-operation at the local level between health service providers and agencies responsible for prisoners and offenders. This is not just a matter of making a wider range of treatment options open to men in the criminal justice system (although that is important and has been widely called for in the past by mental health campaigners). There are numerous other connections between public health and criminal justice and many of the risk factors for experiencing health inequality and/or poorer mental health mirror those for offending.

We support the recommendations of the Bradley Report and the implementation plan associated with it. There is a good case to be made for a national study considering the relationship between masculinity, male life experiences and offending, which parallels, where relevant, the approach of the Corston Review of the needs of vulnerable women.

Older men

Some degree of loss is a common experience for many people in later life. Loss of employment, role and status may be accompanied by a decline in material wealth resulting from reduced income. Older men also face the increased likelihood of relatives and friends dying.

Older men are less likely than younger men to have their mental health problems diagnosed. The suicide rate among older men is three times that of women in the same age group. Older men are also less likely to be offered any treatment or a variety of treatment options, such as psychological therapy. This under-diagnosis and under-treatment of mental health problems in older men may be due to the erroneous belief that older people cannot change their behaviour or that mental distress is an inevitable part of ageing for some people. Yet it is known that older men can benefit from treatment and that their mental health can be improved. Arguably, services which are under-effective with older men are age-discriminatory – as we pointed out in Chapter 1, the Equality Act has created a statutory duty to offer equal treatment to people regardless of age.

Primary care is the main community-based service used by older people. Older men are proportionately more likely to visit the GP than younger men. In the case of older men who take their own lives, contact with primary care services will often have been high in the preceding months. Primary care services therefore have a good opportunity to recognise and respond to mental health problems in older men. Although it is challenging to do so, GPs could proactively discuss mental health problems and suicide ideation with older men where they consider that mental distress may underlie ostensible physical problems.

Acute physical health wards may be well-placed to identify mental health problems among older men. Older people are the most numerous group of patients in acute care, and around 60% of hospital inpatients are thought to have mental health problems. However, the recognition and treatment of mental health problems in these settings remains low. Liaison mental health services – mental health practitioners working collaboratively with general care teams – have been shown to improve this situation. These services provide mental health education and training to acute care staff and enable rapid access to a specialist mental health team when needed.

Many of the effective treatments for older men will be the same as those for younger men, although older men can encounter barriers gaining access to this help. Since 2008 the IAPT programme has been accepting referrals of people aged over the age of 65 but take up of these services among older men remains low. Older men can benefit from access to meaningful activities, such as volunteering and lifelong learning, but may be prevented from doing so due to physical access issues or ageist attitudes that lead to these opportunities not being promoted to older men.

The organisation of mental health services into those for “working age adults” and those for “older people” can create problems for older men and is increasingly viewed as anachronistic and a barrier to age equality. Transition between services is a key time for older men and the aim should be for the process to be managed successfully from the service user’s point of view. Effective communication between these services is required for this to be realised. For some older men, services aimed at younger adults will be more appropriate for their needs and they should not be denied access to such services.

Many mental health trusts have now developed formal agreements between working age adult and older adult mental health services that seek to ensure older service users are provided with the best individual care regardless of age. The central principle of these agreements is that age should be used as a guide but, because it is a very poor proxy indicator of need at an individual level, never an absolute determinant of the service offered. Such agreements also call on working age adult and older adult services to exercise joint working where such collaboration is considered beneficial to the service user.

As with the move from adult to older adult services, the transition to residential care is a major change in a man’s life and, not surprisingly, may be associated with mental distress. In fact, around 40% of older people in care have depression.¹³ Although care homes are well-positioned to provide mental health support to older men, this is often not done effectively or may not happen at all. Staff are not necessarily trained in mental health awareness and there is often little access to specialist mental health services, such as psychological therapy.

¹³ Age Concern. *Improving services and support for older people with mental health problems: The second report from the UK Inquiry into Mental Health and Well-Being in Later Life*. London: Age Concern; 2007.

Older men: *ideas for practice*

Services will need to adapt in light of the Equality Act and ensure that they are provided on the basis of need and not age. This should involve older men being offered the full range of treatments available in an area. As part of this, IAPT should ensure that its service is effectively promoted to older men and that health professionals are encouraged to make more referrals for this population group.

Staff in primary care, acute care and care home settings should be better trained to recognise and respond to mental health problems among older men. Mental health services should be given the opportunity to work within these settings in order to provide better access to specialist services, such as the development of liaison mental health services in acute wards and “in-reach” mental health specialists working in care homes.

Older men should be given equal access to meaningful occupations within their local community. Such opportunities should be widely promoted to older men and physical access issues addressed.

Any transition between adult and older adult mental health services and a move into care homes should be well managed. Formal agreements between working age adult and older adult mental health services should be drawn up in all mental health trusts in order to ensure that older service users have access to the treatment and support they need. The mental health needs of older men should be routinely assessed prior to moving into residential care, and monitored subsequently.

Men living in rural areas

The rates of mental distress among the rural community are, in general, lower than rates among the population as a whole. It has been argued however, that this could be a consequence of both the rural population and rural health practitioners being reluctant to label symptoms as relating to mental health conditions due to greater concerns about mental health stigma and confidentiality in small communities. It is also thought that men in rural areas are particularly constrained by socialised expectations to be “hyper-masculine” – able to endure physical labour, be decisive and overcome adversity.¹⁴ It may be because of this that male farmers are among the occupational groups at highest risk of suicide, although external factors related to the decline of British farming over recent years are thought also to play a part, as is easier access to the means of suicide. It should also be noted that although male farmers are just as likely to visit the GP in the three months before taking their lives as the rest of the population, they are significantly more likely to focus only on physical symptoms.¹⁵

Even if men from rural communities do seek help, there is often a severe lack of specialist services in these areas. Men often have to travel long distances to access appropriate support and the lack of rural public transport can make this particularly difficult. Added to this, the coverage of information services in rural areas can be inadequate and less likely to provide information in the preferred format or language necessary.

¹⁴ Robertson S, Elder K and Coombs R. *Rural men's mental health* in Conrad D and White A (eds). *Promoting Men's Mental Health*. Oxford: Radcliffe Publishing; 2010.

¹⁵ Ibid



Men living in rural areas: *ideas for practice*

Anti-stigma campaigns, such as Time to Change, should consider developing strategies that focus on addressing mental health stigma within rural settings.

GPs in rural areas should be made aware that farmers and agricultural workers experiencing mental distress are likely to present with exclusively physical symptoms. As with older men, GPs should therefore be more proactive in talking about mental health problems with this group.

Services should become more accessible to the whole rural population by providing information and interventions through the internet and by phone where appropriate, develop materials in formats and languages needed by the local community and encourage outreach services where possible.

Black and minority ethnic men

The problematic relationship between mental health services and people from black and minority ethnic (BME) communities is long-standing and extensively documented, particularly in the context of the Delivering Race Equality action plan. As we pointed out in Chapter 1, although these entrenched problems are widely recognised as needing to be tackled within a framework of improved responsiveness to issues of race, they are also problems which particularly affect male service users from BME communities.

In particular, as evidenced by the *Count Me In Census*, African-Caribbean men with mental health problems are over-represented in the coercive parts of the system and under-represented in their engagement with primary care. BME men also have more aversive pathways into and through the mental health system. There are a range of interrelated factors driving these trends, ranging from cultural differences in ways of understanding and responding to mental health issues to cultural stereotypes associated with particular ethnic groups, which influence interactions between service users and providers.

This is widely recognised to be a contentious aspect of mental health service provision. It is also an area of practice that has, in recent years, been commented upon in much more detail than we are able to here. In general terms, we recommend taking account of the work that has already been done in this field and we acknowledge that many services are already working hard to do this. Mental health services are not able to resolve the range of causes of ethnic disparity but they do have an important role in moderating their effects. At its most basic, the acknowledged solution is to tailor services to the needs of particular communities.

Black and minority ethnic men: *ideas for practice*

Services need to be based on a comprehensive understanding of the dynamics of communities; how they understand mental health issues and how they engage with support systems. Services should aim to make cultural competence (service delivery based on an understanding of cultural difference) intrinsic to their strategic development, performance management, outcome measures and success criteria.

In practice this means, where possible, developing services in collaboration with existing community organisations which have expertise in engaging with particular ethnic groups. This could include more flexible approaches to service delivery, such as involving community organisations in the provision of services.

Reflection on the issues associated with BME men's use of services in the context of the issues outlined here should be an integral element of supervision for all front-line staff. To complement the strategic focus referred to above, the aim should be to understand how best to tailor practice to the needs of men from diverse ethnic groups. Strategic and operational responses to these issues will ensure that local provision continues to develop and improve.

Men with eating disorders

Little research has been carried out on the subject of men and eating disorders and much of the available research is ten years out of date. At least 10% of diagnosed cases of eating disorders are in men. However, as *Untold Problems* explains, this figure may be underestimated; the Eating Disorders Association suggests that male eating disorders may be under-diagnosed because doctors tend not to look for the conditions in men and because young men are less likely than young women to seek help. It is suggested that the real prevalence may be as high as 25% of cases.¹⁶

Risk factors for developing an eating disorder include: being overweight or teased about weight as a child; dieting or trying to lose weight; participating in a sport that demands a particular size; and living in a culture fixated on diets and physical appearance. Gay, bisexual and transgender men are more likely to suffer from eating disorders than heterosexual men but the gap may be closing.

The issue of eating disorders offers a clear example of how mental health services may risk failing men by feminising provision. The prevailing culture assumes that eating disorders only affect women. As a result, specialist services tend to be targeted at women and this can discourage men from accessing help.

¹⁶ www.mengetedstoo.co.uk

Men with eating disorders: *ideas for practice*

Services should make a concerted effort to ensure that information produced on eating disorders and specialist services is not solely directed at women. This might involve showing images of both women and men, and refraining from routinely using the pronoun “she”. Services should also take a proactive approach to raising awareness among health professionals, and particularly GPs, about eating disorders in men to ensure that service users are met with an understanding response when they first present.

In addition, eating disorder services should develop publicity and interventions targeted specifically at men. This could include using some of the ideas already mentioned in this guide relating to providing treatment in male friendly environments, engaging men through traditional male activities and recruiting male workers.

The mental health of ex-servicemen

There is a misconception that post-traumatic stress disorder (PTSD) is the most common mental health problem experienced by ex-servicemen and that any mental health problem experienced is a direct result of active service. In fact, the mental health problems most frequently diagnosed in ex-servicemen are common disorders such as depression and anxiety. The prevalence of mental health problems among service veterans overall is broadly similar to that of the general population. PTSD remains a rare condition affecting between 3-4% of veterans. However, the rate of alcohol abuse has been found to be higher for veterans than the rest of the population and is increasingly related to mental health problems among ex-servicemen. Additionally, certain groups of ex-servicemen are believed more likely than others to be at risk of developing mental health problems. Suicide risk is associated with: lower rank; service in the army (rather than other branches of the armed forces); being single; having a length of service of four years or less; and being aged under 24 at discharge. Reservists¹⁷ are at greater risk of experiencing mental health problems. The causes of mental health problems among ex-servicemen can be a mixture of pre-service vulnerabilities and transition/post-service experience, as well as experience during the time spent as a full time member of the services.

The stigma surrounding mental health problems within the veteran community is very strong and can prevent ex-servicemen from seeking help (the average delay between becoming ill with psychological problems associated with active service and seeking help is ten years). It may also be that men in this group are more likely than others to exhibit “macho” tendencies that, as already discussed in this document, can discourage help-seeking. In addition, it is known that some veterans are put off approaching the NHS due to a belief that clinicians will not have sufficient appreciation of their services background. This does not mean that veterans need to receive help from a person who is or has been in the forces. In some cases this may even be particularly unwanted. It is however, important that practitioners working with veterans have a basic understanding about what being in the forces involves, including its culture and language.

¹⁷ A reservist is a member of a reserve military force. Reservists are otherwise civilians and will have careers outside the military in peacetime. They are usually former active-duty members of the armed forces.

There are a number of programmes in place that aim to improve the treatment ex-servicemen receive but both practitioners and veterans are often unaware of their existence. These include the Ministry of Defence Medical Assessment Programme (MAP) and the Reservists Mental Health Programme (RMHP). The NHS Priority Access Scheme asks clinicians to prioritise veterans over other patients with the same level of clinical need where the veteran's condition is likely to be service-related. There are also six pilot programmes in various parts of the country which seek to improve access to services for military veterans. It is vital that these programmes are better publicised in order to ensure that eligible veterans receive the help to which they are entitled.

The mental health of ex-servicemen: *ideas for practice*

Mental health services should aim to create a gateway that enables veterans to seek help. This could include working with veterans' charities (such as Combat Stress and the Royal British Legion) to publicise and direct men to appropriate services. It would also help to ensuring that practitioners in these services have a basic knowledge of forces culture. Communication should be clearly targeted to ex-servicemen in order to demonstrate that services will be sympathetic to their background.

We recognise the work that the Royal British Legion and Department of Health have undertaken to try and raise awareness of the NHS Priority Access scheme. Services should build on this work to ensure that clinicians, and particularly GPs, know about both this programme, the MAP and the RMHP.

Commissioners should ensure that the needs of ex-servicemen are taken into account when planning services. Commissioners could look to the recommendations in the IAPT Veterans Positive Practice Guide for ideas on how to achieve this.

The mental health of gay men

Research has consistently shown that gay men are more likely to experience mental distress than heterosexual men. This may be related to the negativity that many gay men encounter when "coming-out". Isolation, bullying and the impact of general homophobia within society may also be contributory factors. The effect of school-bullying may be particularly harmful to the mental health of gay men for, as this document has made clear, childhood is a crucial time where many of the barriers to good mental health are formed. However, although 30-50 per cent of gay men experience bullying in educational settings, one recent study found that half of the teachers surveyed failed to respond to homophobic language when they heard it.¹⁸

One third of gay men are believed to receive negative or mixed reactions from professionals after disclosing their sexual orientation.¹⁹ This suggests that the majority of practitioners are not prejudiced against gay men; instead, the biggest obstacle to meeting the needs of gay men may be a lack of confidence among practitioners in how to handle the subject. This uncertainty can lead to some professionals inappropriately overemphasising sexual orientation within clinical settings or avoiding the issue completely.

As with all groups, the key to providing appropriate services for gay men is respect and dignity. However, there are certain changes that services can make to ensure that the needs of gay men are met. We have listed the foremost ideas for practice below but recommend that

¹⁸ Varney J. (2010), "Gay men's mental health" in Conrad D and White A (eds). *Promoting Men's Mental Health*. Oxford: Radcliffe Publishing; 2010.

¹⁹ Ibid.

services also look to more detailed guidance on this issue, such as NHS Scotland's *Fair for All – The Wider Challenge: good LGBT practice in the NHS*.

The mental health of gay men: *ideas for practice*

Services need to take an active approach to improving services for gay men. For example, training on LGBT issues should be provided to all mental health staff, including managers and medical staff, with no opportunity to opt-out. To support this, services may choose to use the "champions" model whereby a member of staff is responsible for developing and promoting specialist knowledge of the issue.

Services should build relationships with local organisations and groups that work with gay men. Not only will this enable practitioners to refer service users on to other resources in the local area, these organisations could also be consulted when services are planned and priorities are set.

The visibility of gay men should be raised in the marketing of services in order to make gay men feel welcome and included. For example, literature could explicitly mention gay men and include positive images of this group.

The mental health of men who have been sexually abused in childhood or sexually assaulted as adults

The long term effects of childhood sexual abuse are well documented and are known to include a wide range of harmful psychological, emotional, physical and social harms. These include anxiety, depression, low self-esteem, confusion about sexual identity, drug and alcohol problems, eating disorders, post-traumatic reactions and dysfunction of relationships (including parenting). The symptoms in an individual may be specific or general, episodic or chronic. The precise percentage of adult men who experience long term effects is not known.

The stigma and continuing social taboo around sexual violation of men and boys acts as a disincentive for this group to seek help. Continuing perception of sexual abuse as "gay crime" further complicates disclosure as the majority of victims identify as heterosexual and may fear being "labelled" homosexual. There is also a reluctance to make connections between sexual assaults and other forms of dysfunction and survivors often express anxiety that their GP will be unqualified to deal with what they fear is a too difficult subject.

No specific NHS service exists to meet the specific mental health needs of men and boys in relation to sexual trauma. Many survivors identify negative reactions within health services when they have disclosed experiences of sexual assault or childhood sexual abuse. This suggests that practitioners may lack confidence in dealing with disclosures of this type and are uncertain of appropriate specialist referral avenues. This lack of confidence and subsequent uninformed reaction can lead to further traumatisation of the survivor who already feels that his experience may be too taboo or difficult for practitioners to deal with safely.

Men who have been sexually abused in childhood or sexually assaulted as adults: *ideas for practice*

Training for medical and mental health practitioners is important to help them identify where childhood sexual abuse or adult assault may be presenting directly or as part of a more complex diagnosis. Services may choose to use the “champions” model whereby a member of staff is responsible for developing and promoting specialist knowledge of the issue. Services should also take steps to de-feminise language and literature relating to sexual assault services which are currently aimed primarily at women and girls. Where possible, support workers of both sexes should be trained and available.

Services should build relationships with local organisations and groups that work with sexually violated men. Not only will this enable practitioners to refer service users on to other resources in the local area, these organisations could also be consulted when services are planned and priorities are set.

The visibility of sexually violated men should be raised in the marketing of services in order to make these men feel welcome and included. For example, literature could explicitly mention sexually violated men.

SOS Men's Group

CASE STUDY

Sarah Lindzey

The SOS Men's Group began in February 2009. The concept was born out of Southend Mind's Racial Equality Accessing Support Opportunities Now (REASON) project. REASON is a Community Development Worker service to improve access to mental health services for Black and Minority Ethnic (BME) communities. REASON staff identified a need for BME men to have somewhere to meet and socialise and, more importantly, to be informed about appropriate services that are available in the local area. The men came from the "hidden" communities in the Southend-on-Sea area, many of whom had turned to drugs and/or alcohol through depression and were found "hanging around" parks and streets with nowhere to go. Mind workers approached these men directly in these settings in order to recruit members of the group.

REASON staff identified a need for BME men to have somewhere to meet and socialise and, more importantly, to be informed about appropriate services that are available in the local area.

Many of the men initially identified were suffering from variants of Post Traumatic Stress Disorder or Adjustment Disorder due to coming to the UK from war-torn or chaotic countries. Due to their culture, it was important to recognise the need for a "men only" group as, in many of their birth countries, it is not appropriate for women and men to socialise together.

Initially, the men we engaged with mostly came from North African countries and were Muslim. These men were ostracised from the Mosques due to their alcohol abuse. However, whilst in the planning stages of the group, word got around and men from different cultural backgrounds began to attend the meetings.

Southend Mind's REASON team managed to identify funding for a venue on a weekly basis for the group to meet and two of the men came forward to be community volunteers for the group.

In the 18 months that the group has been running, attendance has grown to between 12 to 20 men from diverse backgrounds each week. The group receives IT classes from a member of the local Adult Education centre who attends during term. We also arrange speakers from a wide range of sectors, including: housing/benefit workers; social workers; police; drug and alcohol services; counsellors; health practitioners; art teachers; fitness coaches; immigration services; and English language tutors.

The mental health of older men


 VIEWPOINT

Philip Hurst

National Development Manager – Health

Age UK – Age UK is the new force combining Age Concern and Help the Aged

Age discrimination has strong roots in our society and in our approach to mental health. The promotion of good mental health, services for people with mental health problems, and even criteria for access to services are often designed to exclude older people and are based on a notion that mental health needs change with the arrival of state pension age.

For men in particular the loss of role that can accompany retirement, particularly if this is forced retirement, can have a devastating effect on mental health.

Of course age discrimination affects both men and women. But for men in particular the loss of role that can accompany retirement, particularly if this is forced retirement, can have a devastating effect on mental health. The feeling of separateness and lack of worth can be reinforced by concepts such as services for “adults of working age” or designing services such as psychological therapies to have a main aim of getting people back into work.

Whilst women are more likely to be carers at younger ages, by age 65 this has evened out and, by age 75, men are more likely than women to be carers. Carers

experience high levels of mental health problems but strategies and services to support carers often assume a younger and/or female carer profile. Suicide rates remain high amongst older men – each day in the UK over three older men take their own lives. Yet suicide prevention strategies to date have ignored the needs of older men and the detection and treatment of depression (a major factor in suicide amongst older men) remains poor.

All those in contact with older men should be aware of the high levels of depression and how this might manifest itself. They should seek to find a language acceptable to older men to discuss the issues and have confidence in offering a range of treatments which are known to be effective at all ages. They should also seek out older men who are carers – offer them an opportunity to share with each other their experiences and their strategies for coping, at the same time as offering practical help and support.

The Government has committed to remove the default retirement age. All employers providing mental health services could provide leadership now by changing employment practice to remove automatic retirement at age 65.

MindOut

CASE STUDY

www.lgbtmind.com

MindOut was set up as an advocacy, advice and information service for lesbian, gay, bisexual and transgender (LGBT) people with mental health difficulties in 1999. There is a particular lack of trust of statutory services based on realistic fears of homophobic and heteronormative attitudes and behaviour in both staff and other service users. This has been especially true in relation to mental health services. Historically, gay men have been perceived as mentally ill per se. It was not until 1973 that homosexuality was removed as a diagnostic category from the Diagnostic and Statistical Manual and, as late as 1992, homosexuality was included in the World Health Organisation's International Classification of Diseases. Recent reports of Conversion Therapy do nothing to help allay this distrust.

One issue that arose frequently with users of MindOut's advocacy service was their sense of isolation related to both their sexual/gender identity and to their mental health difficulties. There was an expressed need to meet up with other people in similar situations. Out of this, MindOut set up peer support groups that take place within an exclusively LGBT environment. Currently, there are three facilitated groups that run concurrently and are followed by a social hour. We also run the "Out of the Blue" group that is specifically for those affected by suicidal distress. "Out of the Blue" and two of the other groups are "closed" in the sense that members are selected by interview in addition to the general assessment given to all group members, and are asked to commit to attending a minimum of seven sessions out of any ten session "term". The remaining group is an "open" group where anyone who has been assessed may attend as and when they wish.

All the work of MindOut is carried out in a mixed LGBT environment. It is difficult to say whether this is the best environment for gay, bisexual and trans men to access support. Men do make up a smaller percentage of service users overall despite the more or less similar incidence of mental health difficulties across both genders in LGBT communities. Men, however, are much more likely to participate in adjunct activities such as walking, cycling and working on the allotment.

Men Get Eating Disorders Too

CASE
STUDY

Sam Thomas

www.mengetedstoo.co.uk

“Men Get Eating Disorders Too” Peer Support Group in Brighton and Hove was set up in September 2009 in response to the lack of support services available to men who are affected by eating and exercise disorders. To our knowledge, there are no other similar groups that are exclusively for men in the country at present.

Many of the men were unable to get support, mostly because they felt the conditions they had were considered to be “female conditions” and feared not being taken seriously by health professionals.

We set up the group after several men made contact with us following the launch of the website in Spring 2009. It was apparent that many of the men were unable to get support, mostly because they felt the conditions they had were considered to be “female conditions” and feared not being taken seriously by health professionals. Some of the men had been to generic groups but were the only male member – this enforced feelings of isolation. Other men we had been in contact with weren’t keen (or ready) to seek professional help but wanted to meet with other men alike.

Having identified this need, we sought funding from Scarman Can Do Health Fund and Co-operative to pilot a monthly meeting space. We felt as though “peer support” would be the better way to describe

the group because it would be more inclusive to the men wherever they were on the spectrum of recovery. We felt “self-help” would imply you have to be thinking of recovery, which not all the men were ready for. Moreover “peer support” sounds more friendly, relaxed and possibly more engaging with men.

The Peer Support Group is for men of all ages, backgrounds and sexualities with the aim to ease the isolation and secrecy they experience. The meetings are led by two facilitators – one of whom has experienced an eating disorder himself and the other is a counsellor from the Men’s Counselling Service.

We aim to have a different theme for each meeting. So far themes have included: food and mood; benefits of alternative therapies in the treatment of eating disorders and the benefits of hypnotherapy. Where possible, we have a guest speaker to talk about the month’s theme. For example, an eating disorder dietician attended the session on food and mood. The idea behind this is to give the group members fresh insight, which may help them in their pathways to recovery.

To date we have had fourteen guys attend the group and this will grow as the group becomes more established. The men’s feedback has been hugely positive so far and several participants are considering or have already gone on to get professional help via the NHS.

9: Summary of the big ideas

In the preceding chapters we have offered a number of ideas for improved practice. These ideas vary from one area of practice to another and relate to a number of different aspects of male mental health. In reflecting on these ideas, we have come to recognise that there are underlying similarities between some groups of them. Thinking about the threads that run through these groups of ideas has enabled us to identify a combination of principles and high-level objectives that might underpin the continuing development of good practice in the longer term. These seven “big ideas” are listed below in no order of priority, except perhaps for the first.

1. Treating men as individuals

Gender is perhaps the most fundamental determinant of an individual’s sense of self. Ensuring that mental health service users are treated as individuals will therefore greatly increase the likelihood that their gendered needs as men (or women) are taken into account. If all service users are treated as individuals that should also lead to a greater recognition of the shared needs and experiences of groups and communities in general. The existing moves towards greater personalisation of care and support (for example direct payments and personal budgets) are already giving some people with diagnosed mental health problems greater control over the way their support needs are met. This approach is to be welcomed and has the potential to contribute significantly to the better recognition of male mental health needs.

2. Inter-agency working in the early years

Many of the attitudes and beliefs that underpin people’s mental health behaviours are established in childhood – arguably during early childhood in particular. There is much more that could be done to support boys during childhood, especially those boys whose circumstances increase their potential lifetime vulnerability to mental health difficulties and may reduce their capacity for seeking help. Supporting the development of good mental health is not currently a shared objective for health, education and social service providers in any organised way. There is significant scope to prioritise the development of happy, well-adjusted children, and a very strong case to be made for taking the gendered needs of boys into particular account.

3. Stigma

Few dispute that mental ill health is much more more stigmatised than most forms of physical ill health. The damaging experience of stigma is commonly reported by mental health service users of both sexes. There has been little work to examine whether stigma affects men and women in different ways and/or in different degree. Nor is there much detailed knowledge about whether prejudicial beliefs among the general public are more marked in relation to one sex or the other. We believe that it is at least possible that, in general, men may feel stigma more strongly than women, and that public attitudes may be more prejudiced against men with mental health problems than women. A greater understanding of the relationship between stigma and gender is needed.

4. Promoting services

The evidence suggests that men tend to under-use mental health services. There is probably no single explanation for why this should be. Structural reasons probably play a part, as probably do stigma and “traditional” male attitudes, which can make the acknowledgement of vulnerability extremely difficult for many men. It is probable that a more sophisticated and nuanced approach to the promotion and delivery of services could improve male uptake. Men who find help-seeking difficult are not going to change in the short term – but mental health services can.

5. The role of third parties

We make the point in several places that third parties may have a very particular role in encouraging men to seek help for mental health problems. It is possible to argue that the focus should be on moving men towards taking greater responsibility for their own health but other people, particularly life partners, are likely to remain a crucial element in the decision-making process for many individual men. Because even married men tend to have fewer, and less intimate, social and family contacts than women, there may also be a place for other people who are in contact with a man in mental distress to support him in the process of seeking help. Male friendship groups may have a particular part to play here, as may men prepared to talk about their personal experience of mental health problems. There may be ways to facilitate and support the role of these third parties.

6. Joined-up approach

Men in mental distress often exhibit difficulties in other areas of their life and functioning. Alcohol and drug misuse – which may have been used as a coping mechanism – are common. Relationship problems, social disengagement, offending behaviour, and difficulties with work (chronic unemployment or work-related stress) also occur. “Whole-life” problems need whole-life solutions. Joined-up approaches which include the involvement of social care, employment, and housing providers may be of particular value for men, who sometimes lack supportive networks of their own.

7. Professional training and an improved knowledge-base

Professional training is an important element in making progress on all equality issues. Training in relation to the most important issues in male mental health may be particularly useful, given the range of the issues that have been identified. Beyond developing practitioner expertise however, we believe that there is a good case to be made for the development of a much greater professional and academic knowledge base. There is little history of the dissemination of good practice, and the academic literature is sparse. At the very least we would encourage the professional mental health bodies to develop an internal focus on male mental health. We would also like to see a national focus on the issue, for example in the establishment of a inter-disciplinary network with a conference or seminar programme. Ultimately, perhaps an academic centre for research on the issue might be established.

A psychological perspective 2

VIEWPOINT

Luke Sullivan

Clinical Psychologist in Training

Salomons Clinical Psychology Doctoral Programme, Canterbury Christ Church University

Many men and boys are not receiving appropriate psychological services when they really need them. Traditional psychiatric diagnoses, such as depression, may not fit the experiences of men in psychological distress that well. Men are more likely than women to express psychological distress through behaviours such as aggression and substance misuse. Historically, statutory mental health services would often exclude people presenting with anger and substance misuse. Men can also present a degree of risk and from very early on they can attract more reactive and punitive interventions from services. This is often at the expense of addressing any underlying psychological distress.

If rigidly adhered to, traditional westernised ideas of maleness may have significant implications for men who experience psychological problems. Psychological therapy itself may be perceived by some men as unmanly, involving discussions about emotions and

feelings, dependency on another, psychological weakness and a close intimate relationship with a therapist. Common assumptions about men, such as their poor emotional literacy, may also be somewhat misguided.

It needs to become okay for men to access the right help when they need to without it compromising their sense of maleness.

Men may struggle more with intimacy than women throughout life. This can lead to greater social isolation and fewer relationships to fall back on if things do become difficult. The individualised and competitive nature of western capitalism has meant men are less likely to support other men and traditional community networks have disappeared with little to replace them.

Historically, I think that men's mental health has been overlooked and a lot is required to get up to speed with the pioneering work into the psychological wellbeing of women. Clinical psychology needs to look in greater depth at the impact of its work on men and women as distinct groups. Before this can happen there needs to be more openness to discussion of both genders. In my experience as a clinical psychologist in training, even raising men's mental health as an important issue can feel controversial.

Collectively, it needs to become okay for men to access the right help when they need to without it compromising their sense of maleness. A more empathic approach to men's psychological distress is required with greater acknowledgement from services of the underlying causes of distress rather than just a shallow interpretation of observable behaviour.

The Scottish Football Reminiscence Project

CASE
STUDY

Martin Rothero
Alzheimer Scotland

The Scottish Football Reminiscence Project was established in 2009, initially as a pilot scheme, in order to provide reminiscence therapy to people with dementia. The Scottish Football Museum secured funding from Museums Galleries Scotland and worked in partnership with a number of organisations including Alzheimer Scotland (project consultant), Glasgow Caledonian University (project evaluation) and selected football clubs from the Scottish Football Heritage Network.

Hundreds of paper and photographic artefacts from the collections of the museum and the football clubs were digitised and uploaded onto a website. These images varied from old match programmes and action shots from games to photographs of football related objects held within the museum's collection. Staff from the Scottish Football Museum

The importance of the work can be summed up by one carer involved in the study, who commented: "I drive here with this sad person with dementia and take home my husband."

and volunteers from the football clubs then linked up with selected care homes in four areas across Scotland. Images were accessed from the website, printed off and put into reminiscence packs, which could be tailored to meet the diverse football interests of the participating men.

Glasgow Caledonian University evaluated the therapeutic benefits of the reminiscence therapy and published their findings in March 2010. The report provided evidence that the therapy could temporarily alleviate the condition of participants, improving their ability to communicate and increasing their confidence. The therapy also

led to a short-term improvement in behavioural patterns which not only benefited the participants, but provided some respite for their carers. The importance of the work can be summed up by one carer involved in the study, who commented: "I drive here with this sad person with dementia and take home my husband."

Such was the overwhelming success of the pilot scheme that in March 2010 Alzheimer Scotland announced their intention to establish a national programme. The Scottish Football Museum is currently working with Alzheimer Scotland to secure the significant levels of funding required for the project to be rolled out across Scotland and to establish a facility at Hampden Park for hosting reminiscence sessions and training volunteers. It is envisaged that the enlarged project will involve hundreds of volunteers and require tens of thousands of digital images.

Samaritans' Men on the Ropes Campaign

CASE STUDY

David Wrottesley

The project began in January 2010, when Samaritans announced a five-year partnership with Network Rail to reduce the 220 suicides on the railway each year by 20%.

Part of the partnership involved all rail staff being trained by Samaritans in dealing with potential suicides and the aftermath of a suicide, partnering with mental health, social and other services in the local community and ensuring responsible reporting of suicides in the media.

However, Samaritans had to devise a publicity campaign to reach out with a message to the people who were taking their own lives on the railway. The people dying tended to be men in their thirties, forties and fifties, unemployed and from a poor socio-economic background.

We realised we had to appeal to all men as there was no other way of targeting the at-risk individuals with our message. Around 6,000 people in the UK take their own lives every year and three-quarters of them are men. Of these, the men most likely to die by suicide are those aged 25-55. We believe that many men don't feel able to talk about their emotions and,

Many men don't feel able to talk about their emotions and, instead, either bottle them up or let them spiral out of control, sometimes with tragic consequences.

instead, either bottle them up or let them spiral out of control, sometimes with tragic consequences.

So, Samaritans decided to devise a media campaign encouraging men to open up about their feelings and getting them to consider calling the Samaritans helpline as an option for them.

To find out more about our target group we interviewed men in deprived areas. We found men often couldn't talk about their problems because they saw it as "weak". We also tested a variety of images on them and it was the boxer that they could really identify with.

As a result, the main advertising image of the campaign was a boxer with the strapline: "A Samaritan helped me find my strength". Poster space was provided by Network Rail in 200 stations. Space was also being donated free of charge by media companies in a variety of media, including billboards, radio, newspapers and online.

We kick-started the campaign in the media by holding launch events at London Waterloo, Edinburgh Waverley, Manchester Piccadilly and Cardiff Central stations. We also got Welsh International Rugby referee Nigel Owens and former Premier League footballer Warren Aspinall, both of whom had attempted suicide, to attend the launch and do media work to publicise the campaign. So far the campaign has generated over 115 news articles.

Appendix 1: Membership of the Expert Advisory Panel

Dr Peter Branney

Senior Research Fellow in Men's Health
Centre for Men's Health, Leeds Metropolitan
University

Adrienne Burgess

Head of Research
Fatherhood Institute

Lawrence Butterfield

Joint Social Inclusion Lead
Middlesbrough Council

Member

Shift Speakers Bureau

Stuart Dobinson

Psychology and Wellbeing Practitioner
Talking Space (IAPT), Oxford

Graham Durcan

*Associate Director, Prison and Criminal
Justice Programme*
Sainsbury Centre for Mental Health

Sam Goold

Vocational Advisor
Solent Mind

Philip Hurst

National Development Manager (Health)
Age UK

Dr Frank Keating

Senior Lecturer in Health and Social Care
Royal Holloway University

Mariam Kemple

Policy and Campaigns Officer
(mental health services)
Mind

Dr Richard Laugharne

Consultant Psychiatrist
Cornwall Partnership NHS Trust
Hon. Clinical Lecturer
Peninsula Medical School

Tony Letford

Clinical Nurse Specialist
Combat Stress

Trevor Lowe

Mental Health Trainer
Charlie Waller Memorial Trust, Thames Valley
University

Nick McMaster

Lead Activities Facilitator – Star Wards Lead
OT Service, Mill View Hospital, Hove

Dr Liz Miller

*General Practitioner and Occupational
Health Physician*
Director
Well and Working

Prof Roz Shafran

Charlie Waller Institute
University of Reading

Luke Sullivan

Clinical Psychologist in training
Canterbury Christ Church University

Sam Thomas

Project Leader
Men Get Eating Disorders Too

Andrew White

Psychologist
Berkshire Healthcare Foundation Trust

David Wilkins

Policy and Projects Officer
Men's Health Forum

Dr Jennie Williams

Clinical Psychologist
Director, Inequality Agenda

Toby Williamson

Head of Development
Mental Health Foundation

Appendix 2: Attendees at the consultative conference, hosted by the Charlie Waller Institute at Reading University on March 29th 2010

Gloria Amadi

Occupational Health Nurse Adviser
St. George's Healthcare NHS Trust

Adam Blanch

Sports Instructor
St Andrew's Healthcare

Tom Bodkin

Physical Recreation Instructor
St. Andrew's Healthcare

Peter Branney

Senior Research Fellow
Centre for Men's Health, Leeds Metropolitan
University

Glen Bristol

Acting Deputy Nurse Manager
St Andrew's Healthcare

Lawrence Butterfield

Shift Speakers Bureau

Cass Casseem

BME Community Development Worker
Rethink

Sarah Coleman

Equality and Diversity Officer
Oxfordshire and Buckinghamshire
Mental Health NHS Foundation Trust

Ylva Dahlin

Clinical Psychologist in Training
NHS

Ben Dew

The Men's Network

Stuart Dobinson

Psychological Wellbeing Practitioner
Oxfordshire Mind (Talking Space - IAPT)

Megan Earl-Gray

Trainee Clinical Psychologist

Amanda Eglington

Senior Healthcare Assistant
St Andrew's Healthcare

Emma Eriksson

Supported Housing Worker
Hestia Housing and support

Graham Estop

Involve Project Coordinator
Doncaster Mind

Rhiannon Evans

PhD student
Cardiff Institute for Society and Health

Mary Eweka

Occupational Health Nurse Adviser
St. George's Healthcare NHS Trust

Angela Fordham

Manager
Greenshoots

Catherine Freese

National Project Lead – Gender
National Mental Health Development Unit

Sam Goold

Vocational Advisor
Solent Mind

James Grant

Locality Officer
Berkshire Mental Health User Group

Linda Griffiths

Group Facilitator
The Hampton Trust

Andy Hogan

Senior Project Worker
Sevenoaks Area Mind

Sarah-Jane James

Coalition Coordinator
Children and Young People's
Mental Health Coalition

Dennis Jones

Senior Health Improvement Specialist
Bradford and Airedale Community Health Services

Des Kehoe

Samaritans

Mariam Kemple

Policy and Campaigns Officer
(mental health services)
Mind

Kim Kenobi

Postdoc Statistics Researcher
Nottingham University

Elizabeth King

Roger Kingerlee

Psychologist
Norfolk and Waveney MH NHS Foundation Trust

Kim Knowles

Community Wellbeing Worker
Sandwell Mind

Tony Letford

Clinical Nurse Specialist
Combat Stress

Kent Long

Physical Recreation Instructor
St. Andrew's Healthcare

Trevor Lyalle

Patient Advice Liaison Service Co-ordinator
Berkshire Healthcare NHS Foundation Trust

Philip Martin

Mental Health Carers Support Worker
Carers Support Service North and Mid Sussex

Iain Martin

Trainee Counselling Psychologist
London Metropolitan University

Agnieszka Maziarz-Demas

Volunteer

Michael McLean

Manager & Therapist
Mind in North Tyneside

Nicholas McMaster

Lead Activities Facilitator - Star Wards Lead
OT Service, Mill View Hospital

David Mushati

Trainee Clinical Psychologist
Surrey and Borders NHS Trust

Pam Myles

Charlie Waller Institute
University of Reading

Peter Pojuner

Self Help Facilitator
Families Need Fathers

Glen Poole

Chair
Men's Network

Simon Price

Community Wellbeing Worker
Sandwell Mind

Donald Rhead

Flintshire Mind

Jenny Robinson

Client Services Manager
Tameside, Oldham and Glossop Mind

Mark Savage

BME Community Development Officer
Rethink

Samantha Slaytor

Community Development Worker
Hertfordshire Partnership Foundation Trust

Sam Sooi

Representative
Surrey Link

Katherine Stokes

Student Social Worker
Age Concern Sheffield

Luke Sullivan

Clinical Psychologist in Training

Salomons Stuart-Taylor

Founder/Director
Kyosei Institute

Maya Twardzicki

Public Health Lead (Mental Health)
NHS Surrey

Rajnish Virk

*Community Development Worker
in Mental Health for BME*
South Staffordshire & Shropshire
NHS Foundation Trust

Sudip Virk

Community Wellbeing Worker
Sandwell Mind

Richard Wakerell

Director
Plymouth & District Mind

Andrew White

Counselling Psychologist
Berkshire Healthcare NHS Foundation Trust

David Wilkins

Policy and Projects Officer
Men's Health Forum

Jackie Wilkinson

Chair
Berkshire Mental Health User Group

Jennie Williams

Director
Inequality Agenda

Toby Williamson

Head of Development and Later Life
Mental Health Foundation

Ingrid Wolpert

CBT Therapist (in training)
OBMH (Talking Space)

Julia Worms

Sherwood Associates

Appendix 3: Authors and photographer

David Wilkins

David Wilkins has worked for the Men's Health Forum since 2002. He was responsible for the MHF's overarching policy document *Getting It Sorted* and has written policy papers on several specific aspects of male health, including: men's mental health; men's sexual health; male obesity; and cancer in men. In recent years he has edited the *Gender and Access to Health Services Study* for the Department of Health and, with Erick Savoye, *Men's health around the world: a review of policy and progress across 11 countries*.

David has managed a number of practical projects aimed at improving men's physical and mental health, both for the Men's Health Forum and in the NHS. Most recently he has led a three year project, funded by the Department of Health, which aims to help redress the imbalance in uptake between men and women in the National Bowel Cancer Screening Programme. David writes frequently on men's health issues and represents the "men's health interest" on a number of national and regional policy development bodies.

David was a community worker for several years. He has also worked in local authority social services and youth work. Immediately prior to his present appointment he worked for eleven years in the NHS, for the last three years of which he was a Lecturer/Practitioner in Health Promotion on a joint academic appointment with a local university. David lives in North Dorset with his wife and son.

In 2009 David wrote *Untold Problems: a review of the essential issues in the mental health of men and boys* for the National Mental Health Development Unit. *Untold Problems* is the forerunner of the present document.

Mariam Kemple

Mariam Kemple worked as a Policy and Campaigns Officer in the Mental Health Services Team at Mind throughout 2009 and 2010. She was responsible for the charity's "Men and Mental Health" campaign and produced the Mind Week report *Men and Mental Health*. As part of this, she ran numerous focus groups with male service users on the subject of male attitudes towards mental health. Mariam also worked on the "We Need to Talk" campaign which calls for better access to psychological therapies. As part of this campaign, Mariam produced the *We Need to Talk* report.

Other issues on which Mariam worked for Mind include: the scrapping of prescription charges for those with long term conditions; increasing the take-up of personalisation initiatives for mental health services users within both health and social care; and the campaign for the independent and statutory regulation of counsellors and psychotherapists.

Mariam previously worked in the Campaigns Team at Help the Aged. There, she ran the “Learning for Life” campaign that called for improved access to lifelong learning for older people. In addition, she provided support to the high-profile and award-winning “Just Equal Treatment” campaign that successfully fought for the outlawing of age discrimination.

Mariam lives in London and is now completing a Human Rights Law MA at the School of Oriental and African Studies.

Dave Atkinson

Dave Atkinson recently graduated from the Arts University College at Bournemouth with a degree in commercial photography. His creative interests are in portraiture and still life. Dave has a personal interest in mental health issues and has donated his time and photographic skills to the Mental Health Foundation as well as to the present document. Dave is soon to take up an internship for twelve weeks with the agency, *Art and Commerce*, and the photographer Jake Chessum, in New York. In the long term his ambition is to work in the field of editorial photography in London and New York. More examples of Dave’s work can be viewed at <http://alittlebitofme.blogspot.com>.

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