

**MEN'S
HEALTH
FORUM**



HOW TO MAKE MENTAL HEALTH SERVICES WORK FOR MEN



MEN'S HEALTH MADE EASY





THE MOVEMBER FOUNDATION

The Movember Foundation is a global charity raising funds and awareness for men's health. It has raised more than £450 million since 2003. The Foundation's vision is to have an everlasting impact on the face of men's health.

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MEN'S HEALTH FORUM

Founded in 1994, the MHF is the independent voice for the health and wellbeing of men and boys in England and Wales. Our goal is the best possible physical and mental health and wellbeing for all men and boys.

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HOW TO... MAKE MENTAL HEALTH SERVICES WORK FOR MEN

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HOW TO... GUIDES

Men are often considered 'hard to reach' when it comes to health. The Men's Health Forum's 'How To...' Guides give you the blueprint to change that.

INTRODUCTION

- THIS RESEARCH PROVIDES A SUBSTANTIAL EXAMINATION OF PRACTICE IN RELATION TO MALE MENTAL HEALTH PROMOTION IN THE UK.

Over the past few years, there has been increasing interest among mental health professionals, academics and service users in the benefits of creating services for men that consciously take account of men's experiences and are in tune with male sensibilities. Recognition of the link between gender and mental health has long been a feature of service planning and delivery for women and it is generally accepted that this 'gendered' approach has helped make services more accessible and effective for female users. Those campaigning for improvements in services for men have, however, been hampered by the lack of an easily-accessible evidence base. No substantial review of the evidence around male mental health promotion has been published and there has been little structured investigation of good practice.

This situation changed significantly for the better in 2014, when the Movember Foundation commissioned research that included a review of the academic literature in relation to promoting male mental health, along with a detailed examination of the practical learning from existing initiatives. This research was undertaken for the Movember Foundation by the Centre for Men's Health at Leeds Beckett University with the support of the Men's Health Forum (MHF). The research was led by Professor Steve Robertson. The Movember Foundation is using the findings from the research to inform its internal thinking and decision-making but a comprehensive public version of the research has also been made available online*. The findings will also be disseminated to professional and academic audiences via a series of academic papers.

This research provides a substantial examination of practice in relation to male mental health promotion in the UK. The original research report

runs to 400 pages, supported by 15 separate additional papers from a network of academics and practitioners. A summary of the research methodology and an outline of the Movember Foundation's commitment to the improvement of male mental health promotion are given in the Appendix, which we encourage you to read.

This 'How To' guide takes the findings from the research and condenses them into practical, user-friendly advice for those whose job it is to design or deliver mental health services.

* The public version of the report, 'Promoting Mental Health and Wellbeing with Men and Boys: What Works?', is available via the Men's Health Forum website at www.menshealthforum.org.uk/howto-mh

MEN ARE ONLY 38% OF NHS
'TALKING THERAPY' (IAPT) REFERRALS



YET 78% OF DEATHS BY SUICIDE ARE MALE



Sources: HSCIC IAPT Quarter 2 data, 2014–15 and
Suicides in the UK 2013, ONS


WHAT ARE THE KEY ISSUES IN MALE MENTAL HEALTH?

- MANY POPULATION-LEVEL INDICATORS SUGGESTIVE OF DIFFICULTY, DISTRESS AND DISCONNECTION REVEAL MEN TO BE THE MAJORITY AFFECTED.

This guide concentrates on the 'common mental disorders' (CMDs). CMDs, which include such conditions as anxiety, depression, phobia and obsessive compulsive disorder, make up the great majority of mental health diagnoses in the UK. Severe psychotic illnesses such as schizophrenia and bi-polar disorder are relatively uncommon and affect only 0.4% of the population.¹ CMDs, on the other hand, are sufficiently common that they will touch everyone in the land at some point; if not as a sufferer, then as a carer; if not as a carer, then as a relative, friend or colleague. CMDs cause considerable personal distress and are often highly disabling. They can affect people's ability to work, damage their enjoyment of family life and friendships, and reduce their capacity to function in the wider community.

Statistics suggest that women are at significantly greater risk of developing a CMD. At any one time, one woman in five is believed to meet the diagnostic criteria for a CMD compared with one man in eight. Women are also more likely to receive treatment for a CMD: 29% of women have received treatment compared with 17% of men. For depression specifically, the gap is even greater; one woman in four will receive treatment for depression at some point in her life compared with just one man in ten.²

These kinds of statistics, however, account only for people who have been able to describe accurately their own difficulties and/or who have taken themselves to a GP or mental health professional for advice. It is often suggested that, for a variety of commonly-understood socio-cultural reasons, men may be less likely than women to recognise emotional and psychological distress in themselves and less likely to seek treatment. If this is so, it means that at least some of the individual-



level data will understate the numbers of men experiencing mental health problems.

Certainly, there is a case to be made that strong evidence for men's poorer help-seeking and unacknowledged mental health problems can be found by looking at population-level data instead of at individual-level data. Many population-level indicators suggestive of difficulty, distress and disconnection reveal men to be the majority affected. For example:³

- > Over three quarters of those who take their own lives are male.
- > 73% of adults who 'go missing' from home are men.
- > 87% of rough sleepers are men.
- > Men are nearly three times more likely than women to become alcohol dependent (8.7% of men are alcohol dependent compared to 3.3% of women).
- > Men are three times more likely than women to report frequent drug use (4.2% and 1.4% respectively).
- > More than two thirds of drug-related deaths occur in men.
- > Men make up 95% of the prison population. 72% of male prisoners suffer from two or more mental disorders .
- > Men are nearly 50% more likely than women to be detained and treated compulsorily as psychiatric inpatients.
- > Men have measurably lower access to the social support of friends, relatives and community.
- > Men commit 86% of violent crime and are twice as likely to be victims of violent crime.

- > Over 80% of children permanently excluded from school for behavioural difficulties are boys.
- > Boys are performing less well than girls at all levels of education from primary school to university.


It is possible, of course, to argue about the extent to which these population statistics may indicate undiagnosed CMDs capable of responding to conventional forms of treatment. Whatever view one takes on this point however, it is inarguable that these statistics demonstrate that for some men life is very difficult. We already know that many men do not feel comfortable in seeking advice or support from the traditional services available. The statistics also suggest that some men in this position may fall back on 'coping' strategies that may themselves be problematic.

- FOR SOME MEN,
LIFE IS VERY
DIFFICULT BUT
THEY MAY NOT
FIND IT EASY TO
USE THE SERVICES
THAT COULD HELP.

As well as being less likely to visit their GP with psychological problems, men are under-represented as users in almost all forms of 'talking therapy'. This under-representation of men among help-seekers may also mean that the structure and style of services has tended to become better attuned to the needs of women - thus adding a further layer of difficulty for men in finding help when they need it.

It is also worth noting that some academics and practitioners now believe that the internationally-recognised symptomatology for depression is inclined to emphasise a more 'typically female' form of presentation; that is to say, one in which the subject is tearful, withdrawn, and lacking in motivation and energy.

It is suggested that a male subject may exhibit behaviours which differ significantly from this

A pencil is shown pointing to a set of architectural blueprints. The blueprints feature various lines, numbers, and text, including the word 'TREPPENHAUS' and the number '0.4'. The pencil is positioned vertically, with its tip pointing towards the center of the page.

standard range of symptoms but which are equally likely to indicate the presence of depression. The most important idea is that the expression of distress in an externalised way ('acting out') is more commonly seen in men. This may take the form of, for example, physical aggression, heavy drinking or uncontrolled anger. It is hypothesised that these more 'typically male' symptoms are not only often unrecognised as symptoms of depression but may also militate against a sympathetic response from health professionals and other agencies or even from family and friends.⁴

In 2010, the Men's Health Forum (MHF) published 'Untold Problems', a report commissioned by the National Mental Health Development Unit, which provided the first real consideration of the most important issues in men's mental health. Untold Problems concluded that:

... 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' also drew up a summary of the key challenges facing those seeking to improve male mental health.

- > Male mental health in the UK is not as good as it might be.
- > Men are more likely to lack some of the known precursors of good mental health.
- > Men appear less likely to recognise or act on warning signs.
- > Men seem more unwilling to seek professional help.

- > Men in psychological distress are more likely than women to choose maladaptive coping strategies.

It is always necessary to add a note of caution to observations about gender differences seen in population level data. Generalised gender differences do not mean it is safe to make assumptions about all men (or all women) or about any one individual man or woman. Nevertheless, the population level data does tell us that there are legitimate questions about whether we are doing as well by men as we could or should.

This 'How To' guide aims to encourage us to think about some of the questions the data challenges us to ask. Can we communicate better with men about mental health? Can we tackle the stigma that many men feel about mental health? Can we encourage more men to use support services? And perhaps, most importantly, can we adapt our present services so that they take better account of both male and female sensibilities?

1. Severe psychotic illness of this kind is evenly distributed between the sexes.
2. These data are taken from the Mental Health Foundation publication, The Fundamental Facts.
3. References for all the data in this list can be found on the Statistics pages of the Men's Health Forum website: www.menshealthforum.org.uk.
4. This argument is explored more fully and with academic references in 'Untold Problems' (see reading list on page 29 for details).

74% OF WOMEN WHO ARE DEPRESSED HAVE TALKED TO SOMEONE ABOUT IT



BUT ONLY 53% OF DEPRESSED MEN HAVE



Source: A Crisis in Modern Masculinity: Understanding the Causes of Male Suicide CALM, 2015

WHAT OBSTACLES DO MEN EXPERIENCE USING ADVICE AND SUPPORT SERVICES?

Before reading the guidance in Section 3, it is worth considering briefly the reasons why some men may fail to seek help when they need it and the reasons why some men feel uncomfortable about using mainstream services. Although this makes for negative reading in some ways, it is important to know what the obstacles are before designing or delivering a new service. The value of this 'How To' guide is enhanced by awareness of the underlying problems the guide is seeking to address. Note that the information in this section is the only part of this 'How To' guide that does not derive from the research conducted by Leeds Beckett University on behalf of the Movember Foundation.

It is both surprising and regrettable that relatively little is known about why men may under-use mental health services. The qualitative research conducted by the Men's Health Forum in partnership with Mind in 2010 may be the most detailed so far undertaken. That research suggested that the problems arise from two main sources: men's own attitudes and beliefs in relation to mental health; and the failure of service providers to take account of those attitudes and beliefs.

The quotes on the next four pages are all verbatim statements made by men with experience of mental health services who took part in that research. These research participants either responded to an online survey or took part in a series of focus groups held in a number of different communities around the country. The quotes are grouped within themes that recurred frequently in both the online survey and the focus groups. All these quotes, along with the rest of the research, can be found in the joint MHF/Mind report, 'Delivering Male' (see the reading list on page 29).

SOME MEN FEEL PRESSURE ALWAYS TO BE 'STRONG'

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

'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' ... 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.'

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

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

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

SOME MEN MAY FIND IT DIFFICULT TO VERBALISE OR EVEN RECOGNISE THEIR PROBLEMS

'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.'

'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.'

'[We need] 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.'

'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.'

'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.'

SOME MEN FEEL STIGMA THAT IS SPECIFIC TO MEN

'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 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 ...'

'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 ...'

'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 on drugs, drink or violent. Even if they've never met you.'

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

SOME MEN BELIEVE THAT SERVICES ARE MORE FOCUSED ON THE NEEDS OF WOMEN

'In [city] 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.'

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

'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 ... it's a place I'd rather not be.'

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

'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.'

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

SOME MEN MAY FEAR OTHER PEOPLE KNOWING THEY HAVE A MENTAL HEALTH PROBLEM

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

'... the fear of work finding out, which in my experience is the biggest drawback for men seeking help.'

'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 man)

'Nobody will admit they have mental illness, if they speak out [they] will be discriminated.' (Chinese man)

'The stigma is on the whole family.' (Indian man)

SOME MEN BELIEVE THAT SERVICES ARE NOT SENSITIVE TO THE NEEDS OF THEIR COMMUNITY

'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.'

'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 man)

'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 man)

'[Services have] no compassion or sympathy to your background.' (African-Caribbean man)

'Travel is the main thing. The distances involved.' (Man living in rural Cornwall)

'It is difficult for us to tell our symptom when seeing an English-speaking GP.'
(Chinese man)

SOME MEN BELIEVE THAT SERVICES ARE COMPLICATED AND IMPERSONAL, AND MAY BE THREATENING

'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.'

'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.'

'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.'

'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.'

'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.'

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

'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 your, your rights.'

'I felt I could have done with the doors being open all week so I had a safety net.'

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

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

CASE STUDY:

'I WAS IN THE ARMY'

My name is John. I proudly served in the British Army Royal Logistics Corp as a chef. My first posting was Northern Ireland. While a serving soldier I was diagnosed with severe depression.

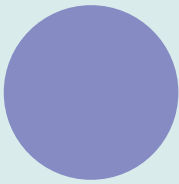
I left the army in 2003 and my mental health and well-being was at an all-time low due to being conditioned to 'muster on through it'. I continued in this way for the next 10 years. Then in 2014 I got in touch with Glasgow's Helping Heroes.

When I attended my initial interview, I was welcomed into a small office to discuss my issues with a staff member who was ex-military. When I disclosed my current situation and how I was living, it was reassuring to hear that the staff member had lived the same experiences, had overcome their troubles with the right support and now were in a position to help people who may still be struggling. It helped me to be open and honest with them as I knew that they had lived this and it wasn't something they had learned at university.

I was given the opportunity to attend a 16-week programme around well-being and lifestyle which has absolutely changed my life from having nothing to do and being isolated to having a purpose and a meaning. Plus, it was good to mix with other veterans who were in similar situations. It made me realise I wasn't alone by meeting these new people. But what I needed the most was advice and guidance and I have been advised correctly step by step at my own pace.

I sometimes have bad days but know I can phone my worker and they will not judge me and at all times they will treat me with respect and empathy.

**JOHN, 32,
GLASGOW**



CASE STUDY:

‘THE GIFT OF EMPATHY’

**JUSTIN, 43,
BELFAST**

I don't know when I first realised I had mental health issues. I just know I didn't feel right inside. I never could feel happiness in the smallest of things.

I have had several lapses in my mental health – my first at 16 and my current at 43 - all marked by personal seismic incidents in my life course. I came from a stoic family where emotions were kept in check: unfortunate for me being the gay vocal emotive one – the runt of the litter. Living in the 80s still in the infancy of my gayness, the only way I could understand that what meant being gay was by proxy through music, film and art. These offered virtue in my solitude that I was not unaccompanied.

I never had or heard of a support group or thought to seek out one for fear of being ‘found out’. So it might sound strange that at this stage of my life, I would go on a Personal Development course with The Rainbow Project. You would think that life should have taught you all you ought to know about yourself by now.

A diversely-aged motley crew established. In the faculty of brotherhood and true faith, over the 8 weeks each of my kindred fellow travellers began to recount their own stories.

As you age, you become nostalgic. But there is something special about communing with like-minded souls and having that facility to create empathic bonds. Isn't that the undeniable breath-taking gift of humanity? Is it possible to calculate the impact of such? As men, we do have a certain lack of this in our liaisons. But when you find that moment, it lasts forever!

WHAT WORKS IN MALE MENTAL HEALTH INTERVENTIONS?

INTRODUCTION

In this section we have taken those findings from the Movember Foundation research that are most valuable to mental health commissioners and practitioners, and condensed them into summary guidance, or recommendations. These recommendations will help with the commissioning, design and delivery not just of male-only interventions but also mixed-sex interventions where it is important to make sure that men are effectively engaged.

The recommendations are presented under the following headings:

- > What encourages men to take part?
- > What kinds of setting are effective for men and boys?
- > What 'style' of intervention works for men?
- > What therapeutic approaches are effective with men?
- > What does 'success' look like?

We have based the recommendations on two distinct parts of the Movember Foundation research.

The first group of recommendations draws on the findings of the literature review element of the research. The literature review looked at good-quality academic papers that presented measurable results from interventions intended to improve the mental health of men and/or boys. The recommendations in this group are evidence-based. **These recommendations are shown against a blue background.**


- WE ARE CONFIDENT THAT THE ADVICE INCLUDED IN THIS 'HOW TO' GUIDE IS THE MOST AUTHORITATIVE CURRENTLY AVAILABLE IN RELATION TO MALE MENTAL HEALTH.

The second group of recommendations draws on the reports from the 'investigative network' and on the visits made by researchers to existing UK projects on male mental health that were recognised as exemplars of good practice. The recommendations in this group are essentially the distilled wisdom of the highly-experienced practitioners and experts interviewed during these parts of the research. These recommendations are based on the expertise and insight of these practitioners and experts. **These recommendations are shown against a teal background.**

The methodology of the research on which the advice is based is summarised in the Appendix. Readers are strongly encouraged to look at this appendix which will provide confidence in the recommendations. Those readers who wish to know more can explore the public version of the full research report, 'Promoting Mental Health and Wellbeing with Men and Boys: What Works?'. This report is available via the Men's Health Forum website at: www.menshealthforum.org.uk/howto-mh. Sources for all of the 'How To' recommendations can be found by word searching the full report.

Because the research project was wide-ranging and conducted to high standards, we are confident that the advice included in this 'How To' guide is the most comprehensive currently available in relation to male mental health.

There is, however, one important proviso. The research could only look at those interventions that have been reported in published academic papers and/or those that are known currently to be delivering good practice.



As we have seen, the field of male mental health practice is under-researched and under-developed. It is not the intention of this guide to restrict commissioners and practitioners only to developing interventions that look like those that already exist. There is plenty of scope for further innovation and learning. Using this guidance thoughtfully should however improve the chances of newly-developed interventions becoming successful.

In order to ensure that the research base continues to develop, we strongly urge those developing new interventions to collect good data and to put in place thorough evaluation structures. The field of male mental health needs more learning, more published research and indeed, greater public and political attention.



90% OF PRISONERS HAVE A MENTAL HEALTH PROBLEM

95% OF PRISONERS ARE MALE



30-50% OF ROUGH SLEEPERS HAVE MENTAL HEALTH PROBLEMS (25% DIE BY SUICIDE)

87% OF ROUGH SLEEPERS ARE MEN



AT SCHOOL, BOYS ARE 4 TIMES MORE LIKELY TO BE DIAGNOSED WITH A BEHAVIOURAL, EMOTIONAL OR SOCIAL DIFFICULTY

Sources: Mental Health Foundation: The Fundamental Facts, 2007 and Men's Health Forum, Untold Problems, 2010

WHAT ENCOURAGES MEN TO TAKE PART?

The personal approach: A personal letter from a GP stressing the privacy and confidentiality of consultations has been shown to encourage adolescent boys to use primary care for all health concerns, including mental health concerns.

Removal of stigma: A well-being initiative for young people successfully increased the number of young people using mental health services, with a measurable increase in young men self-referring by comparison with men in the community. Effectiveness was attributed to users of the service not necessarily having to present with identified mental health needs in the first instance. This was facilitated by building the service into generalised support services for young people, which meant it was co-located with – for example - youth centres and internet cafés.

Positive stories: Newspaper stories about men with mental health problems are associated with increased use of helplines by men in the three weeks following publication. Those stories that generated the most calls were stories about hope and recovery that featured men who were either admired or who could be easily identified with.

Good leadership: Designing and delivering effective interventions requires a familiar range of skills but the core value most commonly identified was to hold a positive and enthusiastic view of boys and men. There is sometimes debate about whether the sex of those delivering the intervention makes a difference but almost all of our experts believe that holding this 'male positive' view is a much more important factor in achieving successful engagement of users.

The right language: The language used within interventions is important and makes a significant difference to men's willingness to engage. 'Male-friendly' language that is appropriate for the specific group using the intervention is the key to good communication. It is also helpful to avoid the detailed language of 'health' and 'mental health' where possible.

WHAT KINDS OF SETTING ARE EFFECTIVE FOR MEN & BOYS?

School: A structured school-based intervention based on playing football was successful in helping teenage boys to build relationships. It was also measurably effective in reducing problem behaviour and in improving social engagement.

The workplace: Attendance at two 90-minute workshops weekly for eight weeks delivered in the workplace was successful at reducing work-related stress among men. Similarly an intervention offering the support of occupational therapists and psychologists to individuals in the workplace was successful at reducing psychological stress, with men benefiting more than women.

The natural world: There is consistently good evidence that programmes based on engagement with nature are effective in improving self-esteem and mood in both sexes. Programmes built around 'green exercise' (activity in natural settings) are often used but the evidence suggests that simply visiting a natural setting has measurable benefits for many people. It is unclear, however, how long the benefits last beyond the duration of the intervention.

Safe settings: It is crucial that the setting in which an intervention is based is a safe male space. 'Safe' settings are often those considered familiar and in some way 'male-friendly'. These latter concepts may vary by culture or demography but some settings stand out consistently as appealing to certain groups:

- > Schools for younger boys
- > Physical activity settings for young and middle-aged men
- > Workplace settings for men who are in work
- > 'Shoulder-to-shoulder' settings for adult men (i.e. interventions in which the therapeutic support or social engagement is built around shared activity rather than face-to-face discussion)
- > 'Virtual' settings for boys and young men.

The right setting can also act to reduce mental health stigma and tackle the discrimination sometimes experienced by marginalised boys and men.

WHAT 'STYLE' OF INTERVENTION WORKS FOR MEN?

Activity-based: Several activity-based interventions have shown success in improving male mental health, including art therapies, music therapies and 'adventure weekends' combined with peer support.

Exercise-based: Exercise-based interventions show promise for treating depression and anxiety in men of all ages although there is insufficient evidence to conclude whether group-based exercise activities have greater benefit than individual exercise programmes.

Sports-based: Sports-based activities (especially, in the UK, football-based activities) have been shown to be particularly successful, both in offering the opportunity to play and/or in using sports venues or sports metaphors in combination with therapeutic interventions. It is extremely important, however, not to make the mistake of assuming that all men are interested in sports and/or identify with sporting metaphors. Using sport as a basis runs the risk of actively discouraging some men, so other forms of intervention may be needed in addition.

Social support groups for older men: Group-based social activities show promise in reducing depression and anxiety, and increasing life

satisfaction among older men. Academic evidence is still relatively limited for the 'men's sheds' movement, which uses this approach, but there are some findings of improved self-reported health, improved well-being, and improved sense of male identity. There is also evidence of skills development.

Peer support: Peer support programmes show promise for supporting men in some specific settings (eg. prisons). It is possible therefore that peer support might appeal to men more generally. It is believed that some men prefer to use peer support programmes because they are less threatening to traditional masculinities than seeking professional help. Peer support programmes can also have a positive impact on the well-being of those providing the support.

Multi-component approaches for suicide prevention: A combined approach to suicide prevention is more effective for men than approaches that focus on tackling one particular aspect of suicide risk. Multi-component approaches have been shown to influence attitudes, change behaviour and reduce stigma (multi-component programmes might, for example, combine training for professionals, development

of support groups and raising public awareness). It is accepted though that no suicide prevention programme can reach all men at risk.

‘Arms-length’ approaches for suicide prevention: Suicide prevention services such as telephone helplines and online ‘chat’ services that are instantly accessible and do not require face-to-face contact are effective. Such services are more appealing to men than women.

Male-specific promotional materials: A brochure specifically written for men was found to have created more positive attitudes to counselling and a reduction in stigmatising views of mental health problems. There remains, however, much to be learned about how to improve male help-seeking.

‘Ownership’: Interventions that are embedded within communities - especially those that use peer support and mentoring - are particularly effective in generating ‘ownership’ by users. Such interventions also help create trusting relationships and allow the freedom for men to discuss the relationship between mental health and their ‘lived male experience’.

A direct route to a personal goal: Men are often found to prefer direct, practical and easily-understood interventions that are demonstrably ‘solution-focused’.

‘Doing something’: For many men, being able to ‘do something’ is the most important element in the intervention. This is often a practical activity but it may also be the sense of doing something about the problem. Many successful and long-established UK interventions for men include shared activity as an important element – even where the main focus is talking therapies. Activities might include sports, outings or skills training. Activity-based approaches help overcome stigma, enhance social engagement and, over time, act to facilitate more open and relaxed discussion.

Involving users: Interventions can help ensure they have the right ‘feel’ by involving male service users (or potential users) in the planning and development of the programme. User involvement may be particularly important for men.

WHAT THERAPEUTIC APPROACHES ARE EFFECTIVE?

Stress management programmes:

Short (2-3 hour), closely-structured workshops delivered in established settings (eg. the workplace) can help men cope with anxiety and stress. Interventions based on CBT, delivered in the workplace, have also proved effective in helping men cope with workplace stress.

School counselling: There is good evidence that secondary school counselling interventions are effective at reducing psychological distress, although there is significant variation between schools, depending partly on the methods used. Girls are more likely to use school counselling than boys but positive outcomes are similar for both sexes, suggesting there is scope to promote school counselling specifically to boys. Boys are significantly more likely to be referred to school counsellors for anger-related problems.

Mindfulness for boys: Mixed-sex interventions aimed at improving mental health among school and university students have shown inconclusive results but mindfulness-based interventions to reduce stress and anxiety have shown effectiveness with boys aged 12-15.

Cognitive behavioural therapy for men: CBT, used either alone or alongside other therapies, has been

found to be effective for fathers (ie. rather than men in general) against phobia, co-occurring anxiety/depression and alcohol misuse, and post-natal depression. Some evidence suggests CBT in combination with medication may be more effective for men than women in reducing the severity of depression. A telephone-based CBT programme was, however, unsuccessful at reducing work-related stress, suggesting that personal contact is important.

Cognitive behavioural therapy for boys:

There is modest evidence for the use of CBT-based interventions in school for children with anxiety and depression - with boys and girls equally likely to benefit. But note that, in one study, the control group, who did not receive CBT but did participate in structured, non-therapeutic group activity, gained as much benefit as the CBT group. This suggests that for children the benefit might be associated simply with receiving attention and participating in organised group activity.

Mentoring for boys: There is some evidence for the effectiveness of interventions intended to encourage male help-seeking. A 'male role model' mentoring programme was found to have changed attitudes to accepting support in African-Caribbean boys.

CASE STUDY:

'FRIENDS AND A FUTURE'

**PAUL, 37,
MAIDSTONE**

I have a long history of problems with mental health starting many years ago with the death of my mother.

I have lived on the edge and experienced problems with substance abuse, drugs and alcohol, been homeless and lived on the streets. The first time was when I absconded from home aged 15 to look for my father, who himself was an alcoholic, when he disappeared for a bit without telling anyone. I spent 6 months in Newcastle-Upon-Tyne searching for him before I found him.

I found my way through with heartache aplenty along the way and I have now been free of substance misuse for 7 years. I still on VERY rare occasions have a shandy or two but nothing any further than that.

I try to use my experiences to help others. I know what it is like to be down at the bottom and have nothing and nobody. My philosophy is that if I can help one person avoid how I felt on those lowest times it will be worthwhile.

I have been going to Kent Sheds for two years. I enjoy the company and making new friends. Although there have been ups and downs on the way, I have stayed with the group. It benefits me immensely. Without the group, I would be spending most of my time indoors. Instead I get to go out, meet great people and share ideas and information while socialising. I find myself being useful and my skills are put to the test.

I hope to improve my employability and future prospects as well as make some more friends.



CASE STUDY:

'MINDFULNESS HELPED'

**FABIO, 29,
BRISTOL**

On the face of it, growing up I really didn't have it hard at all. People often seem surprised to hear I've really struggled with low mood and anxiety. The causes of my decade and a half of depression were quite subtle, mainly to do with beliefs I built up about myself growing up.

The underlying force periodically taking me out of action for months, years even at a time, was self-criticism. And, as Yoda would say, self-criticism leads to anger, anger to self-hatred and self-hatred is the path to the dark side.

I've tried drugs and had more types of therapy than Woody Allen. Some helped at the time, some didn't. It was only when I came across mindfulness and compassion-focused therapy that things really started to click. Bulbs have continued to light up ever since.

Practising mindfulness has massively helped, by teaching me to step back from the intensity of difficult thoughts and feelings, to stop myself from over-thinking. The compassion part of it, which has been just as important, has been about coming to see myself as like anyone else: great just the way we are.

- **Fabio is one of the authors of 'Beat Stress, Feel Better', the Men's Health Forum's easy-to-read 36-page booklet for men on stress and anger that keeps mention of the words 'mental health' to a minimum. More information at: www.menshealthforum.org.uk/beatstressmanual**

WHAT DOES 'SUCCESS' LOOK LIKE?

Partnership: Inter-agency partnerships are often an important part in the success of an intervention. Partnerships encourage engagement; improve the credibility of a programme; extend the reach and availability of activities; help make effective use of scarce resources; and increase the potential for sustainability and growth. Partnership working is not always simple however and may require significant time and effort.

Increasing ambition: Successful interventions do more than provide a service. They work towards positive social change and engage in constructive challenge to mainstream services where that is necessary. They may also act to challenge stigma and exclusion. This latter involves considering the overlap between gender and mental health. It may also involve acknowledging the possibility of prejudice and discrimination against certain groups of men.

Local knowledge and personalisation: The most successful interventions are those that understand local circumstances and are flexible enough to offer a range of services that respond to the individual user's needs.

Sustainability: Models for sustainability in communities include: increasing the representation of men with lived experience of mental health problems in organisational structures; developing forms of regional and local federation; and making sure that evidence of success is properly recorded and clearly demonstrated.

OTHER INFORMATION SOURCES AND FURTHER READING

There is a limited amount of specialist literature written for a UK audience. The following books, reports and papers provide useful background.

Prof. Steve Robertson, Prof. Alan White, Prof. Brendan Gough, Dr Mark Robinson, Dr Amanda Seims, Dr Gary Raine, and Dr Esmée Hanna: 'Promoting Mental Health and Wellbeing with Men and Boys: What Works?', 2015. Free access: Movember Foundation and Centre for Men's Health at Leeds Beckett University websites.

David Wilkins: 'Untold Problems: A review of the essential issues in the mental health of men and boys' (National Mental Health Development Unit, 2010)*

David Wilkins and Mariam Kemple: 'Delivering Male: Effective practice in male mental health' (Men's Health Forum and Mind, 2011)*

The Psychologist men's mental health special issue, 'Being a Man - putting life before death'. British Psychological Society, June 1914. Free access: archive section of The Psychologist website.

Samaritans: 'Men, Suicide and Society', 2012. Free access: Our Research section, Samaritans website.

Mental Health Foundation: 'Grouchy Old Men', 2010. Free access: Publications section, Mental Health Foundation website.

Mind: 'Get it off your chest: Men and mental health', 2009. Available online.

David Conrad and Alan White: 'Promoting Men's Mental Health' (Radcliffe Publishing, 2010)

David Wilkins: 'Try To See It My Way: Improving relationship support for men' (Jointly published by Relate and the Men's Health Forum, 2013) Free access: Publications section, Relate website.

Young And Well Co-operative Research Centre (Australia); 'Game On: Exploring the Impact of Technologies on Young Men's Mental Health and Wellbeing', 2013. Free access in the "Research" section of the Young And Well Co-operative Research Centre.

The website Men's Minds Matter at www.mensmindsmatter.org, encourages professional debate about male mental health. Men's Minds Matter 'aims to bring awareness to the experience of being male while developing ways of helping and supporting men and boys in the UK.'

You can find all above on the Men's Health Forum website: www.menshealthforum.org.uk/howto-mh

TOP TEN TIPS

- ✓ **Start by understanding what the obstacles are:** Seeking help and using services may seem so difficult to some men that they prefer either to struggle on unaided or to find their own ways of coping. Sometimes these alternative ways of coping make matters worse. Often the obstacles that men experience are 'male-specific'. Sometimes the obstacles are particular to a particular community of men. It is important to establish what these obstacles are and to take steps to remove them where that is possible.
- ✓ **Communicate with men in a way that respects their maleness:** There is much about the experience of psychological distress that can threaten men's sense of themselves as men. Not all men feel this threat but those who do may believe themselves stigmatised and may consequently find their distress compounded. Understanding and respecting these difficulties will help engage men in the intervention.
- ✓ **Be positive about men and boys:** Successful interventions view men and boys with enthusiasm. This 'male-positive' approach is considered to be a core value of many of the most effective interventions and is widely regarded as the most important element in effective leadership.
- ✓ **Ensure that the intervention has clear objectives that its users understand:** Men tend to like interventions that are 'solution-focused'. In other words, many men would rather have a personal 'goal' than a generalised helping process, regardless of how accommodating and effective that process is known to be. Approaches based on cognitive behavioural therapy may be particularly useful in this respect.
- ✓ **Consider basing social support interventions on shared activity:** Activity-based interventions have proved consistently successful at engaging men. Evidence suggests that, by and large, men prefer coming together to 'do something'. Activity-based interventions help address stigma by not being overtly about mental health. They also facilitate openness of expression by allowing relationships to develop, and discussion to arise, in a more natural way. Men may also benefit from activity-based interventions by being able to 'give' skills and experience as well as 'take' advice and support.

- ✓ **Make sure the setting is right:** The setting for an intervention should be a 'safe male space'. Generally this means somewhere familiar that qualifies as in some way 'male-friendly'. Some settings stand out consistently as appealing to certain groups. Examples include: schools - particularly for younger boys; physical activity or sports settings for young and middle-aged men; and the workplace for those in work. Carefully-planned 'virtual' settings may work for some groups of young men.
- ✓ **Incorporate peer support:** Interventions incorporating an element of peer support show promise for effective working with men. This may be because the sense of having experiences in common reduces the perceived threat to the masculinity of the man being supported. Peer support programmes can also have a positive impact on the well-being of those men providing the support.
- ✓ **Publicise positive examples:** It appears probable that positive media stories about men with mental health problems may encourage help-seeking among the male audience. Stories about hope and recovery seem most likely to have this effect, especially where they feature men who are either admired in some way or who can be easily identified with.
- ✓ **Look beyond the intervention:** Mature and successful interventions often do more than provide a service. They work towards positive social change and engage in constructive challenge to mainstream services where that is necessary. They also often act to challenge stigma and exclusion. These objectives are particularly important in the drive to improve male uptake of services.
- ✓ **Plan evaluation from the outset and make your results known:** Thinking on male mental health has come a long way in recent years but the field is still hampered by the shortage of good research. Most interventions will record data about their users and some will try to find ways of measuring outcomes. It is crucial, however, that we move beyond just keeping records to satisfy funders or commissioners. Good practice is dependent on people making information about interventions widely available, even if their intervention has not been a success. This enables good practice to be replicated and helps avoid the repetition of approaches that have been shown not to work.

APPENDIX: THE RESEARCH BASE FOR THIS GUIDE

BACKGROUND

Since its establishment in Australia in 2003, the Movember Foundation has grown to become the most important global funder of male-specific health initiatives. To date, Movember has raised £450 million to fund over 850 men's health programmes in 21 countries, including, since 2007, the UK.

Internationally, the Movember Foundation's primary focus has been to fund research and development in the field of male cancer, particularly prostate cancer. In Australia, however, it has had an interest in funding male mental health programmes since 2006 and, in more recent years, has begun to expand that interest to other parts of the world. More information about the history of Movember and the objectives and current activities of the Movember Foundation can be found at www.movember.com.

In 2014, as part of the preparation for its expansion into male mental health in the UK, the Movember Foundation commissioned an important piece of research from the Centre for Men's Health at Leeds Beckett University. This research, conducted in collaboration with the Men's Health Forum and led by Professor Steve Robertson, sought to:

'Gather together current research evidence and practical knowledge about existing programmes or interventions that are demonstrably successful or show promise in relation to men's mental health and well-being.'

The research was primarily intended to inform the Movember Foundation's own internal decision-making in relation to its future plans to improve male mental health in the UK. For obvious reasons however, the findings from the research are also of great value to those commissioning and providing mental health services. Recognising this, the Movember Foundation has allowed the Centre for Men's Health to publish academic papers drawn from the research and has kindly funded the MHF to take the key findings from the report and present them in this 'How To' guide.

OBJECTIVES OF THE MOVEMBER RESEARCH

The research sought to answer the following questions:

1. What are the 'essential elements' of those approaches that are demonstrably effective in engaging men and boys about their mental health and wellbeing (both from an early intervention and prevention perspective)?

2. How can these be replicated across other programmes and in other countries?
3. What is the role of 'action-oriented' approaches in the prevention of mental health problems and increasing a sense of wellbeing?
4. What are the benefits and challenges of talking therapies ('face-to-face') versus action-oriented ('shoulder-to-shoulder') approaches for men and boys, particularly those who have low-level mental health problems?

Within this brief, the research worked to the following protocols:

1. It focused largely on those projects or programmes promoting male mental health and/or those that related to early intervention for CMDs. It largely excluded projects or programmes working wholly or primarily with boys and men with acute, or chronic and enduring mental health problems.
2. Emphasis was placed on diversity. The research considered how different aspects of culture and identity (such as ethnicity, sexuality or disability) may influence boys and men differentially in terms of the actions they

take to maintain mental health and/or seek early intervention. It also looked at whether these differences overlap with men's experiences of mental health discrimination.

3. It explored the relationship between programmes that take an 'action' approach (have a base in activities or 'doing') and those primarily focused on talking.
4. The research was not limited to the UK context but incorporated learning from an international perspective, particularly from those countries where the Movember Foundation is already actively supporting male mental health (Australia, Canada, New Zealand and the United States).

METHODOLOGY

The research had five distinct component parts:

1. Literature Review

A literature review aims to find previously published academic papers that cover a particular subject. All the papers are examined against an agreed set of standards that measure the quality of the research they report. Once papers that meet these criteria have been found, they are examined in detail and the common themes are

collated and reported by the reviewers. A well-managed literature review is able to make confident conclusions because it can pick out findings that have been consistently repeated in a range of comparable circumstances.

For this review, six academic databases were searched. This search resulted in an initial list of 9,000 papers with relevance to the concerns of the research. This list was screened against criteria designed to narrow the papers down to those that concentrated on mental health promotion and/or early intervention, and were targeted specifically at men or boys. 291 papers met these criteria and were retrieved for further assessment. Of these, 107 were subsequently included in the literature review.

A search was also conducted of the 'grey' literature (good-quality literature that has not been academically published - for example, local project evaluation reports). This search resulted in the addition of a further six papers, making a total of 113 papers to be included in the review.

2. Existing databases

A search was made of UK funding databases (for example, the Big Lottery database) that might help identify existing projects or

programmes addressing male mental health and well-being. Generic online searches were also undertaken. These searches identified 58 projects or programmes already working with men or boys on mental health. Information about the objectives and the working approach of each of these projects was recorded. This information was collected online or by making e-mail requests to the organisations concerned.

3. Investigative network

An 'investigative network' of sixteen health professionals and academics working in male mental health was asked to seek information and opinion within particular professional, geographical or community contexts. In many cases, investigators chose to do this by interviewing colleagues and reporting their views. The investigators' findings were supplied to the research team in written reports. In total, these reports contained over 55,000 words. Note that not all members of the investigative network were based in the UK.

Each member of the investigative network was also asked to identify up to four projects or programmes within their field of interest that were known to be particularly successful or to show good promise in mental health

work with boys and men. 45 such projects were identified.

4. In-depth analysis of 15 projects

Fifteen of the projects identified at 2. and 3. above were selected for further examination. The objective was to establish in greater detail what it was about each of these projects that made it successful, for which user group, and in what settings. In most cases, these projects were visited by a researcher who interviewed managers and practitioners working on the project. Where a visit was not possible, interviews were conducted by telephone.

5. Expert symposium

This event, held at Leeds Beckett University in November 2014, brought together 46 experts in male mental health from a variety of public bodies, academic institutions and communities of practice. Speakers included senior figures from the Movember Foundation, Mind and Public Health England. After hearing the findings of the research to that point, attendees participated in structured debates and workshops designed to elicit their views about the kinds of provision that are needed. A report of this symposium is available on the website of the Movember Foundation.

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Clare Shann, Global Mental Health Lead, The Movember Foundation

Martin Tod, CEO, Men's Health Forum

Finally, I am grateful to John, Justin, Paul and Fabio for their willingness to describe their experiences and to the following services they used: Glasgow's Helping Heroes (John), The Rainbow Project, (Justin) and Kent Sheds (Paul). These organisations were among the exemplars of good practice identified in the research.

David Wilkins

ABOUT THE AUTHOR: DAVID WILKINS

David Wilkins worked as Head of Policy for the Men's Health Forum (MHF) from 2002 to 2014. Now a freelance writer specialising in male health, he remains an Associate of the organisation.

For the MHF, David wrote policy papers on several aspects of male health, including men's mental health; men's sexual health; male obesity; and cancer in men. He also 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 experience of managing practical men's health projects both for the MHF and in the NHS. During his time at the MHF, he represented the 'men's health interest' on a number of local and national policy-making bodies.

David has a particular interest in male mental health. When he worked in the NHS, he was involved in the development of a local suicide prevention strategy and led the organisation of suicide prevention training courses for professionals in other agencies. In 2010, David wrote the national report 'Untold Problems' for the National Mental Health Development Unit and in 2011, a follow-up report, 'Delivering Male', co-written with Mariam Kemple and jointly published by the Men's Health Forum and Mind.

In 2013, David wrote 'Try To See It My Way', a report commissioned by Relate, which looked at men's poorer uptake of relationship support services. For several years David was a member of the Ministerial Working Group on Equality in Mental Health.

HOW TO... MAKE MENTAL HEALTH SERVICES WORK FOR MEN



Three-quarters of the people who take their own lives are men. Male mental health has become a key concern for professionals, policy-makers and academics alike. Yet surprisingly little is known about what mental health services will actually reach men and deliver effective outcomes for them.

In 2014, the Movember Foundation commissioned the Centre for Men's Health at Leeds Beckett University with the support of the Men's Health Forum to carry out a review of the academic literature relating to male mental health and a detailed examination of the practical learning from existing initiatives.

This 'How To...' Guide condenses the findings from that review into practical, user-friendly advice for those whose job it is to design and deliver services to meet male mental health needs.

Men are often considered 'hard to reach' when it comes to health. The Men's Health Forum's 'How To...' Guides give you the blueprint to change that.

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