

Men's mental health and work

The case for a gendered approach to policy

The Work Foundation



About the Work Foundation

Through its rigorous research programmes targeting organisations, cities, regions and economies, now and for future trends, the Work Foundation is a leading provider of analysis, evaluation, policy advice and know-how in the UK and beyond.

The Work Foundation addresses the fundamental question of what Good Work means: this is a complex and evolving concept. Good Work for all by necessity encapsulates the importance of productivity and skills needs, the consequences of technological innovation, and of good working practices. The impact of local economic development, of potential disrupters to work from wider-economic governmental and societal pressures, as well as the business-needs of different types of organisations can all influence our understanding of what makes work good. Central to the concept of Good Work is how these and other factors impact on the well-being of the individual whether in employment or seeking to enter the workforce.

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About the Health at Work Policy Unit

The Health at Work Policy Unit (HWPU) provides evidence-based policy recommendations and commentary on contemporary issues around health, wellbeing and work. Based at the Work Foundation, it draws on the Foundation's substantial expertise in workforce health, its reputation in the health and wellbeing arena and its relationships with policy influencers. The HWPU aims to provide an independent, authoritative, evidence-based voice capable of articulating the views of all stakeholders.

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Executive summary

Background

Gender and sex have a considerable effect on individuals' experience of the workplace and health. While a lot of attention has been given to female emancipation over the last century, and the effect of women's increasing participation in the labour force on their lives, perhaps less attention is given to the changes that male workers have seen during the same period.

On the face of it, it may seem that the 'average' man in the UK has not experienced the same rate of change as the average woman, but scratch a little deeper and we see rapid and, often, significant changes to men's experience of work, with attendant implications for their health and wellbeing.

Men's and women's health differs in a number of ways. These differences are created and reinforced by the type of work that men and women typically do. Men, for example, are more likely to do physically dangerous work. Furthermore, male-dominated sectors, such as construction, have disproportionately high rates of suicide. In many cases, exposure to these risks conspires with men's apparent reticence to engage with health services – with inevitably bad implications for their health and wellbeing.

These inequalities have clear and important implications for government policy.

This paper assesses some of the structural changes over recent decades that have influenced men's role in the labour market and the implications this has had for their health – and how to address them. This has been informed by the academic and grey literature, and by conversations with a number of expert interviewees. Although not all of the issues highlighted are unique to men – nor relevant to all men – for this paper we look explicitly through a 'male lens' in order to better understand where there might be a need for specific approaches and support.

Key messages

It is clear that changes to the UK labour market in recent decades have created a predominantly male displaced workforce which, by and large, has struggled to either find work of similar quality or any work at all. Work is considered central to male masculinity and, as such, these structural changes have had significant implications for men's mental health. Furthermore, men often work in jobs that pose threats to their physical health and safety, frequently characterised by low pay and insecurity, requiring them to work for extended periods away from family. All of this poses particular challenges for men's physical and, in particular, mental health.

To a large extent, the health problems presented by the changes to and the type of work that men typically do are compounded by the way in which they handle it.

Men, relative to women, are reluctant to express concerns about their mental health and engage with professional help. They are also significantly more likely to engage in risky healthy behaviours, e.g. alcohol and drug abuse, and are disproportionately affected by suicide. Furthermore, they are less likely to visit a GP, attend an NHS health check, get screened for

cancer, visit a pharmacy or have a sexual health test¹. They are also less likely to seek help for a mental health problem. Reasons for low levels of engagement are complex and more research is needed. However, cultural barriers have been cited, e.g. seeking help is not 'masculine', as well as practical barriers, e.g. being unable to fit GP appointments around work or working away from home preventing access to the local GP.

There are clear differences between men and women regarding how they experience and manage mental ill health. This has important implications for the type of support that men need.

There are several examples – in the UK and internationally – of good practice seeking to address the need for appropriate services that promote men's mental health (in and out of work) and support those who experience poorer mental health. Whether they aim to stimulate peer interaction, promote engagement with health services, de-stigmatise mental health or operationalise a 'gendered' approach to health, they share a similar aim: improving mental health outcomes for men. Our recommendations, set out below, draw on these examples and the evidence presented throughout the paper.

Recommendations

The evidence suggests that there may be a need to look at mental health and related support services through a 'male lens', incorporating the role of work as an important influence, and the workplace as a setting for providing support.

What should employers do?

Workplace support, provided by services such as Employee Assistance Programmes and Occupational Health services, can effectively deal with employee health and wellbeing issues. However, the issues they typically tackle – mental health problems including anxiety and depression – are issues that men are reluctant to seek help for. Thus, these services should be communicated to male workforces in a manner that will resonate with them. Terms like 'mental ill health' carry connotations that alienate men. These services should be presented as tackling 'stress' – or, rather than focusing on mental health specifically, focus on health generally, i.e. physical and mental, rather than just mental health (creating parity).

In addition, consideration should be given by employers in certain sectors, particularly construction, regarding the likely impact that the nature of the work will have on their (predominantly male) workforce's health.

What should health services/providers do?

Currently, we don't know enough about the effectiveness of gendered approaches to healthcare, or the full extent of the differences in health experienced by men and women. Many support services do not differentiate outcomes by gender – they simply do not collect these data. Gendered outcomes of services in data collection and evaluation should, therefore, be prioritised. Within this, we argue that work should be recognised as a health outcome. This has potential benefits for both men and women, but it is arguably of greater importance for men given that their mental health – self-confidence, esteem, etc. – is

¹ Men's Health Forum. (2017). Men's Health Manifesto. Retrieved from https://www.menshealthforum.org.uk/sites/default/files/pdf/mens_health_manifesto_lr.pdf

apparently contingent on not just whether they are in work or not, but the status and prestige attached to it.

What should government do?

Based on a review of the literature and conversations with a number of key informants, **we make four broad policy recommendations**. To improve men's health outcomes, Government should:

1. Re-think policy design;
2. develop awareness, understanding and engagement;
3. improve access and support; and
4. build the evidence-base.

Re-think policy design

Policy models should be re-designed for 'gendered' health interventions. A 'universal health strategy' should focus on general physical and mental health promotion, including the importance of a healthy diet, physical activity and stress reduction. It should be supported by two 'strands', one focused on women and health conditions affecting them (e.g. reproductive and gynaecological health conditions) and another focused on men and the conditions that typically affect them, including drug and alcohol abuse, suicide.

Furthermore, **specific policies should be targeted at groups considered to be at 'high risk' of mental ill health, engagement in adverse health behaviours, and suicide.** These include: unemployed men, those aged 45-59, men working in high-risk sectors (e.g. construction), men experiencing relationship breakdown and those in the criminal justice system.

Develop awareness, understanding and engagement

Given men's reluctance to engage with health services, the onus is on government to take a proactive stance and reach out to them. Targeted health campaigns in predominantly male settings (e.g. male-dominated workplaces, public houses, sports grounds, betting shops, etc.) should be prioritised.

Government should work with employer groups, the criminal justice system, and the emergency care services to extend the scope of occupational health services to include screening and preventative health measures. 'Mental health diversion' schemes, which operate at the interface between criminal justice and mental health, should be expanded.

Government should also explore ways of increasing health check outreach and uptake amongst men.

Marketing strategies for mental health services should be re-designed with men in mind. The Department of Health and Social Care (DHSC) and relevant third sector organisations should explore ways in which they can re-brand services in ways that resonate with men. Materials should use more accessible and less alienating terminology.

- The DHSC should consider creating resources like 'Stress Manuals' and 'Wellbeing Manuals' detailing how to identify and treat stress and mental health conditions.
- Suicide prevention and mental health treatment should not be a 'last resort'. Emphasis on early intervention and – ideally – prevention should be considered a priority.

Government should prioritise tackling the stigma associated with mental health by putting it on an equal footing with physical health, creating 'parity of esteem'. Mental health should not necessarily be distinguished from physical health but treated as just one dimension of health and wellbeing.

Improve access and support

To improve men's access to general and mental health services and support, the feasibility of 'out of hours' and 'after hours' services should be explored by government. Too often, access to services is prohibited by inflexible opening times that do not accommodate full-time workers.

Government should promote greater use of self-help groups, peer-led support and provide out-of-hours support and walk-in clinics (e.g. with counsellors and mental health support). Mental health episodes cannot be accurately predicted therefore the ability to access services quickly is of vital importance.

Build the evidence-base

Government should commission new research to help build the evidence-base on the causes of poor mental health and suicide in men, especially for high-risk groups. Suicide disproportionately affects men more than women in the UK, though the reasons why are not fully understood.

Finally, there is a need for more impact assessments and evaluations of health services, interventions and policies. Many services, interventions and policies – particularly mental health ones – do not differentiate outcomes by gender. It is therefore difficult to appreciate the differential impact that these services have on women and men, and, in turn, design policy to address gender-specific issues.

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1. Introduction

1.1. The context

Gender and sex have a considerable effect on individuals' experience of the workplace and health. While a lot of attention has been given to female emancipation over the last century, and the effect of women's increasing participation in the labour force on their lives, perhaps less attention is given to the changes that male workers have seen during the same period.

On the face of it, it may seem that the 'average' man in the UK has not experienced the same rate of change as the average woman, but scratch a little deeper and we see rapid and, often, significant changes to men's experience of work, with attendant implications for their health and wellbeing.

Men's and women's health differs in a number of ways (see Box A below for an overview). These differences are created and reinforced by the type of work that men and women typically do. Men, for example, are more likely to do physically dangerous work. Furthermore, male-dominated sectors, such as construction, have disproportionately high rates of suicide. In many cases, exposure to these risks conspires with men's apparent reticence to engage with health services – with inevitably bad implications for their health and wellbeing.

These inequalities have clear and important implications for government policy.

Box A – The context: men's mental health and wellbeing²

- One adult in six (17%) has a common mental disorder (CMD), e.g. depression, anxiety, phobia, obsessive compulsive disorder and panic disorder. One woman in five has CMD (20.7%) compared with about one man in eight (13.2%).
- Nearly half of adults (43.4%) think that they have had a mental disorder at some point, 35.2% of men and 51.2% of women. A fifth of men (19.5%) and a third of women (33.7%) have also had diagnoses confirmed by a professional.
- Both drug and alcohol dependence were twice as likely in men as women.
- Reports of self-harming doubled in men and women and across age groups between 2007 and 2014 (though it should be pointed out that changes in reporting may account for some of the increase).
- Since 2007, there had been increases in CMD symptoms in late midlife men and women (aged 55 to 64).
- Men aged 55-64 have the highest rates of registered suicide³.
- Over half of men (54.6%) in receipt of Employment Support Allowance (ESA) have a CMD – as do over three quarters of women in receipt of ESA (77.9%).
- Just under half of men (45%) on any out of work benefit have a CMD, and more than one in three (38%) of those in receipt of housing benefit.

² McManus, S., Bebbington, P., Jenkins, R., & Brugha, T. (2016). Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014. *Leeds: NHS Digital*, 1–405.

³ Thomas, K., & Gunnell, D. (2010). Suicide in England and Wales 1861-2007: A time-trends analysis. *International Journal of Epidemiology*, 39(6), 1464–1475.

1.2. This paper

This paper assesses some of the structural changes over recent decades that have influenced men's role in the labour market and the implications this has had for their health – and how to address them. This has been informed by the academic and grey literature, and by conversations with a number of expert interviewees. Although not all of the issues highlighted are unique to men – nor relevant to all men – for this paper we look explicitly through a 'male lens' in order to better understand where there might be a need for specific approaches and support.

In the first chapter we consider men's changing role in the world of work, i.e. the changes to the UK labour market and the implications for the male workforce. This is followed by an assessment of men's mental health, how this contrasts with women's mental health and men's relatively higher propensity for engaging in risky health behaviours and suicide, as well their reticence to seek help. In the third chapter we explore what support is available to men for their health and wellbeing, drawing on best practice examples from around the world. We then discuss what employers, health services/providers and government can do to better support men, before outlining our recommendations.

This paper is the second in our ***Gender, sex, health and work series***, which explores the issue of health and work through a 'gendered' lens. This series focuses on areas where gender and sex have a significant impact on work and/or health outcomes. Other papers in the series include:

- [*More than 'women's issues': women's reproductive and gynaecological health and work*](#)
- *Managing migraine: a women's health issue?*
- *Who cares? The implications of informal care and work for policymakers and employers*

For more information, see our [background paper](#) and accompanying [infographics](#).

2. Men and work

2.1. Changes to the UK labour market and their implications

The globalisation of world trade and subsequent changes to the UK labour market have affected people's daily lives and their access to employment⁴. Though there are many benefits of globalisation for the individuals of countries across the world⁵, these structural changes have had far reaching implications, including changes to the viability of local industry⁶.

Over the past four decades, the UK labour market has seen considerable shifts due to globalisation and technological change; tying the UK's economic fate to a global economy. This change came on top of a period of wider deindustrialisation across the UK which has seen many factories and centres of manufacturing relocate overseas to access cheaper labour and reduce operating costs⁷.

The number of UK workers employed in heavy industry – in sectors such as mining, manufacturing and steel production – has collapsed. In 1952, 40% of the workforce was employed in manufacturing⁸; by 2017, this had dropped to around 9%⁹. In 2005-10 alone, 600,000 manufacturing jobs disappeared and although the sector still accounts for around a tenth of GDP, this has fallen in recent years¹⁰. During this period, we saw large, high profile businesses/works being shut down, with subsequent clusters of unemployment.

The biggest falls in output, and therefore the biggest impact, were seen in the North of England and in Wales – areas which have long struggled economically – even before this period of industrial decline¹¹.

But why is this a gendered issue? Heavy industry has historically been a male-dominated sector – this is still true today, albeit to a lesser extent¹². Consequently, the sector's decline and subsequent widespread job losses were predominantly felt by the male workforce. What jobs – if any – replaced these, and who filled them? Workers were not necessarily all “scooped up” by what came next¹³; the subsequent growth of the service sector (see Figure 2.1 below) did not necessarily fill this gap. Indeed, while 79% of UK GDP came from the service sector

⁴ Diamond, P. (2010). How globalisation is changing patterns of marginalisation and inclusion in the UK. Retrieved from <https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/globalisation-marginalisation-inclusion-full.pdf>

⁵ Autor, D. H., Dorn, D., & Hanson, G. H. (2016). The China Shock: Learning from Labor-Market Adjustment to Large Changes in Trade. *Annual Review of Economics*, 8(1), 205–240.

⁶ Ibid.

⁷ Hanley, T. (2011). Globalisation, UK poverty and communities. Retrieved from <https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/poverty-community-globalisation-summary.pdf>.

⁸ Comfort, N. (2012). *The Slow Death of British Industry: a 60 year Suicide, 1952-2012*. London: Biteback Publishing.

⁹ Office for National Statistics. (2017). EMP13: Employment by industry. Retrieved from <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/employmentbyindustryemp13>

¹⁰ The Economist. (2016). Britain's manufacturing sector is changing beyond all recognition. Retrieved from <https://www.economist.com/britain/2016/11/05/britains-manufacturing-sector-is-changing-beyond-all-recognition>

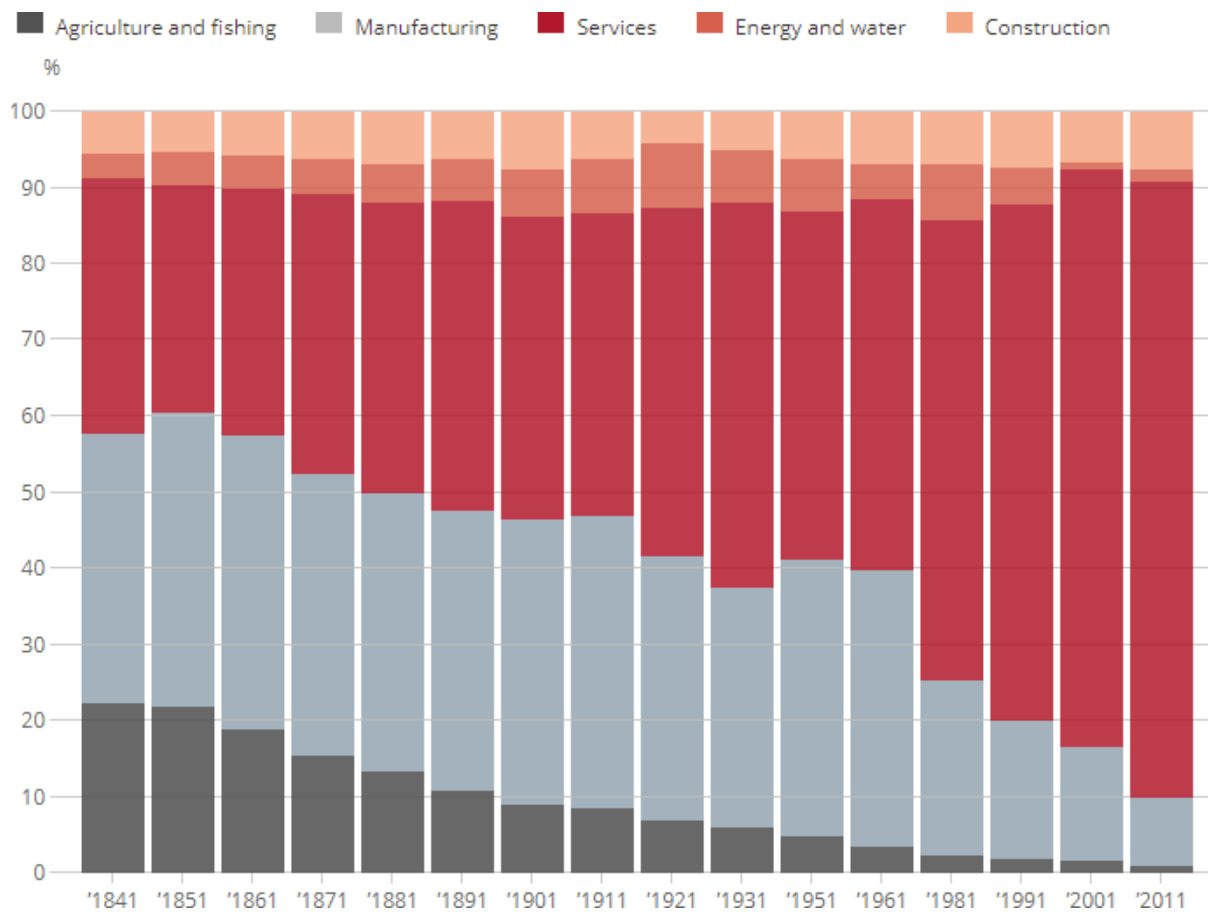
¹¹ Industrial Communities Alliance. (2007). The other half of Britain. Retrieved from http://www.industrialcommunitiesalliance.org/uploads/2/6/2/0/2620193/the_other_half_of_britain.pdf

¹² Perrons, D. (2009). Women and Gender Equity in Employment Patterns, Progress and Challenges. *Institute of Employment Studies*, (WP23), 1–23.

¹³ Autor, et al. (2016).

in 2014^{14,15}, its workforce has traditionally been predominantly female, in contrast to male-dominated manufacturing¹⁶.

Figure 2.1 – Percentage of the labour force working in each sector of the economy, England and Wales, 1841 to 2011



Source: 2011 Census Analysis, Office for National Statistics

Men with lower levels of education and formal skills tend to find structural labour market changes particularly difficult to adapt to¹⁷; many (despite having worked their way up in the industry) struggle to transfer their experience and find a job of the same status and wage in a different sector¹⁸. In the case of manufacturing closures, a significant drop in earnings for former employees is not unusual, and nor is it temporary; this was demonstrated in Stern's study of plant closures in the US in the 1960s and 70s¹⁹. More recently in the UK, a study of the closure of an MG Rover site in the West Midlands found that the labour market status of the 91% male workforce was damaged for a considerable period of time: six months after being laid off (although two-thirds had found new jobs) 40% saw their new role as a 'stop-gap' on the path to a better quality job (i.e. where they felt valued and enjoyed their work), and the

¹⁴ The service sector includes retail, banks, hotels, real estate, education, health, social work, transport, computer services, recreation, media, communications, electricity, gas and water supply.

¹⁵ Office for National Statistics. (2016). Five facts about... The UK service sector. Retrieved from <http://visual.ons.gov.uk/five-facts-about-the-uk-service-sector/>

¹⁶ Office for National Statistics. (2013). Women in the labour market: 2013. Retrieved from <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/womeninthelabourmarket/2013-09-25>

¹⁷ Autor, et al. (2016).

¹⁸ Ibid.

¹⁹ Stern, J. (1972). Consequences of Plant Closure. *The Journal of Human Resources*, 7(1), 3-25.

majority were earning significantly less than they had been at MG Rover (£3,523 less a year on average)²⁰.

In addition to the financial penalties of such change, there may also be social penalties. With the traditional role of men as 'breadwinner', it has been suggested that male identity is more intertwined with, and dependent on, work than it is for women²¹. Work is therefore considered to be *central* to masculine identities, roles and relations²². As such, shifts in employment which impact on financial status, but also perceived work status (i.e. in terms of work quality, value and 'prestige'), could have implications for self-esteem, wellbeing and – ultimately – health. The case of MG Rover offers some support for this interpretation: workers who perceived their new job as 'worse' quality than their previous one at MG Rover role reported higher anxiety²³.

Anxiety levels were higher still for those who had not found work²⁴. It is well known that unemployment has a strong, causal association with poorer mental health^{25,26}. In 2014 an estimated 25% of unemployed men had a common mental health condition²⁷, and unemployed men are at a substantially higher risk of suicide than their employed counterparts²⁸. Furthermore, unemployment may have more of an effect on the mental health of men than women²⁹. It has been suggested that in the event of job loss it may be easier for women to replace the emotional rewards of work with family roles than men, resulting in less emotional distress³⁰. In contrast, for men, work is more directly associated with a 'provider role'³¹. We also see a relationship for men between length of unemployment and poorer mental health that we do not see as clearly for women. Poor mental health is, therefore, comparatively a bigger barrier to work for men than it is for women³². This should inform and shape the design of return to work policy.

The quality of work also impacts on mental health³³. Prolonged economic instability in the UK over the past few decades has reduced access to fulfilling, sustainable paid work; some suggest this has increased men's propensity to develop mental health problems³⁴. Indeed, mental illness has increased over the last decade for men who are in – as well as out – of work³⁵. There is in fact evidence that, for men, income level can influence perceived or actual

²⁰ Armstrong, K. (2006). *Life after MG Rover: the impact of the closure on the workers, their families and the community*. London: The Work Foundation.

²¹ Fryers, T. (2006). Work, identity and health. *Clinical Practice and Epidemiology in Mental Health*, 2.

²² Oliffe, J., & Han, C. (2014). Beyond Workers' Compensation Men's Mental Health In and Out of Work. *American Journal of Men's Health*, 8, 45–53.

²³ Armstrong (2006).

²⁴ Ibid.

²⁵ Waddell, G., & Burton, A. (2006). *Is Work Good for Your Health and Well-Being?* London: The Stationery Office.

²⁶ Jefferis, B. J., Nazareth, I., Marston, L., Moreno-Kustner, B., Bellón, J. ángel, Svab, I., ... King, M. (2011). Associations between unemployment and major depressive disorder: Evidence from an international, prospective study (the predict cohort). *Social Science and Medicine*, 73(11), 1627–1634.

²⁷ McManus et al. (2016).

²⁸ Milner, A., Morrell, S., & LaMontagne, A. D. (2014). Economically inactive, unemployed and employed suicides in australia by age and sex over a 10-year period: What was the impact of the 2007 economic recession? *International Journal of Epidemiology*, 43(5), 1500–1507.

²⁹ Artazcoz, L., Benach, J., Borrell, C., & Cortes, I. (2004). Unemployment and mental health: understanding the interactions among gender, family roles, and social class. *American Journal of Public Health*, 94(1), 82–88.

³⁰ Kuhn, A., Lalive, R., & Zweimüller, J. (2009). The public health costs of job loss. *Journal of Health Economics*, 28(6), 1099–1115.

³¹ Oliffe & Han. (2014).

³² Butterworth, P., Leach, L. S., Pirkis, J., & Kelaher, M. (2012). Poor mental health influences risk and duration of unemployment: A prospective study. *Social Psychiatry and Psychiatric Epidemiology*, 47(6), 1013–1021.

³³ Butterworth, P., Leach, L. S., Strazdins, L., Olesen, S. C., Rodgers, B., & Broom, D. H. (2011). The psychosocial quality of work determines whether employment has benefits for mental health: Results from a longitudinal national household panel survey. *Occupational and Environmental Medicine*, 68(11), 806–812.

³⁴ Oliffe & Han. (2014).

³⁵ Ibid.

treatment by colleagues, which can affect their mental health³⁶. Furthermore, there are clear associations between underemployment, failure to achieve career goals, academic underperformance, and poorer mental health^{37,38}.

2.2. 'Risky business': do 'men's jobs' pose a greater mental health risk?

The nature of traditionally 'male' work may also have implications for men's mental health. Men are significantly more likely to work in dangerous jobs than women. The three jobs with the highest in-work injury and death rates (lorry driving, farming and construction³⁹) are all male dominated^{40,41,42}.

The risk of physical accidents and injuries in work has fallen significantly in recent years while the risk of mental ill-health in the workplace has grown. The construction industry is a case in point: it is estimated that, nowadays, ten times the number of construction workers die from suicide than from industrial accidents⁴³. Thus, while a focus on workplace health and safety remains crucial, the evidence suggests that men's *mental* health is a bigger public health priority.

We also see concerning figures about occupation and suicide which appear to have particular implications for men and traditionally male jobs. Compared to the rest of the male population, there were significantly higher suicide risks for men in the lowest skilled occupations (44% higher risk) and skilled trades (35% higher risk). Particularly high-risk occupations for male suicide were among low-skilled male labourers, particularly those working in construction roles (where the risk was three times higher than the male national average) and building finishing trades, e.g. plasterers and painters and decorators. The higher risk of suicide for people in certain occupations was associated with three main factors⁴⁴:

1. Job-related features such as low pay and low job security increase risk – linking into the evidence around good work and other social determinants of health.
2. People at high risk of suicide may selectively go into particular kinds of occupations - i.e. predefined characteristics may attract people to certain lines of work which increases their suicide risk.
3. Having access to, or knowledge of, a method of suicide increases risk – e.g. those that work in health or agricultural/farm workers with access to dangerous implements.

Research on the construction industry has further explored the risks of mental ill health among its, primarily male, workforce⁴⁵. It is suggested that the unique demands of working in a

³⁶ Dolan, A. (2007). "Good luck to them if they can get it": Exploring working class men's understandings and experiences of income inequality and material standards. *Sociology of Health and Illness*.

³⁷ Dooley, D., Prause, J., & Ham-Rowbottom, K. A. (2000). Underemployment and depression: Longitudinal relationships. *Journal of Health and Social Behavior*, 41, 421–436.

³⁸ Olfie & Han. (2014).

³⁹ Health and Safety Executive. (2017). In-year work-related deaths reported to HSE. Retrieved from <http://www.hse.gov.uk/foi/fatalities/in-year-names.htm>

⁴⁰ Of the 315,000 registered lorry drivers in the UK, 2200 are women. Data from the Freight Transport Association, 2015 figures.

⁴¹ 28% of agricultural workers are female: UK Government. (2016). Environment Secretary salutes Britain's women farmers. Retrieved from <https://www.gov.uk/government/news/environment-secretary-salutes-britains-women-farmers>

⁴² Data from UCATT estimates that 99% of construction workers undertaking manual labour/on site activities are men.

⁴³ Wilmore, J. (2017). Mental Health is the Biggest Threat to the Safety of Construction Workers. Retrieved from <http://www.acceptfusion.com/mental-health-biggest-threat-safety-construction-workers/>

⁴⁴ Office for National Statistics. (2017). Suicide by occupation, England: 2011 to 2015. Retrieved from <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicidebyoccupation/england/2011to2015>

⁴⁵ Meltzer, H., Griffiths, C., Brock, A., Rooney C., and Jenkins, R. (2008) Patterns of suicide by occupation in England and Wales: 2001-2005. *British Journal of Psychiatry*, 193 (1) 73-76

physical environment combined with pressure caused by transient working patterns (often spending long periods away from home) amplifies the impact of work on emotional health and wellbeing⁴⁶.

2.3. Can men really 'have it all'?

We are seeing more discussion about the challenges for men, especially parents, in terms of achieving a work-life balance which enables them to contribute to domestic life as much as they would like. The role of male is often still seen through a financial or 'breadwinner' lens, while at the same time there is the pressure, and the desire, to spend time at home⁴⁷.

Whether or not a partner is working may also have implications for men's mental health. According to a recent study, men's, but not women's, mental health is adversely affected (through stress) by being the sole breadwinner⁴⁸. It is thought that this is due, in large part, to cultural expectations about male and female roles⁴⁹. Such expectations are still prevalent; although in the UK while there have been legal changes around parental leave, in practice uptake has been tiny – with many citing cultural and economic factors as the main barriers.⁵⁰

The hours and location of work can have a significant impact on family time. Men are more likely to work night shifts (around 1 in 7 male employees compared to 1 in 11 female⁵¹) and are more likely to work longer hours than women (around 40% of male UK employees regularly work 40 hours or more per week)⁵². The time spent away from home due to longer working hours and erratic work patterns is added to by long commutes. This was suggested by one informant as being particularly challenging in the construction industry, where (often male) workers – unable to afford to live in relatively expensive inner city areas – may have to add several hours of commuting time onto their working day. As highlighted in a recent report by the Royal Society for Public Health, men, on average, spend over an hour commuting every day. Longer commutes have been associated with modest reductions in time spent preparing food, exercising, spending time with family and, in particular, sleeping⁵³. Particularly for men, long commuting times are strongly associated with having less sleep⁵⁴.

Further challenges were highlighted by the key informants we consulted. They suggested that, in certain male-dominated industries (e.g. construction), there is considerable travelling which takes men away from their families for long periods of time – possibly regularly on a week by week basis. Men more often than women also work in another country, away from their family, only returning home for holidays. This to some extent reflects the situation of 'fly in fly out' (FIFO) and 'drive in drive out' (DIDO) workers in Australia. A study exploring the health

⁴⁶ Ibid.

⁴⁷ The Economist. (2017). The Man Trap. Retrieved from <https://www.1843magazine.com/features/the-man-trap>

⁴⁸ Knapton, S. (2016). Being sole breadwinner is bad for men's health but good for women. Retrieved from <https://www.telegraph.co.uk/science/2016/08/19/being-sole-breadwinner-is-bad-for-mens-health-but-good-for-women/>

⁴⁹ Munsch, C. L., Rogers, M., & Yorks, J. (2016). Relative Income, Psychological Well-Being, and Health: Is Breadwinning Hazardous or Protective? In *Paper presented at the 111th Annual Meeting of the American Sociological Association, Seattle, Washington, August 20-23, 2016*.

⁵⁰ Topping, A. (2017). Few fathers can afford to take shared parental leave, say campaigners. Retrieved from <https://www.theguardian.com/money/2017/apr/05/few-fathers-can-afford-to-take-shared-parental-leave-say-campaigners>

⁵¹ Trades Union Congress. (2016). Number of people working night shifts up by more than 250,000 since 2011, new TUC analysis reveals. Retrieved from <https://www.tuc.org.uk/news/number-people-working-night-shifts-more-250000-2011-new-tuc-analysis-reveals>

⁵² OECD. (2018). LMF10: The distribution of working hours among men and women. Retrieved from https://www.oecd.org/els/family/LMF_2_1_Usual_working_hours_gender.pdf

⁵³ Royal Society for Public Health. (2017). Health in a hurry. Retrieved from <https://www.rsph.org.uk/uploads/assets/uploaded/b1320af3-7ba3-4b4e-a14351e7d8cfb24b.pdf>

⁵⁴ Chatzitheochari, S., & Arber, S. (2009). Lack of sleep, work and the long hours culture: Evidence from the UK time use survey. *Work, Employment and Society*, 23(1), 30–48.

implications of FIFO/DIDO reported that the most stressful aspect of this type of work was family/home separation –particularly for workers with young children. A significant number of FIFO workers also used alcohol and/or illicit drugs to manage stress and disrupted sleep patterns⁵⁵.

2.4. Key messages

Changes to the UK labour market in recent decades have created a predominantly male displaced workforce which, by and large, has struggled to either find work of similar quality or any work at all. Work is considered central to masculinity and, as such, these structural changes have had significant implications for men's mental health. Furthermore, men often work in jobs that pose threats to their physical health and safety, frequently characterised by low pay and insecurity, requiring them to work for extended periods away from family. All of this poses particular challenges for men's physical and, in particular, mental health.

To a large extent, the health problems presented by the changes to and the type of work that men typically do are compounded by the way in which they handle it, as we explore in the next chapter.

⁵⁵ Sellenger Centre for Research in Law, Justice and Social Change. (2013). FIFO/DIDO Mental Health Research Report 2013. Retrieved from http://www.workplacehealth.org.au/_literature_175869/FIFO_DIDO_Mental_Health_Research_Report

3. Men and mental health

Men's reticence to express concerns about their mental health and engage with professional help is thought to contribute to the apparently low rate of men with depression and anxiety, compared with rates for women⁵⁶. That said, diagnostic studies have found similar differences in prevalence⁵⁷. This implies that either (i) men experience lower rates of common mental health conditions, or (ii) diagnostic tools and criteria for common mental health problems may be less sensitive to the way these conditions present in men⁵⁸.

3.1. Distinctions between men's and women's mental health

One of the key informants we consulted suggested a major challenge is that men's mental health is often not dealt with, but rather, it is criminalised. Among men, poor mental health is more likely to present as alcohol and drug abuse, or as violence. These tendencies are linked with men's higher suicide rates.

3.1.1. Risky health behaviours: alcohol and drugs

The use of alcohol and/or illicit drugs in order to self-medicate is a greater concern for working men than women. Men have a greater propensity to engage in such "risky behaviours"⁵⁹. Heavy drinking or substance abuse serve as an 'outlet' for stress, anxiety and depression⁶⁰.

Engaging in these behaviours can have deadly consequences. In the UK, men account for 65% of alcohol-related deaths (15.9 per 100,000)⁶¹. Across all age groups, men are more likely than women to drink at higher risk levels, with men also more likely to drink alcohol five or more times during the week^{62,63}.

Use of illicit substances (e.g. drugs or other substances for a purpose not consistent with legal or medical guidelines) is relatively common in the UK, with 35.4% of men and 22.6% of women admitting to doing so at least once in their lifetime. Dependency on such substances often brings health risks, social isolation and an increased likelihood of being economically inactive. Again, the risks are higher for men: an estimated 4.3% of all men show signs of illicit drug dependency compared to just 1.9% of women. Figure 3.1 (below) illustrates men's higher propensity, relative to women, for illicit drug use.

⁵⁶ Winkler, D., Pjrek, E., & Kasper, S. (2006). Gender-specific symptoms of depression and anger attacks. *Journal of Men's Health and Gender*, 3(1), 19–24.

⁵⁷ McManus et al. (2016).

⁵⁸ Cochran, S. V., & Rabinowitz, F. E. (2003). Gender-sensitive recommendations for assessment and treatment of depression in men. *Professional Psychology: Research and Practice*, 34(2), 132–140.

⁵⁹ Richardson, N. & Smith, J. (2011). National men's health policies in Ireland and Australia: what are the challenges associated with transitioning from development to implementation? *Public Health*, 125(7): 424-32

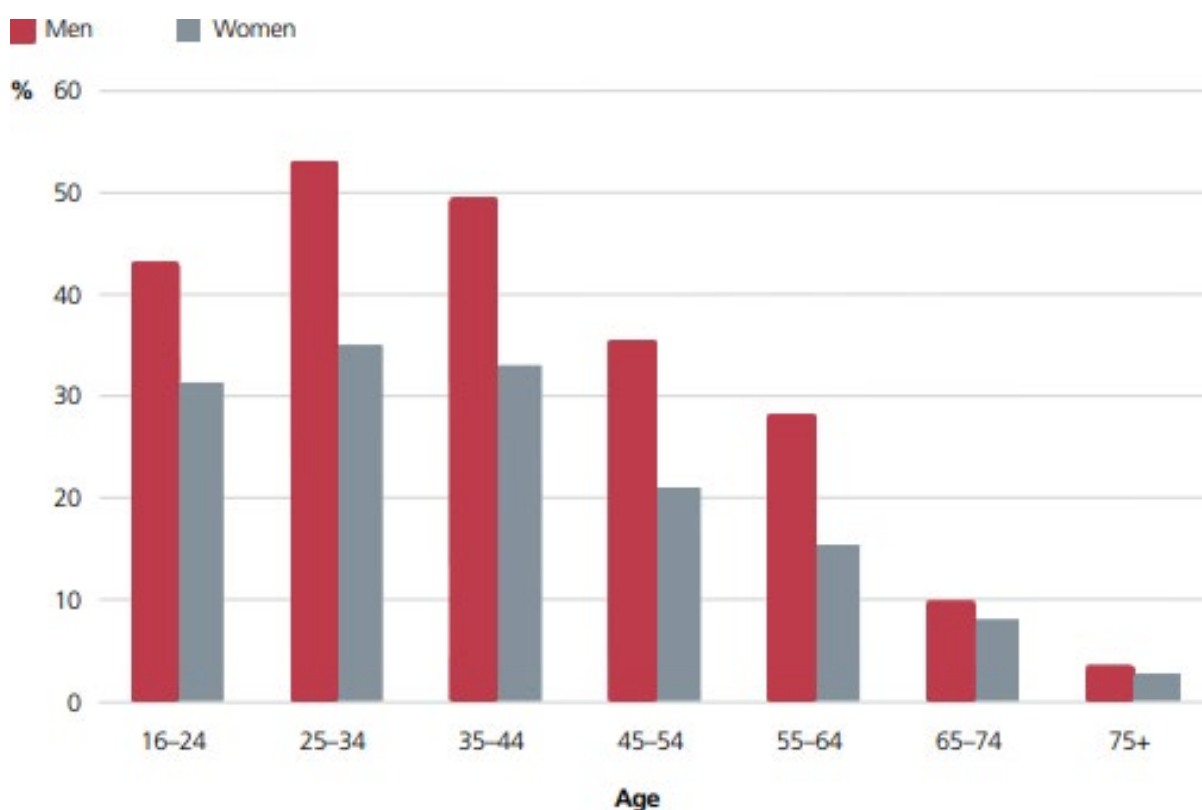
⁶⁰ Richardson, N., Clarke, N., Fowler, C. (2013). Young Men and Suicide Project. *Department of Health (NI) and Department of Health/An Roinn Sláinte*. Retrieved from <http://www.mhfi.org/ymspfullreport.pdf>

⁶¹ Office for National Statistics. (2014). Alcohol-related deaths in the United Kingdom: Registered in 2012. Retrieved from <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsinthetunitedkingdom/2014-02-19>

⁶² NHS Digital. (2016). Health Survey for England 2015: Adult alcohol consumption. Retrieved from <https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/health-survey-for-england-2015>

⁶³ Dey, M., Gmel, G., Studer, J., & Mohler-Kuo, M. (2014). Health-risk behaviors and quality of life among young men. *Quality of Life Research*, 23(3), 1009–1017.

Figure 3.1 – Prevalence of illicit drug use, by age and sex



Source: Adult Psychiatric Morbidity Survey 2014

Both alcohol and drug abuse are associated with poor mental health. For example, it is estimated that half of all people with signs of dependence on drugs (excluding cannabis) are receiving mental health treatment⁶⁴. Mental health issues such as anxiety and depression are more common in heavy drinkers, and vice versa⁶⁵, indicating a negative feedback loop between the two.

The effect that drugs, such as alcohol, have on the decision-making process can lead to impulsive actions that may not otherwise have been taken, including self-harm and suicide⁶⁶. For example, alcoholism and higher alcohol consumption are both associated with higher suicide risk^{67,68}. It has been suggested, therefore, that measures to address alcohol use are important in a suicide prevention strategy. This approach was taken in Russia where policies designed to reduce alcohol consumption (enacted in 2006) led to a 9% reduction in male suicide mortality⁶⁹.

Alongside these and other health risks, there are also significant compounding social risks. In particular, misuse of alcohol and illicit drugs can be both a cause and consequence of

⁶⁴ McManus et al. (2016).l

⁶⁵ Drinkaware. (2017). Alcohol and Mental Health. Retrieved from <https://www.drinkaware.co.uk/alcohol-facts/health-effects-of-alcohol/mental-health/alcohol-and-mental-health/>

⁶⁶ Royal College of Psychiatrists. (2017). Alcohol and Depression. Retrieved from <http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/alcoholdepression.aspx>

⁶⁷ Darvishi, N., Farhadi, M., Haghtalab, T., & Poorolajal, J. (2015). Alcohol-related risk of suicidal ideation, suicide attempt, and completed suicide: A meta-analysis. *PLoS ONE*, 10(5).

⁶⁸ Ramstedt, M. (2001). Alcohol and suicide in 14 European countries. *Addiction*, 96(1), 59–75.

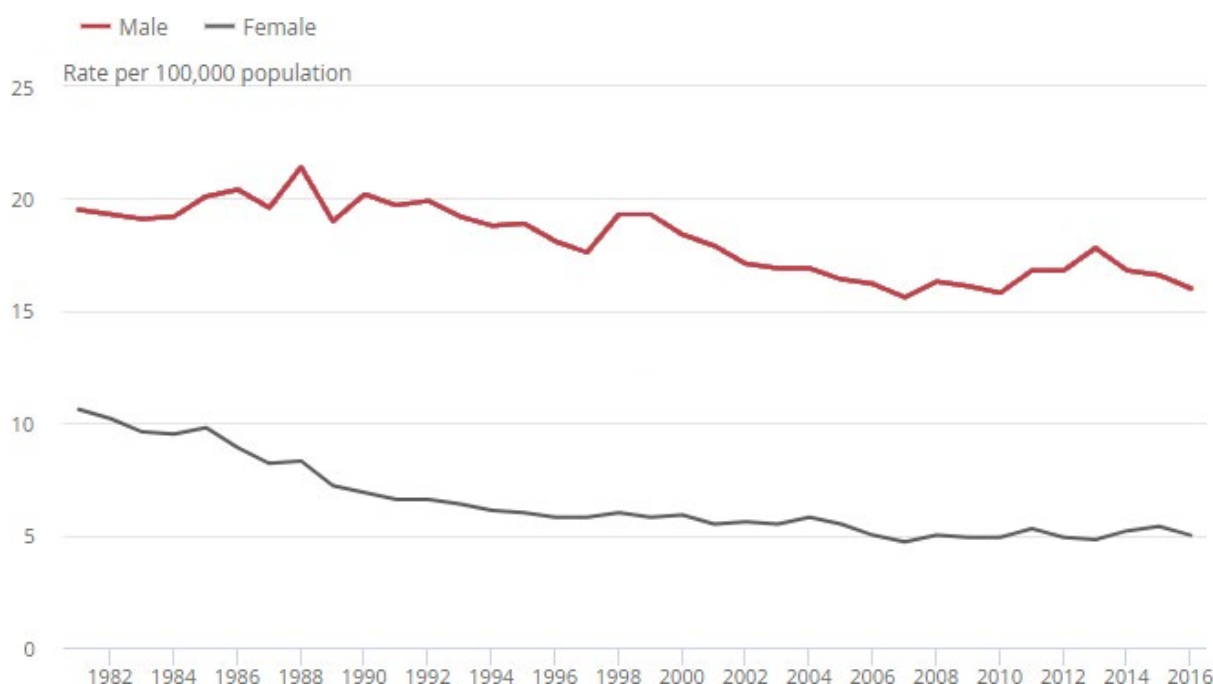
⁶⁹ Pridemore, W. A., Chamlin, M. B., & Andreev, E. (2013). Reduction in male suicide mortality following the 2006 Russian alcohol policy: An interrupted time series analysis. *American Journal of Public Health*, 103(11), 2021–2026.

unemployment⁷⁰. Furthermore, all risky behaviours, e.g. smoking, drinking and taking illicit drugs, can lower overall quality of life.

3.1.2. Suicide

Suicide in the UK disproportionately affects men; it is the leading cause of death for men under the age of 50 in England⁷¹. Of the total number of suicides registered in 2014 in the UK, 76% were males. Suicide rates have been consistently lower amongst females since the Office of National Statistics (ONS) started collecting these data⁷². The suicide rate is highest amongst middle-aged men (45-59 years old)⁷³. It is therefore an unfortunate truth that suicide – unequivocally – affects men more than women in the UK (as illustrated in Figure 3.2 below). The reasons why are not fully understood.

Figure 3.2 – Age-standardised suicide rates by sex, for the UK, registered between 1981 and 2016



Source: Office for National Statistics

Furthermore – as we explored earlier in Section 2.2 – it is evident that suicide is more common in certain industries, e.g. construction. The latest ONS data show that, in England and Wales, suicide rates for men were highest amongst those employed in the construction industry. In addition, the risk of suicide was three times higher among low-skilled male labourers compared to the national male average⁷⁴. The occupation with the highest risk of suicide in this group was roofers, tilers and slaters, where the risk of suicide was 2.7 times higher than the national average.

⁷⁰ Black, C. (2016). An Independent Review into the impact on employment outcomes of drug or alcohol addiction, and obesity. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/573891/employment-outcomes-of-drug-or-alcohol-addiction-and-obesity.pdf

⁷¹ Office for National Statistics. (2015). What are the top causes of death by age and gender? Retrieved from <http://visual.ons.gov.uk/what-are-the-top-causes-of-death-by-age-and-gender/>

⁷² Office for National Statistics. (2015). Suicide by occupation, England: 2011 to 2015. Retrieved from <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicidebyoccupation/england2011to2015>

⁷³ Ibid.

⁷⁴ Ibid.

One of the experts we spoke to attributed male construction workers' heightened suicide risk to their failure to seek help. This, they argued, was due to the 'transient' nature of the construction industry – as well as a general lack of access to health facilities, health support and health professionals. Men working in the construction industry tend to move 'where the work is' and this, in turn, limits their access to mental health care services. For example, if a man is registered with a GP in their hometown, and then has to move to another part of the country temporarily for a construction job, accessing mental health services through their GP becomes inconvenient. Therefore, more should be done to build relationships between men and the health services (e.g. GP practices, NHS mental health services), and to create a dialogue on the importance of personal health and wellbeing.

Another problem is the stigma associated with poor mental health, which affects both men and women. As one of our expert informants advised, the 'macho' culture of the construction industry can prevent men from talking about their mental health, because doing so is viewed as a weakness. Furthermore, it is often the case that men are less comfortable and confident sharing their problems than women. Indeed, there was some agreement between the key informants we consulted that women tend to have fewer issues sharing personal problems, whereas men can be inclined to 'just get on with it' (i.e. '*man up*') and ignore their problems. There is support for this in Census data for England and Wales⁷⁵

As such, there is a need to encourage men with mental health issues to access treatment services and remove the stigma surrounding it. This could be achieved by designing interventions and policies that do not unnecessarily 'single out' men. Policies should therefore be designed to benefit both genders, but perhaps with an emphasis on mental health issues that typically affect men.

A potentially effective way of engaging men could involve creating parity between physical health and mental health – rather than exclusively focusing on mental health as a separate issue. Such an approach circumnavigates the stigma men often attach to mental health issues. Our expert informants suggested that men often seek services for their mental health issues by coming forward with a physical health condition first. Due to the stigma associated with disclosing a mental health condition, physical health conditions can serve as a vehicle for men to access mental health services and treatment.

In addition to this, being mindful of the language used to engage men with mental health is vital for interventions to be successful and to potentially prevent outcomes like suicide. For example, mental health issues can be discussed using the term 'stress'. It does not carry the same connotations as 'mental ill health', 'depression' or 'anxiety', which could alienate a male audience. Thus, so-called 'Stress Manuals' could be an effective means of linking men with relevant mental health services. Finally, it should be pointed out that one-size-fits-all solutions were not encouraged as best practice by our expert informants. However, it was also emphasised that any interventions should not discriminate on grounds of sexual orientation or ethnicity.

⁷⁵ Ashley, J. (2010). Women 'more likely to report ill health than men'. Retrieved from <http://news.bbc.co.uk/1/hi/health/8588686.stm> on 20

3.2. Dr Who? Men and disclosure/help seeking

The risks to men's health are further exacerbated by their lack of engagement with health services⁷⁶. They are less likely to visit a GP, attend an NHS health check, get screened for cancer, visit a pharmacy or have a sexual health test⁷⁷. They are also less likely to seek help for a mental health problem⁷⁸. Certain groups of men, despite having higher mental health risks, are even less likely to engage with the health system. This includes unemployed men, those experiencing relationship breakdowns, and those in the criminal justice system⁷⁹. Perhaps the most at risk are homeless individuals, 88% of whom are men; they have an average age of death of 48⁸⁰.

Reasons for low engagement are complex. Some argue there are cultural barriers: seeking help or expressing vulnerability runs counter to hegemonic masculinity⁸¹, constraining male choices⁸². It is argued that men feel obliged to behave in a certain way when ill, that men feel they should be stoic about illness, and not waste doctors' time⁸³. On an individual level, reasons men give include embarrassment, shame, fear of stigma and concerns about confidentiality⁸⁴. For some, the GP surgery itself is a barrier, with suggestions that the atmosphere is 'too feminine', having been designed to meet the needs of women and children⁸⁵.

For some men, being in work is in itself an important reason why they don't access health services. Informants suggested that, once retirement age is reached, men and women access health services a similar amount. Our informants and the literature suggested that being employed makes it practically difficult to visit the doctor, i.e. the cost of the visit in terms of potential lost earnings and difficulty making an appointment outside of working hours⁸⁶. The latter is especially true when someone works far away from where they live – meaning that they get home late or at unpredictable times, or are only near their registered GP at weekends.

3.3. Key messages

There are clear differences between men and women regarding how they experience and manage mental ill health. This has important implications for the type of support that men need. In the following section we look at examples of existing support and ways of managing men's mental health.

⁷⁶ Richardson et al. (2013).

⁷⁷ Men's Health Forum. (2017).

⁷⁸ Maria Isabel Oliver, Nicky Pearson, Nicola Coe, G., & David, A. (2005). Help-seeking behaviour in men and women with common mental health problems. *BRITISH JOURNAL OF PSYCHIATRY* *BRITISH JOURNAL OF PSYCHIATRY*, 186(Table 1), 297–301.

⁷⁹ Men's Health Forum. (2017).

⁸⁰ Crisis. (2011). Homelessness: a silent killer. Retrieved from https://www.crisis.org.uk/media/237321/crisis_homelessness_a_silent_killer_2011.pdf

⁸¹ Emslie, C., Ridge, D., Ziebland, S., & Hunt, K. (2006). Men's accounts of depression: Reconstructing or resisting hegemonic masculinity? *Social Science and Medicine*, 62(9), 2246–2257.

⁸² Oliffe & Han. (2014).

⁸³ Harvey, S. (2013). Why are men reticent to see their GP? Retrieved from http://socialsciences.exeter.ac.uk/media/universityofexeter/collegeofsocialsciencesandinternationalstudies/politics/projects/mme/Mens_Health_Forum_Project.docx

⁸⁴ Richardson et al. (2013).

⁸⁵ Harvey. (2013).

⁸⁶ Ibid.

4. Good practice in promoting men's health

There are several examples – in the UK and internationally – of good practice seeking to address the need for appropriate services that promote men's mental health (in and out of work) and support those who experience poorer mental health. These services, outlined below, prioritise different, but often complementary, areas. For example, some address men's lack of engagement with health services, while others aim to de-stigmatise the issue of health – particularly mental health – and conversations about it amongst male communities.

4.1. Promoting health through peer interaction and 'meaningful activity'

4.1.1. Men's Sheds

'Men's Sheds' are safe, friendly and inclusive venues where groups of men come together to work on practical projects, e.g. carpentry or bike repair. The concept is based on the 'typical' garden shed found in one's back garden – defined as a place "where he feels at home and pursues practical interests with a high degree of autonomy".

Developed in Australia⁸⁷, where they are now an established part of the health infrastructure, there are now around 300 Men's Sheds in the UK⁸⁸. The majority of attendees are older men and Sheds are seen as particularly relevant to those experiencing significant changes in their working lives, due to retirement or illness, for example⁸⁹. Participating in a Men's Shed enables individuals to engage in work-like activity with their peers⁹⁰. The aim is to reduce isolation and contribute to the mental wellbeing of older men through social contact and meaningful activity. Evaluations indicate that participation offers a range of benefits for older men, including: learning new skills; sharing knowledge; personal achievement; community engagement; and the opportunity to meet and interact with others⁹¹. Sheds provide access to social support for those experiencing loneliness and isolation/depression⁹², and there are further indications that they have a positive effect on men's mental and physical health and wellbeing^{93,94}.

4.2. Promoting engagement with health services

4.2.1. The Pit Stop Programme

The 'Pit Stop Programme' was developed in Australia to encourage men in rural communities to engage with health services. The programme provides a range of men's health screening tools, delivered in non-medical settings in rural areas⁹⁵. It uses a 'mechanical' – 'Pit Stop' – theme to get its message across. For example, there are 'stations' that provide non-invasive medical tests; 'health mechanics' discuss participants 'oil pressure' (blood pressure), 'fuel additives' (alcohol consumption) and 'shock absorbers' (coping skills). Once participants pass through the 'Pit Stop' they are given a 'roadworthy' or 'unroadworthy' sticker. Those receiving the latter are advised to follow up with a GP.

⁸⁷ See: <http://www.mensheds.org.au/>

⁸⁸ See: <http://menssheds.org.uk/>

⁸⁹ Milligan, C., Neary, D., Payne, S., Hanratty, B., Irwin, P., & Dowrick, C. (2016). Older men and social activity: A scoping review of Men's Sheds and other gendered interventions. *Ageing and Society*, 36(5), 895–923.

⁹⁰ Ibid.

⁹¹ Milligan, C., Dowrick, C., Payne, S., Hanratty, B., Irwin, P., Neary, D. & Richardson, D. (2013). Men's Sheds and other gendered interventions for older men: improving health and wellbeing through social activity. Retrieved from <https://sphr.nihr.ac.uk/wp-content/uploads/2014/12/SPHR-LIL-PH1-MIS-Age-UK-brief-report-FINAL.pdf>

⁹² Ibid.

⁹³ Ibid.

⁹⁴ Beyond Blue. (2013). Men's sheds in Australia. Retrieved from <https://www.beyondblue.org.au/docs/default-source/research-project-files/bw0209.pdf?sfvrsn=2>

⁹⁵ Lynch, W. (2013). Men's health in Australia. *Trends in Urology and Men's Health*, 4 (1), 7-10.

An evaluation of the programme in 2005 found that, over a three-year period across three regions in rural Victoria, Australia, the 'Pit Stop' reached 40-50% of men with significant health risk profiles. For 43% of them, the engagement resulted in a change in health behaviours and/or a connection with a health care professional. The programme was also found to have increased the skills of rural health professionals⁹⁶.

The scheme is mobile and can be taken to non-medical settings, such as areas where men have low health engagement levels. For example, it was taken to the Farm World Agricultural Show in 2010.

4.3. De-stigmatising men's mental health

We identified two initiatives seeking to promote men's health through de-stigmatisation. The first, 'Mates in Mind', is primarily focused on the construction industry and also aims to build greater awareness of mental ill health amongst men. The second, Haynes' 'man manuals', seek to provide authoritative and impartial guidance and advice on a range of men's health issues.

4.3.1. Mates in Mind

The 'Mates in Mind' pilot, started in 2017, was developed to address the mental ill health challenges in the male-dominated UK construction industry. It is based on the Australian 'Mates in Construction'⁹⁷ model, which began in 2008, and is championed by the Health in Construction Leadership Group, supported by the British Safety Council⁹⁸.

The purpose of Mates in Mind is to bring the construction industry together to openly talk about and address the stigma associated with mental ill health. This is in response to increasing concern about the prevalence of poor mental health and high suicide rates in the industry (as well as amongst working age men generally).

There are several reasons why the initiative is focused on the construction industry. As explained in previous sections, its workforce is male-dominated and it is a tough and competitive industry – projects often have strict deadlines and workers suffer financial penalties for not meeting them. The physical work environment is not only physically dangerous but outdoor projects further subject workers to all kinds of weather, as well as being noisy. In addition, many construction workers have to travel away from their homes to work, with long commutes and long periods away from home – thus, loneliness is a significant risk. Many construction workers are also self-employed, with a higher risk of job insecurity. Lastly, the 'macho' image of the industry is seen as a barrier to seeking help for health and wellbeing problems⁹⁹.

Mates in Mind provides support and a ready-made programme of training and mental health promotion materials and campaigns in partnership with leading mental health and construction partners. It is supported by Mind, Mental Health First Aid and the Samaritans.

⁹⁶ Research undertaken by Debbie Chambers of the Combined Universities Centre for Rural Health, from 2002-2005

⁹⁷ See: <http://matesinconstruction.org.au/>

⁹⁸ Office for National Statistics. (2017). Suicide by occupation, England: 2011 to 2015. Retrieved from <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicidebyoccupation/england2011to2015>

⁹⁹ Croner. (2017). The hidden problem: mental health in construction. Retrieved from https://app.croneri.co.uk/feature-articles/hidden-problem-mental-health-construction?product=17/%3Futm_source%3Dtwitter

4.3.2. Haynes' 'man manuals'

Based on the popular series of manuals for car, motorcycle, scooter and ATVs maintenance, Haynes and the Men's Health Foundation developed the 'Haynes Brain Manual' in 2008. It provides a step-by-step guide for men for achieving and maintaining mental well-being. These 'plain language' guides seek to tackle the stigma associated with men's mental health and explore key issues, such as stress at work, the importance of physical activity and good mental health, in an informal way.

A second manual, 'Beat Stress Feel Better'¹⁰⁰, focuses on stress and its causes – including work – as well as tips from relevant health practitioners and guidance on self-management¹⁰¹.

4.4. A men's health policy

Unlike those outlined above, this final example of good practice is not a specific initiative, but rather represents the operationalisation of a 'gendered' approach to health, recognising that such approaches can be beneficial for both healthcare and service delivery. At present, three countries – Ireland, Brazil and Australia – have introduced specific men's health policies. We consider one approach below.

Ireland was the first country in the world to have a 'National Men's Health Policy' (from 2008-2013). Though designated as a health strategy, it operated across policy borders. The rationale given was the continued sex differences in life expectancy and mortality, health inequalities within subpopulations of men (especially marginalised groups, such as travellers, ethnic minorities or GBT, as well farmers/agricultural workers), and the body of evidence supporting a gender specific approach¹⁰². The focus was on community engagement, capacity building within existing provision, partnership and service sustainability. It sought to address the low engagement of men with health services¹⁰³. It focuses on how, for many men, the women in their lives are the "gatekeepers of health", and, in turn, "challenges men to take increased responsibility for their own health"¹⁰⁴.

A review of its impact concluded that the Policy had made "a significant contribution" to advancing men's health in Ireland by "making the issues of men's health more prominent" and "by providing a framework for action"¹⁰⁵. It was considered to have promoted an increased focus on men's health research; helped develop health promotion initiatives that support men to adopt positive health behaviours and increase control over their lives; build social capital within communities for men; and developed and delivered men's health training for health and other professionals¹⁰⁶. A particular benefit was that the implementation of specific male strategies was accompanied by an increase in advocacy by patient groups and charities¹⁰⁷.

¹⁰⁰ Men's Health Forum. (2014). Beat Stress Feel Better. Retrieved from https://issuu.com/menshealthforum/docs/beat_stress_v7_toprint_lr/8

¹⁰¹ Ibid.

¹⁰² The Irish Health Repository. (2017). National Men's Health Action Plan Healthy Ireland - Men HI-M 2017-2021 Working with men in Ireland to achieve optimum health and wellbeing. Retrieved from <http://www.lenus.ie/hse/handle/10147/621003>

¹⁰³ Men's Health Forum. (2017).

¹⁰⁴ Richardson, N., & Smith, J. A. (2011). National men's health policies in Ireland and Australia: What are the challenges associated with transitioning from development to implementation? *Public Health*, 125(7), 424–432.

¹⁰⁵ Baker, P. (2015). Review of the National Men's Health Policy and Action Plan 2008-2013. Retrieved from <http://www.mhfi.org/policyreview2015.pdf>

¹⁰⁶ Ibid.

¹⁰⁷ Richardson & Smith. (2011).

4.5. Key messages

Evidently, there are a number of examples of good practice seeking to promote men's health. Whether they aim to stimulate peer interaction, promote engagement with health services, destigmatise mental health or operationalise a gendered approach to health, they share a similar aim: improving mental health outcomes for men. In the following, and final chapter, we draw on these examples – and the evidence presented throughout the paper – to make a number of policy recommendations.

5. Conclusions and recommendations

The evidence presented here suggests that there may be a need to look at mental health and related support services through a ‘male lens’, incorporating the role of work as an important influence, and the workplace as a setting for providing support. This reflects previous work which calls for a reconfiguration of health services to support the development of more targeted, appropriate services which address men’s specific needs¹⁰⁸.

In the following sections we outline, based on the evidence, what employers, the health system and government can do to better support men’s health.

5.1. What should employers do?

While the workplace can present risks to employees’ physical and mental health and wellbeing, it is also a setting where health problems can either be prevented or addressed, for example through providing support. Support can be provided in a number of ways. Employee Assistance Programmes (EAPs) – services that help employees with personal problems impacting on their work through e.g. confidential assessments and short-term counselling – are now available to roughly half of employees in the UK¹⁰⁹. While there is limited evidence of the effectiveness of EAPs, a recent Work Foundation report, comprising an online survey of HR managers and EAP providers, found they were “viewed as an important investment for organisational health and wellbeing plans”¹¹⁰. These services are typically available as telephone, online and face-to-face counselling; mental health issues (e.g. work-related stress, depression and anxiety) are common reasons why employees access them¹¹¹.

EAPs are often implemented alongside occupational health (OH) services – another form of effective workplace support for health wellbeing¹¹². OH services are designed to maintain and improve employee health and wellbeing through absence management, rehabilitation, risk assessments and health promotion and wellbeing¹¹³. However, only a minority of the UK workforce have access to such a service: a telephone survey of 2,250 UK employers in all sectors of the economy reported that only 13% of employers provide access to OH services¹¹⁴. Furthermore, the UK Government’s OH service – Fit for Work – was recently discontinued¹¹⁵. The value of OH services, however, is not in question. Two recent wide-ranging reviews concluded that, when implemented, these services provide effective workplace health support, offering a range of benefits for multiple stakeholders – employees, employers, government, and health services^{116, 117}.

Workplace support, provided by EAPs and OH services, can effectively deal with employee health and wellbeing issues. However, as we discussed earlier, the issues they typically tackle

¹⁰⁸ Richardson et al. (2013).

¹⁰⁹ Barrett, P. (2017). It’s time for EAPs to realise their full potential. Retrieved from <http://www.theworkfoundation.com/2017/03/29/its-time-for-eaps-to-realise-their-full-potential/>

¹¹⁰ Work Foundation (2017). Employee Assistance Programmes (EAPs): Supporting good work for UK employers? Retrieved from http://www.theworkfoundation.com/wp-content/uploads/2016/10/410_EAP_Supporting-Good-Work.pdf

¹¹¹ Ibid.

¹¹² Ibid.

¹¹³ NHS Health at Work. (2018). Workplace Health for the UK. Retrieved from <https://www.nhshealthatwork.co.uk/workplacehealthforuk.asp>

¹¹⁴ Society of Occupational Medicine. (2017). Occupational health: the value proposition. Retrieved from https://www.som.org.uk/sites/som.org.uk/files/Occupational_health_%20the_value_proposition.pdf

¹¹⁵ Personnel Today. (2018). Fit for Work service scrapped in workplace health policy overhaul. Retrieved from <https://www.personneltoday.com/hr/fit-work-service-scrapped-workplace-health-policy-overhaul/>

¹¹⁶ Society of Occupational Medicine. (2017).

¹¹⁷ Society of Occupational Medicine. (2018). Occupational Health: The Global Evidence and Value. Retrieved from https://www.som.org.uk/sites/som.org.uk/files/Occupational_Health_the_Global_Value_and_Evidence_April_2018.pdf

– mental health problems including anxiety and depression – are issues that men often ignore and, as a result, are reluctant to seek help with. Thus, these services should be communicated to male workforces in a manner that will resonate with them. As we suggested earlier, terms like ‘mental ill health’ carry connotations that often alienate men, leading to disengagement. Instead, these services should be presented as tackling ‘stress’ – or, rather than focusing on mental health specifically, focus on health generally, i.e. physical and mental, rather than just mental health (creating parity).

Consideration should be given by employers in certain sectors, particularly construction, regarding the likely impact that the nature of the work will have on their (predominantly male) workforce's health. For example, given that construction workers often have to travel far away from home to work, often staying in temporary accommodation for extended periods of time, they are at risk of feeling isolated and lonely. Workplace health support, such as EAPs and OH services, offered by these employees should be cognisant of this fact, and tailor services accordingly.

5.2. What should health services/providers do?

Currently, we don't know enough about the effectiveness of gendered approaches to healthcare, or the full extent of the differences in health experienced by men and women. For example, there is still uncertainty around the diagnostic criteria used for common mental health conditions and whether they are appropriate for men, i.e. whether they truly account for the apparent differences in the way that men and women experience mental health. Furthermore, as one of our expert informants told us, many support services do not differentiate outcomes by gender – they simply do not collect these data.

Gendered outcomes of services in data collection and evaluation should, therefore, be prioritised. Within this, we argue that work should be recognised as a health outcome. This has potential benefits for both men and women, but it is arguably of greater importance for men given that their mental health – self-confidence, esteem, etc. – is apparently contingent on not just whether they are in work or not, but the status and prestige attached to it.

There is much to be gained by looking at work as a health outcome – particularly for men. That men, particularly younger working age men, are significantly less likely to visit the GP than women is a concern. This has important – and negative – implications for early intervention (which is typically an effective form of intervention). Men's reticence in this regard likely has a profoundly negative effect on their health – which is largely avoidable. This inequality poses a serious challenge for public health practitioners – a GP appointment concerning an apparently minor problem could amount to early detection and treatment of an otherwise fatal illness.

Some campaigns have been successful, and – in particular – male specific mental health campaigns (such as those described in the previous section) can be valuable.

In terms of more practical changes to the health system that would benefit men, there are several. For example, improving access to ‘out of hours’ services and allowing more flexibility with GP appointments, specifically allowing individuals (or maybe men working in particular sectors) to have access to GP surgeries away from their ‘home’ surgery, should be prioritised. As one of our expert informants told us, out of hours or ‘after hours’ services have great

promise. Men – typically – do not want their bosses or colleagues to know they are receiving help for mental health issues. This would help address that problem.

Regarding health campaigns, historically, those specifically targeted at men – by their placement in male oriented places and their use of male-specific language – have had some success¹¹⁸. We suggest building on that success by continuing to run campaigns that not only focus on gendered health issues, e.g. suicide (which is much higher amongst men), but communicate messages in a gendered way. For example, rather than using laden terms such as ‘mental ill health’, which may alienate male audiences, opt for ‘stress’ instead.

Finally – and related to the above point – there is an apparent need to ‘de-feminise’ support. Although reasons for men’s generally low engagement with health services are complex, there is evidence to suggest that the GP surgery itself – being perceived as ‘too feminine’ – represents an important barrier. There is a perception that these settings are primarily oriented towards women and children and their needs – rather than men’s.

5.3. What should government do?

Based on a review of the literature and conversations with a number of key informants, **we make four broad policy recommendations**. To improve men’s health outcomes, Government should:

1. Re-think policy design;
2. develop awareness, understanding and engagement;
3. improve access and support; and
4. build the evidence-base.

5.4. Re-think policy design

5.4.1. Re-design policy models for ‘gendered’ health interventions

Models for any health intervention solutions should include two ‘pillars’ that support a universal health strategy. This model should consist of two vertical ‘columns’, one for women’s health conditions and a second column for men’s health conditions, supporting a ‘universal health strategy’. The universal health strategy should include general physical and mental health promotion, including the importance of a healthy diet, physical activity and stress reduction.

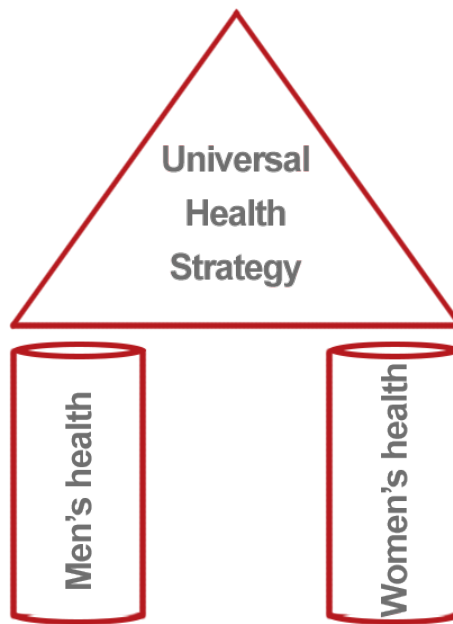
The women’s health pillar should include health conditions experienced exclusively or primarily by women. For example, reproductive and gynaecological health conditions (e.g. endometriosis, infertility, pregnancy and health, and menopause) – as set out in our sister paper on women’s health¹¹⁹ – breast and ovarian cancers, and some common mental disorders (e.g. anxiety and depression), which are more common amongst women.

The men’s health pillar, on the other hand, should include conditions identified in this paper as predominantly affecting men, e.g. drug and alcohol abuse, suicide. Cancers affecting men, such as prostate and testicular cancer, should also be included.

¹¹⁸ Harvey. (2013).

¹¹⁹ Work Foundation. (2017). More than ‘women’s issues’. Retrieved from http://www.theworkfoundation.com/wp-content/uploads/2016/10/419_MoreThanWomensIssues.pdf

Figure 5.1 – A universal health strategy



It is imperative that any solutions and/or interventions that are implemented are evaluated and that impact assessments are carried out to measure their performance and effectiveness. This is necessary for long-term sustainability as well as the development of solutions and/or interventions as needed and to fill the knowledge-gap that currently exists for men's mental health and suicide.

5.4.2. Design policies targeted at high risk men

To complement the universal strategy set out above, specific policies should be targeted at groups considered to be at 'high risk' of mental ill health, engagement in adverse health behaviours, and suicide. We outline the characteristics of these high-risk groups in in Box B (below).

Box B – Male groups at high risk of adverse health and health-related outcomes

- Unemployed men
- Men aged 45-59
- Men working in high-risk occupational sectors, e.g. construction
- Men experiencing relationship breakdown
- Men in the criminal justice system
- BAME men (who have a relatively high risk of prostate cancer, mental health and diabetes)
- GBT+ men (who have a relatively high risk of sexual health conditions and smoking)
- Male carers
- Homeless men
- Isolated older men
- Men transitioning out of work and into retirement

Examples of good practice with the potential to address the issues experienced by these groups were outlined earlier in Chapter 4. For example, the ‘Mates in Mind’ initiative is targeted at the construction sector, while the ‘Men’s Sheds’ initiative is specifically designed to reduce social isolation experienced by older men, e.g. those transitioning out of work and into retirement. These examples should inform and direct policy design.

5.5. Develop awareness, understanding and engagement

Government policy should prioritise improving awareness of men’s mental health, men’s – and the public’s – understanding of it, as well as engagement with health services.

5.5.1. Government should proactively reach out to and engage men with their mental health

Given men’s well-documented reticence and reluctance to engage with health services, the onus is on government to take a proactive stance and reach out to them. For example, targeted health campaigns in predominantly male settings (e.g. male-dominated workplaces, public houses, sports grounds, betting shops, etc.) should be prioritised. Information can be disseminated via leaflets and pamphlets, avoiding the use of language that has been shown to alienate men (such as ‘mental health ill’, ‘depression’, etc.), taking cues from some of the initiatives outlined in Chapter Four, e.g. the ‘Pit Stop’ programme, which uses carefully chosen words thought to resonate with male audience.

Furthermore, government should work with employer groups, the criminal justice system, and the emergency care services to extend the scope of occupational health services to include screening and preventative health measures. For example, ‘mental health diversion’ schemes, which operate at the interface between criminal justice and mental health, should be expanded. These schemes help ensure that people with mental health problems who come into contact with the criminal justice system are directed towards appropriate care instead of being criminalised¹²⁰. We therefore echo calls from the Men’s Health Forum to set up a ‘Mental Health Diversion Duty’ to help ensure that fewer people with mental health conditions are imprisoned¹²¹. Emergency care and the criminal justice system should not be men’s first point-of-contact for receiving mental health services – this arguably represents a failure of access to mental health treatment and services.

Government should also explore ways of increasing health check outreach and uptake amongst men. When men do engage in these services this opportunity should be seized upon; mental health checks should also be carried out and, where possible, the potential for co-creating and co-designing new services for men should be explored.

5.5.2. Launch a new marketing strategy for mental health services

Marketing strategies for mental health services should be re-designed with men in mind. The Department of Health and Social Care (DHSC) and relevant third sector organisations should explore ways in which they can re-brand and re-market their services in ways expected to resonate with men. Thus, as above, materials should use more accessible and less alienating terminology, e.g. ‘wellbeing’ over ‘mental ill health’. Marketing strategies should also account for men’s apparent inability or lack of will to discuss health problems in same way that women are typically comfortable with.

¹²⁰ Sainsbury Centre for Mental Health. (2009). Diversion: a better way for criminal justice and mental health. Retrieved from <http://www.ohrn.nhs.uk/resource/policy/DiversionSCMH.pdf>

¹²¹ Men’s Health Forum. (2014). Men’s health manifesto. Retrieved from <https://www.menshealthforum.org.uk/dont-wait-men-engage-especially-mental-health>

- The DHSC should consider creating resources like 'Stress Manuals' and 'Wellbeing Manuals' (drawing on the examples of good practice outlined in Chapter 4) that detail how to identify and treat stress and mental health conditions and manage them at work and during daily life.
- The experts we consulted suggested that organisations providing suicide prevention and mental health treatment and counselling services are currently not being marketed in a way that appeals to men or encourages them to engage. Instead, they are too often presented and marketed as a 'last resort' for mental health issues – and are subsequently perceived as such – when they should be marketed as a 'first resort'. Emphasis on early intervention and – ideally – prevention should, therefore, be considered a priority.

5.5.3. Remove the stigma attached to mental health by creating 'parity of esteem' with physical health

Government should prioritise tackling the stigma associated with mental health. There has been an increasing focus on mental health by government – and society in general – in recent decades and there is evidence of a growing acceptance of and willingness to talk about mental health issues¹²². Specific attempts to reduce the stigma associated with mental health are evidenced by recent government-backed initiatives, such as 'Time to Talk' (from Time to Change – a campaign backed by mental health charities Mind and Rethink Mental Illness). Such initiatives are not, however, necessarily designed with men – and their typically low engagement with such campaigns – in mind. Thus, their effectiveness amongst male populations will likely be lower. One way of addressing this is putting mental health on an equal footing with physical health, i.e. creating 'parity of esteem'. Mental health should not necessarily be distinguished from physical health – instead, it should be treated as just one dimension of overall health and wellbeing.

The Royal Mail have operationalised this concept with their 'Feeling First Class' initiative. Rather than specifically focusing on mental health, it is treated as a constituent part of an overarching, holistic, health and well-being programme. This helps 'normalise' mental health, reducing the stigma associated with it.

Furthermore, the experts we consulted suggested that case studies featuring men that have experienced common mental disorders such as anxiety and depression are effective forms of good practice. Again, it helps normalise mental health, and has the potential to encourage others, who may be suffering in silence, to come forward and seek help.

5.6. Improve access and support

To improve men's access to general and mental health services and support, the feasibility of 'out of hours' and 'after hours' services should be explored by government. Too often, access to services is prohibited by inflexible opening times that do not accommodate full-time workers. While this applies to both men and women, there are indications that men could benefit more as they typically do not want their boss or colleagues to know they are seeking medical help – particularly for mental health problems.

Furthermore, given the nature of the work men often do, being able to see their local GP is not possible as they may be away from home for extended periods of time. Access to health

¹²² Public Health England. (2016). Attitudes to mental health problems and mental wellbeing: findings from the 2015 British Social Attitudes survey. Retrieved from <http://www.bsa.natcen.ac.uk/media/39109/phe-bsa-2015-attitudes-to-mental-health.pdf>

services can also be improved by providing online services, e.g. ‘virtual’ GP appointments, and the ability to book appointments online.

Government should promote greater use of self-help groups, peer-led support and provide out-of-hours support and walk-in clinics (e.g. with counsellors, and mental health support). Mental health episodes cannot be accurately predicted therefore the ability to access services quickly is of vital importance. Men working in male-dominated sectors that are disproportionately affected by poor mental health and suicide need more convenient ways of accessing care, especially when men in industries like construction currently lack access to health facilities, health support and to health professionals due to the transient nature of the work that they do.

5.7. Build the evidence-base

5.7.1. The causes of poor mental health and suicide in men

Government should commission new research to help build the evidence-base on the causes of poor mental health and suicide in men, especially for high-risk groups. As we have outlined in this paper, suicide disproportionately affects men more than women in the UK. However, the reasons why this the case are not fully understood.

5.7.2. Impact assessments and evaluations of health interventions and policies

There is a need for more impact assessments and evaluations of health services, interventions and policies, particularly for mental health. The experts we consulted informed us that many services, interventions and policies – particularly mental health ones – do not differentiate outcomes by gender as they simply do not collect the data. As such, it is difficult to appreciate the differential impact that these services have on women and men. To improve men’s engagement with such services, it is essential that these data are collected. These data can then inform and shape the design of new policy – or the re-design of existing policy.

5.8. Final comment

This paper demonstrates the need for a ‘gendered view’ of mental health in order to properly support men’s health and wellbeing. Though not necessarily true in all cases, there is a clear rationale for taking a gendered approach to improving mental health. Men’s relative reluctance to seek help, combined with their increased likelihood of undertaking risky behaviours and propensity for suicide, should shape and inform policy. With appropriate support, designed the right way, both employers and the health service can deliver better outcomes for men and, ultimately, save more lives.

