HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Men's health, HC 139

Tuesday 5 December 2023

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Watch the meeting

Members present: Steve Brine (Chair); Paul Blomfield; Mrs Paulette Hamilton; Dr Caroline Johnson; Rachael Maskell; James Morris.

Questions 1 - 51

Witnesses

I: Joy Hibbins, Founder and Chief Executive Officer, Suicide Crisis; and Anthony Davis, Therapist, and Registered Member of the British Association of Counsellors and Psychotherapists.

II: Charlie Bethel, Chief Executive Officer, UK Men's Sheds Association; Tim Taylor, Head of Public Health, Leeds City Council; and Sarah Meek, Managing Director, Mates in Mind.

Examination of witnesses

Witnesses: Joy Hibbins and Anthony Davis.

Q1 **Chair:** Good morning. This is the Health and Social Care Committee. We are live from the Palace of Westminster. This morning, Tuesday 5 December, we are holding our first evidence session in our brand new inquiry into men's health. This is the first time that a proper parliamentary Select Committee has really looked at the issue in a very long time.

We published the terms of reference a while ago, back in July, and asked for written responses in evidence. The wider inquiry into men's health will look at the factors that drive lower and falling male life expectancy: male cancers, and obviously prostate cancer within that; suicide among men, which is one of the issues we are going to focus on today; men's use of health services; the role that community and sport-based projects play in reaching men at higher risk of poor mental health and isolation; and male sexual health. The session today will focus on the reasons for higher rates of suicide among men; the symptoms of, and the risk factors for, poor mental health among guys; and the role that different organisations can play in supporting men's mental health, including local authorities, employers and community groups.

We have two panels, but we have to finish by 11.30 this morning because there are Health questions in the Chamber. We have Joy Hibbins, the managing director of Suicide Crisis, and Anthony Davis, a registered therapist at the British Association of Counsellors and Psychotherapists. Thank you very much for coming and for joining us for this men's health inquiry, part one. You are very welcome.

Anthony, how would you describe the situation around men's mental health at this point?

Anthony Davis: At the BACP, we conducted a survey with over 3,000 of our therapists and counsellors, looking at men's mental health specifically. Among those 3,000 therapists, 52% found that there has been an increase in men's presentation of depression over the past year; and 56% of those therapists found that men are less likely to receive mental health support. This means that men are suffering in silence. Researchers also found that men are looking at ways of accessing mental health services differently. As opposed to talking to people, they may prefer seeking out help independently or using other means of taking action, such as utilising typed messages. Talking to someone, particularly a stranger, has been quite difficult for men.

We found some disparities among men when it comes to mental health. As we are talking about suicide today, we found that 73% of deaths by suicide in 2020 were among men. That is quite an alarming rate and has been pretty consistent since the 1990s. Among men who are willing to seek help, there has been quite a significant amount of stigma around seeking help, due to traditional masculine norms and toxic masculinity.

Those ideologies have entrenched in men that they should be emotionless and stoic, and not talk to people about their problems. Talking about your mental health is seen as somewhat weak.

Thinking about some of the stigmas associated with mental health among men, it is difficult for men to make meaningful connections. Research has found that this is the case, starting from childhood, among men. Sometimes it is difficult to form attachments with either parental figures or caregivers. This has been persistent throughout their adult lives. If men who are experiencing difficulties with their mental health have not formed those connections from childhood, they find it difficult to form the connections as adults and to reach out for help when they are experiencing mental health illness.

According to MIND, men are more likely to externalise symptoms around mental health. This may be exhibited as a lot of physical aggression or a lot of violence, and is often overlooked as difficulties with mental health illness. Sometimes it may be picked up by the criminal justice system, so, as opposed to men who exhibit those symptoms getting help for depression or anxiety, they are often thrown into the criminal justice system and do not receive the psychological support that they need.

We found some important intersectional differences to consider when thinking about the mental health of men. Race is one that we strongly look at because racially minoritised men are significantly more likely to experience severe mental health illness than white men. Unfortunately, due to issues around systemic racism and cultural and societal expectations of masculinity, racially minoritised men are less likely to access mental health support. This is possibly due to a combination of mistrust in services and fear of discriminatory treatment once they access those services.

From my experience as a psychotherapist, and previously as a social worker, this is something that I have seen among a lot of men of colour I have worked with. They may go to their GP and try to express how they are feeling. Sometimes they may be ignored or pushed to the side, and that breeds a lot of distrust in reaching out for services in the NHS. Sometimes, men who exhibit a lot of the symptoms that I mentioned before—violence and aggression—are over-medicated and hospitalised. Among black men particularly, quite a large proportion are over-represented in secondary mental health services and psychiatric hospitals.

It is really tricky. There is a huge population seeking our support, but because of the disparities, the stigma and cultural expectations around masculinity, and some of the prejudices and stereotypes within mental health services and the community mental health service, they are not reaching that population or giving them the support that they need.

Q2 **Chair:** We will come to suicide specifically. My colleagues are going to mention that, and we will bring Joy in at that point. I want to stick with

you, Anthony, on lifestyle behaviours and how men display behaviour as a result of challenges.

We always say to young boys, and I do to my children, "Use your words as opposed to your actions." If you look at lifestyle and behaviours, such as tobacco smoking, men are much more likely to smoke than women. They are more likely to be overweight or obese than women. They are more likely to consume over 14 units of alcohol per week than women. Globally, men account for almost two thirds of unintentional injury-related deaths. They are at greater risk of both domestic and occupational accidents. Male infertility is a growing area of concern. It is quite a challenging picture for us, isn't it?

Anthony Davis: Definitely. This brings me to think about the campaign that the BACP launched in November for Men's Mental Health Month—the R.A.I.S.E. campaign. R.A.I.S.E. stands for risk-taking, anger, isolation, substance misuse, which is the area you were just discussing, and exhaustion. The campaign primarily focused on depression among men, particularly because of the rise in depression that the BACP therapists who were surveyed found among their male clients.

The campaign looked at some of the sometimes overlooked symptoms of depression. As we have found as therapists, depression can manifest in many different ways. It can affect your mood, your behaviour and your thoughts. It can also impact how you are managing emotionally and your relationships. What we found with the R.A.I.S.E. campaign, through the acronym, was that some of the more well-known symptoms of depression have been risk-taking, isolation, anger, substance misuse and exhaustion.

As part of the campaign, we as therapists, including myself, put together a booklet to explore all of the different areas of the acronym, to identify how they are manifested and how they are triggered, and to provide some explanation and ways of seeking help if you are experiencing any risk-taking behaviour; if you are exhibiting any anger; if you are exhibiting any isolation; if you are engaging in substance misuse or over-smoking or drinking, overeating, and if you are experiencing any exhaustion. The booklet is a tool for you to understand how you are experiencing that, how to seek support and ways of accessing that support through the NHS, the third sector—private therapists—and workplace employee assistance programmes.

As therapists, we have found that among a lot of younger men at university there is often under-utilisation of counselling services. The booklet specifically states that accessing your university counselling service is quite helpful in managing the symptoms of depression. As you said, it is quite a difficult picture. We are hoping that, through the campaign, we can actually shed some light on managing some of the difficult symptoms of depression in addition to some of the physical and—

Q3 **Chair:** Are you aware of a book by Matt Rudd called "Man Down: Why

Men are Unhappy and What We Can Do About It"? It is a very amusing, but touching, book. You are nodding, so I guess that you are aware of it.

Anthony Davis: I have heard of it, but I haven't read it.

Q4 **Chair:** Could you expand on the exhaustion bit of R.A.I.S.E? I think a lot of men of middle age, in which I just about count myself, would understand and identify with exhaustion. You say in your R.A.I.S.E. campaign that it manifests as burnout from work and irregular sleeping patterns. This Committee is very interested in poor sleep and withdrawing from normal activities as a public health and mental health issue. Could you expand on exhaustion?

Anthony Davis: Those are the very common symptoms of exhaustion. Among men it is quite tricky because we may find that "While I feel exhausted, sleepy, fatigued and burnt-out, I have to keep going because I don't want to appear weak." What the campaign and the symptoms are trying to help you identify is that they are a sign you have to slow down. You have to relax. You have to set more boundaries. If you are feeling fatigued or burnt out, it can actually help you to feel more emotional, but if you are not able to access those emotions, you are going to continue to engage in the cycle of overworking yourself and not setting boundaries. We hope that recognising the symptoms can break that cycle and help you to access the emotions that contribute to you feeling exhausted, feeling burnt-out and increasingly fatigued, and help you to seek help for that immediately.

Sleep hygiene is very important. I talk to a lot of my clients about that. Interestingly, most people do not really understand the benefits of getting a good night's sleep. Some people think that three or four hours is enough. I would say definitely not. Ideally, at a minimum, it should be six hours, but seven is the optimum level. When I shed this light around sleep hygiene with clients and they start to change their patterns of sleep, ideally not being on screens before going to bed and taking a good 10 or 15 minutes to settle into bed and using bed as a way of relaxation, not to engage in obtrusive thoughts, anxieties and stresses about the day but changing that routine, they realise the next morning that they are actually energised and able go into work and engage with their colleagues, loved ones and friends.

Just changing minimal habits around sleep hygiene and minimising the exhaustion the following day from not getting a good night's sleep can make a significant difference to your mental health and wellbeing. It is really important with exhaustion that we look at many different facets. It is burnout, sleep hygiene and even healthy eating, just engaging in eating healthier foods—meats, fruits and berries—and drinking lots of water. People do not drink water. It is quite tricky. I know we have water here, but most people forget to drink water during the day. Drinking water, flushing out the toxins from your body and making sure that you digest food properly can really have an impact on your health and fitness

and minimise exhaustion. It is just highlighting some of the habits that can be infused into your daily routine to minimise that for men.

Q5 **Chair:** Can people find details of the R.A.I.S.E. campaign on your website and social media?

Anthony Davis: Definitely.

Q6 **Chair:** I am going to bring in Paul Blomfield, who will bring in Joy, and bring us joy as well. Male sexual health, and male fertility and impotence, is a huge problem across the western world. We heard about it when we were in Asia last month. We shouldn't be ashamed or embarrassed to talk about that. Would you talk about the role that male sexual health plays in men's mental health as it stands today?

Anthony Davis: When we think about men's mental health in terms of sexuality and engaging in sexual behaviour, it ties into the ideologies around masculinity. It is important to understand that just because you are either infertile or maybe your performance is inhibited and you are experiencing some impotence, it does not mean that you are less of a man per se. It is thinking about different ways with men of how to explore their sexuality, sexual performance and sexual behaviour, rather than the more traditional ways of having sex or engaging in sexual pleasure.

There has been more of a conservatist view around sex and it is difficult to break out of that. That is particularly the case among heterosexual men, as I have found with my clients. They are very concerned about being able to procreate, please their partner and engage in long periods of sex. Sometimes, it is just exploring the pleasure, and not the time or virility of your sexual performance. It is breaking outside that paradigm of conservatist views around sexual performance, and looking at infertility not as a weakness but as something that can be explored differently. It is thinking about adoption if you want to have children, or thinking about different ways of exploring that with your partner. With gay or bisexual men, it can lead to some unhealthy behaviours around sex. Having a healthier view around their sexual behaviour is really important.

Chair: Fascinating; thank you. Let's bring in Paul Blomfield.

Q7 **Paul Blomfield:** Thank you, Chair. As you say, I want to bring in Joy to talk a little bit more about some of the issues around suicide, which Anthony has touched on. Obviously, we know that the suicide rate among men is three times higher than for women. It is the biggest killer of young men. What we are interested to find out more about is why that is not improving for men, as it is for women. Since 1981, the suicide rates for women have halved, although from a lower base, but for men they have only fallen by 17%. Why isn't more progress being made in tackling male suicide?

Joy Hibbins: There are many reasons. One of the ongoing reasons is the challenge that men find in seeking help. It perhaps still is not recognised

how difficult it can be to take the first step to seek help. It is something that became very apparent when we opened our suicide crisis centre 10 years ago.

The usual way to access our service initially is by phone, but we found from the very first weeks that a lot of men did not feel able either to pick up the phone to seek help or to walk into a centre to seek help. We found that we were getting short emails or short text messages. To give an example, one of our first clients was a man who sent a three-line email explaining that his wife of 20 years had left him unexpectedly and he was planning to end his life. Of course, when we met him there were multiple contributory factors. It is nearly always a complex interplay of different factors that leads someone to the point of wanting to end their life, but it was more possible for him to start to seek help by sending a short, written message.

Part of that seems to be about sending an exploratory text or email. If they have never sought help before, what they are doing in that email is seeing what kind of response they get, and how they feel about the response. Do they feel comfortable with what comes back to them? Over the course of about three days, we were emailing back and forth. It was only at that point that he felt ready to come into the centre and see us, but even then, on the day he came in, he was pacing up and down outside. One of our team needed to go out and gently encourage him in. He said that, even when he came in, his first instinct was to run out.

I was the person who happened to see that client. I came in pretty much immediately he came in and was seated. That first appointment built a connection that allowed him to continue to have face-to-face support. What he was seeking initially was not text support or email support, because that is available very helpfully in other services. It was about the small steps he needed to take to seek help, and to be able to seek help in a way that is not always possible when you are trying to access a face-to-face service. Ultimately, what he wanted was to find the kind of support where he would be known, where he could build a connection and where he could feel that the team cared about him and cared about his survival, because at that point he felt so alone.

The other aspect, which I think applies to a lot of men in their middle years—he was a man in his middle years—was that he was someone who was perceived as the rock of the family, someone everybody else turned to. That made it incredibly hard for him to be the one seeking help. He ruled out seeking help from his family members, his young adult children, and similarly from his peers. As has already been mentioned, talking about deeply painful emotional issues was not something that he grew up being used to. There were many factors that influenced how he accessed the service.

Another important point is that many men, when they are seeking help, do not want anyone else to know that they are, other than the service.

There are many wonderful crisis cafés that have been set up around the UK. They are wonderful for people who, when they are seeking crisis support, like to have the support of their peers, to be around other service users and to feel additional support from that. We found that many of the men who were accessing our service needed to know that they could come in and not be seen by anyone but us, and not be seen by anyone else accessing our service.

As well as applying to men in general, it applied in particular to certain groups of men. Doctors or police officers were worried about being seen by someone they had met on a police welfare check or someone they had treated at their GP surgery. There are mental health clinicians, psychiatrists and many other groups of professionals, such as university lecturers, who were worried about meeting a student if they went to a drop-in crisis centre. Teachers worried about meeting a parent. There were many challenges in accessing alternatives to crisis services, and challenges to accessing statutory mental health services or even going to their GP. That would lead to their mental health crisis being documented on their medical record and many men, particularly in certain professions, worried about the impact that that could have on their current employment and on their future employment.

One of the reasons why men's suicide rates are not falling as much as we all would have hoped is that there are many challenges to accessing care, so we should realise that we may need to tailor crisis care very much to men's needs. Another aspect that has been touched on is that when men seek help they feel vulnerable. Feeling vulnerable can be incredibly difficult for men. It is not something that they may have done before. What often happens in statutory services is that you go to a statutory mental health service and feel a loss of control because the clinicians decide how often they see you, what kind of treatment you receive and when you are ready to be discharged.

We put all our clients in control as much as possible. We found that for men in particular that seems to be very important. It seems to counteract the sense of vulnerability that they feel in seeking help. They need to understand, right from the start, that as much as possible, "You will be in control of your care in terms of how often we see you, the kind of care you receive and when you feel ready to leave our service." But when they are at risk, we must actively and tenaciously intervene to protect their life. That is a key part of how all crisis services should work.

There is ongoing tenacity, and proactively staying in contact with the clients in crisis, recognising that at every stage during their crisis journey it may be harder for them to reach out to you. It is about proactively reaching out and ensuring their safety.

Q8 **Paul Blomfield:** Thank you very much. We recognise many of the points that you make from the evidence we have had. There is a commonality in men's reluctance to seek help that applies across mental and physical

health. There is a whole lot which we could explore at enormous length, but I won't.

Are there any other lessons? Obviously, we have been very successful in tackling women's suicide rates. Are there any lessons from that that we can apply, or are men just so profoundly different?

Joy Hibbins: Perhaps there are differences. We know that there are differences in the kinds of methods that men usually use. They tend to use methods that are more immediate, more violent and more likely to have the end result that they die by suicide.

One of the things that we found in our research into deaths by suicide, where we attend at inquest and listen to every word of evidence, was that sometimes men were seeking help from their GP but, for example, GPs were not always aware that someone appearing brighter in mood might be a sign of increased risk. So often, we hear that at the last GP appointment before they died, they seemed brighter and to have improved. That is still a point to be incredibly vigilant. Being brighter in mood can, for various reasons, mean that someone has more energy, sadly, to end their life having previously been profoundly depressed. Being brighter in mood can be a sign that someone has made a decision. Of course, being elated can very much be a sign that someone has made a decision to end their life. That is widely known among psychiatric services, but we found that it was not so widely known among GPs.

There seem to be many factors; for men in their middle years, there are the particular aspects of the challenge in seeking help and being the person that everyone turns to. That applies in terms of work. If you are a doctor or a senior police officer, you are perhaps the person clients turn to, and your colleagues as well. You may be someone who is used to being there for everyone else. You may be someone who is very used to relying on your own resources. I think this is what happens to a lot of men in their middle years. They are very used to being self-reliant. Although that is perceived to be incredibly positive, it often means that a self-reliant person has never, at any point in their life, had the experience of seeking help. They are simply not used to seeking help. They are used to going through life, and when traumatic, painful events happen, they usually compartmentalise them, store them away and look after everyone else, whether it is looking after everyone else in the family or looking after clients and colleagues. Everything is supressed and buried.

Q9 **Paul Blomfield:** What we are interested in is how we can tackle that. We have seen relatively recently the publication of the latest suicide prevention strategy. How far do you think that addresses the issues that you are sharing with us? What more could it do? Does it adequately tackle the point that Anthony was making about the difference between men, not simply on the basis of ethnicity but class and other factors?

Joy Hibbins: Anthony, do you want to comment on that?

Anthony Davis: There are various environments where we can think about intervening with men, particularly, as you were describing, where there is the desire to be the provider, particularly the financial provider, for the family and not to seek help if they are experiencing stress or approaching burnout. An important source of intervention is normalising and being able to encourage men to talk about their mental health in the workplace, particularly workplaces and environments that foster a lot of stress, such as construction, farming, the financial industry and where men are travelling for long periods of time on the road. Those are the ones who usually come from some of the lower economic backgrounds. The ones who are the main financial providers come from working-class backgrounds and do not normally seek help for their mental or physical health. Enabling them in their work environments to talk about their mental and physical health—the two are linked—would be quite useful.

We found at the BACP that fostering more work with employee assistance programmes, encouraging men to do more training, and having mental health first aiders in the workplace can normalise that it is okay to talk about how you are feeling. It is okay to seek help, and it is okay to understand that your mental health and physical health are linked. If you are experiencing physical health symptoms, they may be linked to low mood or anxiety.

The BACP is one of the only professional bodies to have developed a recognised competency framework around tackling workplace counselling and mental wellbeing. This competency framework has been adopted by occupational health organisations, EAP providers and other employers across the sector. The framework, as I explained before, has been helping to encourage employers to ensure that they are providing the highest quality of mental health services for their employees, normalising talking about mental health and mental health illness and improving the quality of life for a lot of men, particularly those who work in organisations.

Suicidality, committing suicide and dying from suicide is highest among men who experience workplace stress, so one way that we, at the BACP, have found to tackle suicide is by encouraging employers to talk about mental health and helping them to encourage services that can support men who are experiencing mental health illness.

Q10 **Rachael Maskell:** I want to start by asking a little bit about the Department's suicide prevention strategy, which it published earlier this year. Do you think it goes far enough? What is missing from that strategy? Ultimately, we want to inform Government from this inquiry about opportunities to improve the mental wellbeing of men, and obviously reduce suicide in that sense. I am particularly interested in the light of the Zero Suicide Alliance being funded up to the tune of £2 million, and now that funding has been ended. What are the implications of that, Joy, and then Anthony?

Joy Hibbins: Thinking in general about the suicide prevention strategy, there was one thing that needs to be highlighted. Louis Appleby, very helpfully, talked about mental capacity and how that is sometimes a reason why people are denied services. Something that has come up very clearly from our research into deaths by suicide is that when men frequently access crisis services, and frequently access emergency services, what will happen is that mental health services start to require that the individual takes more responsibility when they are in crisis. This is a phrase that is also being used by clinicians at inquests, tragically: "We wanted them to take more responsibility."

To give you an example, Ashley, a young man whose inquest we attended, was someone who had frequently assessed crisis services, including emergency services, in the months before he died, expressing an intent to end his life. What that meant was that, on the night when Ashley died, he initially called 999 expressing the fact that he had harmed himself. There was a multi-agency plan in operation, with the emphasis on Ashley taking responsibility in a crisis. The 999 call handler asked Ashley to go home and tend to his wounds himself, as the plan was in operation.

As the evening went on, Ashley continued to call 999. It was only in his final call that the call handler, in her evidence at the inquest, said that she felt something was different. She asked for an ambulance to go out to him at the location where he was. Tragically, in the area where he was, they could not find him in time. It is believed that he died shortly after he made that final call. At inquest it was not designated an article 2. An article 2 inquest is when it is recognised that there is a real and immediate risk to life. The coroner was persuaded that because Ashley had frequently expressed an intention to end his life in the months before that night, they could not have been expected to realise that there was a real and immediate risk.

What we know from 10 years of running a crisis service is that every time someone comes to us in crisis, every time they express suicidal intent, we must take that as a real and immediate risk and respond. It is a mental health emergency every time it occurs. It is an absolute tragedy that instances like that continue to happen. We know from ongoing attendance at inquests that again and again psychiatrists say, "We wanted them to take more responsibility," and that has happened even when individuals are detained under the Mental Health Act in a psychiatric hospital, where individuals have been able to access items on the ward to end their life because, as the clinician said at the inquest, "We were trying to encourage them to take more responsibility." That phrase does not understand what it is like to be in a suicidal crisis. There needs to be a change in the training of psychiatric clinicians, particularly crisis teams in psychiatric hospitals, to really understand how profoundly different someone's thinking is when they are in suicidal crisis. In almost every case, they are not thinking in the way that they usually would. It is the least likely time when someone is able to navigate their way out of a

crisis—to be able to think clearly enough to take the steps to navigate out of a crisis. They are not thinking in a clear enough way to be able to do that. That is why we need to intervene and protect life.

One of the things I would love to see in a suicide prevention strategy is an examination of the kind of training that crisis teams have, and psychiatric teams in general, including psychiatrists. We have advising psychiatrists and advising psychologists in our charity who openly say that they do not have enough training in suicide prevention. There is not enough understanding. If they could really understand more about someone's thought processes at that time, it might move us away from the expectation that someone who frequently accesses services should be able to use their own strategies. Having your own strategies to use in a period of crisis is really important, but for any one of us there may come a point when we are no longer able to draw on our own strategies. A change that I would love to see is recognition that there is a need for a change of training for crisis teams.

Q11 **Rachael Maskell:** Anthony, what else would you want to see in that strategy?

Anthony Davis: I completely agree with the description of statutory mental health services not being understanding, or as inclusive or nuanced in understanding someone's suicide ideation and intervening quickly. There has to be more support and funding for third sector organisations like Joy's, to ensure that they can provide vital and important work in the community for men who are experiencing suicide ideation, and giving support as quickly as possible.

The BACP found with the Charities Aid Foundation that 82% of charity leaders are worried about the cost of utilities, maintaining staff and getting volunteers, and 71% are concerned about the increase in demand for their services. Given those statistics, it is really important that we call for recognition in a suicide prevention strategy of the vital role that third sector organisations have in meeting men's mental health needs and preventing suicide, and for further funding to offset some of the financial pressures that organisations are facing, particularly in a cost of living crisis. Rent is increasing, utilities are increasing, and people require more support to maintain basic needs. Services specialising in work with men in preventing suicide have expertise; they are removing the barriers for men seeking support. More funding for those third sector organisations is vital.

It would be great to have more training offered for therapists in private practice and therapists working within organisations. I myself have a background in social work, so I have quite a lot of training around safeguarding, adults' procedures and suicide ideation, as well as understanding mental health illness and working in the statutory services in the NHS and local authorities. Some therapists do not have that background and training. There should be more funding towards that for therapist access in the community. What we find in private practice is

that we are usually at the frontline of supporting a client and hearing about their suicidal thoughts and suicide ideation. We usually refer them to access statutory services, but, as Joy was explaining, sometimes those services are not as responsive or nuanced in their approach. Training therapists in the community to support quickly and have an understanding around managing suicide ideation and preventing suicide is really important as well.

Q12 **Rachael Maskell:** I was interested in the evidence we looked through on the need for better literacy around suicide. It is really important for agencies as well as for individuals.

I want to turn to young people. A lot of what we are doing as a Committee is to look at prevention and where risk can occur, making early interventions to put people on a different trajectory. I was very interested in the identification of risk factors in boys and what is seen in early childhood. There are links to trauma and other experiences for boys, which then could lead on to a trajectory that puts them at higher risk of suicide. Anthony, is there anything that you have seen in practice or across the BPS which could identify those risk factors and where intervention can be made to de-escalate that risk?

Anthony Davis: I primarily work with adults over 18, but in listening to their histories I find that a lot of the adults who exhibit symptoms of trauma in their late 20s or early 30s usually have a traumatic or adverse life event in childhood that has not been processed and has not been recognised. All those emotions are suppressed and under the surface. Once they reach adulthood and they are triggered in some way, or they are in a relationship that triggers some attachment issues or residual trauma, it comes to the surface. Usually in therapy with adults, we are working through childhood trauma that has not been processed.

The BACP proposes counselling and therapy in schools so that we can recognise and support young boys who exhibit some behaviours that may be characteristic of experiencing either trauma or adverse life events. We are hoping to have more therapists in schools to support teachers and families, and enable them to recognise those symptoms in young boys so that we can intervene quickly and not wait until they are adults. We can support them to process trauma that has not been in process before.

We are trying to encourage a strategy for funding for therapists in schools, and we are proposing that to the Government at the moment. It is quite tricky because they usually separate a lot of the therapies that are provided in schools and making them either more privatised or in the third sector. Sometimes they come under adult social care, which does not really provide therapy per se. It is more of a case management function. We are hoping that there will be a separate stream of therapy for children in schools. That is what we are proposing.

Q13 **Rachael Maskell:** Joy, I have a very quick question. One of the observations was that 45% of males aged 40 to 54 lived alone. Earlier,

you were talking about access to services. Is there a correlation anywhere that you can identify between the fact that perhaps people are quite isolated and their access to services?

Joy Hibbins: One of the things that is important is looking at GP surgeries. We often think about the GP's role in identifying risk factors, and we are currently working with a group of GPs in Birmingham who are devising a training programme for receptionists and frontline staff. Part of it is to try to identify risk factors at the point when they access the GP surgery and to recognise the very important role that receptionists and admin staff can play.

What we are doing with the GP surgery is creating a package that identifies some of the known risk factors and making frontline reception staff aware— for example, when individuals are experiencing chronic pain. We know that chronic pain is, indeed, a risk factor and someone who contacts the service about chronic pain may well be experiencing suicidal thoughts. Those are going to be routinely explored when somebody is accessing the service for other kinds of health issues, recognising the profound difficulty in disclosing those thoughts and with frontline staff being part of identifying individuals who may be at risk. It was the doctors' idea to create that. I think it is a fantastic idea.

Q14 **Rachael Maskell:** Thank you. It reminds me of an expert who came to one of my constituency surgeries and said that whether it is A&E, your GP or other interfaces, it is really important to ask direct questions, and to make that the routine, which backs that up.

Joy Hibbins: Even when it is not being disclosed, when they come for a completely different matter, a health issue, it is recognising that that health issue may place them at higher risk, and exploring whether they are experiencing thoughts of suicide.

Chair: Thanks. We are fairly tight on time because we have another panel, of more people than this panel. We have to be done by 11.30—five minutes either way. James is going to demonstrate that.

Q15 **James Morris:** I have a quick question on psychological approaches. If you take a man who is suffering from what you would call depressive symptoms, typically they would go to the GP. In the health system we have at the moment, they would probably get referred to what was previously called IAPT, which broadly speaking is cognitive behavioural therapy, and that is the dominant mode of psychotherapy available on the NHS. Is there any evidence that that is adequate or inadequate to the needs? Do we need to think a little bit more about ensuring that we have greater choice or a greater range of psychotherapeutic interventions available on the NHS?

Joy Hibbins: That is an incredibly important point. In psychiatric services, if somebody gets as far as psychiatric services, they are increasingly taking a person-centred approach and thinking, "Do we need to give this individual a therapist who can draw on other types of therapy

as well as CBT?" Of course, that is usually when someone is going into what may be called complex psychological interventions. As you rightly say, if you go into IAPT it is nearly always CBT.

Anthony Davis: It is like a postcode lottery per se. I am speaking for London specifically. Depending on which local authority you live in, when you go to your GP, some IAPT services have different tiers. You may be offered some guided help around CBT, and you will be directed to a website or given a book, or you will be seen by a psychological wellbeing practitioner. That is for more low level, low intensity symptoms of depression or any mental health illness.

In tier 2, you will be seen by a high-intensity CBT therapist. Depending on where you live in London, they may offer interpersonal therapy or mindfulness-based cognitive behavioural therapy. Those are more intensive forms of psychotherapy. Tier 3 is usually statutory services with community-based mental health teams, or a psychiatric hospital under the Mental Health Act.

I would suggest that, if there can be more funding to ensure that there is a more universal offering of more intensive services in IAPT, all local authorities could access it, as opposed to saying, "If you are in one local authority you will get a more sophisticated service versus another one where you may get a lower-level service." More funding goes into IAPT because they have the therapies we want to offer—the more intensive therapies—and they have the strategies in place, but they do not have the money. Offering more funding towards IAPT services in various local authorities could be quite helpful in order to make it a more varied approach. At the moment, because IAPT is so inundated with referrals, they are referring out to private therapists. I often get referrals from clients who say, "I went to my GP, but I couldn't access even the lowest level of IAPT support. I need private therapy." Funding is definitely needed.

Q16 **Mrs Hamilton:** A lot of what I wanted to talk about has been covered, so I just want to raise one point. I think you are lucky if you get the support you need. It is literally a roulette wheel, and you are really lucky to get the services.

I do not want to say "most men", but men do not like talking to others, as you have identified. If you go to the doctor, they probably give you five minutes or some madness. A lot of men haven't even got through the first sentence in five minutes. You get very high-performing men who have survived with alcohol—as it says here, the percentage is 36%—and 31% have drug misuse.

I am specifically looking at ethnic minority groups. A lot of young men in our community cannot even read because they did not go through schooling. You get that in the white working-class community and some of our Bangladeshi and other communities. I know I am lengthening it, but the question is this. What are the best ways to raise awareness of

symptoms of men with mental illness? How do we get into those groups? They are not hard to reach, but we do not reach them and then they go and walk in front of a train.

Anthony Davis: It is important, as I mentioned before, that we identify the third sector organisations within a community that are embedded in the black minority ethnic community, the south Asian community—

Q17 **Mrs Hamilton:** Let me stop you there. The funding for many of them is being withdrawn.

Anthony Davis: I completely agree. What I want to propose is that more funding is given to those organisations in order to provide those vital services, to reach out to those under-reached men who are not able to access services and who find it difficult to actually discuss their mental health. There are quite a lot of third sector organisations, particularly in the east London area and the south-east London area, that are trying to reach those under-represented groups but they do not have the funding to do so, so they cannot provide that support. I think there are third sector organisations that can be identified and more funding can be given to them in order to be able to reach the groups that you are identifying.

Q18 **Mrs Hamilton:** If I spin it to you, Joy, what about very high-performing men: men working in the City or men who use cocaine or heroin or—I call it "wacky baccy"? Forgive me. What's the proper name? You know the one I mean.

Joy Hibbins: Cannabis.

Q19 **Mrs Hamilton:** That's it. They use cannabis as standard. How can we get to those groups? They are very intelligent and articulate, but they have chosen to do it their way.

Joy Hibbins: Yes. For many individuals who are using drugs of any kind, trauma is often at the root of it. It may be about the kind of awareness campaigns that we do. We have not yet seen a television programme on prime-time television that focuses on the kind of things that everybody can do to help somebody else in a suicidal crisis. Everybody can be aware of their colleagues around them. A lot of it is about creating greater awareness, and perhaps having role models who come from the specific groups that you have mentioned, who are willing to speak publicly about their experiences. They can recognise that somebody else is in a similar position to them and is very willing to say that they are struggling and that they have struggled. That is incredibly important to talk about openly.

It is often the people who are in very high-profile positions who struggle to seek help because they feel that there is a perception that they are an incredibly capable person, and what it would imply to seek help. There needs to be a lot of media awareness around the challenges that people in high positions face in seeking help in a mental health crisis. Documentaries are powerful in reaching many people; someone can

watch privately at home without anybody else knowing that it is something they are learning from.

It is thinking about different ways that we can reach individuals that are comfortable for them. There is not enough on prime-time television to help educate the public in general about warning signs and what everyone can do to help someone in a crisis situation. It is so important to recognise that someone in a position of authority may not go to a statutory service or may not go to a drop-in service, but may need a particular kind of tailored support that they know they can access anonymously, but be known to that service.

Mrs Hamilton: Thank you for that excellent answer.

Chair: Finally, #wackybaccy.

Mrs Hamilton: I really am sorry.

Chair: No, I like that. It's very good. Caroline Johnson wants to ask Joy a quick question.

Q20 **Dr Johnson:** I want to talk about identifying those at risk. You gave the very compelling story of Ashley and his repeated calls for assistance that fell on deaf ears until, tragically, it was too late to save him. You mentioned the training and professionals, and how that relates to it.

One of the things that is commonly said—I was told this as a doctor when I was training—is that it can be very difficult to identify patients who are going to commit suicide because those who say they are going to and very frequently come in a crisis are often not those who commit suicide. Those who do very often have no predictor at all. Do the current statistics bear that out? If they don't, what proportion of people have no perceived signs before they commit suicide? What are we doing to identify the signs that are there?

Joy Hibbins: Thank you. That is a really helpful question. It is helpful to go back to what you mentioned about someone frequently accessing services. What we know from attending inquests, and it is recognised more now among psychiatric services, is that people who frequently access services and state suicidal intent tragically do frequently go on to end their life. I think that is known about now in psychiatric services, but perhaps not outside psychiatric services. That is why, understandably, the perception remains, including in the wider public, that someone frequently accessing services will not go on to end their life.

Sometimes, it is an accidental death, where someone is frequently self-harming in a way that carries huge risks. Equally, it can be that something changes in the final days or weeks and their intent increases. It is about that change. Sometimes there are predictors; for example, someone who was self-harming in a very high-risk way in a hospital, rather than doing it in a public area, did it for the first time in their room, and doing it in their room a second time, tragically they ended their life.

In terms of no warning signs, there is an important area to explore. Part of it is that, as adults, we become adept at presenting as though we are okay when we are going through the most painful and challenging times. In order to do our daily work, we have to suppress all the kind of inner pain and turmoil that we might be experiencing in our personal lives. We become very well equipped at presenting as though we are okay when we are very far from okay. That is why someone who is planning to end their life may not show any visible signs because they have become so accomplished, as part of existing in modern society, at presenting as though they are okay in work and at home.

That is an area that needs a huge amount of exploration. Sometimes there are signs, and I will give a couple of examples from our research into deaths by suicide. A family member was concerned about one of their loved ones and took them along to see a doctor. The doctor said, "They are absolutely fine, a lovely young man; he's not suicidal at all." The parent asked about some of the body language that the young man was using. One of the things that they said was, "Was he covering his mouth when he spoke to you?" The doctor said, "Yes, he was covering his mouth with his top." The family, who knew him, said, "Well, he does that when he's trying to withhold something, or he's not telling the truth."

There may well have been very subtle signs of change that might only be recognisable to someone very close to that individual. Yes, we hear people very frequently say, "I saw no signs at all." I think that is absolutely because we are so accomplished at presenting in a particular way in our daily lives. Tragically, many of the men who come to us say that they do not want to tell their family members because they perceive that it would be a burden to them; it would worry them and it would frighten them. Of course, in almost every case they would much rather know and have the opportunity to help. The reasons why people keep this very tight inside them are many and varied.

The way that we can change this is at a much earlier stage through education. It is still perceived as very desirable to be self-reliant. You rely on yourself. You do not need other people to help you through difficult times. It is actually a really unhelpful approach in the longer term. If we can encourage help-seeking from an early stage, it is beneficial for our mental health. It is not something I ever learnt growing up. I am a female. I am a very self-reliant person, but that was incredibly unhelpful for me and one of the reasons why I experienced a suicidal crisis. I wasn't used to asking for help. It is something we need to learn and it needs to be very much part of our earlier education. Instead of encouraging us to be self-reliant and independent, we also need other people. It is really good for our ongoing mental health to seek help and to talk to people.

Q21 **Chair:** I am going to stop it there, because next we have a three-person panel. Joy Hibbins and Anthony Davis, thank you very much for being part of us. The second panel guests are sitting behind you. We will have a

very quick changeover now while I introduce them. Thank you very much. Enjoy Christmas, when it comes.

Examination of witnesses

Witnesses: Charlie Bethel, Tim Taylor and Sarah Meek.

Q22 **Chair:** I am going to kick off the second panel by asking some general stuff, and then I will bring in Dr Caroline Johnson. We are very fortunate to have Charlie Bethel with us, who is the chief executive officer of the UK Men's Sheds Association. We all have men's sheds in our constituencies. It is very nice to have you here. We have Tim Taylor, the head of public health at Leeds City Council. In the reading that I do around this inquiry, I continually hear about Leeds and its approach to how seriously it takes men's health. That is good. You are the apple of our eye. Sarah Meek is the managing director of Mates in Mind, which is a charity that provides information to employers on how to support mental health and wellbeing among staff. I have a quick question to all three of you, starting with Charlie. What are the common threads that you see and would identify around where men's mental health is in our country today?

Charlie Bethel: The most common is that it is not talked about. People are not prepared to talk about it in open environments.

Q23 **Chair:** Is that right? We are always talking about it in here. We are always hearing about it in the media, and people say it is not talked about. I am sorry to challenge you, but why would you say it is not talked about? Surely it is constantly talked about.

Charlie Bethel: I don't think it is really talked about in open conversation with people. You need to be in the right environment, perhaps with the right activity, and then it is talked about. Very often, and it is quite common—I was accused of this last week by my wife—I go and talk to somebody for 20 minutes. She will say, "What were you talking about?" I say, "Oh, nothing really." It is just passing time. We may have a conversation, but to really talk about how you are feeling and to come up with solutions, it is important that you are in the right environment to do that. In the case of men's sheds, it is doing the right activity. We observe that men talk shoulder to shoulder, but they will not talk face to face. The outcomes from sheds are quite clear on that.

Q24 **Chair:** Shoulder to shoulder?

Charlie Bethel: Yes. The example I would give is that if you put 12 men in a square room, like this one, and ask them to talk about their feelings, six will leave and the other six will try to find the corners of the room, but being men, we can't quite work it out. However, if you put a lawn mower in the middle of the room and say, "Fix it," after two hours those men will know each other intimately. They will know what ails them, their names, the names of their grandchildren, how they take their tea and coffee and how they are feeling. It is because there is that activity, that focus, that

purpose. That is the environment where men will talk and open up a lot more. It could be an art class. It could be whatever. It happens in the workplace when people are comfortable and feel safe. It needs to be non-competitive as well.

Q25 **Chair:** That's what happens in the sheds.

Charlie Bethel: Yes, that's what happens in the sheds, but it is a model that doesn't have to just stay in the shed. It can happen in other environments as well. I think that is really important.

Q26 **Chair:** Shoulder to shoulder at the urinal. You can talk then, or does that not happen? Anyway, I will leave that one hanging, so to speak. Tim, common threads.

Tim Taylor: I think I would agree with that. Men talk about mental health in different settings. In Leeds, we have some great examples of businesses like Kier Construction, male-dominated businesses, talking about men's mental health. You also have barbers; you have chip shops; you have non-typical settings. One of the approaches that we have taken in Leeds, which is successful, is that, rather than waiting for people to go to services, you actually go out into communities. We have services that go to working men's clubs. We have services that go into pubs. They are perhaps non-typical public health places, but they engage with people, find out what they are interested in and then set up groups around that. Some men don't want it in their face when they are talking about health, whereas with others it is health by stealth and doing it through different approaches as well. That is one of the main points I wanted to make. The other point is that men are homogeneous. Some men will love sheds. I like a shed. Other men like different approaches. Some men like sport. Some men might like to go walking. There are different approaches for different people.

Another thing to state is that there are multiple risk factors. It is not just being a man. It might be that you have a protected characteristic. It might be your ethnicity. It might be issues around how much money you have. We have to look at it through different lenses.

Q27 **Chair:** Sarah, the same question to you.

Sarah Meek: We focus predominantly on construction. We see a lot of men on the sites, of all different backgrounds, ethnicities and aspects that you find in a building site. Will they talk about absolutely everything else? Yes, probably, but we are seeing some really good pockets of best practice now, where it is becoming part of someone's induction to the site and is as important as the safety aspect that has taken the construction industry from where it used to be to where it is now. Where you treat health like safety, you will start to get some really good changes.

We work with apprentices coming through colleges as well. We are preparing the next generation coming into the construction industry to be more aware of themselves and others. We are training their tutors to

deliver that on an ongoing basis because we saw that the predominantly male students coming through were not accessing the colleges' pastoral care, as compared with students on all the other courses running through colleges. People wanted to know why that was. There is an absolute shift after they have had an awareness session, after they know about it, know that it is okay and can recognise the signs in themselves and in others.

Chair: Fascinating. An illuminating start.

Q28 **Rachael Maskell:** This is a really fascinating area of inquiry. I was struck by the Norwich City football advert that was launched in October. I thought that it was incredibly powerful. How can popular media play a stronger role in some of the work that you are doing, Charlie, to make connections with people?

Charlie Bethel: I think it is about awareness, but awareness with a language that speaks to people. That advert was excellent, not only because of the football setting but because of the behaviours of the two men. Men won't necessarily say that they are feeling depressed or that they are anxious. They won't necessarily recognise it either; they talk about being angry or fed up.

The media can promote that as well, so that people can recognise how they are actually feeling, but again in a non-invasive way. It is not, "Here we go again about our health." It can be funny and there can be a fun way of doing it, but it can also allow people to explore how they feel. That language is really important because—I don't think it is just men—we do not necessarily recognise how we feel.

We see it a lot of the time in sheds as well, with the way people talk, and it will change with who they talk to, which is one of the reasons for men-only sessions. For example, at a shed in Camden a guy was talking to me about how he felt depressed and down after he retired and the honeymoon period was over. As soon as the person I was meeting—a lady—came in, he said, "Ah, I was at a loose end." It is important not only that the media uses the right language but that it translates that language.

Q29 **Rachael Maskell:** Sarah, can I go on a slightly different path with you to look at the workplace? Obviously, it is a very powerful place. We spend most of our waking hours at work. We often talk about physical health checks. Mental health checks are equally important. What more can be done in the work space, particularly with occupational health?

Sarah Meek: In things like construction, you have a real mixture of people from all different backgrounds; one in every four in construction identifies as neurodiverse. There is a direct link with an increase in mental health challenges. You have people who have touched the criminal justice system. Again, we have some aspects there. Within the suicide prevention strategy, if we know that we have someone coming

into the workplace who is in the high-risk categories of people, what can we do proactively and preventively to support them through their mental health challenges?

As we know, mental ill health does not discriminate according to someone's job role, background and so on. It can come to anybody at any time. Work-related stress, in particular around psychosocial risk factors, can have a huge impact. A lot of employers are not aware of their duty of care around making sure that it is a psychologically safe environment for somebody to thrive in.

A lot of services favour crisis support—the reactive rather than the proactive—when actually it should be a completely holistic model. When you have prevention, you are breaking down the barriers and normalising mental health in the workforce in order to signpost, hopefully at an earlier stage, rather than waiting for services to respond quickly. Unfortunately, in some areas it has become a bit of a tick-box exercise. We see situations where one in every two members of the organisation is mental health first aid trained, but that is unregulated and it is not doing anything around prevention, to stop people getting to the point of crisis.

Chair: As we know from our prevention inquiry, that is not exclusive to mental health. It is everything.

Q30 **Rachael Maskell:** Could the HSE do more? I am particularly interested in bullying at work. I have draft legislation around that. Is there more that could be done in the interventions that are made on that front?

Sarah Meek: We have certainly advocated that. The HSE has management standards in place. It has the ability to go into any organisation at any time to see the risk assessments and the proactive steps that have been taken to address those, but very few, if any, assessments are undertaken. My background is in healthcare, where the CQC had to start coming in unannounced and taking a real stance on quality and safety. There needs to be that element of expecting a visit to take place.

We might see some enforcement of that as well, where there is some consequence when somebody has failed in their duty. As we know, work-related stress can have a huge impact. Our patron lost her husband, Chris, to work-related stress. He was 30 years in the construction industry and was a very well-respected manager. Unfortunately, through work-related stress and lack of sleep, it got to the point where he took his life. There needs to be strong acknowledgment that work-related stress can kill.

Q31 **Rachael Maskell:** Tim, I love what you are doing in Leeds. It's amazing, but there is an issue: ensuring that there is sustainable funding. I notice that you have drawn down National Lottery funds, which come and go. How would you get a sustained funding model to be able to deliver a comprehensive service? What do you need from Government?

Tim Taylor: That is a really good point. "The State of Men's Health in Leeds", which we put together, talks about the assets and needs of the city. We have the men's health network, which has been going since 1998, so for quite a while. That is a really diverse set of third sector partners. I listened to the last conversation, which was about the messenger being more important than the message and about trust—lack of trust in local government, central Government and the NHS. Local voices are crucial in getting some of the messages across. We also had Professor Alan White, who is an expert, just next door to where we were. He advised us on lots of our approaches.

The first bit is that we try to mainstream our approach. By having the needs assessment, we are able to train up commissioners in the city. In all of our contracts, we looked at it first from a men's perspective, looking at the state of men's health. Then we looked at it from a women's perspective and did the subsequent report. We are also able to bid for money from the Big Lottery. We got money for three years. We are going through another bid at the moment. We are having discussions with the Big Lottery about it as we speak. That is great, but I don't think it is a massively sustainable option.

One of the approaches that we took was to work not just with the partners on men's health but with the network, to try to represent all the diversity of the organisations. That was probably what was missing in Leeds. We worked really closely with a consortium of women's organisations called Women's Lives Leeds. We looked at their model of a consortium of all of the different talents and interests in the city. There is definitely a need for recurrent funding for that. We have become an expert reference group. If people have issues around men's health, they go to Men's Health Unlocked, but if you start up a brilliant project and don't have more than three years, you are starting again, aren't you?

Q32 **Chair:** Do other local authorities contact you all the time, Tim, and say, "We've heard about what you're doing in Leeds. How did you do it?"

Tim Taylor: Yes, a bit of that. A variety of people—myself, colleagues from Men's Health Unlocked and Alan—have presented at different conferences, so we often get inquiries about that approach. There is similar great work happening up and down the country. We are lucky to have done the needs assessment and built on that work, and to have a really strong foundation. We try to share it, where we can.

Chair: Brilliant. That is really interesting.

Q33 **James Morris:** Tim, I don't know whether you were here in the previous session when I asked a question about access to services in the public health system, particularly around IAPT and so on. Do you have any comments about the level of funding, the appropriateness and the ease of access to cognitive behavioural therapy for men? Is it adequately funded? Do we need a greater variety of approaches? Do you have any observations on that?

Tim Taylor: I am not an expert on IAPT, but I know that there are pressures in terms of access to IAPT in Leeds, as there are in other parts of the country. It is an evidence-based approach, but it will not work for all men. There need to be alternatives, depending on what the need is.

Q34 **James Morris:** Sarah and Charlie, there is a lot of evidence that peer-to-peer support is much more powerful. I have done some work on this in the school environment. Where peers talk to peers about mental health issues, when you take away authority figures or interaction that suggests that it is some sort of shameful problem to be talked about, the outcomes are incredibly positive. Sarah, what you said about apprentices was interesting. Do we need to do more about peer-to-peer support?

Sarah Meek: Absolutely. The whole model of Mates in Mind is around developing a peer-to-peer support network. We start with the general workforce so that it becomes everybody's business. You are going to identify the person you want to speak to, not the person who has the right-coloured lanyard on. You should not have to go through an office to get somewhere or to go to a particular room, the wellbeing room, for example. You are going to find where you feel most comfortable, which is why it is so important to have that peer-to-peer aspect.

It important to have a particular focus on the line managers as well—the squeezed middle who are trying to support whatever the exec direction is, but also to manage the operational things on the ground. Very often they have the tools and the ability to change somebody's work pressures. That is another area we focus on, to make sure that it becomes everybody's business and that gradually, through the organisation, as we have seen in Balfour Beatty, it becomes part of the induction, there is refresher training—

Q35 **James Morris:** It is mainstreamed, as it were.

Sarah Meek: Absolutely. At the colleges, training tutors to deliver it on an ongoing basis means that it is not just a flash in the pan but becomes widespread in the college as well.

Another issue is the transition from classroom to workplace. As we know, this is a generation who have lost a lot of their education and mental health maturity through covid. They are perhaps not quite as prepared. Earlier we touched on the importance of social media, diet, sleep and all the other contributory factors, such as gambling, alcohol and drugs. Particularly when it comes to a construction site, you have some of those coming into play. There is a link with accidents, potentially, as well. If employers understand the training and awareness that the students have had, it starts to create the culture change and sea change that we so desperately need.

Q36 **James Morris:** Charlie, I presume that peer-to-peer support is fundamental to your concept.

Charlie Bethel: Yes. It is pretty much what it does. It is not only about mental health. It is also around the physical. One of the key things about the environments that are sheds is that they give an opportunity to talk about other health issues, such as prostate cancer.

One example is Fred. I think his name is Fred, but we will anonymise him to Fred. Fred had lost sight in one eye and was starting to lose sight in the other. His colleagues—his peers—decided to try to do something about it, because Fred would not go to the doctor, the chemist or pharmacy. We see that when we look at Thriving Communities only 24% were men, which is pretty high, bearing in mind that they probably wouldn't go to the doctor's in the first place. He wouldn't go, he followed the trend, but his peers looked it up to see what he had. They took him down to the doctor's, and he can now see out of both eyes. Wellbeing is not just about mental health. It is also about the physical.

The same applies to prostate cancer. Last week, one shed told me that they sent, or actively encouraged, or bullied—whichever way you want to look at it—one of their shedders to get his prostate checked. He came out with a prescription for something completely different, because when he got there it was a female doctor. The environment there was not right for him. He is going back and he now knows what to do. That group of peers can encourage you more than somebody telling you. It is them helping you to come to that conclusion yourself.

Q37 **Chair:** That is amazing. You call them shedders.

Charlie Bethel: Yes.

Q38 **Chair:** Sarah, have you ever been asked to work with the UK Parliament?

Sarah Meek: No, but we absolutely encourage any organisation to work with us. Although we started up originally around construction and have moved into transport and logistics, any workplace is absolutely open to work with us, anywhere there is a degree of work-related stress and you need some awareness, particularly around the restoration and renewal of the building. We had 6,317 suicides in 2021; 507 of those were in construction. When we take on a project of any size, it is extremely important that we build into any procurement and contract award what we are going to do preventively. We would relish the thought of supporting Parliament on anything to do with mental health awareness and education.

Q39 **Chair:** We would be a ripe environment, with lots of stress and lots of people who don't look after themselves, in an organisation that just wants to get on with doing what it is doing.

Sarah Meek: We look forward to hearing from you.

Chair: Don't hold your breath. Paulette, would you like to come in?

Q40 **Mrs Hamilton:** Yes, thank you. Good morning, all. Charlie, my first

question is specifically for you. It is about the sheds. I love the idea. Where are the sheds based? The reason I am asking is that I am a fanatic, not that I have an allotment. How are you getting people to communicate with the sheds? How have you spread that across to other areas? I go to a walking group and do parkrun. There are other men who join parkrun. You have men who do sports activities. My husband is mad on records, so he has joined a community where they play only vinyl records, and nothing past 2000. That can tell you how old I am. He is not a fanatic, but he enjoys it.

Chair: It sounds like you need a shed, Paulette.

Q41 **Mrs Hamilton:** Trust me. The point I am trying to make is, how are you finding these sheds and building the groups?

Charlie Bethel: First, your nearest is Perry Common work shed. You have one.

Q42 **Mrs Hamilton:** It's in my patch.

Charlie Bethel: Yes. That's yours.

Q43 **Mrs Hamilton:** I didn't know that. I will go and visit it.

Charlie Bethel: Get him down there.

Mrs Hamilton: Yes.

Charlie Bethel: You all have sheds within 15 minutes of where you are. Sheds will appear. We help to develop sheds. There is a need, so we are quite reactive in some ways, but proactive in others. We talk to community groups. We try to bring groups of men together to set up the sheds because that makes them sustainable. Rather than doing it to the communities, we work with communities to set up the sheds.

The biggest challenge that we have is property. You do not need a property to be a shed. As soon as the men come together, they can help each another by being in that group. We find them in retail units, industrial units and community centres, in particular. There are also a couple in disused morgues.

Mrs Hamilton: Morgues?

Charlie Bethel: Yes. Any kind of facility that is disused. They are not being used any more. They try to find any patch of land. Allotments are starting to develop sheds, because they have added value. There is one shed, in Weybridge, that provides security over the winter months. Because the shed is there, they have built a toilet for everybody. They fix everybody's sheds for them. They mow the lawns for everybody.

Getting the word out is difficult. A lot of sheds are already over capacity. They opened a lot more after covid lockdowns because of the rule of six. That encouraged them to open on more days, but they are at capacity.

We get questions from social prescribing, saying, "Why won't this shed take anybody else?" There is a waiting list of 20 from the local community, or 20 miles away. Our ambition is to see at least 2,500 sheds. We are at 1,200 across the UK at the moment, thanks to the work of many organisations. Our aim is to see that doubled so that there is a shed for every 4,000 people. Somewhere like Orkney has two sheds, so it is quite possible for a town of 10,000 to have two or three sheds.

The issue is trying to find the property. Not to do anyone a disservice, it is the case that, if you build it, people come, because it is such a needed environment. There is a shed in Aldridge, not far from you, where a group of men make guitars, banjos and other musical instruments because that is their interest. They have formed a band as a result. There are lots of offshoots from the activities that happen. All sheds will form what they do, whether it is 3D printing or carving.

Q44 **Mrs Hamilton:** That's fantastic. My last question is for Tim. I know quite a bit about the work that you guys do in Leeds. You have someone who promotes it really well. I want to ask about Leeds Dads and the fact that you managed to get 1,000 fathers together. I am about numbers. How on earth did you do it?

Tim Taylor: I can't talk to it. Errol, who leads that programme, would be able to. I can give you some of the contact details around the work they do. They are a brilliant group. They are incredibly diverse, with different backgrounds and ethnicities. All sorts of different men go to that group. I think that it is by being fun and being accessible in different places. I can forward the details and find out a little more about it.

Q45 **Mrs Hamilton:** I'll tell you why I ask. It goes back to Rachael's question. My concern is this. Back in the early days, I was the mental health champion in Birmingham. We managed to start so much of this work. We went on for two or three years, with bits of funding. Then it all died a death because the money got removed. Is there anything happening to mainstream that work in Leeds so that you do not lose the good work that has been done?

Tim Taylor: It is a real risk around third sector funding. A recent report was done by the third sector about the significant losses that it has had in the past year or so. I don't know Errol's particular funding formula, but we can find out about it.

Q46 **Mrs Hamilton:** It is just a thought. It is so forward thinking, as an authority. Local government is always thought of as being reactive and not proactive. If this is as important as people are saying, how are local authorities looking to mainstream some of this work at the end of the three years?

Tim Taylor: Absolutely. I agree with you.

Q47 **Mrs Hamilton:** But no answer. I will leave it there.

Tim Taylor: We need more money.

Chair: That was a fascinating insight into the Hamilton household. Where she is going to store all this vinyl, who knows? The last five minutes or so are with Caroline Johnson.

Q48 **Dr Johnson:** I want to ask about the men's sheds project. You talked about fixing lawnmowers and doing productive activities together. Do you literally break a lawnmower for it to be fixed or do you link with other organisations so that your activity is adding to the community in different ways?

Charlie Bethel: Yes. We don't go around breaking lawnmowers.

Q49 **Dr Johnson:** How do you choose the activities? How do you make them link to wider community projects?

Charlie Bethel: First, purpose and focus is really important for the shed. Time and again, we get told, "It's that that has allowed me to forget about being lonely or depressed or about my finances."

Sheds are all autonomous of us. They find local projects. A shed will do probably 30% of the work on itself, to make projects. This Christmas they will be making lots of reindeer and Christmas trees to sell in the community to fundraise for themselves. Thirty per cent. of the time will be spent on shedders making stuff for themselves or their families.

The other element will be working in the community. That might be making bird boxes. There is a shed on the border of Wales that makes owl boxes for the local wildlife trust and a whole variety of things. You cannot walk in because there are bird boxes of different sizes everywhere. Last year, a shed made 17 xylophones for a school. The shed found out that the school had an issue with funding for the music department, so they did that. Unfortunately for the kids, they then played the xylophones to them. They do raised flower beds at community centres, particularly for groups of people with disabilities. They do work in the community.

One of our surveys, involving 500 shedders, showed that part of the impact of that was that 88% felt more connected to the community after joining a shed. It is not only about the value to the community. We have not assessed that. We have not paid for that kind of research, to look at the pound that the shed delivers in the community, but we know that 88% of the people doing that work feel more connected. They go on to volunteer in different groups. Railway stations on the way to my village railway station have planters made by a local shed. They do all sorts of things. They make quite bizarre things as well.

Q50 **Dr Johnson:** That is brilliant to hear. The other question I have is about boys. Presumably, a lot of the attitudes and behaviour of men to do with asking for help, which we have talked about a lot this morning, are set at some point during childhood. What work are you aware of with boys to

try to encourage them to develop the help-seeking behaviour that has been talked about so that they can talk about their feelings openly?

Charlie Bethel: I don't quite understand. Within the shed?

Q51 **Dr Johnson:** This morning we talked about how men don't like to seek help. They don't ask for help, compared with women. Presumably, that is a behaviour that is learnt at some point during childhood; they're not born not to ask for help. There will be an extent to which that is a condition from society. Is there any work to help young boys—teenage boys, perhaps—to consider how they can best share their feelings and seek help? How can we signpost them to what is there?

Charlie Bethel: From my perspective and what we observe, it is about role models. There are a number of sheds that work with schools. One, in particular, works with children who are close to being excluded from those schools. It is showing them positive behaviours. There was an example at a health conference that I attended a couple of weeks ago where somebody went the opposite way. This was in the early 2000s. He was excluded, went to work on a building site at 13 and then went down a dangerous path towards crime, alcoholism and drugs. He managed to turn himself around. It is about giving positive role models in those spaces.

At Men's Sheds, we are very much in favour of the decision to bring in a men's health champion because it gives a platform for the conversation to happen. That is essential. It helps where you can give those positive role models. In my children's primary school there is only one male teacher, but that is so important to me, and to my son particularly. I have two girls and a boy. The role model piece is essential. If you get the right messaging, it will help on the journey. It will not solve it completely. We have thousands of years of patriarchy.

Chair: Brilliant. Thanks very much, Tim Taylor from Leeds City Council, Sarah Meek from Mates in Mind and Charlie Bethel, chief shedder at the UK Men's Sheds Association. That was one of the most interesting sessions that we have had in a long time. Thank you very much for your time.