

Women and Equalities Committee

Oral evidence: [Mental health of men and boys](#), HC 1721

Wednesday 12 June 2019

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Members present: Mrs Maria Miller (Chair); Tonia Antoniazzi; Sarah Champion; Vicky Ford; Eddie Hughes.

Questions 1–61

Witnesses

I: Sarah Niblock, Chief Executive, UK Council for Psychotherapy; Ruth Sutherland, Chief Executive Officer, Samaritans; Andy Bell, Deputy Chief Executive, Centre for Mental Health.

II: Dr Andrew Molodynski, Mental Health Policy Lead, British Medical Association; Dr Louise Theodosiou, Vice-Chair, Child and Adolescent Faculty, Royal College of Psychiatrists; Professor Tim Kendall, National Clinical Director for Mental Health, NHS England.

Written evidence from witnesses:

- [British Medical Association](#)
- [Centre for Mental Health](#)
- [NHS England](#)
- [Royal College of Psychiatrists](#)
- [Samaritans](#)
- [UK Council for Psychotherapy](#)

Examination of witnesses

Witnesses: Sarah Niblock, Ruth Sutherland and Andy Bell.

Q1 Chair: Good morning. This is the first oral evidence session of the Select Committee's inquiry into the mental health of men and boys. We are going to be dealing with some quite difficult issues this morning and I am conscious of that. I would like to suggest that anybody who is listening to this who wants to talk more about any of these issues, if it affects them personally, might want to consider calling the Samaritans. Their public number is 116123. Obviously, we will try to deal with this in a way that gets the evidence aired in an appropriate manner. Before we go to questions that members have, could I just ask each of our witnesses to say their name and the organisation they represent?

Ruth Sutherland: I am Ruth Sutherland. I am the CEO of Samaritans UK and Ireland.

Sarah Niblock: I am Sarah Niblock and I am chief exec of the UK Council for Psychotherapy.

Andy Bell: I am Andy Bell from the Centre for Mental Health.

Q2 Eddie Hughes: Good morning. Can you talk us through what the main causes are of poor mental health among men and boys?

Ruth Sutherland: The first thing to say is that men are not a homogeneous group. We should be cautious about generalisations. That said, Samaritans report on men and suicide sets out how, for many working class men in particular, the male gender role is very narrow and constraining.

Mental health issues are often a factor in suicide, but it is important to think of suicide not just as being to do with mental illness. The majority of people who die by suicide are not known to services in any way. That is significant. There are risk factors amongst men and boys, which include things like personality traits. Samaritans research found six traits to be particularly significant to making people more vulnerable to suicide, including things like the desire to be perfect, self-criticism, concrete, black-and-white thinking, brooding and no positive thoughts for the future. Suicide risk is especially high when these traits interact with other factors, such as deprivation, isolation and distressing life events and behaviours.

There is also an area around middle age. Problems with relationships and employment in mid-life are experienced intensely, because this stage of life is usually associated with stability and security. When plans, decisions and things that have been made earlier in life fail, they can be felt intensely. It can be devastating when people think that they have made mistakes that they are then trapped in and they cannot do other things.



In terms of alcohol and drug use, men are more likely to self-medicate around their emotional health. The risk of suicide when someone is abusing alcohol is eight times higher than when they are not drinking or not abusing alcohol.

Adverse childhood experiences increase the suicide risk. For men who have experienced difficulty in childhood and maybe have had mental health problems or alcohol problems, they all culminate in mid-life. It is that 45-to-49 age group that are the most at risk.

Sarah Niblock: I would agree with what Ruth has said. One of the big challenges is that it is very much a silent crisis. It is a silent epidemic amongst men. We do not know enough. There needs to be a lot more interrogation of the issues.

I have a couple of things to really stress, one of which is the emotional and psychological distress that is felt by certain groups of men. I agree with the point that we cannot make generalisations about men per se, but the way that these things are sometimes revealed do not sit well with the typical ways in which mental health is diagnosed within services. It is certainly the case that men, masculinity and gender can intersect with certain contextual issues that affect the way that men will respond and feel. It is shown through research that some men may be much more likely to lack some of the precursors for good mental health, such as a positive engagement with education. As you said, boys are unfortunately often excluded from school for acting out, which may actually be something to do with mental distress. Likewise, there is the emotional support of family and friends, and this acute relationship with the identity of work as well. It is important to look at that.

It is also the case that 36% of referrals to IAPT were through men. We have to take into account that women, by a significant proportion, are more likely to make attempts upon their own life, but 76% of completed suicides are by men.

Q3 **Eddie Hughes:** Do you have anything to add, Andy?

Andy Bell: I will try to add what I can to that. First of all, what we know is that many of the causes of poor mental health will be similar for men and women, and indeed boys and girls, in terms of the things that are toxic to our mental health or protect our mental health. Clearly, there is a gendered element to them and they may be experienced differently by boys and men or girls and women. Broadly, we are talking about economic and social inequalities. We know there are higher rates of depression in more unequal societies. There is good international evidence for that. We know that living in consistent, persistent poverty is a big risk factor for poor mental health, as is insecure housing. Being a child from insecure housing is associated with very high rates of later poor mental health.

Q4 **Eddie Hughes:** For example, for the issue of housing, that would be a



similar impact regardless of gender.

Andy Bell: Yes, but nonetheless it is really significant. Again, abuse, neglect and bullying are huge risk factors for poor mental health. That can be bullying at any stage of your life. Again, boys may experience abuse and bullying differently to girls, but it is still an incredibly important risk. We have particularly found experiences of discrimination and marginalisation are really important for young men. We have looked at the experiences of young men growing up in African and Caribbean communities in Birmingham and found that the things that are toxic to their mental health are very often related to experiences of everyday racism and micro-level aggressions that wear and tear away at wellbeing, putting them at risk.

Of course, there are also things that protect mental health, such as positive parenting, good education and having enough money to live on. There are ways in which we can protect and promote good mental wellbeing. It is about maximising the things that protect you and minimising the things that put you at risk.

Q5 Eddie Hughes: Can we stick with that theme? Could you elaborate on some other ideas with regard to how we could address the issues that have been identified?

Andy Bell: We know a lot more now about the things that can help to prevent poor mental health or promote good mental health. Again, some of these will have a gender element. For example, we know that boys are particularly at risk of serious behavioural problems at a young age. Serious behavioural problems put you at a massive risk of every possible adult life adverse outcome. Very often, we still see persistent bad behaviour as being a disciplinary issue. We know that is very often how poor mental health is manifested in boys and girls when they experience them.

We know evidence-based parenting programmes that work with groups of parents who are struggling to manage their children's behaviour, or are at risk of doing so, can have a really positive effect. It is one of the areas of evidence-based mental health intervention that we barely do at any kind of scale in this country, and yet we know from international evidence it is really effective.

We also know it is really important to have whole-school approaches to mental health, which is a bit of a jargon phrase for embedding a culture of supporting mental health across an entire school. That is about having anti-bullying programmes; it is about having social and emotional learning in the classroom; it is about supporting teachers with their mental health, giving them knowledge and training.

We know that youth work is incredibly important, particularly for the most vulnerable groups of young people. We are seeing many of the most creative and interesting approaches to supporting emotional



wellbeing among young people, and young men in particular. For example, the work of MAC-UK is very much about using traditional youth work approaches but with a really strong psychological dimension.

Q6 Chair: You said that serious behavioural problems would be a particular issue for boys. Are there any other particular issues for men and boys that might be triggers for mental health problems?

Andy Bell: There are probably not many that are so specific to men and boys, but we know that there will be things such as financial insecurity or debt that may be particular issues in later adult life. Again, most of the risk factors are as much for women and girls as they are for boys and men, on the whole. I suspect we probably need to do more targeted and focused research to understand which groups of people face particular risks from what adverse experiences in life and how we can work with those groups to support them to have better wellbeing.

Q7 Eddie Hughes: Why would men be considerably less likely to access support for mental health problems?

Sarah Niblock: That is a very interesting question. I echo the point that we need to know more. We need to design services based on a lot more in-depth evidence and research into this.

One thing that we hear all the time is that there seems to be this blanket term that is applied to particular gender identities. Men are a very diverse group. We hear that perhaps the services designed are very much more female-coded, as is the language around therapeutic or treatment approaches to mental health. There is something that we need to do to make these services more appropriate and acceptable for men to come forward. One of the huge problems we have is that the issue around stigma is much more acutely held amongst certain groups of men. It is very difficult sometimes to recognise the feelings of distress. There is plenty of research that shows that, even though men may be suffering, they do not necessarily recognise that because that emotional literacy, even from a very early age, is not inculcated. As Andy was saying, in terms of talking about mental health at an early stage in schools, there is not that language for boys.

In terms of responses, it is very important—and we would say that there is an opportunity—for the Government and for the Department of Health to look into ensuring that there is much more cultural awareness and competencies amongst the workforce. For instance, walking into my local GP, you have to tell somebody on the desk, who is often female, why you want an appointment and what it is that is causing you concern. That immediately could be a huge barrier for men coming forward and speaking about it in the first place.

I love the data. I really welcome the amount of data-gathering that is being done around this issue. One of the problems with data and empirical data is what that is based on. Since men often do not talk and



cannot self-assess their situations, are you really getting the data that is going to help to design services that will work? Within our organisation, there are about 10,000 therapists who are hearing, every day, men's experiences, lived experiences, of dealing with work, family issues and all kinds of things. The key question that our psychotherapists are asked by men is, "Am I normal? Is what I am experiencing normal?" That goes to show that, societally, we still have a huge hurdle to cross to foster a much more inclusive, diverse and psychotherapeutically informed language around men's mental well-being.

Ruth Sutherland: If I could just add on this thing about the difference between men and women, in terms of the journey towards suicide—and this is where it is perhaps different from mental illness per se—is that the propensity to it is the same. The difference between men and women is the opportunities to interrupt that thinking. Women are more likely to give out distress signals that are read by other women and people will ask you if you are okay. Healthy ways that men cope with stress and things are things like exercise, sport, music and hobbies. Those will be ways that people manage stress, but in those relationships that they have with other men, usually, in those hobbies and things, they are not sharing information about emotions. They are more sharing information about the activities that they are doing, so the opportunities for recognising that somebody is in distress are not there. As people get deeper into suicidal thinking, which is really difficult, it starts to become attractive because it is a solution to your problem.

Suicide is a response to unbearable emotional pain and there will be personality traits, circumstances, an adverse childhood and difficult things that happen that all contribute. It is not that everybody will have those same things, but it is that terrible mix of things and then not getting interrupted and then thinking, "I am a burden. I am trapped. The decent thing for me to do here is to leave and to end my pain".

We have to have very different ways, and one of the examples I would give is the work we do in prisons, where we train prisoners to provide peer support to other prisoners. We are not saying to those people who we are training, "You make yourself vulnerable. Tell us about your emotional health". We are saying, "Can you help your mate? Can you help somebody else?" In the process of them helping somebody else, they are acquiring skills and knowledge themselves. We have been running that service for over 25 years now, it operates in every prison in the country and it is a really important intervention with a very at-risk group.

One last thing I wanted to say was about Network Rail training rail staff to intervene. The impact on the workers themselves, who are mostly middle-aged men, has been really impactful, as well as saving lives on the rail.

Q8 Vicky Ford: On the issue about men not reaching out and showing the



distress signals, do you think that the next generation is a bit better at that?

Ruth Sutherland: Younger people, in my experience and through the work in Samaritans, are much more emotionally literate, and I think that it will be. We did do a piece of research this year on men, and there was quite a high level of men who said, "It is okay not to be okay"—they got that message—but when asked, "What are you likely to do about it?" 40% said, "I should deal with my own problems".

We are reducing stigma and we are getting to people. On your point about the literacy and the words, when people ring Samaritans we have long silences. Half of the people who contact Samaritans—we have 5.5 million contacts a year—are men. Men do talk, but our model of service is confidential, non-judgmental, you are in charge and it is peer support and coaching, but there are long, long silences, because people do not have the words.

Sarah Niblock: That is absolutely right. We do not want people to get to the point where they feel that they have reached a situation where they are at crisis. We are at a very exciting time, in the sense that we do have celebrities and what might be described as "alpha male" characters—top sportspeople, members of the royal family and military veterans—talking and encouraging other men to talk about this.

One of the problems we are facing—Ruth is at the sharp end of this—is about where they go with that conversation. Can they start talking to their immediate friends and family? Is that something they feel they can do? Therapies offer a safe, completely non-judgmental and highly confidential space for people to share what they cannot share with their workmates. The idea that you have a chat with the colleague sat next to you still has a huge amount of stigma around it. What we do know is that where there is patient choice, where people are able to have some agency, as Ruth was describing, about people being able to act and to make decisions, we found that in health trusts where people offer more of a range of options, where people are able to choose the intervention, that has been most successful. We have seen much better outcomes in those cases.

Q9 **Eddie Hughes:** We have Fathers' Mental Health Day coming up on 17 June. Do you think enough is being done to support fathers and perhaps particularly new fathers in respect of mental health?

Sarah Niblock: We welcome the movements in relation to parental leave, particularly for fathers, but one simple step is to recognise that for both parents, whether that is a male-female family or whether it is a much more diverse family, childbirth impacts partners regardless of gender. There is lots of research to show that postnatal depression is felt by men as well as women. It may be different; it may come out in different ways. It is certainly more apparent in situations where the mother themselves is experiencing depression after a birth. People tend



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to associate that or reduce that to hormones in women, but it can be due to very stressful situations that are contextual that people find themselves in, worrying about work or worrying about the relationship, and men feel that acutely.

Imagine a man who has become a father for the first time; maybe he does not have strong parental role models in his own life; maybe his partner has had an extremely difficult birth; maybe she is struggling a little bit. He may be very worried. He might have a very uncertain job situation. These things happen.

One of the things that would be a good solution—there is so much evidence from Sweden and Iceland of how effective this is—is to equalize parental leave for whatever gender is in the relationship. That way, instead of it being optional, it means that, where it is men, fathers will be able to gain confidence in their parental skills. There is also so much research that the children benefit from that parental involvement at an early stage. There is a simple solution.

It is also about, again, designing services that recognise that it is not just men who are breadwinners and women who are the caregivers; men can be and should be caregivers, in lots of different ways. Again, it gets back to cultural competency of the services and making sure that they are accessible and appealing to all.

Ruth Sutherland: Could I just emphasise that point about the inequality? What could be done to alleviate concerns is working on the wider determinants of health. Suicide is not just a gender inequality issue; it is an economic inequality issue. Prosperity for all—jobs, income, housing—is something that Government can work on. At local authority level, all local authorities now have suicide prevention plans. We have just been involved in an assessment of those plans. It is yet to be published but our belief is that they are targeting men. With local authorities, as you will know, it is amazing, when it is not a mandatory thing, that they even have their plans in place. It is difficult for them to prioritise the amount of resource that is needed at local level, but it is at local level that we would probably make the most difference.

Andy Bell: We had a look at the distinctive role that fathers and partners have in a child's mental health, and there are some really important things that it is really important not to miss. We know that for women during pregnancy, poor mental health and anxiety before the baby is born is often a predictor of postnatal depression, for example, and so it is really important to intervene at that point. Very often, the partner is the person who will act as a buffer against the stresses of being pregnant, particularly if someone is having a difficult pregnancy and, indeed, may be the person who encourages the woman to seek help. Supporting fathers at that time, during pregnancy, as well as after the baby is born is really important. Fathers will have their own mental health support



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needs, which again are sometimes seen as secondary and not as important, but we know they are.

The point about father-friendly employment practices is absolutely right, but also making sure that where you have access to parenting programmes, they are seen as being for partners as well as for mums. Very often, parenting programmes are seen as something that is for the mum and it is absolutely for both.

We can do a lot more to support fathers, to enjoy good mental health themselves but also to fulfil their potential as positive parents.

Q10 Tonia Antoniazzi: How effective do you think the national suicide prevention strategy has been in reducing suicide rates amongst men and boys, especially those who are most at risk?

Ruth Sutherland: There has been a huge amount of progress on the suicide prevention plan. The Health Select Committee did a review recently of how effective the plan was. The big message out of that was around implementation: that the strategy was sound, but it was how it was being enabled and implemented. The focus in this last phase has been a lot more about implementation.

The Minister for Suicide Prevention, Jackie Doyle-Price, has been appointed. That is the first Minister for Suicide Prevention in the entire world. It is a brilliant thing, but probably as important is her leadership of a cross-Government group. There is a suicide prevention delivery group, and it is about each Government Department dialling up what they are currently doing to see what the contribution is. I would say that is work in progress. It is a good start, but some Government Departments are a bit more animated than others and they could join up more. There are things like the loneliness strategy. It is obvious that the loneliness strategy should integrate with the suicide prevention strategy, and I believe that there have been strides to do that.

There has been £25 million of additional money that has made available through NHS England. Samaritans argued, at the time, that that money would be best spent at local government level. That has been listened to and it has now been distributed through STPs, the sustainability and transformation partnerships.

Q11 Tonia Antoniazzi: How does that work for the devolved nations? Does it come from their Governments?

Ruth Sutherland: It is only England. There is no additional money for other countries. Scotland, Wales and Northern Ireland have their own suicide prevention money.

The other thing that has been very positive about that is the money has been targeted to the areas with the highest risk. Rather than give to all, it has been given to the areas of highest risk. There are eight pilots that are going on in areas of highest risk. The most important thing will be to



learn, and this is where we still have work to do. There are lots of initiatives and lots of things, but we need a proper review of what works with men. You have Men's Sheds, barber initiatives and lots of things that are really good, but if you only have a finite amount of money, would it not be better to have an evidence base so that we could spend the money on the things that work?

Q12 Tonia Antoniazzi: What more do you think can be done?

Ruth Sutherland: That thing about what works for who is really important. Local authorities need more money to do what they are trying to do. Directors of public health were moved to local authorities, which was a really good thing, but as soon as they were moved most of their budgets were cut, so they cannot deliver on what they want to do. Their commitment to their plans shows they want to do it, but often they cannot.

We have to think a lot more about more innovation and different ways. Doing more of the same is not going to tackle the men and boys thing, but I would keep going back to the low-income groups and the hardest-to-reach groups. That is where the work needs to be done. For the closest people and people in services, things are improving, but 70% of people who die by suicide are not in contact with any service, so it will be at local government level.

Sarah Niblock: Just as an example, there is a fascinating project that started in Colorado, involving the State of Colorado, a not-for-profit charity and a marketing agency, which have created a thing called Man Therapy. It was so successful in destigmatising and rearticulating men's mental health. It had huge uptake and was very much around early intervention.

On the strategy, I have said it already, but the danger with empirical data is that you are perhaps missing a huge seam of qualitative research and case studies. Our organisation has such a wealth of first-hand experience from talking to countless men every day about their experiences.

We must invest in early intervention. It is far more cost-effective than having to deal with the long-term outcomes. One solution is to ring-fence CCG mental health budgets, particularly in times of economic instability. It is critically important, because it is often the early intervention services that get hit and it is not cost-effective because of what you have to do further down the line when people hit acute crisis.

I agree we should invest in the research to find out what audiences will respond to, get the data, and then that data is just sitting there and we can help with that, but we also need to ring-fence budgets, because it is much more cost-effective. Ultimately, though, we still have a lot of work to do to challenge stereotypes, and some of that might be around the whole care profession, the way it is portrayed and understood as being very feminine-coded. You hear about primary school children thinking



that girls are nurses and boys are doctors. There is so much work to be done at societal and cultural level still, which we cannot do alone; we have to work collectively to challenge those stereotypes.

Andy Bell: What colleagues have said has been brilliant. The overall strategy for England is a very good one; it is very evidence-based and very thoughtful. It is an extraordinary achievement that every local authority in this country now has a plan to prevent suicides in their local community, and there is something about the urgent need to equip them with the resources to be able to implement those effectively. We know there is an extraordinary amount of commitment out there.

One of the things we do at the centre is to support a network of local elected members who are champions for mental health. Many of those have taken personal responsibility around suicide prevention, for example to provide bereavement support to families who have lost a family member through suicide, to support them through that process and reduce the risk for them.

The element that we really need to grasp hold of is where there are particular groups of people where there are very high risks, where it is not about changing the people but about changing the environment that they are in. We did a piece of work with the Howard League looking at prison suicides, and one of the messages that came out clearly from that is we need to change the prison environment and regime, to make it more appropriate for well-being to prioritise safety. We heard many examples of prisoners and staff who would say that they were not believed when they said that they felt suicidal or at risk, and that well-being is secondary to other things.

This is one example where, if you had an approach of mental health in all policies, you would begin to think about what prison would look like. What would schools look like? Would we be doing the same things around restrictive interventions in schools, among children, for example? You could begin to build institutions around psychological safety rather than just trying to influence the individual people and their own decisions.

Sarah Niblock: I have a couple of examples of that. We are working with urban psychology, working with planners and policymakers about the design of urban spaces, which of course are going to expand massively—city expansions globally are huge—and looking at climate change as well. Those are just two examples, as you say, of how getting involved in different areas of policymaking can create much more mentally healthy situations.

Q13 **Sarah Champion:** I am very interested in what you are saying. You have spoken about the broader pressures and risks on men and boys. I wonder if we can keep going in the direction that, Andy, you have taken and look at the specific societal pressures that might be on certain groups of men and boys, and the risks that they pose to their mental health. For example, young gay boys have a lot of bullying in school; as they grow



older, there is a lot of pressure around body image. Male survivors of childhood abuse tend to disclose decades later, if at all, and that could have a cumulative risk impact on their mental health. Ruth, you have 5.5 million calls, Sarah, you have 10,000 members, and Andy, from your experience, are there particular groups of men and boys who are at higher risk of mental unrest and poor mental health?

Ruth Sutherland: Yes. Again, low income—you are 10 times more likely to die from suicide if you are a middle-aged man in a low-income group than your male counterpart in a different group, so it is stark there. The disadvantage, as Andy said, starts all the way along. One of the things we have not talked about so much is about drugs and alcohol and the pressures to manage emotions yourself; that is where men and boys are at risk. There is risky behaviour, and things that we do not know anything about. There are the amount of single-vehicle deaths that there are. It is risky behaviour and the cocktail of all of those things.

If I may, just for a moment, I am also a Samaritan volunteer and I take calls on a weekly basis. I took a call from a man who was furious. He had had a row with his wife; he was at the end of the road. He was driving; I think he was drinking and he was driving, and he was driving erratically. I thought, "At any minute, I am going to hear a bang and this man has gone". With 40 minutes of talking, at 11.00 on a Friday evening, he had pulled in to a service station and we were talking in a more rational way. He needed a service to be available immediately. He had a heap of problems, from childhood difficulties to alcohol to all sort of problems—relationship problems, debt and everything—but he was not somebody who was going to go to his doctor. He had got to the point where this row was the moment that he was going.

When we finished the call, I thought about it. We had rehearsed with him what he was going to do when he went home to his relationship and what he was going to say and all of that kind of thing and he practised it all. I thought how different that would be from getting a policeman at your door to tell you that that person was not coming home anymore. He was in a high-risk group. I do not think that a woman would have been drinking and driving erratically and doing risky behaviour, though that is a generalisation. I think that people are more at risk from that kind of thing.

Q14 **Sarah Champion:** Sarah, are there particular groups of men and boys who are particularly at risk of poor mental health?

Sarah Niblock: I absolutely agree with what Ruth said. Our psychotherapists obviously do talk about experiences of black and minority ethnic clients and LGBTQ+, in terms of that sense of isolation and perceived or real rejection, but it is, by and large, middle-aged men who are experiencing under-employment or unemployment, who are often experiencing relationship breakdown as well. There are some NICE-approved therapies around family therapy and things like that, but certainly family structures is something that really affects men hard,



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when relationships collapse, so some work around that is quite important, but just generally where there is often a lack of social support.

Histories within families is another area. I grew up on Merseyside and worked as a journalist on Merseyside. I saw situations where, due to decline in traditional manufacturing industries, you had generations of boys—grandfathers, fathers, sons—with very little prospect of being able to work. That spiralled, in many cases, into substance use and dependency. You see that there are still huge historical, cultural notions around pride in one's professional identity and role as a breadwinner, which then get passed through generations.

There are shame-based situations. We are a culture that seems to create shame. We have had lots of conversations around digital media and social media images lately, and that is impacting men now very hard, in terms of role models for fathers. It is very difficult, but for that group particularly, middle-aged men, it is a hugely confusing picture.

Q15 Sarah Champion: Andy, you spoke about prisoners.

Andy Bell: Yes. I have a very long list and I shall try not to go through all of it.

Sarah Champion: Just give us the headlines.

Andy Bell: Yes. We know that, in terms of groups where there is a particularly high risk, we are certainly talking about some black and minority ethnic communities, though not all. Really importantly, we found that at the age of 11 being from a black, Asian or minority ethnic community is protective of good mental health, but something happens in teenage years that creates higher rates of poor mental health in early adulthood and onwards.

We know, again, that gay, bisexual and transgender men have very much higher rates of poor mental health, and it is really important to say that is not as a result of that sexual identity; it is a result of their experiences. We think bullying is really important there.

We know about people with any kind of disability. Learning disabilities, autism, physical disabilities and physical health problems inflate the risk of poor mental health markedly.

We know about anyone who has been looked after or in the care system, including those who were many years ago. There are homeless people, people who are unemployed and people on low or insecure incomes. There are also, really interestingly, people who leave the armed services early, not necessarily those who have seen active combat. The highest rates are in those who joined the armed services and leave early, for a variety of reasons. We know that is where you see very high rates of poor mental health.

Q16 Sarah Champion: In terms of the next step on from that, looking at



those specific groups, are there particular interventions that work with those groups?

Andy Bell: As ever, it will depend on what the group is, but what we know is that the most effective approaches are normally based on working with a group of people to find a solution that they find helpful. Again, looking at the work we evaluated in Birmingham, the ethos there was very much about working with young black men to design supportive interventions that they found helpful, in an environment they found comfortable. It is very much support based on relationships and building a continuous, consistent relationship with someone rather than seeing endless people, and certainly not going down the route where you have to be diagnosed with an illness and go along to a building marked "Mental Health". There are many barriers to traditional forms of help-seeking.

One of the few negatives that came out of that work in Birmingham is, even at the end of it, the young people said they still would not go near formal NHS services, so we have a long way to go to design services with and in partnership with some of these groups of people who have the highest levels of vulnerability.

Q17 Sarah Champion: Has there been any protective work, so before someone is facing poor mental health, to identify and put that support in place?

Andy Bell: There are examples of that. We know, inevitably, the earlier you intervene the better, so one of the important things is, if you take a youth work approach, for example, with young men, you are not waiting for someone to have a diagnosable illness to get access to a thing. You are saying, "Let us do some projects in our community. Let us create a psychologically safe space". We know, particularly for, say, young men in school who are at risk of exclusion that is a really important point. School exclusion follows a long period of undealt-with behavioural problems, and that school exclusion, in itself, is a massive risk for later problems. Working with people in schools, supporting good behaviours and not going down the route of restrictive interventions or off-rolling or all these other things we are seeing, and actually working creatively and constructively to manage that risk and to support that person and their family, if they are young enough, will make a marked difference later. Again, we really do need to build the evidence base around specific interventions with specific groups, but these are going to be the characteristics, we think.

Q18 Sarah Champion: Is there any work being done by Government at the moment on capturing that data?

Andy Bell: I am not aware of anything specific. The Government have put a lot of focus on school mental health and most of us have really welcomed the Green Paper and the actions around transforming children's mental health there. Inevitably, we do not think it goes far enough. We think it focuses on improving access to treatment, which is



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fantastic, but it does not necessarily do that earlier stuff. One of the things we would like to see is a broader, cross-Government approach to supporting children's mental health and well-being, particularly those who are most vulnerable and from the most excluded and marginalised communities. We think that would make a big difference. But there is commitment in Government. There is also a prevention Green Paper coming; that is a golden opportunity to embed some evidence-based approaches to supporting children, in particular, for their mental health and well-being, to put these interventions in place at a scale such as we have never seen before.

Q19 Vicky Ford: I was very taken by your story of the phone call. I have been told that men and boys can sometimes find an eyeball-to-eyeball conversation very challenging and that it can be easier to download on the telephone or, indeed, digitally, through a Skype conversation. Is there evidence for that?

Ruth Sutherland: Interestingly, across our channels—and we have email, text, with webchat coming, and phone—we get more men on the phone than on the digital channels. The digital channels seem to be more popular with women, and webchat is very popular with girls. 80% of Childline's activity is webchat, not phone.

Q20 Vicky Ford: I was told that the Skype face to face is easier than a physical face to face sometimes.

Sarah Niblock: It is very difficult to say. There is certainly evidence that shows it is the unique relationship that is built between the client or service user and the person they are working with; there is lots of evidence for that. We just do not know enough. To echo Andy's point, in terms of research, the funding has tended to go much more towards perhaps biomedical solutions or interventions when, in fact, there is not enough research going into the effectiveness of a wide variety of different therapeutic interventions, potentially preventative, and certainly not into the effectiveness of particular therapies for particular gender groups. That is something we would really urge for, and that should be qualitative as much as it is empirical, because it is so hard to get that testimony.

Echoing what has been said, particularly by Andy, one of the most important things again goes back to the language about not making people feel there is something wrong with them; it is what may have happened to people during their lifetimes. That is an important way, perhaps, of helping men and boys feel more heard and positive about their intervention.

Chair: Thank you very much. We have covered all the things that we want to cover today and thank you for making our first evidence session so informed and so informative. Thank you very much.

Examination of witnesses

Witnesses: Professor Tim Kendall, Dr Andrew Molodynski, and Dr Louise Theodosiou.

Q21 **Chair:** I would like to welcome our three new panellists to the second of our sessions today. As usual, members have a number of questions that they want to ask, but before we start with that, perhaps I could ask our witnesses to just say their name and where they are from.

Dr Theodosiou: Louise Theodosiou, Royal College of Psychiatrists.

Dr Molodynski: Andrew Molodynski, British Medical Association.

Professor Kendall: Tim Kendall, national clinical director for mental health, NHS England and NHS Improvement.

Q22 **Vicky Ford:** What are the biggest barriers preventing men and boys from accessing mental health services?

Dr Theodosiou: One of the biggest barriers is the cuts that there have been in the commissioning to addiction services. We know that addiction services are commissioned through the local authority and we know that there has been £700 million worth of cuts, and there is more to come. We also know that, in addition to the lack of resources, there is a need for ongoing training so that we can have enough staff at all levels of services for men and boys. We need those services to be offered in the flexible ways that were being touched on in the session before.

The other thing we need to think about is the vulnerabilities of specific groups of men and boys. For example, boys with ADHD, which we know is over-represented in people who have mental health needs, may need services that are delivered in specific and flexible ways. These are the different barriers that people face.

Q23 **Chair:** Why do you think, at a local a level, this area of funding is not being given priority?

Dr Theodosiou: Since the funding is coming through the local authority and there have been those cuts, they are simply—

Q24 **Chair:** Overall, the amount of money is not diminished; it is the relative priority in the local area. Why is the priority not being given to this area?

Dr Theodosiou: In terms of awareness of the area, it is about making sure that the importance of this area is emphasised. While addiction services were being commissioned through the same health routes as other health conditions, people had a clear understanding of the needs of people with addiction.

Q25 **Vicky Ford:** It is because of the link between drug, alcohol and mental



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health issues, so if you do not address the addiction services there is an impact on mental health services.

Dr Theodosiou: The two services do need to be delivered.

Q26 **Vicky Ford:** Andrew or Tim, do you want to add to that?

Dr Molodynski: As you say, overall funding for mental health services has increased a little bit over recent years, after a number of years of progressive reductions and cuts, which are very significant. As a very brief example, my team sees twice as many patients as it did five years ago, with exactly the same staff. You do not need to be a health expert to understand what that means for the patients, men and women.

Substance misuse services have been particularly hit. We are an interesting country in that we predominantly see substance misuse problems as a social and a personal issue, whereas if you go to the States or much of continental Europe, they are seen very much as a health issue, a medical issue. I would not say either is right or wrong, but our substance misuse services really have been neglected over recent years and they are not particularly assertive. They tend to rely on people going to them to access help; if you are drinking a couple of bottles of vodka a day or using crack or both, you are not that likely to get a couple of buses to go to your local or your not so local substance misuse service.

That particularly affects men, because 60% to 70% of people under the care of substance misuse services are men; they vastly outnumber females. It is the same for problem gambling and problem gaming; men vastly outweigh women in those realms. These things are all associated with a significantly increased risk of suicide, but also a significantly increased risk of just dying. There are many tens of thousands of men and women, but particularly men, who die from alcohol in this country, not through suicide but just by ruining their bodies.

Q27 **Sarah Champion:** You said 60% to 70% of people accessing the services are men. Do you think that correlates with the number of people who are misusing drugs and alcohol?

Dr Molodynski: My understanding of the evidence is that that is about right, yes; men are, roughly, twice as likely as women to be substance misusers.

Q28 **Vicky Ford:** You said that substance misuse in the UK tends to be treated as a societal issue rather than a health issue, and then you said that, in America, they treat it like a health issue. My impression was that substance misuse in America was high.

Dr Molodynski: Yes.

Q29 **Vicky Ford:** Are you recommending we should treat it as a health issue? What I am trying to ask is whether there are other countries that you think we should focus on as a good model here, because I am not sure that the American example is.



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Dr Molodynski: No, I was not suggesting that we should do what the Americans do. As a very specific example, in Geneva, a colleague of mine has a community assertive outreach service for people who are substance misusers who come to the attention of the police or casualty regularly. They will go and find them and assist them with practical things such as rent, benefits, detoxes in the community or in an inpatient environment, in order to help them. Also, particularly, they have found that it is cost-effective, because it reduces their healthcare use overall and their use of benefits in the long term. It is not a perfect system, but that part of the system does appear to be something that we could or should look at, and particularly look at the evidence for these things.

One of the big overarching issues in mental health care is the lack of research. In this country, our research spend on mental health research is 6% of what is in the national portfolio of NHS and other big charities, whereas we know the activity in mental health healthcare and social care is at least 25% to 28%. The disparity is enormous and there is so much we do not know.

Q30 **Chair:** It feels very much like we need to bring Tim in here to defend the NHS's position. You are coming under attack a bit.

Professor Kendall: It did not feel like an attack.

Q31 **Chair:** You are not getting the right priorities in the expenditure; you are not having a loud enough voice in terms of getting that resource on the ground.

Professor Kendall: In terms of the burden of mental health, out of the total burden of all health issues, 28% is mental health. If you go back to the beginning of the five-year forward view, before money was invested, it was about 10% investment going into mental health. Everybody agrees that mental health is under-invested and the consequence of that is poor access to services. If you go back three or four years, in terms of the access to children's mental health services, one in four children were getting care. To my mind, that is shocking. The five-year forward view is going to change that from 25% up to 35%. That is exactly the reason why NHS England, the Department of Health, the Secretaries of State for Education and Health invested in the Green Paper. That will address both the boys' problems and the girls' problems.

Q32 **Sarah Champion:** Sorry, I am just caught on your stat. You are saying that, in five years, one in three children will get access to mental health CAMHS.

Professor Kendall: At the end of the five-year forward view, yes, it will be one in three.

Sarah Champion: That is still really bad.

Q33 **Chair:** Is that one in three children who need help or one in three of all children?



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Professor Kendall: If you go out into the community, you find three times as many children with a mental health problem than are in CAMHS. The Green Paper started this year—

Q34 **Sarah Champion:** So it is not one in three referrals; it is one in three children would benefit from it.

Professor Kendall: No. One in three children who need mental health services are getting mental health services.

Q35 **Vicky Ford:** What happens to the two out of three children who need it and are not getting it?

Professor Kendall: Generally speaking, they are not getting anything. That is it.

Q36 **Vicky Ford:** There is no intention to change that.

Professor Kendall: No, there is. That is exactly what the Green Paper is. The Green Paper is going to change that radically. When asked what we should do to address this problem, get a mental health service into schools; that is exactly what we are going to do. That will go a long way to solving this problem about access.

Q37 **Vicky Ford:** Do you want to just give a bit more detail on how the Green Paper will solve it?

Professor Kendall: Over a period of 10 years—it sounds slow but this depends on workforce—we are gradually building up an entirely new mental health workforce that will work specifically in schools. That will double the number of people working with children's mental health. Effectively, for every 12 or so primary and secondary schools and colleges, you will have a team of eight or so specifically trained mental health workers who will go into schools. There will be people in schools who are trained to recognise mental health problems; they will have a lead in the school who is trained up to be the lead for mental health. We are assured that it will go into teacher training and that there will be more awareness around mental health for teachers.

Those services will be linked up with CAMHS services, they will deal predominantly with the mild to moderate, but probably some uncomplicated severe, and any who need more than that will be rapidly brought into CAMHS. This is a fantastic change, which the two Secretaries of State brought about.

Q38 **Vicky Ford:** That will help people of school age.

Professor Kendall: Yes.

Q39 **Vicky Ford:** What about older young people?

Professor Kendall: The long-term plan, which has kicked in this year, now sets out that our ambition is to have full services from nought to 25-year-olds. You probably know this. In terms of adult mental health,



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50% of all adult mental health problems have started by the time you are 14, which is why it is so awful leaving children's services at the level they have been. By the time you are 22, it is 75%, so we want to get a service in every part that goes from perinatal services right through to 25 years old, working with universities, which we have already started to do.

Q40 Vicky Ford: I can understand that, and I can understand that is great for the future, but what about people who are already over that age group?

Professor Kendall: We started working with universities about two years ago and we now have agreement with the universities that we are going to do joint work with them.

Q41 Vicky Ford: What about if you are 45?

Professor Kendall: It depends what the problem is. The long-term plan is going to invest £2.3 billion into mental health services across the entire age range. That will include services for middle-aged men, et cetera. One part of the five-year forward view is to invest £25 million specifically into suicide prevention and suicide reduction, which I have been asked to lead on. What that means is we already have eight STPs, by the end of this year that will be 14 STPs and by the end of next year it will be half of England. We will spend that money on targeting men who are, at the moment, not in touch with services, so that will mean working with football clubs; we have the Professional Footballers' Association working with us. It will also be looking at people who self-harm, which is the highest single risk factor for later suicide, and we will be working with people in mental health services to improve safety levels. About a quarter of all suicides are within mental health services.

There is a lot that we are doing. That will be expanded through the long-term plan to cover the whole of England by 2023-24.

Q42 Vicky Ford: Why could you not do that now?

Professor Kendall: Because you need money to do it.

Q43 Vicky Ford: Is it the money or is it the training?

Professor Kendall: It is both. £2.3 billion is the biggest investment in mental health in our history. To turn that into a workforce is a massive challenge, so we are thinking about what the new ways of doing it are. One of the reasons I thought schools was a great way of doing this is because it gave us the chance to train a completely new workforce. If you go on to UCL's website or NHS Jobs, you will see advertised, right now, educational mental health practitioners. We are asking for people who are graduates who have some basic experience in health, et cetera, and we will train them up. Half of their time will be spent doing training; half will be supervised practice.

We are doing similar sorts of things in other parts of health. We are looking at how we can expand the workforce when it takes so long to



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train a consultant psychiatrist and pretty long to train a nurse. Workforce is a limiting factor.

Q44 **Vicky Ford:** You just said that it is the money that means you cannot do it. The money is there.

Professor Kendall: We now have money.

Q45 **Vicky Ford:** You now have the money and it is the training.

Professor Kendall: It is turning that into a workforce. I should say that that money is ring-fenced. For the next five years, the money going into CCGs, we are requiring them to tell us exactly how they are going to spend that money on mental health and they will be required to spend it on mental health. It is the first time in the history of the NHS, as far as I know, that that has happened.

Q46 **Vicky Ford:** In the earlier panel, we were told that particularly men in their 40s were at risk of taking their own lives.

Professor Kendall: That is true.

Q47 **Vicky Ford:** Presumably, there are some who are not self-harming, there are some who are not drug and alcohol misusers. How are you addressing those groups?

Professor Kendall: In terms of the suicide reduction work, the plan is—and we are doing it; we are about 18 months into it—we are helping localities and the STPs. They have come back with plans on how they reach hard-to-reach men. There is a lot of local stuff already going on. If you go to Leicester, there is one, which is working with football clubs, called It Takes Balls to Talk. What they are doing is in different locales they are trying to connect with men and saying, “If you need to talk, if you feel desperate, if you have debt, if you are drinking a lot, if you are feeling down in the dumps, if you are feeling suicidal, this is the number to call”. We are trying to connect them with services that they are not currently connected to.

It is worth saying that, over the last 15 years, the number of people coming through mental health services has gone up, but the suicide rate in mental health services has been coming down. It is hardly talked about, but mental health services have a phenomenal success with this, so we want to get these men who are hard to reach into mental health services and give them the help they need, whether that is in primary care or, for young people, in schools and colleges.

Q48 **Vicky Ford:** I hear stories about people asking for help and then waiting lists and time, et cetera. Has the parity of esteem between mental and physical health made a difference, because that was set into law in 2012, and are the Government going to achieve that 2020 goal? I wonder if Louise and Andrew want to comment on that.



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Dr Theodosiou: The parity of esteem has made significant progress, but what we have to remember is that we need that parity of esteem to be across all services. Just thinking about the impact of mental health, we know that mental health impacts on physical health and we need to make sure that, in all settings, there is recognition of the sequelae of mental health problems. That needs to be in the criminal justice settings and it needs to be in all services.

Dr Molodynski: First, I just want to correct something. I, personally, and the British Medical Association are in no way critical of Tim and his team. They have worked tirelessly.

Chair: I was being slightly flippant, sorry.

Dr Molodynski: They have worked tirelessly in a very difficult environment to get as good a deal as possible for mental health.

On parity of esteem, I have never really understood what it means. It is a very easy thing to talk about. As a profession and as a professional body, we would much rather talk about parity of resources—so 28% or something getting towards that—and parity of access; people should wait for therapy no longer than they wait for minor surgery or to see a rheumatologist; those waits can be pretty terrible as well. We would also like to see parity of outcome, so that people have the right services that are evidence-based and that give them the best chance of having a decent outcome. Sadly, on those counts, the Government are failing abysmally, as we hear.

Mental health services are good for most people who use them. I spend every day working in them. Tim is right: we work hard and are holding a suicide rate—that is probably the best way to put it—in the face of massively increasing societal distress and demand. What is needed is this genuine parity for a step change in what we can provide, which will take time because there is a massive training issue and a massive workforce issue. If the Government were to suddenly release lots of money for mental health services, I do not think we would not be able to spend it.

Chair: Which is what Tim has just said.

Professor Kendall: Yes, that is absolutely true.

Dr Molodynski: There are specific things that we could do. Coming back to boys and men, substance misuse services; services for male survivors of abuse, because traditionally those services are very geared towards females. In fact, in my county, the county-sponsored service excludes men.

Q49 **Chair:** Which county is that?

Dr Molodynski: Oxfordshire. Our sexual abuse and rape crisis centre does not cater for men; they get signposted elsewhere. Most places now do, but it is still very much female-dominated and, as we have heard,



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many more men are coming forward, often very late. Veterans are a very high-risk group. Men make up a larger proportion of the homeless and rough sleepers, and they have a nine times higher suicide rate and very reduced life expectancy. There are many things that could be done.

Professor Kendall: Some of those are. For example, we are investing £30 million in homeless mental health, which is the service I work in, in Sheffield. It is not coming to my service, but we are investing in a number of different parts and trying to find out what is the best way of doing things. One of the very smart ways in which Simon Stevens encourages us all to work is the first phase of investment is finding out what is the best way of doing it. If we seem sometimes to take a few years longer than people would like, it is because we do not often have enough evidence to know what the best way is of configuring services. We are doing quite a lot in the homeless area.

Gambling is a hugely male-dominated thing. The whole footballing community is probably in danger of becoming problem gamblers. There is a great deal that we are doing in that sense.

In terms of how we provide services for men, that is through what we are doing with community mental health services. The biggest investment that we are pulling out of that £2.3 billion is going to go into community mental health and that has to be taking account of what men need.

Q50 **Chair:** We need to move on, but specifically within your goal of parity of esteem, are the needs of men and boys specifically considered: yes or no?

Professor Kendall: Yes.

Q51 **Sarah Champion:** I have quick-fire questions, starting with Tim. You were talking about CCGs commissioning services. I have been concerned that the Department of Health, when it comes to support services, does not have the data about what the CCGs are commissioning. Will you be able to specifically ask what they are commissioning and, most importantly, how effective what they are commissioning is in treating mental health in men and boys?

Professor Kendall: With the long-term plan, we say, "This is what we would like to spend the money on", and we are now making it a requirement that they have to come back later this year and say, "This is exactly how we are going to spend that money". We can then hold them to account for that.

The second thing is that we are monitoring the spend of CCGs through the Mental Health Investment Standard and our dashboard that you can get on the website. Because we have now merged with NHSI and NHSE, we now have direct contact with providers much more, so we know if the providers are saying, "I know they say they are spending it on this, but they are not". We are in a much better position to do this ring-fencing than we have been before.



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Q52 Sarah Champion: On the step before that, in the last panel and in this panel, they have been talking about specific risk factors. Do you have the data to identify what those risk factors are and, therefore, put the money and ask the CCGs to specifically spend on support services to address those risk factors?

Professor Kendall: Yes. A lot of the long-term plan is quite detailed. We spent months and months and months putting together the different bits of service that we thought we needed.

Q53 Sarah Champion: Is that evidence-based?

Professor Kendall: Yes.

Q54 Sarah Champion: Do you have the stats to say why you need it?

Professor Kendall: Absolutely. Wherever we have a NICE guideline, which I spent 15 years producing, we put the NICE guideline into it as part of what we do. For example, for the Green Paper for children, I did a systematic review, at the request of Jeremy Hunt, to look at the best evidence for interventions that will help children reduce the likelihood that they will need mental health services when they are older. That is what everyone is being trained in.

Q55 Sarah Champion: Then the services being commissioned will be looking at the outcomes, so that they are reducing those risk factors.

Professor Kendall: I will not pretend that we are as good at that as we should be. In some parts, when you look at IAPT, the Improving Access to Psychological Therapies in primary care, they have 98% outcome measures. They can tell you exactly what the recovery rate is in different parts of the country. We are doing exactly the same with the children's stuff in schools, for any new one we are doing. The problem is it is sometimes difficult teaching old dogs new tricks and getting professionals to really record outcomes at the beginning of treatment and at the end of treatment is hard, but we are doing it.

Q56 Sarah Champion: Is there cash attached to it: "You will not get funding unless you can demonstrate your outcomes"? That is quite an incentive. Could you consider that in the future with the commissioning?

Professor Kendall: It might be something that we could consider. It would not mean no funding, but it is certainly something that we could consider in terms of a proportion of funding. What I do not think we should do is say that we will pay you for good outcomes. What I do think we should do is say, "We really need to know outcomes". In exactly the same way as the surgeons have done it with heart surgery, so we know what the mortality and morbidity rate is, we need to know that with all of our stuff, not just IAPT, not just the Green Paper, but all of them.

Q57 Sarah Champion: Andrew, you spoke really well and passionately about drug and alcohol dependency and its impact on mental health and how it is not predominantly men but more men who are susceptible to that. You



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spoke about the services that were available. Do they also deal with the underlying mental health issues or would they then be referring people on, and should there be a joining up of those two?

Dr Molodynski: Thank you for asking that question. The current answer to that is that it is very variable. There are some places where there are and, in fact, where I work, our substance misuse services left the National Health Service and went into the third sector and have been excellent. They do provide a holistic service. They have group work, including at my boxing club, they go and have group sessions, which is very popular, particularly with the men. They link in very well with us; I think that is more about the individuals concerned.

There is a concern nationally that because of commissioning arrangements, probably the majority of substance misuse services are outside the National Health Service now. In itself, that is not necessarily a problem, but it does create gaps and it does create a real issue with training the next generation of addiction specialists. Small private sector organisations are usually not in a position to train specialist doctors. They can provide the care here and now, but in 15 years or fewer we might be facing a major problem with having enough specialists to deal with it.

My answer is that it is patchy. I would imagine there are very few places where it meets the standards that we would aspire to in being able to reach out to people who need it. It still predominantly requires people to want to have it and go and get it.

Q58 Sarah Champion: How has the change in commissioning affected referrals? I am thinking, in sexual health, if it is part of the NHS then it is automatic that they pass them on to contraception care or maybe talk to someone about abortion facilities, and that has been seamless because it is all within the NHS. Are you seeing a drop in referrals for some of the third sector dependency services? Is it more difficult for them to get into the system rather than being part of the whole NHS?

Dr Molodynski: I have not seen any big-scale evidence for that, I have to confess. In terms of how it works clinically, in my understanding and from colleagues, yes, it does mean that it is a referral from an outside agency, in the same way as it would be a referral from a general practitioner rather than an email or a call from a colleague within the organisation. That should not, in itself, mean that there is a problem with that person having joined-up care, but it can create gaps and, in a very stretched and pressurised service, yes, we would want there to be as few of those gaps as possible, so there are implications.

Q59 Sarah Champion: Louise, talk to us about children. Tim has rightly identified how presenting problems are happening predominantly before the age of 14, definitely before the age of 22. Early intervention, clearly, is key. Is it good enough at the moment and what should happen?

Dr Theodosiou: Early intervention needs to be available in all places. School is a fantastic place for people who are in school, but we know



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that, for boys with mental health needs, they are more likely to be excluded. Therefore, we need to make sure that in youth justice settings, in police settings and in all the other places where distressed boys will be presenting, there are those interventions available.

We also need to think about the language that people might use if they are distressed and remember that boys might not be using words like "sad"; they might be talking about being "tired" or "stressed".

We also need to remember that, in some cases, fighting or other kinds of behaviour that may lead you into contact with the criminal justice system might be about distress. We know that boys are over-represented in the criminal justice system and the youth justice system. We need to make sure that, in all of those places, there are people with adequate training in terms of mental health needs and that the systems are set up so that if, for example, the police are concerned about somebody, the very good mental health youth justice initiatives available are all resourced and continue to have clear pathways in and out of services.

Also, we need to be working alongside education so that, once again, if a boy who is in education, for example, and has a developmental condition like ADHD, for instance, there is the opportunity for staff to be thinking about how that might manifest. There have been some brilliant initiatives in schools, where schools have been trained to understand the ways boys might present if they have developmental conditions or if they are distressed. If they are handled differently, they can stay in school.

What we want is for future generations of men and boys to trust systems and to feel that systems will work with them. If you feel that systems will be helpful and will be advocates for you, you will access them. We heard that 70% of people who commit suicide are not in contact with services. If we can start young and work collaboratively with men and boys, not only can we be helping them look after their own mental health but we might be encouraging them to work in this field and to be these advocates and role models both working in education and making sure that they are there, perhaps with lived experience of having used substances or being parents themselves, supporting other fathers and just making sure that they have the tools to look after themselves and others.

Q60 Tonia Antoniazzi: Some of our evidence has suggested that mental health services are geared towards women in terms of both workforce and service delivery and, Andrew, you have spoken about Oxfordshire particularly. If this is the case, does it mean that men and boys, as a result, are receiving a poorer service?

Dr Theodosiou: I do not think it is necessarily about the gender of the person you see, but it is about that person communicating very clearly that they will understand the language that you use, that they may be able to step into the language that you are using and to not be judgmental about how you frame things. We also need to ensure that if



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you are, for example, accessing services following an accident in A&E, all the initiatives to keep staff aware of mental health needs are in place. It is about people being able to recognise your distress, speak in the language that you are speaking and recognise different communications of distress.

Dr Molodynski: I would agree with all of that. I do not think they are necessarily serving men and boys badly; it is that men and boys have less access because of some of the issues that we have talked about. There is a need to try to make services more male-friendly.

We have not really touched on prevention. There are some of the things that Tim was talking about in terms of getting the message to men. I hope people are familiar with the Men's Shed movement. Men do tend to get together—I know it is a generalisation—to do stuff and then maybe talk while they are doing it. We need research to know that those kinds of interventions are effective. They seem to be positive and helpful, but we need research evidence to show that they are effective. Assuming they are, if they were part of mainstream mental health services, that could be a real step forward for men and men's mental health care.

Professor Kendall: I am sure you might say, "You would say that, wouldn't you?", but we would like to get to a point where anyone coming into the health service gets the help that they need. Whether it is physical health or mental health, whether they are a boy, a man, a woman, a girl, whatever colour they are, whatever, people need to get the care that they need. What that does mean is that we have to be able to identify people who are not getting what they need.

As was mentioned on the last panel, we have now opened up perinatal services to men. In the perinatal period there is an increased risk that men will succumb to depression and anxiety, for all the reasons that were said. We have now opened it up so that, in those services, men can get access to help. That is particularly so if the mother has a postnatal depression and that, in a way, is helping both of them. The mother gets help, the father gets help and, in some cases, you could do that jointly. I do not want to say men have the problem in the perinatal period; they do not. It is women who have huge rises in mental health problems after birth. There is no doubt about that and that is why we have perinatal services, but we do not want to forget how that does affect men, so we are doing that.

In the Green Paper, one of the things that they will do is start doing parenting programmes for parents of boys with conduct disorder. We went through a period where you could get that through your local authority or whatever. Through various cuts, that has come down and it has become more and more difficult to access. We would like that to be accessible in every school. These workers will be trained to do parenting programmes, because that is a group of kids who do very badly if you do



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not help them. The same goes for boys with ADHD, which is five or six times more common in boys than in girls.

Wherever we find that there is an inequality we do want to address it, but we do not always know where they are, hence the research issue.

Q61 **Chair:** I just have one very final quick question: what training do you think would benefit service providers to ensure that their services can be adapted to provide the best services to men and boys? How can you put training in place to make sure that those people really do know how to support men and boys?

Professor Kendall: I think that what we are doing in schools is exactly what we should be doing. We should be training up the workforce to do evidence-based interventions that we know are going to help those different groups. We need to do that across the health service, to make sure that men are getting the services they need as well as women.

Dr Molodynski: I agree.

Chair: Thank you very much for your time this morning. We are really grateful for you to come along and to share those experiences. If there is anything else you want to add, please do drop us a line. Thank you very much.