

Women and Equalities Committee

Oral evidence: [Mental Health of Men and Boys](#), HC 1721

Wednesday 26 June 2019

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[Watch the meeting](#)

Members present: Maria Miller (Chair); Tonia Antoniazzi; Angela Crawley; Philip Davies; Eddie Hughes; Stephanie Peacock; Jess Phillips.

Questions 62–123

Witnesses

[I](#): Ben Twomey, Head of Policy and Research, National Youth Advocacy Service; Kate Stanley, Director of Strategy, Policy and Evidence, NSPCC; Samuel Howell, Policy Officer, London Youth.

[II](#): Martin Tod, Chief Executive; Men's Health Forum; Professor Brendan Gough, Director of Research, Leeds Beckett University; Samir Jeraj, Policy and Practice Officer, Race Equality Foundation.

Written evidence from witnesses:

- [Leeds Beckett University](#)
- [London Youth](#)
- [Men's Health Forum](#)
- [NSPCC](#)
- [National Youth Advocacy Service](#)

Examination of witnesses

Witnesses: Ben Twomey, Kate Stanley and Samuel Howell.

Q62 Chair: To those watching online and those joining us in the Public Gallery, this is the second session in our inquiry into men and boys and mental health. Today we are hearing from two panels of witnesses, and we are going to hear about the issues affecting boys and young men specifically in the first panel, and then about how social and economic factors can affect mental health for men and boys in the second panel. Before we start our questions, perhaps I could get each of our panellists just to say their name and the organisation they represent.

Samuel Howell: I am Samuel Howell, from London Youth.

Kate Stanley: I am Kate Stanley, from NSPCC.

Ben Twomey: Good morning. I am Ben Twomey, from NYAS—the National Youth Advocacy Service.

Q63 Jess Phillips: Good morning. What do you think are the three most important things that policymakers need to understand about the mental health of boys and young men?

Ben Twomey: Good morning, Jess. The first question is a really important one, and narrowing it down to three was really difficult because it is such a broad topic—I know that this Committee is finding that out as you go through the oral evidence sessions. NYAS supports care-experienced young people, and we look to empower them to have their voices heard in decisions made about them.

There are three things that we think are really important, particularly applying to men and boys. The first is help-seeking behaviour and how that might be perceived, so how likely men and boys are to seek help and then how likely it is to be received. There is also the issue of stigma. There is a high prevalence of care-experienced young people feeling stigmatised and feeling isolated.

Also, as a final point, there is the fact that there are certain groups that are more at risk of poor mental health. In particular, I would focus, again, on care-experienced young people. The risks to their mental health often come before they enter the care system, through some of the most unimaginable trauma that they suffer. The trauma of being put into the care system, so being taken away from their family with a very sudden change of circumstances, is very important as well. We also know that, throughout their time in the care system, their mental health often gets worse as well. For this group in particular, there should be special focus from the Committee and from the inquiry.

Kate Stanley: Of the three things from me that I think you need to know, the first is that boys who experience abuse and neglect may



develop maladaptive behaviours—so behaviours that are appropriate to the environment of neglect and abuse that they are growing up in, which serve them and protect them in those circumstances, but when that abuse stops those behaviours are not seen as appropriate and not helpful to them anymore, but the behaviour continues. That might take the form of a conduct disorder, for example, or other behavioural, emotional difficulties. That then winds those boys up into contact with the criminal justice system, or being excluded from school, and so instead of getting help they get further trouble.

Q64 Jess Phillips: Why would that be different for boys and girls?

Kate Stanley: The maladaptive behaviour may be similar, but for boys it is more likely that that behaviour will manifest itself in the form of conduct disorders and behavioural problems. It can happen with girls too, but it is more likely with boys. People see anger, aggression and what would be termed bad behaviour, instead of seeing a child seeking help or who needs help. That winds up with them in contact with criminal justice and the care system and so on, which makes their problems worse, not better. That is the first one.

For the second one, I would echo what Ben said about help-seeking behaviour. We know from Childline, for example. We have over 300,000 children contact us a year, and 75% of the counselling sessions we deliver are to girls. Boys are less likely to seek our service, certainly, but there is evidence that Childline is not the only service like that where girls are more likely to take up the help.

Q65 Chair: Why?

Kate Stanley: We do not know. We can only ask those who contact us, so it is hard to get a picture, but certainly it is the experience of other services that girls are more likely to be prepared to engage with services, talk about their experiences. There is some evidence that is related to stigma associated with help-seeking and impressions that it is weak.

Q66 Chair: Given that you have identified that boys are more likely to have issues around conduct behaviour as a result of difficult experiences in their childhood, and you know that they are less likely to seek help, why is it that you are not doing more work on that to try to understand how to address the lack of seeking help?

Kate Stanley: We focus our marketing activity for Childline service towards boys and places we expect boys to be. Specifically, we ran a campaign the year before last targeting boys, which did result in an increase in contacts from boys to the service. One of the challenges we have is that if we promote the service more widely, we end up with demand that we cannot meet. The last thing we want is for children to reach out and be brave enough to take that step and for us not to be able to meet that demand. It is a tough one.



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The third area I would say is slightly different, which is around fathers' mental health, particularly around the perinatal period. We know that pregnancy and the first weeks and months of a child's life are really critical moments for the mental health of both parents. Mothers are more likely to experience mental health problems during that period, but men can too, and fathers are a critical support to mothers during that period, so their mental health is really important. It is also really important in terms of their ability to bond and develop attachment with their babies. That is crucial for the mental health of the next generation. We actually know that, for children aged between two and four, boys are more likely to have a mental health disorder than girls in that period. Something is going on.

Q67 Jess Phillips: If you were to suggest a policy to a policymaker in that regard, it is something to do with the idea of the first 1,000 days, is it not, of the child's life, to do with fathers' specific involvement? That is just off the top of my head, on the back of a fag packet.

Kate Stanley: Absolutely. It could be antenatal letters from services, for example, making it clear and explicit that fathers are welcome at those appointments; the hospitals making it explicit that fathers are welcome; and midwives and health visitors being trained to know how to help fathers get support that they need, if it seems to them that that would be helpful. At the moment it is weak for mothers during that period, so it is especially weak for fathers.

Samuel Howell: When talking about young people's issues, it is incredibly important to start with the voice of young people. We know from listening to young Londoners who we represent here that the major issues that they see around their mental health—which we know they are talking about and thinking about as a problem, as a group—are around the cost of living and existing in an increasingly expensive and unequal city; concern about safety and violence, which disproportionately affects young people and young men; and access to both youth and mental health support services, both statutory and through the community and voluntary sector. We feel all three of these can be grouped together under a rough grouping of a lack of positive opportunities for young people, and this is a major challenge in how they perceive their future.

Q68 Jess Phillips: Just to go to the first one in that group, the idea of economic disadvantage—and just so I have the idea here in my head, because we are talking about boys and young men in this instance—you are not talking about people who are going out on their own; even for children as young as 12 or 13, you would still say economic disadvantage was one of the things.

Samuel Howell: According to the Trust for London, I believe it is a fifth of households in London in poverty are in work; I may need to check that, but it is a large percentage. You can make the case that deprivation affects all ages of young people.



Q69 Jess Phillips: I just wondered, with the data that you are referring to, in terms of the voice of the child, whether that is what is cited by children at the younger end, rather than, understandably, people who are 21 to 25 who would be worrying about their own finances.

Samuel Howell: The challenges are different, but we have quite a lot of qualitative data and quotes from young people that show that their life decisions and their mental health is quite adversely affected by deprivation and by money concerns in the family, and that this can leave them down.

Q70 Chair: Is that different for boys and girls?

Jess Phillips: The first one might not be.

Samuel Howell: Particularly with issues around deprivation, we do not have any information about how that breaks down. We can tell you about borough-level data, or of course there are the multiple indices of deprivation, but we do know that how this breaks down around safety and violence is very much gendered.

Going to my final point, all of this can be summarised as lack of positive opportunities for young people, and we think, when we are talking about the mental health of young people, youth work is an incredibly effective way to broaden support, in that it broadens the support for young people's social, mental and physical wellbeing, and is an increasingly important way to widen the amount of provision of mental health support, both for those people who might have trouble accessing other forms of support through the statutory services and child and adolescent mental health services, or who have troubled relationships with schools. Youth work is an excellent avenue, particularly in delivering mental health support through activities that young people enjoy, such as sport, which we have good evidence is particularly effective for young men.

Q71 Jess Phillips: The Committee received evidence suggesting that gender stereotyping and societal pressures have a big impact on boys' and young men's mental health. Why do you think that gender stereotyping has been a repeated theme in much of the evidence that we have received?

Ben Twomey: In NYAS's work, we are not clinicians but we do take advice and work very closely with clinicians, psychologists, psychiatrists and academics. What we are hearing from them—and we see it play out in our advocacy services where we work with care-experienced young people—is that with depression, anxiety and trauma, the worst thing to do, in the long term, is not to talk about it. Who is the most likely not to talk about it? It is men and boys. Who is even more likely than them not to talk about it and not to trust the professionals or the adults around them? It is care-experienced young people.

In terms of what we really see as the two crucial elements of a mental health service in engaging its service users, whether they are stereotyping or not, the first is for the patient to display help-seeking



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behaviour. There needs to be a way that we can find out that these people need help. You can do that from statistics. I am sure we will talk about trauma later on, and there is a large group of care-experienced young people who we already know will need help for trauma and are not necessarily getting it. Otherwise, we rely on those men and boys coming forward.

The second is, at its simplest, help-seeking behaviour being given a positive perception by professionals, adults, colleagues and brothers around those people. That is where you have to recognise the need for help and act accordingly. That is where, on both of those points, men and boys fall down, because they have not been seeking help as often as women and girls, and they are not being given the help or being received in the same way when they seek it. All behaviour is communication—you have probably heard that said before—and when a child is acting out, it is often because of an issue either in the home or prior issues of trauma for which they have not been given the right treatment to recover from, in our experience.

We know that the likelihood of seeking help is reduced even further if they are care-experienced, if they are black or minority ethnic. Again, I am focusing on the certain groups that are most at risk.

Q72 Jess Phillips: So they are less likely to reach out for help in BME groups.

Ben Twomey: Absolutely, yes, and that is quite well evidenced. As a society, we need to be looking at the language we use, and also the services that are there for young people. The language of, “Pull yourself together”, or “Man up”, which I know you have challenged before, Jess, is highly toxic in terms of what men and boys can do. How can we, as a society, square that idea that boys do not cry with the reality that if you spoke to a 15 year old on the playground today, for the next 30 years, in terms of the boys they are playing with, the most likely killer of them will be that they take their own life. We need to change the language around it, and we need to have the services in place that properly engage with young people, and with young men in particular.

One of the issues—and Samuel will probably touch on this from the youth work perspective—is positive male role models. For gender stereotypes, if you are going to stereotype what a man is as a child, you are probably going to look to the men around you. Similar to Kate, this is something where NYAS finds issues with fathers being supported with their own mental health. We have had evidence on that from our own Unity project in Wales.

In particular, if we are looking at youth workers, the youth work provision in the country, as far as I have seen, has been cut by about 70%. What it has not done is provide positive male role models to replace those male role models in the youth service.

Q73 Chair: Of the youth service that was in place before, what was really



working well then, which prevented this from happening?

Ben Twomey: If we look at this simply, in terms of male role models, we look at primary schools or we look at social services—

Chair: No, I am talking about youth work. You said there had been a reduction in the amount of money spent on youth work, and the inference from what you said was that that was working really well. I am not aware from the evidence we have that this problem was anything other than really bad in the last 10 years. I do not think there has been a time where we have had a real improvement in the mental health of men and boys. Why are you implying that a return to more youth work would be helpful? What is your evidence?

Ben Twomey: If we go back to externalising behaviours, externalising poor mental health and some of the issues around violence, aggression and imprisonment that come from that, the reason I referenced children's services or primary schools is that is where there is a predominantly female workforce, and we have lost a largely male workforce in the youth work sector. There is certainly something in the evidence that talks about positive male role models and talks about the ability to express yourself without externalising with aggression, which I believe is a significant hit. I am sure Samuel has more data on this, but when working with care-experienced young people, we know they are going to lack positive male role models in their life, and we need to do something about that.

Q74 **Chair:** Have you done particular work to evidence that the way in which youth work was delivered in the past really improved young men's mental health?

Jess Phillips: Such as knife crime statistics.

Ben Twomey: We are an advocacy service, so in terms of some of the issues that we see care-experienced young people facing, there is going missing more often, for example, issues with county lines and with exploitation, but also then going into criminality and offending later in life. Those are the issues we see. We are not a youth work service, so we have not analysed exactly that end, but looking at outcomes, which is really what we are here for, that is where we are seeing the difficulties.

Kate Stanley: May I build on those points? It is estimated that around 30% of criminal activity is linked to conduct disorders, either in childhood or in adulthood. This is men.

Q75 **Jess Phillips:** When you say "conduct disorder", can you explain to me what that means?

Kate Stanley: Mental health issues are categorised into a series of disorders.

Jess Phillips: Women always have personality disorders; that is what they are told. There is a really frequent way that women are labelled as having personality disorders in service.



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Kate Stanley: Okay, I am not aware of that. Conduct disorders is another category that is used by mental health professionals to describe particular sets of behaviour, and it is what would commonly be understood to be difficulties following rules and acting contrary to social norms. Criminal behaviour is classic conduct disorder, if you like. In school it would be being disruptive in class and finding yourself excluded, for example.

There is a very strong link between conduct disorder, which is a mental health condition, and criminal activity, and the primary line of recommended treatment for conduct disorders is parenting programmes. For children with conduct disorders, it is parenting programmes. What we have seen is a reduction in the availability of those tier 1 universal services, and parenting programmes are amongst them. The evidence collected while they were still available was poor, so it is very difficult for us to say that they were really good and that they were making a difference, because the evidence was not systematically collected well. We know that they are less available now.

It is difficult to say it worked brilliantly in the past, but now we know they are less available. The evidence was not collected at the time, so we have a bit of a gap in our knowledge, but we do know that is the recommended intervention to address conduct disorders, which would then in turn reduce the mental health challenge, but also reduce criminal activity.

Q76 **Jess Phillips:** What about specifically on the gender stereotyping, because that comes up again and again and again as a reason why men do not seek out help?

Kate Stanley: Yes. That is not something specifically that we have looked at, but where we have looked at that is in relation to making services accessible to fathers, specifically, thereby creating an expectation from the very start, from the earliest possible opportunity, even before birth, that a father will be engaged and involved in their child's life. We know that if they are, they are more likely to stay involved later on, even if the parents split up. We know that that is protective for the child; it is a good thing generally for the child.

Taking the example of antenatal programmes, we run one called Baby Steps, which has been shown to improve parents' confidence, both mothers and fathers, to reduce anxiety and depression amongst mothers and fathers, and to help address some of those fears men may have about their new identity as fathers and their taking on that role; it increases their confidence in relation to that. Programmes like that we know can help with that transition into fatherhood; they can set people up much better, with a greater expectation of being involved. Things like paternity leave have also been shown to be very important in creating those early expectations.

Q77 **Jess Phillips:** I was in Kenya recently, and they let people who brought



the fathers of their babies jump the queue in a very long, eight-hour long antenatal queue, and I thought, "That is a cunning way to make you beg your husband come with you, so you can get to the front of the queue".

Samuel Howell: If I can first just respond to your point, Maria, going back to the evidence of mental health support in youth work, particularly over the last decade, it is first important to echo what Kate was saying: it is hard to evidence youth work, particularly open access universal youth work, because of its diffuse nature. It is famously a difficult thing to measure, but that does not mean it is not important and it is not effective. It is also fair to say that we as an organisation cannot stand here and say that we can stand up on the record of all mental health support on youth work before 2011, but it is also fair to typify that as an under-utilised resource, in a situation where we know there is a mental health challenge for young people, it is important to reinvest in.

We think that there has perhaps been a bit of a change in the nature of youth work over the last decade, to do with structural changes in the sector, around how funding and referral pathways have worked in the broader public services, and youth work perhaps moving from a situation of referring young people through to strong public services that could give clinical support, to maybe a situation where youth workers tell us that they increasingly feel that they are themselves acting as stand-in frontline mental health practitioners, because of the increasingly long waiting lines and high thresholds to enter the statutory mental health services. I would say there is good evidence that youth work, because of its relationship-based nature and being based as accessible, community-based and destigmatising, is incredibly effective in building emotional and social capabilities and increased resilience.

Q78 **Chair:** Presumably you are really supportive of the Government's new in-school mental health strategy, in terms of the delivery of that new cadre of mental health support?

Samuel Howell: We are in favour of large amounts of money being invested back into mental health support for young people. At the same time, it is incredibly important to note that the relationships that young people have with schools are not always perfect. We think it is incredibly important to have a range of pathways for young people to access support. We know at the moment that there are structural issues with how some communities relate to education, and we think that it is incredibly important, particularly with exclusions in the situation where they are, that young people, no matter their age—people who are over 16 or over 18—are still able to access good mental health support. Increasingly, we see anecdotal evidence that young people in that 18-to-25 bracket are still having trouble transitioning to adulthood and need extra support. It is also important that young people who are perhaps having confrontational relationships in the formal education sector are still able to access good mental health support. We think that youth work is a good, positive, relationship-based environment for that to happen. We believe that it is not one or the other; it is an "and".



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Q79 Jess Phillips: Just quickly from each of you, do you think that social media is having an impact on driving the gender stereotypes that are causing some of the societal problems, on men and boys specifically?

Ben Twomey: This is not something NYAS has particularly looked at, but I would point the Committee to emerging evidence around the digital divide, which says that, in terms of those who are vulnerable or are already suffering from inequality, that divide may be getting greater through the internet and through social media use. It is very recent academic literature.

Kate Stanley: We have a conference over the road today, "How safe are our children?" That is looking at how digital technology is affecting the safety and the risks to children. It does not relate specifically to gender stereotypes, but one of the key things coming out through the research being showcased there is the child sexual abuse images that are proliferating online. The vast majority of those are of girls, but where they are of boys they tend to be even more serious, described as category A sexual abuse images. There is a social media dimension to that, insofar as that has made it much, much easier for these images to proliferate and to be shared very widely.

I am not sure that is a gender stereotype. That is an under-researched area. We have not looked at that specifically, but certainly digital technology is playing a role in the rise in child sexual abuse, which is very strongly associated with trauma and mental health problems.

Samuel Howell: Again, social media is not an area that we have a huge amount of expertise in. We hear a lot from youth workers and young people who are concerned about it. We think it is important to note that, as with young people's culture, it is incredibly important to draw a line between those activities that young people engage in, which reflect their realities rather than necessarily shape them. We think that social media can definitely be a catalyst of mental health issues, but beyond that we do not have a lot to say.

Q80 Tonia Antoniazzi: This question is for Kate, specifically. The evidence submitted by the NSPCC raised county lines activity as a factor in poor mental health in boys and young men. Why did you decide to highlight this issue particularly?

Kate Stanley: One of the reasons is because it is a growing issue. There are more and more boys being identified as being exploited, criminally. We know that boys aged 15 to 17 are the most vulnerable to it, so it feels particularly pertinent. We also know that, in terms of criminal exploitation of this sort, there is evidence that it is strongly linked to serious mental health issues, as a consequence of the trauma of being involved in this kind of activity and the coercion that is involved in it.

Q81 Tonia Antoniazzi: Are you doing any particular work around it?



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Kate Stanley: We are working with the National Crime Agency around their guidance on this, and I know that Ben's organisation is working directly on the issue.

Ben Twomey: If I can chip in briefly, NYAS has a couple of projects coming up in Wales, very shortly, and I know you are joining us, Tonia, at an event there to discuss missing people and exploitation in county lines.

There is a very short case study, if you do not mind, that I will share that summarises some of the issues that we face. There was a 14-year-old boy who we were working with in the midlands, who was in the care system. He was going missing a lot. Professionals understood that he was being groomed for county lines, he was getting involved with a gang, and so quite rightly they made the decision that he had to move out of the area. They made that decision very suddenly because they thought he might abscond if they told him in advance. Very suddenly he was told he was going to have to move to Wales.

In the car on the way, we were told by the social worker afterwards, he was crying the entire way from the midlands across to Wales. When we spoke to him afterwards, when we were advocating on his behalf, he put across to the NYAS advocate that he was anxious about going to another country. He did not know how far it was, he did not know what the currency was and he thought he might have to be checked for his passport, which he did not have, at the border. He also thought they all spoke a different language, so no one would understand what he was saying. All of these issues were going through his head, and at no point in that car did he either feel confident enough to seek help from that social worker, in terms of asking about his anxieties and trying to ask the questions that would get the answers for him, which were quite simple things to allay his fears, and nor did the social worker manage to get through and get that trust in order to allay those fears for him.

That is a microcosm of the issues, and although county lines certainly affects mental health, the way that we as professionals can deal with them can sometimes make mental health worse too, if we go about it all wrong.

Q82 **Tonia Antoniazzi:** According to NHS data, young boys are twice as likely as young girls to suffer from conditions such as autism, ADHD and emotional disorders such as depression and anxiety. Do you actually think this is the case? I will start with Sam.

Samuel Howell: I am afraid this is one of those questions where we do not have any clinical expertise and we do not have the evidence.

Kate Stanley: I am not sure it is the case that boys are more likely to experience those categories around anxiety and depression, for example. It does spike at particular age points, so at age two to four, for example, boys are more likely than girls to be diagnosed with a mental health



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disorder. Similarly, at age 15 to 19 boys are more likely to take their own lives than girls are. The rest of the time, through the other age groups, girls outnumber boys. It is really quite a complex pitch and quite difficult to unpick.

Certainly, there is very strong evidence that boys are experiencing a high degree of mental distress, which is leading to these spikes in the suicide rates amongst teenagers, which should cause us some concern.

One of the reasons that you see chronic, long-term, recurrent depression, anxiety and even suicidal thoughts is experience of abuse and neglect in childhood. We know that you are twice as likely to have those mental health issues if you experienced abuse and neglect than if you did not. You are also less likely to respond well to treatment. Even if, as we have discussed, boys are less likely to seek help or be offered help because their behaviour is not seen as needing mental health intervention—it is more punishment, in the criminal justice system, for example—then you are less likely to respond well to that treatment. It is much more difficult to resolve those mental health challenges if you have experienced abuse and neglect.

Ben Twomey: As a clinical question, I am woefully underqualified to answer it, but in terms of aggregate risks, there is certainly something that NYAS sees routinely, which is the conditions in which people's mental health can worsen. Abuse and neglect is a common one. If we look at where men and boys are more likely to be than women and girls, and where their mental health will worsen, you have issues such as being excluded from school, suffering from addiction, where men and boys are over-represented, and being imprisoned. If we focus again and home in, care-experienced young people are 25 times more likely to be homeless than their peers, in some studies, five times more likely to have a fixed-term exclusion from school, four times more likely to use illegal drugs or alcohol as a child, and up to 40 times more likely to be criminalised.

That is where we start to home in on all of those situations, and we know those situations have an additive effect to the poor mental health that they suffer. In our submission to this inquiry, I called it a comorbidity of factors. For example, if you are five times more likely to take your own life as someone who has been care-experienced, and you are five times more likely to take your own life as somebody who has been in the criminal justice system, then you combine those two factors, which is more likely to happen than the rest of the community, that is where you end up with some of the issues. That is where men and boys, because they are most implicated in these situations, will probably come into difficulty.

Q83 Chair: Just before we move on, I am hearing a lot about the differences that boys and girls can experience, but I do not really understand why. You were talking, Kate, about abuse and neglect creating this continuum into conduct disorder, but why is it different for boys and girls? Why is



abuse and neglect impacting boys and girls differently?

Kate Stanley: We do not really know, quite simply. What we do know is that there is this broad categorisation—I am sure this is something that will have been described to the Committee before—that holds true in the majority of cases: that girls who have experienced trauma may internalise their mental health problems, for example with eating disorders and withdrawal, whereas boys externalise their mental health problems. Again, that is in the majority of cases; it does not hold for all. Those problems come out in the form of conduct disorders, not following rules, basically getting into trouble and being seen to be aggressive and poorly behaved. Those two different caricatures, if you like, which broadly hold, result in a different response from people around them.

Q84 **Chair:** What you are not saying is that the boys are suffering more; it is that they are suffering differently?

Kate Stanley: Absolutely. Context is everything, so the way in which we as a society respond to those different kinds of behaviour is very different. In boys' cases, it will tend to be a more punitive response, such as exclusion from school, which further compounds and exacerbates the challenges. I am not saying it is all rosy for girls, but it tends not to be that kind of punitive response. The response that children are getting will take them down different channels. We see this compounding effect with the externalising behaviours and the conduct disorders and so on. It is rooted in the response—the nature of the response to the experience.

Q85 **Eddie Hughes:** You have already touched on some of the risk factors with regard to poor mental health, abuse and neglect, but can you summarise for us what are the most common risk factors that lead to poor mental health in men and boys?

Kate Stanley: Disability and special educational needs are risk factors, as are being in the care system, abuse and neglect. These things, as Ben has already alluded to, tend to overlap and occur together, and the more of them that occur, the higher the risk for the child of a mental health issue. "Adverse childhood experiences" is a term for a cluster of 10 different experiences that a child might go through, which might be anything that includes those items such as abuse and neglect. It would also include something like parental divorce, bereavement and those kinds of thing. We know that where children have five or more of those experiences, that puts them at a high risk of mental health issues. It does not mean it is inevitable, but it just creates a higher risk for mental health issues.

Ben Twomey: I would just focus again on trauma. It is one of the major risks for care-experienced young people. What trauma really is, or what post-traumatic stress is, is the feeling of danger at all times. That is where the difference in men and women and boys and girls, in how they respond to danger, really comes out. Kate put it very eloquently in terms of how you internalise and withdraw as a woman and a girl more often



than as a man or a boy, who will externalise and will show aggression. Treatments for post-traumatic stress are out there, they do work and there are NICE-recommended treatments for it. However, they are not routinely applied, and they are certainly not automatically applied when a child enters the care system.

I know there is DfE funding for pilots, which is to be welcomed. However, we know that this group are already suffering from trauma. We need to get this mainstreamed very quickly in order to deal with that, because if a child is feeling in danger at all times and they are going into a situation where they are losing trust in professionals and in adults, or maybe they have already lost it when they enter the care system, then that is where the mental health issues can spiral out of control. Externalising means that the spiral, sometimes, unfortunately is not helped by the professionals who are working with them.

Q86 Eddie Hughes: This seems like a rather obvious question, but just for the sake of the record, is there a link between poor mental health in childhood or adolescence and later in life?

Kate Stanley: Yes, there is.

Eddie Hughes: You might want to elaborate. For example, with regard to those 10 factors, if a child suffers five of them, it is not guaranteed that they will suffer mental health problems, but it is likely. It might seem like an obvious question that poor mental health in childhood or adolescence leads to that in later life, but that is surely not always the case. Can you break that down, please?

Kate Stanley: The first thing to say is that experiences themselves are not the same as trauma. An experience is an experience, and it is how the individual and people around them respond to that that determines whether it becomes a traumatic experience or not. That is the risk factor for poor mental health. That is why we should always see mental ill health as something we can shift, because we can change how we respond to those events and those experiences, such that they do not become traumatic. They are simply things that have happened to people. The right response means that a difficult and adverse experience does not necessarily lead to trauma and poor mental health later.

There are always points along the way to prevent experiences becoming traumatic, becoming mental health problems and becoming lifelong mental health problems. There are all these points at which we can make a difference, but certainly the biggest risk factor for a mental health problem in adult life is having experienced one during childhood. There is not such robust evidence in the UK, but in the US there is a study that shows that nine out of 10 people who have experienced childhood trauma will have a severe mental health problem diagnosed by the time they reach adulthood. There is a pathway there, but there are also moments to intervene and prevent that pathway becoming a determined journey.



Samuel Howell: On that, there is evidence to suggest that, for those people with adverse childhood experiences, the state of experiencing mental health issues later in life falls dramatically for those who participate in some form of community activity. From our own polling we know that, for young men in London specifically, 10% of them say that they feel part of no community whatsoever, as opposed to young women. There is a connection there that we see.

Almost going back to your earlier question around trauma and the experiences of trauma, Ben touched on the idea of hypervigilance. Briefly, it is about the importance, within an experience where people are re-suffering trauma through their environment, of space within that where young people are able to escape from those circumstances. We have very good anecdotal evidence about the importance of things like residential trips, away from the experiences that young people are in, and we did a report last year around the importance of youth work to contributing to strong communities. One of the things that we were not looking for but kept coming back to again and again, when we were asking young people why they enjoyed youth organisations and why they were going along, was that they just said, "I feel safe here." From a quite simple, physical safety point of view, it is about finding places where young people feel safe.

Q87 **Eddie Hughes:** This leads nicely on to the next question. What role should the voluntary and community sector have in providing services to young boys and men to support emotional and mental wellbeing?

Samuel Howell: I believe we are in a situation already where increasingly the voluntary and community sector, certainly within London and the youth work sector, have increasingly been playing a larger role. That resumption of authority has moved; the majority of services have moved away from, for example, local authority youth services and have moved out into the community sector. Whether that has been followed with sustainable funding that will ensure that provision continues in a way that it should, delivering a high quality of service, and that there is provision of a high rate of universal programmes that provide those preventative factors for mental health and specific targeted interventions is increasingly under question.

We feel very strongly that within this, youth work can both provide a very strong basis for supporting young people's mental health and broaden it to those areas where young people find it difficult to engage with traditional support services. Particularly with young men, we have repeated case studies around the effectiveness of young men engaging with mental health support through sports organisations or youth organisations that are delivering sports and physical activity, which we also know that young people are much more likely to feel a part of.

For example, the young people that we have polled are more likely to feel part of a sports organisation than they are to feel part of their wider family. More of them tick that as a community that they belong to. We



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see that as an incredibly effective way of delivering mental health support to young people, through activities that they enjoy and want to go and access.

Q88 Eddie Hughes: The Government's job, then, is not to provide the service but to commission them.

Samuel Howell: There are a number of different ways that you can ensure that, but it is about ensuring that every single young person has access, in a place close to them, to a range of options, both on universal open access options that provide that base of relationships, the spaces and the relationships that all other interventions come off, and then within that you can have more specialist services.

Kate Stanley: There is a really crucial need for both. We need the Government to deliver child and adolescent mental health services that are adequate to meet the demands. Around 6% of the funding for mental health services in this country goes to CAMHS, for children and adolescents, but children and adolescents represent 20% of the demand for those services. There is a really significant funding challenge in child and adolescent mental health. The delivery of lower-tier services—the kinds of things that Samuel has talked about—are really important but should not be focused on at the exclusion of those vital statutory clinical services as well. In terms of what we do want to see, we want to be able to run a campaign targeting boys and to be able to meet the demand that that generates.

Ben Twomey: One of the major questions that we hear from children, young people and vulnerable adults who we support in patient settings for mental health services is, "What is my treatment all about? What is my plan? What is happening to me?" They are really simple questions, but it shows the level of confusion that comes, particularly when there are long delays on waiting times around mental health services. For NYAS, we are calling for advocacy at all stages of engagement with mental health support services, if the young person or the adult requires it.

There is also a function for the voluntary sector and community sector, to stand up for the rights of the young people we work with, and to have that as our sole focus. We are a rights-based charity. It is enshrined in the United Nations convention on the rights of the child, in article 24, that every child has the right to the best possible healthcare and the best possible health. We will continue scrutinising that through mental health services.

Finally, it is worth scrutinising the work that is done once children are taken into the responsibility of the state. Once they are in the care of the state, they are really all of our children then, and the level of focus and priority given to them deserves to be just the same as if our own children were having mental health issues and were struggling to get access to mental health services. It is about moving the priority up. When I said



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that mental health gets worse for many children in the care system, we need to make sure that you are not taking children away from a situation of abuse and neglect, taking them out of the fire and into the frying pan. We can do better than that. There are treatments and NICE guidelines out there that mean that we can do much better for these children.

Q89 Eddie Hughes: In terms of testing what works, the Department for Education has awarded £240,000 to groups and organisations, including NSPCC, to deliver 10 local pilots over two years to improve wellbeing for children in care. How effective do you think that is going to be?

Kate Stanley: Certainly our services are evidence-based, so we only deliver services that we believe have a decent chance of being effective.

Q90 Eddie Hughes: There is a test element of trying something new. Maybe it will or will not work.

Kate Stanley: Yes, absolutely. How many times have we said, "We do not really know," in relation to some of these services? That is when it is easy to cut things, if they are not of demonstrable value. It is not good enough for us simply to have a hunch that these things work; we have to be gathering evidence robustly and using that to make the case. Whether services are commissioned from the voluntary or community sector, or whether they are delivered through the statutory sector, we have also got to be collecting the evidence of the difference they make, so that we can build the case for why they are important and necessary. It is absolutely fundamental that we do that. I do not know, but the evidence will tell us. We are committed to never delivering a service without making sure we are doing that.

Q91 Angela Crawley: Kate, you have mentioned already that the NSPCC has suggested that girls are more likely to respond to mental health difficulties by internalising their behaviours, whereas boys often externalise their behaviours. How can these behaviours be managed in an educational setting, for example? What can education providers do to support young boys, particular if they are struggling?

Kate Stanley: This is not something we work on specifically, but there is growing evidence that keeping children within the mainstream system is the optimum. Keeping children in the mainstream delivers the best outcomes, as does not taking a punitive response of exclusions and going to alternative provision. There is some alternative provision that is building evidence that it can work effectively for some, but there is more evidence that it actually makes matters worse. Keeping children within the mainstream is important.

Q92 Angela Crawley: Ben and Sam, you have also referenced external work that can be done in terms of residential weekends or additional support that can be provided outwith the educational setting. Are there any recommendations you would make within an educational setting that you think would make a difference?



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Ben Twomey: For me, it is a simple one: making education settings and any professional settings where you are dealing with vulnerable children, potentially, trauma-aware and attachment-aware. That is a really important thing. There is Department for Education statutory guidance that says to treat every child in your class the same, behaviourally, could be illegal, essentially, under the Equality Act. It is in the mental health in schools guidance by the DfE. That is really important because when trauma is the reason a child is kicking off in that moment, to treat them the same and go through the same punishment or isolation route is not an appropriate mode of functioning, and it is not an appropriate route to justice. Unfortunately, it does often lead to the justice system, in terms of being excluded from school, ending up being criminalised, and then, as I say, the additive effects of mental health come into play. Being trauma-aware and being attachment-aware will be crucial.

Samuel Howell: I would echo both Ben's points, particularly around trauma-informed training for staff within the educational context. That is incredibly important, not just in education but in wider professionals who are working with young people in the policing and criminal justice system as well. That is incredibly important to acknowledge, and addressing exclusions is a huge cloud hanging over all of this, in the life direction it pushes a lot of young people in.

Q93 **Angela Crawley:** What more can be done within educational institutions to promote positive mental health and wellbeing, for boys specifically. Is there anything more you would like to add on that?

Kate Stanley: I wanted to ask something, actually. The phrase "trauma-informed care" or "awareness" is used quite a lot, but I often wonder how meaningful it is to people. I do not think it means a lot to a lot of people, and we use it a lot to mean a whole host of things. Maybe just to elaborate a bit on what that is all about, basically, if a teacher understands how trauma and negative and adverse experiences get built into the body and the brain of a developing child, that can really help them to understand why that child appears to be flipping, having a very quick temper and being very quick to take offence and to go on the attack. If their brain has been wired up to be hypervigilant and to be ready to protect itself at any moment, and the cortisol levels and adrenaline levels are very easily triggered in that child through their experiences, that teacher can then understand why that child is behaving in the way they are, rather than thinking they are being difficult or aggressive or just challenging. They can understand why it is that they have that adaptation.

There is quite simple training. For example, we deliver something called "Sharing the science" to practitioners, to help them understand some of the basics of early childhood development and how experiences get built into the body and the brain, with consequences for behaviour, and how you can respond to that in a way that is going to bring things down again rather than escalate the situation.



- Q94 **Angela Crawley:** You also referred to attachment theory, and I think it would be helpful to tease out exactly what you mean by that in a similar vein, if anyone wants to take that on.

Kate Stanley: This is about the quality of the relationships between a child and their primary caregiver, usually the mum or the dad but not always. It is formed at the very earliest phases of life, and then built on thereafter. A good attachment is something that helps anchor a child and helps them to build positive, productive relationships with other adults and people in their lives.

A child who has a chaotic or disordered attachment, as it is known, where they have not been able to build that secure, stable relationship with a caregiver in the earliest weeks, months or years of life, can struggle to form bonds and attachments with others; they can be suspicious and find it difficult to trust and build those relationships. Every time a new teacher comes along, for example, that can be quite a challenging, difficult experience for that child, because they are not set up to build positive, reciprocal relationships in the way that other children with secure attachments are. Again, teachers having a bit of an understanding can help them to know how best to respond to those children who are struggling to build a relationship with them.

- Q95 **Jess Phillips:** I obviously think that things should be trauma-informed for all sorts of reasons, including my own experience at work, but just to play complete devil's advocate, in my son's class where there are 33 children, so are you going to be able to give focused and direct attention for any more than 30 seconds if a kid is kicking off? That is the immediate pushback you are going to get to that approach. What would you say to that?

Kate Stanley: What practitioners, including teachers, have told us is that the tips that they get tend to be about how they can conduct a class, for example, in a way that is less likely to trigger that kind of a response in a child. For example, it is about not standing over the desk in an intimidating manner, how they carry themselves, the extent to which they raise their voice and shout, and not using humiliating language. These are things that are going to work for all children and actually will make disruption less likely, if done well.

Ben Twomey: I think that is the point. It is not reactive; it is about being proactive so that the likelihood of it all kicking off is massively reduced.

- Q96 **Jess Phillips:** Again, just to come back, the idea that my kids' schoolteacher does not need to shout is a nonsense, if I was to be perfectly honest, because if the class is noisy, she has to shout to get them to pay attention or to say that it is time to go out, even. I totally agree with you, but I just know that what we will get back is, "How the hell are we meant to do this?"



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Kate Stanley: There are some things that some teachers will do to avoid escalating a situation, such as having a bell that they ring to say, “Be quiet now,” rather than yelling. That can work just as effectively.

Jess Phillips: I would just like to say that my kids’ schoolteacher is lovely; she is not a shouty, horrible person.

Kate Stanley: It requires thinking about, and it is not going to work perfectly every time, but there has to be some basic understanding of some of the principles about what is going to create a more harmonious classroom. Behaviour management and teacher training tends to focus on what happens when it kicks off, rather than creating that environment to start with.

Chair: That is brilliant. Thank you very much. We have finished our questions for the first panel. Can I, on behalf of the Committee, thank our witnesses? Thank you very much.

Examination of witnesses

Witnesses: Martin Tod, Professor Brendan Gough and Samir Jeraj.

Q97 **Chair:** Good morning. On behalf of the Committee, can I thank you for coming in to give evidence today? Before we start with our first set of questions, perhaps I could ask you to say your name and the organisation you represent?

Martin Tod: I am Martin Tod, from the Men’s Health Forum.

Samir Jeraj: I am Samir Jeraj, from the Race Equality Foundation.

Professor Gough: I am Brandon Gough. I am a professor in psychology at Leeds Beckett University.

Q98 **Tonia Antoniazzi:** Evidence we have received has suggested that men and boys from BAME backgrounds experience poorer mental health than their white counterparts. Why is that?

Samir Jeraj: We would say that the evidence shows that BAME boys are more likely to experience the kind of social detriments that you have heard about this morning. For example, that includes the experience of poverty, experiences of racism and wider social determinants such as poor housing, unemployment within the family and traumatic experiences. On the other side of that, they are more likely to be subject to school exclusion, more likely to enter the mental health system via a criminal justice route and more likely to experience the more severe and coercive end of the mental health system—for example, use of the Mental Health Act—to experience of restraint, and to experience medication without consent.



Professor Gough: I do not focus specifically on BAME populations, but we know that, for example, in such groups help-seeking behaviour is more limited compared with other groups of men. We know that help-seeking is a key factor in men's mental health and wellbeing often being worse than women's.

Martin Tod: I do not have much to add to that. Any service response needs to reflect not just on men's ethnicity and the deprivation they face, but on their gender as well. We will probably come on to that.

Q99 **Tonia Antoniazzi:** African and Caribbean men are more likely to enter the mental health services via the courts or the police, rather than from primary care, which is the main route of treatment for most people. Why do you think that is?

Samir Jeraj: In addition to what I have just talked about, there is some evidence to show that there is a lack of awareness of support that is out there. There are often very poor experiences of institutions, whether that is the school, the police or mental health services themselves, either personally or within the broader family and community. For example, people having poor experiences of the mental health system from friends and family is likely to affect help-seeking behaviours.

When there is a delay in seeking help, people are more likely to develop more severe-end symptoms and conditions that will then require more coercive interventions, such as use of the Mental Health Act. Once within the mental health system, people can experience quite severe racialised responses in terms of use of those coercive methods. There have been a number of cases that have been in the public over a number of decades of African-Caribbean men where that has been the case, from Orville Blackwood through to Olaseni Lewis more recently.

Q100 **Tonia Antoniazzi:** Do either of you have anything to add to that?

Martin Tod: Black men are also more likely to receive medication as a response to their issues, rather than talking treatments such as psychotherapy.

Q101 **Tonia Antoniazzi:** What effect do you think entering the mental health services in this way has on both the treatment and the outcome?

Samir Jeraj: It is an extremely traumatic way to enter the mental health system. For example, I have interviewed a number of African-Caribbean men who have entered the system that way, and it is a trauma in and of itself, and then the experience of medication can be devastating. For example, one person I interviewed had been a musician for much of his life, had developed schizophrenia and was given regular injections of quite high-end anti-psychotics, so for most of the week he said he was just too tired to do anything. It was not really a living existence in that way; he had no creative energy to do what he loved and his vocation. This often led to him being what is termed "non-compliant," so he would go off his medication because being on it was so awful, and then that



would lead to an extreme relapse and being sectioned again by the police, and he would re-enter the system that way.

Within criminal justice, we know that black men are more likely to have adjudications brought against them within the prison system. We know that one of the reasons why black men fear seeking help early on is the fear of possible consequences, and that includes loss of status, control, independence and autonomy. Within the criminal justice system, that is all taken away from you. On top of that, you are left with a criminal record and all that entails for your life chances, and you have to deal with the potential consequences of what offence you have done in order to get there in the first place, and that again compounds and has a really detrimental impact on the ability to recover.

Q102 Tonia Antoniazzi: What can the Government and public bodies do to increase the chances of African and Caribbean men engaging with mental health services via primary care rather than the courts and the police?

Samir Jeraj: In our experience, it is that issue of trust, which again we have tried to talk about in terms of childhood and adolescent mental health as well. It is about building on relationships of trust, whether that can happen at an early age within the schooling system, but our experience in the adult setting is about strengthening community organisations and community-based mental health services so that, for example, you are not deeply anxious or worried about seeking help and services because you know and trust that service, because it serves and is rooted within your community. There are a number of examples I can send through of services that try to do that.

The greatest fear for anyone, but particularly for black men accessing any form of mental health service, is that you will end up sectioned, medicated, in a cell, with your life at risk.

Q103 Chair: We are interested here particularly in differentiating between the responses of young men and young women. What you have talked about there—about help-seeking behaviour and the importance of building a trust relationship—presumably is exactly the same for men and women, or is it not? In what way is the situation different for women and men—for black men and black women?

Samir Jeraj: Black men for many decades have had quite a racialised perception of their behaviour. Again, we heard earlier about how boys externalise their mental health issues. If I can give the example of Orville Blackwood—it is a case from the late 1980s, but it is still something that we go back to. He was an example of a person who, if I remember, had both a learning disability and a severe mental health condition. He was restrained and injected with what was a fatal dose of sedatives. The public inquiry into it concluded that the response of clinicians was based upon the stereotyped view that this man was “big, black and dangerous”, which was the subtitle to the report. The response that a large black man receives from the police or from mental health services is consciously or



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unconsciously different. That has again been borne out by a number of specific incidents and pieces of work.

Q104 **Chair:** We have talked so far about the gender stereotyping in terms of men and boys themselves, but you are talking about a stereotyped response to men and boys being part of that.

Samir Jeraj: Yes.

Chair: Would that stereotyped response be any different between black men and women?

Samir Jeraj: The evidence would seem to suggest that.

Q105 **Chair:** The stereotyping is working in both directions, and differently dependent on whether you are a man or a woman.

Samir Jeraj: Yes. There are instances and areas where there are very clear mental health issues affecting a specific group of women within a black and minority ethnic community. For example, south Asian women tend to have higher rates of self-harm. Again, as we have heard here, there is something about the internalisation of trauma and the expression or mental ill health through that.

Q106 **Chair:** Presumably that internalisation and externalisation is actually down to gender stereotyping as well, from a very early age. I presume there is no chromosomal reason why that would happen.

Professor Gough: It is a socialisation process, and there is a lot of evidence to suggest that from early on boys and girls are taught to deal with emotions differently. In the case of boys and men, it is often in very maladaptive and problematic ways, externalising in the ways that we have heard about already.

Chair: It is parenting again. We were talking about that earlier.

Martin Tod: It is important that we do not just treat help-seeking, for example, as an internalised thing: "Why are men not looking for help?" One of the classics we hear is that men do not go to the doctor as much as women do. They do as soon as they retire. There is no difference at all between retired men and women in terms of how much they go to the doctor.

Chair: They are just busier than women, are they?

Martin Tod: Because identity is so tied up in work, they prioritise work ahead of their mental and physical health. There are also greater consequences, in terms of the income hit of having a diagnosed mental health problem in the workplace for men being dramatically bigger than it is for women. One of the things that is quite important when we talk about stigma is that it is real and has real consequences in terms of employment, in terms of income, in terms of promotability and in terms of who gets made redundant first. All these factors need to be taken into account. Sometimes the reason men do not ask for help is a rational



response to the world they see around them, and the expectations that other people have of them, and the reactions that they think other people may have towards them.

Q107 Stephanie Peacock: The evidence we have received suggests that gay, bisexual and transgender men have poorer mental health. What accounts for this?

Professor Gough: We know that lots of different minority groups who experience marginalisation have more difficulty coming forward to mainstream services, because they do not see themselves represented in mainstream services and they do not trust mainstream services. They do not have access to the masculinity capital that will make them more confident about coming forward. They are subordinated within the masculinity spectrum, and they do not feel able to trust services or other men with their vulnerability.

Samir Jeraj: Something that I would add as well, in terms of the race perspective, is that there is a very poor amount of evidence on the experience of black and minority ethnic LGBTQ people. Where it does exist, it tends to show that these are compounding factors in terms of poor mental health. There is virtually nothing on the experience of black and minority ethnic trans people whatsoever, and that is a real gap in terms of our understanding, and in particular our response to need.

Q108 Stephanie Peacock: Following on from your answers, some of our evidence has suggested that mental health service is not inclusive of minority groups. Do you agree with this? If so, why?

Samir Jeraj: I would agree. I would say that generally mental health services, like most health services, are commissioned at a population level. It is generally about numbers; it is generally about numbers within a specific area as well. There is much less understanding and specific commissioning, in terms of understanding and meeting the needs of minority communities. There are pervasive attitudes within the frontline, by virtue of assertion that they do not discriminate. The attitude is, "Because I do not consciously experience direct prejudice towards someone, therefore there is nothing going on there". One of the lines you often hear is that anyone can walk in the door. It can take a lot for someone to expose their vulnerability, whether they are an African-Caribbean man or whether they are an LGBT person who is deeply concerned about coming out to a medical professional and what that might mean for their health, their safety and their state of mind.

Q109 Jess Phillips: I know we are talking about minorities within this already marginalised group who are not coming forward, but when you are talking about commissioning—this goes back to Maria's point about the difference between men and women in this instance—do you think that mental health services are commissioned well for women in this instance? To me, it is an incredibly masculine environment. For example, I think there are two places in the country where you can get specialist women's



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substance misuse services—it just does not exist. I wonder whether you think there is a specific commissioning issue about the services.

Martin Tod: There is interesting work going on in places such as Leeds, where they have just done a whole review of men's health and a whole review of women's health and are looking at how they can tailor services to meet the needs of men better and meet the needs of women better. We have always argued for a national men's health policy. There may be a case for a national gender health policy.

I do think that where people are a minority within a particular problem, you are likely to face issues. Drug and alcohol services are generally tailored more effectively towards men because men are the majority of people using them. There are huge issues to do with dual diagnosis and other such things, but you will get the issue inevitably in those circumstances that women may be underserved.

With regard to mental health generally, sometimes there is an issue that at the moment it feels a bit like some of the discussions we have around heart disease, where we are saying we are not doing a proper job of diagnosing women and offering them the support they need because the majority of people with heart disease are men—

Jess Phillips: Which is not true; the majority of people with heart disease are not men.

Martin Tod: Three quarters of the people who die prematurely under the age of 75 or 65 are men. With mental health, it almost feels like the reverse situation, where quite a lot of the academic case being made is that the way we diagnose depression and anxiety, and the indicators we look at to include are gendered. We are actually underestimating the level of male distress that there is within society, and the people who might benefit from support.

Q110 **Stephanie Peacock:** We have had limited evidence on the impact of having a disability on men's and boys' mental health. Do you have any experience of this subject within your work?

Professor Gough: Like Martin, I work in this field. I have done a big literature review recently and I have not found anything where disabled men are represented, so there is clearly a gap in the literature.

Martin Tod: Yes, this is an under-resourced area. There are a few areas where men are more likely to have a disability—autism, learning difficulties, hearing problems. One whole area where there are clear mental health problems is amputation. Men have three quarters of amputations, either through industrial accidents or through diabetes.

One area where there has been some work in terms of the consequences of disability is with military veterans, a minority of whom face mental and physical disability, and there is obviously a clear link between disability and poor mental health.



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In terms of somebody actually joining the dots in the way that we have just talked about for BAME men's mental health, there really is not very much out there. One of the things that we keep running into in the equalities world generally is the greater need for disaggregation of data, to be looking more intersectionally but also more deeply at inequalities to understand what is going on. We sometimes say that gender is the canary in the coalmine; if people are not even looking at gender, and that quite often happens, then frankly they are not looking at anything at that point.

Samir Jeraj: Something that comes to mind is that when the CQC did its review of deaths in the NHS estate, one of the areas that was flagged was that the people who were at the highest risk of dying within the NHS estate were people with a mental health condition and a physical health condition and/or disability, and people with a learning disability and mental health condition as well. There was some evidence on that.

We have done some work on the experience of Asian women with a disability, which I can send to you, but nothing specifically on experience of men with a disability.

Q111 **Stephanie Peacock:** I have a final question for Professor Gough. In your evidence you say that gender ideals and practices are changing. What did you mean by this and how will it affect mental health for men and boys?

Professor Gough: I will start with a disclaimer. Traditional expectations about men and masculinity are still influential, but there is some emerging evidence, especially with boys and younger men, that they are not so hung up on some of those traditional ideals and that they are becoming more inclusive and more caring to themselves and in their relationships. They are less homophobic and they have more female and gay friends, for example.

The evidence is a bit mixed at the minute, but there are some indications that for younger groups they are moving in that more positive direction. As I say, these more contemporary moods co-exist with prevailing traditional expectations, which of course are related to some of the mental health issues we are talking about.

Q112 **Chair:** It is really interesting to listen to the discussion this morning, and what has come out for me more than anything else is the very corrosive effect of gender stereotyping, not just amongst children but amongst those who are delivering services. That is really interesting. When you start to think about how you can then deliver mental health services, in particular, given the world as it is and not as we would like it to be, are you telling us that we have to have far more specialised provision, or are you saying that the provision we have has to be able to deal with far more specific needs?

Professor Gough: We have to look at the evidence of best practice and of what works, and not just in the UK but across the world. The emerging



evidence indicates that, for many groups of men and boys, community-based interventions are much more preferable. The evidence on effectiveness is not quite there yet, but there are some case examples where community initiatives show a lot of promise.

Q113 **Chair:** Give me an example of a community-based initiative.

Professor Gough: An obvious one—this might have been mentioned before—is the Men's Sheds movement for older men, so men who are retired or isolated, and at risk of mental health problems. They go to a shed—it generally is not a shed; it is a community venue—and they meet other men and make stuff together. It could be carpentry or something. In that process of socialising with other men, doing stuff together, having a chat during the tea break or maybe even going to the pub afterwards, you see mental health benefits. Importantly, it is not badged as a mental health initiative. It is a community initiative, and we know that older men really benefit from this type of intervention.

Q114 **Chair:** So your answer to my question would be that you really need to go specific.

Professor Gough: That is what works. That is what we are seeing from the evidence. There needs to be a range of options, but if I had to choose from a limited range, I would go in that direction.

Martin Tod: The starting point is that general-access services have to work for men as well as they do for women, and they have to work for black men and they have to work for LGBT men, so there is an awful lot that needs to be done to make sure that the frontline, when people do come to the point of accessing services, works for all.

We need to be open that there are interventions that appear to work as well for men as they do for women. With IAPT, for example, the evidence seems to be that it works as well for men as it does for women. The issue there is that far fewer men are accessing it. Then there is a lot of evidence, as well, particularly in getting upstream and dealing with these problems earlier, that community interventions and peer support, often delivered through the voluntary community sector, are incredibly important. Particularly in dealing with very marginalised groups—Gypsy and Traveller men, for example—you need to be working with the community in order to be delivering services that work effectively and engage with those groups.

Samir Jeraj: I am on the side of both, in that from my perspective I want an African Caribbean man in a predominantly white British area to be able to go to a mental health service or enter into a health service, and be as safe and cared for as someone who can access a lovely, nice community setting. It is one of the things that, representing black and minority ethnic people, you are very aware of, in that there is that disparity of what type of services are available and where, which is why mainstream services need to be improved. Even if people are quickly



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routed through to something specialist, it needs to be as safe and effective as possible.

Q115 **Chair:** A lot of that is going to be about the training of people who are not just delivering the service but are the gatekeepers to the service, such as GPs.

Samir Jeraj: Indeed. One of the points I raised at the start was about the wider determinants of health. It is about who has those relationships of trust with people in the community, whether that is through teachers, friendships or other relationships that could and should be there.

Martin Tod: Because of the stigma issue, we did some work with an online chat service that men could access to talk about their mental health. That partly came from the fact that, because of stigma, and because of men's concerns about discrimination, part of the mix probably needs to be access to anonymous and confidential services as well, because people are very worried about the impact on their reputation—what happens if their employer knows, if their community knows, or if their family knows? They are not always happy to do that, so there need to be ways in where people feel like nobody will ever know.

That partly involves when the services are available, because if you can access them only in working hours, it is pretty obvious that something is going on. They need to be available out of hours; they need to be available whenever suits men. There is a need to think about the pressures particularly, and the desire that nobody knows in some cases, because of the concern about discrimination, to make sure the right mix of services is available.

Samir Jeraj: In terms of what works, we know that traumas and the experience of poverty, for example, are a key factor in developing a mental health condition. There are well-established social policies to reduce those risks. We can talk about improving mental health services. There is a key role and quite an important role in reducing disparities through prevention, which might mean looking very specifically at the experience of school exclusion, which you know has a disproportionate impact on Caribbean boys.

It might mean looking at the experience of the type of housing you grew up in: if you grew up in overcrowded housing you are more likely to experience an anxiety disorder. Black and minority ethnic children are more likely to grow up within an overcrowded home. If you grow up within a cold home you are more likely to experience a depressive disorder. Black and minority ethnic children are more likely to grow up within a cold home.

We can be more ambitious than looking at what can be done with mental health services, and actually what can be done with public services. In our experience, when someone ends up in a secure mental health unit that is really high-end—the most expensive and often the least effective



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form of treatment—it is because they have been failed multiple times by other institutions within our society. They have washed around criminal justice, they have washed around other tiers of mental health, and they have ended up there. Preventing that from happening would be a really important thing to want to achieve.

Q116 Jess Phillips: Samir, you have already answered this question in your last answer, so I will put it to Martin and Professor Gough. What is the impact of economic insecurity on men and boys' mental health?

Martin Tod: It is absolutely enormous. If you take suicide, the difference between the richest areas and the poorest areas in the country is about 10 to one. To try to extend the debate, I sometimes make the point that we talk a lot about the fact that a man is three times more likely to die from suicide than a woman, but we also need to be honest about the fact that, given that I am a professional manager, an unskilled labourer is three times more likely to die from suicide than I am.

Q117 Jess Phillips: Is there an axis of that—I do not wish to use you as the example of somebody dying—where a poor woman is more likely than a rich man?

Martin Tod: I think it is about the same, but I am not entirely sure; I would need to check that.

I sometimes make an interesting point that men are more unequal than women. We have all the billionaires, but we also have the majority of people sleeping rough, and the majority of people in prison. We have a bigger life expectancy gap than women do. For men and women, there is a couple of years' difference between the top 10% and the bottom 10%; it is bigger for men than it is for women. One of the reasons we often argue for a men's health policy in general is that those men who are facing the biggest risks of mental health issues are going to be the men who then go on and face the biggest risk of heart disease, the biggest risk of cancer, and the biggest risk of dying prematurely generally.

Q118 Chair: You have painted a very vivid picture of huge divergence within groups of men, but what is driving that huge divergence? Is it discrimination? I find it difficult to understand that it is discrimination that is driving that huge divergence.

Martin Tod: In terms of health outcomes?

Chair: Well, you have just painted a very vivid picture—

Jess Phillips: Of the unequalness that exists between men that does not exist between women. The trouble is that women do not get to the top.

Martin Tod: Women do not get to be billionaires, FTSE 100 directors, chief executives and all those kinds of things, so it is partly that men are populating the very top end of income. But it is important to remember that most men are not populating the very high end of income. There are some particular factors that relate to men's health, particularly in terms



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of health behaviours. Smoking is less of a gap than it used to be, but drinking is an example.

Q119 **Chair:** Some of those health inequalities will also be driven by the other inequalities, which are driven by, one would say, privilege—the pressure and the heart disease.

Martin Tod: Yes, although there is the perception that it is the stressed executive who is most likely to keel over from heart disease, and it is not; it is people in unskilled jobs who are most likely to be at risk, possibly because of the link to smoking.

Q120 **Chair:** The reason I wanted to dwell on that a little is that we sometimes find it very difficult to unpick the difference between discrimination and just difference. We are really focused on the way discrimination law works or does not work, for various groups of people, so the big divergence that you have been talking about very well is not necessarily down to discrimination.

Martin Tod: It would appear to be the case that one of the reasons BAME people might have worse health is that they are also earning less. There are far fewer BAME billionaires, FTSE 100 chief executives and board members, hospital trust chief executives, or whatever area you might want to look at.

Q121 **Jess Phillips:** The issue of smoking, though, is an interesting one that you pick up. Do more men smoke?

Martin Tod: Historically it was a much higher difference

Jess Phillips: Is that just a stereotype thing again?

Martin Tod: It is a very interesting area, because it varies also by ethnicity. There are some ethnic groups for whom there are very big differences in smoking. Among the white population, it is now fairly comparable. There is a difference in profile of what people smoke, so men are more likely to smoke roll-ups, and women are more likely to smoke cigarettes. The huge gap that used to exist between men and women is slightly opening up again. It had almost disappeared a few years ago, where there was almost no gap at all, and I do not think anybody is entirely clear why. It might be to do with the uptake of vaping and various other things, but there seems to be a gap reopening between men and women. In the grand scheme of things, it is still quite small, and the gap between areas of deprivation and the class-based gap in smoking is far bigger now than the gender gap.

Q122 **Jess Phillips:** Going back to the idea of economic impact, the suicide rates alone are stark between the top and the bottom.

Professor Gough: There is clear evidence linking austerity to the rising suicide rate among men, not just in this country but in various European countries. That is clearly tied to meaningful work being connected very deeply to men's identities.



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Martin Tod: Unemployment in particular is pretty devastating for men's health, and it was striking when an analysis was done, in 2014, looking at the consequences of the 2008 economic crisis. We normally talk about a 3:1 ratio in terms of male suicide. The estimate of extra suicides as a result of the recession was 800 extra male deaths and 155 female deaths, so it was even more extreme. That is probably in part down to the gender role of being the provider, having a job and men defining themselves by their job.

Q123 **Jess Phillips:** How can we, as policy makers, stop that? I have stopped it in my house.

Martin Tod: We are on to much wider discussions as to how we create gender equality. Part of it needs to be changing the norm of what being at the top of an organisation looks like; of what success looks like. It is not just always on, 24/7, working completely hard, no caring responsibilities, never taking time off for mental health, for physical health, or for anything else. Part of the agenda needs to be not just removing the barriers for women to get to the top of organisations, which is vital and absolutely important, but in the end, if we just create a model that says women who are always on, work 24/7 and have no caring responsibilities can get to the top, we have not really solved anything.

To me, it is part of an agenda of taking a more ambitious approach towards creating a norm that men are carers, have time off to care and take paternity leave. We should be doing this on a Government level, and saying to enlightened employers in the vanguard of this, "We need you to make this work. We need you to be setting models that go far beyond the statutory minimum". It is only when we start to expand the definition of male success, and allow it to be not just being rich and successful in your job and a successful provider, but open up areas, particularly caring, because that leads to so much inequality, that we will get to the point that some of these other factors may start to reduce. That might be hopelessly optimistic.

Jess Phillips: No, let us be hopelessly optimistic. I am all for it.

Martin Tod: It is something I happen to believe.

Samir Jeraj: As a quick point on rough sleeping, there would be a clear policy issue about how priority need works in terms of why men are more likely to end up rough sleeping.

Chair: That was exactly what was in my mind when Martin was talking. I was thinking about rough sleeping. You are right; that is a policy driver that leaves men more vulnerable.

Samir Jeraj: Interestingly, I did some work on rough sleeping in Northampton, outside of the job in which capacity I am here. One of the issues that came up there was that couples who are on the street together were being required to separate, with men going into a night



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shelter, and women into temporary accommodation, which then meant neither of them wanted to take that up.

Chair: What you have done today, really vividly, is underline the importance of us looking at the issue of stereotyping in our report. It is hugely important that we have some concrete analysis of that and the recommendations that you make about it, because what you have talked about is going to be good for everybody. We need to remove the stereotypes that create that need for individuals to behave or be treated in certain predetermined ways, which are quite a destructive part of the problem.

It was incredibly helpful. Thank you so much for your time and a really excellent evidence session. We are very grateful to you. Thank you very much.