Written submission from the UK Council for Psychotherapy (MHM0062)

About us: Alongside providing professional support for our members, the UK Council for Psychotherapy (UKCP) is the leading accrediting, educational, regulatory and research body working to advance psychotherapies for the benefit of all.

Our membership includes more than 9,000 individual therapists and 75 training and accrediting organisations.

Our individual members work for the NHS, privately, and in third sector organisations, offering a wide variety of psychotherapeutic approaches. Our support for the psychological therapies is research-based and recognises the diversity of approaches that can deliver better mental health outcomes.

Executive Summary

- In discussing the gendered elements of mental health, we feel it is crucial to avoid any language that seeks to essentialise the experiences of men, women or people of other gender identities. Gender is one element of an individual's identity.

- Critiques of masculine norms relating to mental health should be made carefully, clearly framed as structural concerns rather than focused on the behaviour of individuals and avoiding any sense of "victim-blaming".

- We acknowledge the powerful impact that socialised masculine values can have on men's values, the way in which they relate to others, their behavioural traits and the way in which they respond to mental distress.

- We welcome the recent announcement that fathers will be offered mental health checks as part of a broader expansion of perinatal mental health services, given that more than 10% of new fathers experience postpartum depression. However, it is vital that men who are successfully identified as requiring support are offered an appropriate choice of evidence-based talking therapies.

- We urge the Government to consider further equalising measures around guaranteed parental leave as a means of challenging restrictive gender norms around work and childcare, and providing parents with greater freedom of choice.

- We strongly argue that a trauma-informed approach to tackling problematic behaviours of adult men should take precedent over a punitive one. This requires enhancing cultural competence around gendered presentations of mental health problems amongst the police and frontline health staff.

- We recommend that further research into the gendered symptom presentation of depression is supported/commissioned by the Government as a priority.

- The psychological professions are disproportionately white and female. The lack of diversity among practitioners can create barriers to effective care for some groups, including men. We urge the NHS and HEE to provide incentives for underrepresented

groups to work in the psychological professions, and we demand the same of ourselves and other non-statutory accrediting bodies.

- We strongly recommend that the Government, NHS, HEE and regulatory bodies take pro-active steps to promote and fund a consistent model of cultural competence training across the UK for mental health practitioners. This training should include a thorough examination of the way prevailing gender norms influence the presentation of mental health difficulties, as well as receptiveness to treatment. If services are reformed to become more accessible to under-represented groups of service users, including men, it is essential that this work is carried out by a workforce both sensitive to people's gendered experience of services and unwilling to reinforce problematic gender norms.

- Patient choice of treatment has been shown to have a significant effect on outcomes, but choice within the Improving Access to Psychological Therapies (IAPT) programme is often extremely limited. We therefore recommend that the NHS and HEE work closely with training organisations and the relevant accrediting bodies to create pathways into NHS work for therapists delivering a full range NICE-approved therapies.

- We support the co-location of IAPT and GP services. Delivering therapy in a familiar setting not only improves retention, it also increases the likelihood of uptake of therapy from hard to reach groups.

- The gendered response of men to different types of therapeutic intervention is poorly researched, as is the effectiveness of many interventions more generally. We recommend that the Government prioritises funding research into the efficacy of a wide range of talking therapies, with a focus on assessing their relative effectiveness given protected characteristics of patients such as ethnicity, age, religion, sexuality, gender identity, and ability.

Avoiding essentialism

1. In discussing the gendered elements of mental health, we feel it is crucial to avoid any language that seeks to essentialise the experiences of men, women or people of other gender identities. The reproduction of gendered social norms appears to have a very significant bearing on mental health outcomes in the UK, but it is important that these differences are always fully contextualised. Gender is only one element of a person's identity that intersects with countless others. People each have their own experience of what it means to be a man or a woman, or any other identity. Trends that we identify below as disproportionately affecting men in the UK can and do, on an individual level, affect many women and non-binary people as well. It is vital for policymakers and practitioners to avoid adopting essentialist assumptions after having reviewed gendered trends in mental health.

Gendered experience of mental health issues in men

2. Male suicide has often been talked about as a "silent epidemic" because, despite alarming figures around the relative number of male suicides – 76% in the UK – there has been limited public discussion around this topic. We therefore wholly welcome the Committee choosing to focus on men's mental health.

3. In discussing male suicide, it must be pointed out that considerably more women (8%) than men (5.4%) report having attempted to take their own lives (NHS Digital, 2014). So, while it is clearly vital to address the significant gender disparity in completed suicides, this should not come at the cost of seeking to address the gendered experience of women with suicidal ideation. Nevertheless, the disparity is such that it must be a central focus of gender-conscious efforts to tackle men's mental health.

4. We feel it is important to be mindful of the emerging narrative in the academic study of men's mental health that seeks to avoid any notion of "victim-blaming" (Whitley, 2018). Critiques of masculine norms should be carefully qualified, and clearly framed as structural concerns rather than focused on the behaviour of individuals. This is especially important in considering how men interact with mental health services.

5. Men are considerably less likely to seek help from mental services than women. This is well illustrated by the fact that only 36% of people referred to IAPT services are men. There are numerous character traits which are typically coded as masculine which can be associated with a reluctance to seek help – for example, being strong-willed, self-reliant, in control or invulnerable – and a recent meta-analysis showed a strong link between conforming to masculine norms and reduced help-seeking (Wong et al, 2017). This link is of crucial importance in understanding how many men ultimately reach suicidality.

6. However, it is also important to consider the ways in which gendered expectations of men can act as triggers for mental health issues at particular moments in their lives. Patriarchal and heteronormative notions of what families and relationships should look like remain hugely influential in shaping gender roles in the UK. The idea of man as breadwinner and woman as child-bearer still shape our labour market despite significant shifts in recent decades. As of 2013, 87% of men were in full-time work compared with only 56% of women (EHRC, 2013). Work has been seen as a domain from which men are more likely to garner a sense of identity and self-worth (Affleck et al, 2018), and the stress of challenges at work or loss of job can therefore include a gendered element for some men. This is often tied in with financial expectations of man as provider. When employment and/or financial issues arise, this can seriously undermine a man's gendered sense of obligation to provide for their family.

7. The process of having a family itself can also present challenges to men. Postpartum depression is reasonably well-researched in relation to the way it affects women, but far less well-understood in the way if affects men (Affleck et al, 2018). Nevertheless, it is estimated that more than 1 in 10 fathers (Paulson et al, 2010) experience it. We draw a connection here between the broader expectation of men to provide financially, and the process of becoming a father. We therefore welcome the recent announcement that fathers will be offered mental health checks as part of a broader expansion of perinatal mental health services, though it is vital that men who are successfully identified as requiring support are offered an appropriate choice of evidence-based talking therapies.

8. We also draw attention to wider legislation affecting new parents. The significant gap between the amount of parental leave that mothers (26 weeks) and fathers (2 weeks) are guaranteed by law helps to perpetuate traditional parental gender roles. As well as contributing to the gender pay gap, this reinforces the narrative that it is a man's duty to provide financially within a heterosexual relationship, which we argue is damaging for

men's mental health. We therefore urge the Government to consider further equalising measures around guaranteed parental leave as a means of challenging restrictive gender norms and providing parents with greater freedom of choice.

9. Another common risk factor in the experience of mental health issues among men is divorce and family breakdown. Men are more likely than women to rely on a partner for emotional support and can thus be more exposed when a relationship ends (Affleck et al, 2018). There is also evidence to suggest that women are more likely to have a support structure of friends and family in place following a divorce. When someone is lacking a support structure following a relationship breakdown *and* is reluctant to seek help, a dangerous combination may emerge. The evidence suggests this scenario is more common among men.

10. The age at which suicide is most prevalent among men is between 40-54 (ONS, 2015), and this is clearly a time during which many men are affected by some or all the above issues.

11. One further risk factor in the mental health of men is the possible effect of adverse childhood experiences on mental health issues in later life. We advocate trauma-informed therapeutic practice that seeks to understand compassionately the manifestations of childhood trauma in adult mental health. However, a gendered understanding of behaviour often leads people to pathologise men who may be acting out on account of adverse experiences in their past. We strongly argue that a trauma-informed approach to tackling problematic behaviours of adult men should take precedent over a punitive one. This requires enhancing cultural competence around gendered manifestations of mental health problems amongst the police and frontline health staff.

Gender-sensitive mental health services

12. One of the significant obstacles to instilling this type of compassionate approach is that the effect of gender norms on the presentation of common mental health issues, like depression, remains under-researched. According to NHS figures (2014), men are significantly less likely (12%) to experience a "common mental health disorder" than women (20%). Explanations for this include suggestions that men are less likely to recognise or admit to experiencing symptoms associated with depression (Bilsker et al, 2018). However, it has been suggested that the gendered expression of depression in some men results in externalising rather than internalising their problems, resulting in, for example, anger or self-medication with drugs or alcohol (Addis, 2008). We strongly recommend that further research into the gendered symptom presentation of depression is supported/commissioned by the Government as a priority, the results of which should be incorporated into the relevant NICE Guidelines and guidance for any public service roles that regularly interact with people with mental health issues.

Diversifying the workforce

13. Another way in which services could be enhanced and made more accessible is by tackling the diversity of the psychological workforce. We know that the role of therapist is broadly seen as part of the caring professions, which have traditionally been coded as feminine. Aside from psychiatry, which is broadly gender balanced, we know that the psychological workforce is dominated by women, while at a managerial level it is

dominated by men (Morison et al, 2014). This is reflective of a labour market that remains strongly gendered, with better-paid roles more likely to be occupied by men, and caring roles more likely to be occupied by women. The gender balance found across the psychological professions is reflected in our membership, which is just over three quarters women. We also know, from cross-organisational work we are doing around diversity, that people from a BAME background are significantly under-represented in the psychological professions as well. The impact of a lack of diversity among practitioners can create barriers to effective care for some groups.

14. It has been argued, for example, that the dominance of the therapeutic profession by women has led to a perception of the "feminisation of mental health services" in the UK (Morison et al, 2014), which may act as a barrier to some people seeking support. This could be a result of some people having limited access to a therapist of the same gender as them, which they may prefer, or being offered a type of therapy that they don't feel comfortable with. It could also be the result of institutionalised gender norms preventing psychological professionals (regardless of gender) sufficiently probing for emotional suffering in men (Affleck et al, 2018). Nevertheless, having a workforce that is so unrepresentative of society at large is an undesirable outcome. We therefore strongly urge the NHS and HEE to provide incentives for underrepresented groups to work in the psychological professions, and we are demanding the same of ourselves and other accrediting bodies who are not statutorily regulated.

Training a culturally competent, gender sensitive workforce

15. Changing the demographic make-up of the psychological professions is an important step to ensuring they are more representative of the groups they exist to serve. Nevertheless, this provides no guarantees of a culturally competent workforce. We see cultural competence as essential to ensuring that there is a thriving workforce capable of serving the population as a whole. However, the current evidence suggests that existing measures to enhance the cultural competence of the health workforce, particularly within the NHS, are: inconsistent across the country, usually taught from a perspective that doesn't acknowledge that white is an ethnicity, and very often void of discussion beyond race – such as around LGBT+ issues or gender norms (George et al, 2015).

16. We strongly recommend that the Government, NHS, HEE and regulatory bodies take pro-active steps to promote and fund a consistent model of cultural competence training across the UK for mental health practitioners including, where appropriate, as part of continued professional development (CPD). This training should include a thorough examination of the way prevailing gender norms influence the presentation of mental health difficulties, as well as receptiveness to treatment. If services are to be reformed to make them more appealing and more accessible to under-represented groups of service users, including men, it is essential that this work is carried out by a culturally competent workforce – one that is able to cater to people's gendered experience of services, without reinforcing prevailing gender norms.

17. We are currently in the process of enhancing our own training processes in keeping with this recommendation, which fits neatly alongside our work to implement the Memorandum of Understanding on Conversion Therapy.

Changes to mental health provision for the benefit of all

18. We believe there are some changes which could be made to existing mental health provision that would benefit all service users, particularly men. For example, in many parts of the country there is an extremely limited range of treatments available through the IAPT programme – despite a stated commitment that IAPT will provide a range of evidence-based therapies, well over half of its workforce deliver cognitive behavioural therapy (CBT). This means that patients for whom CBT is not appropriate may have no choice but to attend sessions or miss out altogether. For any patient who was sceptical about seeking mental health treatment, a disappointing first session may be a catalyst for the continued avoidance of therapy thereafter – we know that fewer than 40% of referrals end up completing treatment (NHS Digital 2018). This is damaging for mental health, particularly for those individuals who required persuading to attend therapy sessions in the first place. Providing a range of therapies not only increases the chances of matching a patient with an effective intervention, it also enhances the agency of the patient within the referral process. Due to prevailing gender norms around control, this is likely to disproportionately benefit men. We strongly recommend that the NHS and HEE work closely with training organisations and the relevant accrediting bodies to create pathways into NHS work for therapists delivering a full range NICE-approved therapies.

19. Alongside moves to diversify the range of therapies available on the NHS, we also urge the Government to invest in these services, to reduce the extent to which interventions are time limited – currently, IAPT therapies are usually capped at 6 or 7 sessions. Time-limited talking therapies are less effective with those patients or clients who feel less inclined to share emotional problems – which, due to prevailing gender norms, is disproportionately likely to be men.

20. We also strongly support the co-location of IAPT and GP services. Delivering therapy in a familiar setting not only improves retention, it also increases the likelihood of uptake of therapy from hard to reach groups.

21. Mental health research is chronically underfunded in the UK and this is reflected in the poor understanding of how, if at all, gender affects therapeutic outcomes. The evidence base for many talking therapies remains limited. We therefore recommend that the Government prioritises funding research into the efficacy of a wide range of talking therapies, with a focus on assessing their relative effectiveness given protected characteristics of patients, such as ethnicity, age, religion, sexuality, gender identity, and ability.

Conclusion

22. We have sought to outline above some of the ways in which gender norms affect men's mental health and contribute to some significant gender disparities, including the rate of male deaths by suicide. Suicide is the ultimate cost of poor mental health, and we have sought to illustrate some of the pernicious ways in which the prevailing social norms in British society help to facilitate this alarming statistic. We hope that the cumulative body of evidence the committee receives in carrying out this inquiry helps it make significant recommendations that could begin to allay some of these gendered problems.

23. We feel it is critical that a gender sensitive approach to mental health incorporates the experiences of people of all genders. It remains the case that women are

disproportionately disadvantaged by prevailing gender norms. Nevertheless, we have sought to illustrate that sexist attitudes tied up in these norms are damaging to all of us.

24. Our Chief Executive, Prof Sarah Niblock, would be more than happy to attend an oral evidence session and elaborate on any of the matters discussed above.

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