Written evidence submitted by CLOSER, the home of longitudinal research (UCL Social Research Institute) (IMH0092)

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1. About us:

1.1 CLOSER, the home of longitudinal research[1], is the UK's partnership of leading social and biomedical longitudinal population studies and works to increase their visibility, use and impact. Our studies[2] comprise national and regional studies from across the UK. They include the British Birth Cohort Studies, ONS Longitudinal Study, English Longitudinal Study of Ageing, Born in Bradford, Southampton Women's Survey, Avon Longitudinal Study of Parents and Children, Generation Scotland, Understanding Society – the UK Household Longitudinal Study, and more.

1.2 CLOSER has been funded by the UKRI Economic and Social Research Council (ESRC) since 2012 and is based at the UCL Social Research Institute.

2. Our reason for submitting evidence:

2.1 CLOSER represents multiple longitudinal population studies across the UK. These national scientific assets follow the same people and households over time, often from birth, collecting a wide array of data and information about study participants, which enable researchers and policymakers to explore people's complex lives and how changes in society affect health, community and education. CLOSER's strategic position in the research landscape and birds' eye view of the UK's longitudinal population studies makes it an ideal vehicle for identifying and communicating evidence to inform policy.

2.2 The UK's longitudinal population studies are recognised as vital sources of evidence on how early circumstances and experiences affect people's lives from childhood to adulthood and older age, providing insights into individual short and long-term change and the relationship between different elements of people's complex lives that cannot be obtained from any other data sources. They allow researchers to explore how different groups vary, and how and why people's lives change, enabling a greater understanding of the difference between causal relationships and correlation.

2.3 Many UK longitudinal population studies collect physical and mental health data about their participants. Data from several studies has been used in research assessing differences in health between men and women, including:

- The English Longitudinal Study of Ageing (ELSA)[3]
- The 1958 National Child Development Study (NCDS)[4]
- The Avon Longitudinal Study of Parents and Children (ALSPAC)[5]

[1] https://www.closer.ac.uk
[2] https://www.closer.ac.uk/timeline/
[3] https://closer.ac.uk/study/english-longitudinal-study-of-ageing/
[4] https://closer.ac.uk/study/1958-national-child-development-study/

- The 1970 British Cohort Study (BCS70)[6]

2.4 Research has investigated differences between men and women in physical and mental health, including how physical and mental health interact. Evidence from longitudinal population studies has proven particularly helpful in understanding how lifestyle choices more often made by men as adults are reflected in their health when they get older.

2.5 Our response focuses on the following questions in the call for evidence:

- What factors drive lower, and falling, male life expectancy and what action would have the biggest impact on addressing this?
- What is driving higher rates of suicide amongst men and how could this be addressed?
- What role do community and sport-based projects play in reaching men at high risk of isolation or poor mental health, and how can this support be spread equitably across the country?
- What are the challenges in delivering health equity across different population groups among men and how best can these challenges be addressed?

3. What factors drive lower, and falling, male life expectancy and what action would have the biggest impact on addressing this?

3.1 Weight and heart disease

- Overweight and obese people are more likely to develop heart disease compared to people of normal weight [1]. **Men tend to eat more processed or confectionary foods when compared to women, which may lead to them experiencing a greater difficulty in maintaining a healthy weight [2].** This means that men, who are naturally more susceptible to heart disease when compared with similarly healthy women, are often exacerbating the risk.
    - **Cross-nationally, men almost always have a greater susceptibility to heart disease compared to women.** This is true even when controlling for men's higher levels of smoking or greater tendency to be overweight [3].
    - Heart disease is one of the leading causes of mortality in older age ranges, and men have higher mortality compared to women, indicating there would likely be an even larger sex differential in the presence of heart disease if many men had not already succumbed to it [3].
- There is scope for more research to explore diets separately in men and women. This would be of particular importance for targeting public health advice regarding nutrition to those most likely to have poor dietary patterns.

3.2 Smoking

- **Among all factors, smoking has the largest contribution to the difference in mortality between men and women,** yet opposite trends in prevalence of smoking, and associated morbidity and mortality have been observed in men and women, with men smoking more and women smoking less across eras, and a tighter connection between smoking and morbidity observed in men compared to women **[4].**
- **It is important for tobacco control policies to consider gender roles, including how they are evolving, when considering how to prevent smoking related deaths** in men and in the whole

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[5] https://closer.ac.uk/study/alspac-children-90s/

[6] https://closer.ac.uk/study/1970-british-cohort-study/

population. Additionally, the research referenced here specifically looks at adults aged over 50; policies must also consider the intersection of smoking patterns and gender across different age groups.

3.3 Mobility and musculoskeletal

- **Gross muscle[7] limitations and mobility are more of a risk factor for men, which likely reflects the gendered nature of work.** Pain and limitations differentially impact different types of work, for example, manual versus clerical. The result of this is that men are more likely to experience disability-related exit from employment [5]. These gender differences in gross muscle limitations and mobility should be considered by gendered interventions in occupational health.
    - Gender differences in gross muscle limitations and mobility show that more men develop employment-inhibiting conditions. Prolonged unemployment is shown to significantly reduce both socio-economic and health capital by age 33. Research using NCDS data has found that the experience of prolonged unemployment early in the working life of young men looks likely to have a persisting effect on their future health and socio-economic circumstances [6].
- The link between gender differences in gross muscle limitations and mobility and employment is a complex problem. It is important to bear in mind that macro factors such as labour market opportunities, and inequalities in lifetime earnings and pensions, can help to explain gender differences in the effect of chronic conditions on disability related exit from employment [5].

3.4 Mental health

- Poor mental health has been associated with an increased risk of morbidity and mortality in later life in various contexts. **Depression (including among men) is a particularly strong predictor of mortality in relation to cardiac failure and stroke [7].**
    - **Men who have experienced childhood adversities and a lost relationship face a higher risk of having poor mental health outcomes in later life**, even after controlling for socio-demographic characteristics, health-risk behaviours and social support [7]. In this context a lost relationship refers to having a high probability of losing a very close friend or relative at risk of death, or having one who has died due to illness. **The men most at risk of suffering depressive symptoms in older age are those who have suffered more accumulated adversities across their life [7].**
    - An elevated risk of depressive symptoms in later life is sometimes associated with events typical to the process of ageing, such as retirement, widowhood and a reduced ability to perform daily tasks. The finding that those who have experienced childhood adversities are more likely to experience poor mental health outcomes in older age demonstrates that **early life adversities should also help inform preventative interventions in later life**.
- **Among men, relationship quality predicts depressive symptoms. Spousal support or strain are significant predictors of depressive symptoms for men [8].**
    - **Spousal support may be more central to the emotional wellbeing of men than women because, while women tend to seek support from a wider circle of friends, men are less likely to have a close confiding relationship with someone other than an intimate partner.** This leaves them drawing more heavily on their spouses for support [8].
- There is a need to create broader public awareness and understanding about the effects of harmful stress from different types of negative life experiences. This has the potential to

[7] Those used in activities such as walking, running, throwing, lifting, etc.

increase the proportion of older people with depression (many of whom are men) who talk about their symptoms with professionals and go on to receive beneficial treatment [7].

4. What is driving higher rates of suicide amongst men and how could this be addressed?

- Knowing that suicide is more common among those with poor mental health (such as depression and anxiety) [9], the following findings may be of interest to the Committee.
- It is well-established that suicide is the leading cause of death for men under 50 [10]. Longitudinal data on ageing has supplemented this, facilitating research on suicide in later life.
    - **A systematic review on suicide among adults aged 50 years or over found that social intervention programs promoting healthy social interaction and community participation were particularly effective [8].** Such programs have been found to increase wellbeing and social and physical activity, improving quality of life, and ultimately reducing psychological distress [8].
    - Focusing interventions on relationship quality and social integration can therefore be particularly efficient in improving health outcomes by focusing on a broader social context.
- As discussed above, cumulative life course adversities increase the likelihood of men developing depression [7]. Acknowledging this is important to preventing and treating the negative effects associated with adverse mental health for individuals.

5. What role do community and sport-based projects play in reaching men at high risk of isolation or poor mental health, and how can it be ensured that this support is spread equitably across the country?

5.1 Loneliness and mental health among men

- **Multiple studies identify spousal relationship or marital quality as indicators of mental health among men.** Poor relationship quality with one's spouse is especially strongly related to feelings of loneliness in men, confirming that men are intrinsically reliant on their spouses for intimacy and support [8].
- Relatedly, men tend to be more affected by widowhood than women. This can also be through the additional burden of adapting to performing domestic tasks. **Men are at higher risk of all-cause mortality than women after the death of their spouse [11].**
- **Men's reliance on their spouse is reflected in their physical health.** Changes in marital quality have significant effects on cardiovascular disease risk factors. For men this can be more significant as women have larger social networks and are less dependent on their partner [12].
    - Among men, the onset of loneliness has also been associated with an increase in systematic inflammation [11].
    - Loneliness is positively and independently related to an increased risk of developing dementia, whereas being married and having more close relationships are each independently associated with a reduced dementia risk [13].
- As discussed above, poor mental health in older men can be related to cumulative early life adversities rather than just events associated with the process of ageing [7].

5.2 Policy implications

- Research using data from BCS70 has specifically looked at the effects of sport on the psychological status of middle-aged British adults. It found that physical activities that are

predominantly practiced individually are associated with lower psychological distress and higher wellbeing among women, while **team sports are strongly associated with lower psychological distress and higher wellbeing among men [14].**
    - This reflects the research highlighted elsewhere in this submission that men have clearer benefits with the expansion of their social networks than women. Group practices such as team sports can increase social support and integration, which in turn are themselves associated with lower psychological distress and higher wellbeing [14].
- Given the reduction of reliance on a spouse for support, higher levels of social network integration can reduce the risk of depression specifically in men [9]. Our evidence that group practices such as team sports can increase social integration therefore supports calls for community and sport-based projects that reach men at high risk of isolation or poor mental health.
    - **Effective interventions should not only focus on expanding men's social networks, but on improving the quality of existing relationships.** It may be that interventions could effectively target lonely individuals to alter their approach towards existing relationships, eventually improving their mental health.
    - Given that men and women have different needs for supportive networks, tailored solutions to address these specific needs should be implemented.
- Having more good quality social resources is important in mitigating mental health difficulties under particularly stressful circumstances [15].
    - The interventions that are most effective at reducing social isolation and loneliness among older people are educational and social activity group interventions, whereas the effectiveness of home visiting and befriending schemes is less clear [9].
    - **Creating effective means of social integration will be productive as people can benefit from positive social resources in the longer term**, as effects on mental health persist five years following exposure to stress [15].

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Sept 2023