



PROMOTING MENTAL HEALTH AND WELLBEING WITH MEN AND BOYS: WHAT WORKS?




MEN'S
HEALTH
FORUM



LEEDS
BECKETT
UNIVERSITY

PREPARED BY

Centre for Men's Health

Institute for Health and Wellbeing
Leeds Beckett University
LS1 3HE

Men's Health Forum

32-36 Loman St
London
SE1 0EH

ISBN: 978-1-907240-41-6

READER INFORMATION

Leeds Beckett University in collaboration with the Men's Health Forum (England & Wales) were funded to undertake this literature review and environmental scan by the Movember Foundation.

This report was prepared by Professor Steve Robertson, Professor Alan White, Professor Brendan Gough, Dr Mark Robinson, Dr Amanda Seims, Dr Gary Raine, and Dr Esmée Hanna with support from Martin Tod and David Wilkins from the Men's Health Forum (England & Wales)

REPORT REFERENCE:

Robertson, S. White, A. Gough, B. Robinson, M. Seims, A. Raine, G. Hanna, E. (2015) ***Promoting Mental Health and Wellbeing with Men and Boys: What Works?*** Centre for Men's Health, Leeds Beckett University, Leeds.

CONTACT DETAILS:

Professor Steve Robertson,
Centre for Men's Health,
Institute for Health and Wellbeing,
Leeds Beckett University,
Calverley Building
City Campus
Leeds,
LS1 3HE
Phone: 0113 812 4359
Email: s.s.robertson@leedsbeckett.ac.uk

CONTENTS

Reader Information	3
Executive summary	6
1. Introduction	8
2. Rationale & Methods	9
2.1 Rationale	9
2.2 Methods	10
3. Literature Review (WP0)	11
3.1 Approach taken	12
3.2 Findings	13
3.2.1 Suicide prevention	13
3.2.2 Mental health promotion	15
3.2.3 Early Intervention	24
4. Existing UK projects (WP1)	36
4.1 Approach taken	36
4.2 Generated projects	36
5. Investigative network considering ‘what works’ (WP2)	37
5.1 Approach taken	37
5.1.1 Analysis	41
5.2 Key WP2 themes	41
5.2.1 Safe settings	41
5.2.2 Approaches	43
5.2.3 Partnerships	46
5.3 Summary	47

CONTENTS

6. Consideration of existing projects (WP3)	48
6.1 Approach taken	49
6.1.1 Analysis	51
6.2 Key WP3 themes	53
6.2.1 Male sensitive services - building trust	53
6.2.2 Improving men's journey to maintain wellbeing	57
6.2.3 Core values/ethos	57
6.2.4 Changing services; changing society	60
6.2.5 Organisational approaches. Sustaining change	62
6.3 Summary	65
7. Expert Symposium (WP4)	66
7.1 Introduction	66
7.2 Approach taken	67
7.3 Common themes generated from the three groups	68
7.4 Summary of the day and suggested future action points	72
8. Integrative summary and recommendations	73
8.1 Current knowledge in the field (and gaps)	73
8.1.2 Knowledge gaps and opportunities	74
8.2 Suggestions/recommendations	77
Appendix I - Principles of approach adopted	79
Appendix II - Search strategy	80
Appendix III - Project codes and names for WP3	81
Appendix IV - Symposium objectives and schedule of sessions	82
Appendix V - Symposium attendees	83
Appendix VI – Leeds Beckett declaration	85

EXECUTIVE SUMMARY

INTRODUCTION

In May 2014 the Movember Foundation commissioned the Centre for Men's Health, Leeds Beckett University, in collaboration with the Men's Health Forum (England & Wales), to gather the current research evidence and practical ('tacit') knowledge about the core elements that make for successful work with boys and men around mental health promotion, early intervention and stigma reduction.

APPROACH

The work involved several stages of evidence gathering including: a literature review; a scoping of existing UK based projects; the establishment of an international 'investigative network' of experts who could gather 'in field' knowledge from various geographical areas and communities of practice; an in-depth examination of fifteen UK (and Ireland) based projects and; an expert symposium of individual and organisational experts in more senior positions. This information was then considered (analysed) both as individual work packages but also as an integrated whole to provide a view of what works, for which boys and men, in what contexts and why in relation to mental health promotion, early intervention and stigma reduction. This is the most comprehensive piece of work to date in this area.

KEY FINDINGS

- The settings within which interventions take place are critical to the creation of a safe space. Settings need to be 'male friendly' and culturally sensitive to the specific requirements of different groups of men and boys
- Interventions should take a positive approach to working with boys and men. The centrality given to working in a 'male positive' manner is often crucial to sustained involvement
- The style and language used can make a significant difference to successfully engaging men and boys. Using male oriented terms (e.g. 'activity' rather than 'health'; 'regaining control' rather than 'help-seeking') makes projects more familiar and less off-putting

- Staff/facilitator characteristics and skills must align with interventions values and approaches. Taking a non-judgmental and empathetic approach to working with men and boys is vital in providing the right type of environment and supportive approach
- Male familiar activity-based interventions seem to offer promise. Activities can provide a 'hook' to encourage engagement into interventions and provide a group context which promotes social inclusion and enjoyment
- Successful interventions are 'grounded'. Being community based allows interventions to remain close the men and boys they are working with assists in promoting social inclusion
- An awareness of the different socio-cultural contexts of groups of men and boys, such as ethnic minority groups, as well gay and bisexual men, is important. Inequalities faced by different groups impact on mental wellbeing and interventions need to feel relevant to them
- Partnerships are crucial across all phases of intervention development and implementation. Partnership working offers a number of benefits for services, including creating credibility and extending reach and resources. Partnerships need to be sensitive to the 'male positive' approach needed and should be aligned with attributes which promote positive working with men and boys around their mental health
- Virtual or 'arms-length' approaches, such as online settings and telephone services, may offer a useful means for working with men and boys given the element of anonymity, however this in an area where further information about effectiveness is needed
- Integrating the key elements that are conducive to working with men and boys, such as those listed above, allows interventions to work synergistically and therefore helps ensure maximum and cohesive impact
- The wider policy and economic context undoubtedly has bearing on the landscape in which services and interventions are provided, and whether the above elements can be facilitated.

EXECUTIVE SUMMARY

Awareness and appreciation of the intersection of the socio-economic context is therefore pertinent to the approaches taken when working with men and boys

RECOMMENDATIONS

- Organisations should consider the above findings about effective approaches in mental health promotion with men and boys in advance of developing interventions or when commissioning services
- There is potential in terms of arm's length interventions, such approaches (i.e. those using online communication) could usefully be expanded and evaluated
- School based programmes offer promise and could usefully be expanded and more gender sensitive elements incorporated
- Further research into the effectiveness of activity based programmes and how they compare with individual ('talking therapy') approaches would add significantly to the knowledge base about what works best for men and boys
- Further robust research and evaluation of Men's Sheds would be beneficial
- Research around the intersection of ethnicity, age and sexuality, with mental health promotion interventions for men and boys would be fruitful
- Thorough and complex evaluation of promising large scale coherent mental health promotion projects or stigma reduction projects is required to further our understanding about what works and why for men and boys
- Given the dearth of SROI information around mental health projects for men and boys, investment in SROI reporting could be a useful to consider
- There are a number of areas of research that would help develop a strong evidence base around mental health for men and boys including: how men talk and support each other and the settings that facilitate talk and support; how mental health

language is used and the benefits and costs of using mental health language; conceptual work around masculinities and mental health stigma; policy impact around mental health for men and boys within the current socio-economic climate

- A training programme around gender sensitive approaches for working with men and boys would offer a means for linking up provision with the specific needs of men and boys in relation to mental health

1. INTRODUCTION

The Movember Foundation has a long-standing commitment to the mental health and wellbeing of boys and men. As part of taking action on this commitment, in November 2013, the Movember Foundation commissioned the Centre for Men's Health at Leeds Beckett University, to complete a UK Mental Health Landscape Report which aimed to assist the Foundation's thinking concerning the future direction of their male mental health work in the UK. Following on from this work, in March 2014, the Movember Foundation commissioned the Centre for Men's Health, at Leeds Beckett University, in collaboration with the Men's Health Forum (England & Wales), to further develop this work by completing a literature review and environmental scan that considers what works for promoting mental health and wellbeing with men and boys. This work involved gathering together current research evidence and practical ('tacit') knowledge about existing programmes or interventions that are demonstrably successful, or show promise, in relation to male mental health and wellbeing. Specifically, it aimed to identify some core elements that make for successful work with boys and men around mental health promotion, early intervention and stigma reduction and, where possible, to comment on current knowledge gaps.

2. RATIONALE & METHODS

2.1 RATIONALE

There are relevant emerging ideas and empirical evidence about what makes for effective engagement with men and boys in relation to their mental health and wellbeing. However, to date, such knowledge remains dispersed and little work has been done to effectively synthesise this. Existing systematic reviews with tight inclusion and exclusion criteria are limited in their practical utility for those wishing to understand ‘what works’; that is, they are limited in helping understand the broader principles and practices that often need to be taken into consideration to address complex issues. Much of what is currently known about these broader principles and practices resides with key individuals and organisations and within intervention programmes where there has not been the opportunity (possibly because of time or other constraints) to disseminate learning from such work within the academic literature.

With this in mind, we completed a broad review both of the published, evidence-based literature and the ‘tacit’ knowledge gained from ‘on-the-ground’ practice, focusing this review around the three Movember Foundation strategic goals of mental health promotion, early intervention and stigma reduction. In doing this we drew on ‘realistic evaluation’ approaches to give due consideration to how different aspects of social context and different underlying mechanisms influence project or programme success (see Appendix I for more detail). In short, using these approaches allowed more to be said about what works, for which boys and men, in which contexts and why. This approach has helped avoid simplistic and misleading statements that are suggestive of a ‘one-size-fits-all’ solution.

In completing this work several specific aspects were taken into account to ensure the brief was fully met:

- We avoided, where possible, focusing on mental ill-health; on projects or programmes that dealt wholly, or primarily, with boys and men with acute or chronic and enduring diagnosed mental health concerns
- Emphasis was placed on diversity. We considered how different aspects of culture and identity (such as ethnicity, sexuality, disability etc.) may influence boys and men differentially in terms of the actions they take to maintain mental health, seek early intervention and how they experience mental health discrimination
- Exploring the relationship between programmes that take an ‘action’ approach (have a base in activities, in ‘doing’) and those primarily focused on talking was paramount
- The work was not limited to the UK context but incorporated learning from an international perspective, particularly from countries where the Movember Foundation is already active in this field i.e. Australia, Canada, New Zealand and the United States
- Attention was paid to the requirement for good collaborative working and our design aimed to help facilitate such partnerships

¹ Pawson, R. and Tilley, N. (1997). Realistic Evaluation. London: Sage

2.2 METHODS

To complete this work we gathered and integrated data from five work packages (more detail on the method and approach taken for each of these is provided in the appropriate section of this report):

WP0 Literature review – This sought the published evidence on interventions around mental health promotion, early intervention and stigma reduction

WP1 Examining existing databases – This work package examined existing UK databases (such as the Big Lottery database, Research Council Databases etc.) that might contain information about projects or programmes addressing the mental wellbeing of boys and/or men. Additional web-based searches were also completed

WP2 Investigative network - We established an investigative network of 13 key players (UK and international) who acted as information seeking hubs and conduits within different geographical or professional contexts. They completed two separate but related tasks:

a. Gathered information from within their communities of practice on what works, for which boys and men, in which contexts and why concerning the mental wellbeing of boys and men

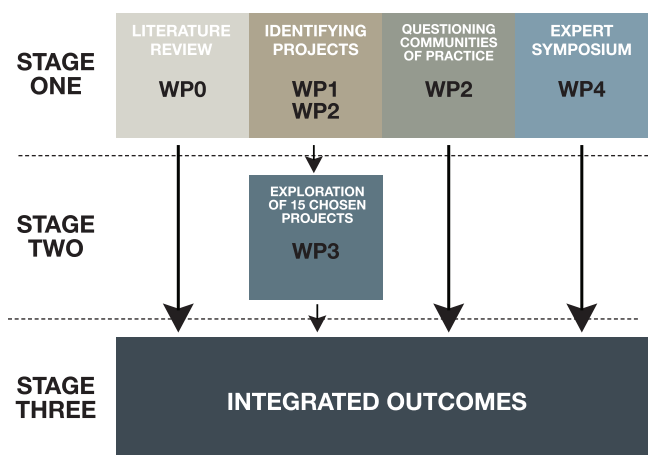
b. Identified 2-4 projects/programmes that are particularly successful or show good promise in mental health work with boys and men

WP3 In-depth analysis of 15 projects - Information about successful/promising projects and programmes gleaned from WP1 and WP2 was collated and 15 projects were then selected and examined in more depth to consider what works, for which boys and men, in which contexts and why in relation to mental wellbeing

WP4 Expert symposium - Tacit knowledge exists at many levels. This work programme aimed to tap into the tacit knowledge of those individual and organisational experts in more senior positions who have involvement of working with boys and men around mental health issues in the UK

These work packages were subsequently integrated in the following way to meet the brief:

Figure 1. Data integration



3. LITERATURE REVIEW (WPO)

KEY MESSAGES

- There is evidence that multi-dimensional approaches to suicide prevention are the most effective. They appear able to act synergistically to reduce stigma, influence attitudes and behaviour, which in turn decrease suicide.
- Even multi-dimensional programmes may be less effective for, or can 'miss', particular groups of men.
- Peer involvement in suicide prevention can provide effective emotional support in specific settings such as prisons, and also potentially has positive effects on the individuals providing the support.
- Several reviews have showed effectiveness for the treatment of conditions from counselling/ simple interventions involving CBT either as the sole form of therapy or in combination with other types. A number of individual studies have provided further evidence that CBT and/or other therapy types can be effective, but sex differences in outcomes have been noted in some studies.
- Health promotion initiatives within educational establishments have reported varied success in terms of stress and depression related outcomes.
- Several reviews of school based early interventions of various types have provided largely positive results for both sexes, but there is inconsistent evidence as to whether single sex groups are more effective than those mixed.
- Some workplace based initiatives for health promotion and early intervention have shown promise.
- Using the internet may not always be an effective strategy for reaching at risk groups of young men.
- Web based health promotion interventions and computer/online based therapies have shown mixed results for boys and men. The evidence also does not currently support the idea that males prefer computer based interventions to 1-1 treatment.
- Some computer and web based programmes have experienced difficulty in engaging and retaining men.
- Activity/social based interventions have achieved success for promoting and improving the mental health of older male participants in particular. This includes initiatives such as the men's sheds approach & gender specific social activities in residential care. Less traditional therapies such as music & art therapy have shown promise for improving mental health outcomes.
- Exercise based interventions show promise for treating symptoms of depression and anxiety in males of varying ages. However, not all studies have shown positive mental health outcomes for males. It also remains unclear whether group based sport interventions are more effective than individual exercise programmes.
- Consistent evidence indicates that short term mental health benefits can be gained from engagement with nature.
- Several interventions have demonstrated effectiveness in terms of promoting helpseeking and reducing stigma, and particularly those that adopted a gender/male sensitive approach
- Involving the target audience (or their representatives) in the developmental stage of programmes may improve engagement and outcomes.

3.1 APPROACH TAKEN

Searches were conducted of six main databases from 2009 to June 2014:

- Pubmed/Medline
- CINAHL
- PsycINFO
- Web of Science
- Cochrane Library
- Centre for Reviews & Dissemination database (includes DARE & NHS EED)

This process retrieved approximately 9000 abstracts that were screened for possible inclusion in the review. Abstracts were screened against the following criteria:

- Intervention was concerned with mental health. This could be prevention/promotion, early intervention or stigma reduction
- Participants were men or boys only of any age (or majority male or the paper reported sex disaggregated results)
- Participants did not have psychosis, schizophrenia, bipolar depression, dementia or other enduring conditions
- No co-morbidity with physical problems e.g. heart disease, HIV, cancer
- Study conducted in industrialised/developed countries, and English language paper

Following the initial screening process, approximately 291 full text papers were retrieved for further assessment. In total, 107 were subsequently included in the review.

A search was also conducted of the grey literature, which involved searching the websites of a range of key mental health/general health organisations in the voluntary and statutory sectors. From this process a further 6 papers/reports met the criteria for inclusion. Therefore in total 113 publications were included in the review. Each paper was assigned to 1 or more of 3 categories based on a preliminary analysis of its main focus.

The categories and number of papers in each one were as follows:

Suicide prevention = 17
Health promotion = 45
Early Intervention = 54

NB: Several papers were included in more than one category

The review process also identified an additional 37 papers related to PTSD, but due to the often chronic and enduring nature of the condition these were not reviewed as part this work.

A copy of the search terms used for Pubmed is provided in Appendix II. A list of all returned papers is available from the report authors.

3.2 FINDINGS

3.2.1 SUICIDE PREVENTION

The following summarises the 17 papers identified that considered suicide prevention interventions. Overall there were 2 reviews, 3 qualitative, 3 mixed methods, 2 pre/post and 4 other quasi experimental studies. One paper was a cost effectiveness study, 1 a cross sectional analysis, and 1 was described as a pilot study. Out of the individual studies, 5 were from the UK, 3 from Australia, 3 from Japan and 4 were from other European countries (Germany, Hungary, Switzerland and Belgium).

A review of 8 suicide prevention programmes in middle and high schools (study 1) found statistically significant improvements in knowledge, attitudes towards suicide/depression and helpseeking behaviour. Five out of the 8 studies reported significant increases in knowledge, and 5 out of 7 that assessed attitudes also found significant change. In addition, half of the 6 studies assessing help-seeking behaviour amongst pupils found significant improvement. Furthermore, the results were mixed in relation to whether interventions were more effective for boys or girls. Two papers reported greater knowledge amongst girls, but another found no sex difference in this outcome. Two papers found sex differences in several other outcomes, with improvements in attitudes, empathy and likelihood of intervening on behalf of peers all favouring females. However, females reported more suicidal ideation in 2 studies and in another, boys had a larger decrease in the Index of potential suicide than girls.

A brief overview of several suicide prevention strategies aimed at older men was reported in study 14. Three primary care based programmes were reported to have shown effectiveness for reducing psychiatric risk factors and suicidal ideation. In addition, 2 strategies were identified from a review of approximately 100 studies as being effective in preventing suicide. Firstly, restricting access to the means to carry out suicide (such as restricting firearms), and secondly, better education of doctors in recognising and treating depression. The latter was reported

to have resulted in a decrease in annual suicides of between 22% to 73%. Furthermore, suicides decreased by more than 60% after a multicomponent population based risk reduction intervention was implemented by the US Air Force. Overall, it was concluded that effective prevention of suicide amongst older adults requires a multi-dimensional approach involving components at both a community and individual level.

The effectiveness of multi-dimensional interventions has also been demonstrated in several individual studies identified for the current review. Community based interventions that have a multi-dimensional focus (training of professionals and key stakeholders, public awareness raising/ social marketing, providing support groups) have been shown to be of benefit in challenging stigma, changing attitudes and behaviour (being more open to talking and normalising such talk), and reducing the number of suicides (studies 5, 8, 9, 12, 13, 15). This has been shown to be true in rural areas, and urban areas for elderly men (studies 8, 9) and, to a lesser extent amongst the gay community (study 17). However, such campaigns may miss certain 'at risk' groups of men such as ethnic minorities or those outside of areas (geographic or 'type' of locations such as sports venue) of specific focus (studies 12, 13). Several papers (including studies 5 & 12) highlighted the importance of the synergetic effect produced by multi-dimensional approaches. Nevertheless as one paper pointed out, it remains unclear as to which elements of multi-dimensional programmes are effective, especially in relation to men.

Public awareness campaigns alone, if intensive, can have impact on suicide reduction in the short term (study 7). Furthermore, arm's length services, such as telephone helplines and on-line chat facilities have been shown to be effective in suicide reduction and first-suicide attempt reduction as well as being cost-effective (study 11). This was particularly the case for men compared to women (studies 11, 15). Notably, 2 studies (5 & 15) suggested that men may prefer, at least initially, services such as hotlines/telephone consultations

may account for some of the positive effects found in multi-dimensional initiatives.

A workplace suicide and early intervention programme for the construction industry (study 4) was effective in raising awareness of signs of suicidality and suicide prevention. Two qualitative studies (studies 3 & 6) showed that peer based listener schemes can be beneficial in providing emotional support to prisoners in need, and there was a belief that the scheme had played a role in reducing self-harm and could save lives. Peer support for some men is preferable to professional support possibly because of issues of trust but also because of potential stigma in using mental health services; being seen to use services was considered antithetical to hegemonic masculine norms (such as 'being tough', 'self-reliant' etc) (study 3). However, for some men, there was a preference for support from outside sources such as family and friends for emotional/ mental health issues (study 6). In addition, it is important to note that when peer support or volunteer listening interventions are well run they can also have a positive impact on those providing the support (studies 2, 3, 16).

An analysis of the Australian National Youth Suicide Prevention Strategy (study 10) failed to find any statistically significant effects in areas with suicide prevention activity in either sex after controlling for socio-demographic variables.

KEY MESSAGES

- Whilst single element interventions (such as awareness raising) can be effective it seems likely that multi-dimensional approaches act synergistically to reduce stigma, influence attitudes, change behaviour (particularly increased talking and help-seeking) and through these processes reduce suicide.
- Even multi-dimensional programmes for suicide prevention may be less effective for, or can 'miss', particular groups of men.
- Arm's length services, such as phone lines and on-line support, may be particularly effective for men (though caution should be applied as this is based on limited data).
- Utilising specific settings where men/boys already congregate can be effective for suicide prevention interventions.
- Peer involvement in suicide prevention interventions can be effective but needs to be well thought through and will likely differ in different health promotion settings.

3.2.2 MENTAL HEALTH PROMOTION

The following summarises the 45 papers that focused on mental health promotion interventions [NB the headings used here are heuristic and used to help cluster projects that seem to share certain characteristics (of setting, of target group etc) and we recognise that some projects could easily sit under different headings].

SHORT/SIMPLE INTERVENTIONS

This category comprised 6 studies of which there were 2 quasi-experimental studies, 2 of mixed design, 1 RCT and 1 cross sectional survey. Two studies were from the USA and 1 from Norway, Japan and Australia. The cross sectional survey was conducted in multiple countries.

There is evidence that a personal informative letter sent by GPs to adolescents can be effective in increasing use of primary care (including for mental health concerns) particularly amongst boys (study 1). This letter addressed health issues of importance such as embarrassment, confidentiality and privacy to enhance the attractiveness of healthcare facilities.

One paper (study 15) compared satisfaction across 4 counties with modified versions of a 1 hour intervention providing mental health training aimed at helping veterans reintegrate. The results showed that 70% of participants across the 4 countries agreed or strongly agreed that they were satisfied with the mental health training. This study did not assess outcome measures, only process.

A study from the USA examined the effectiveness of a 2 hour workshop based on Acceptance and Commitment Therapy that aimed to promote resilience and reintegration amongst veterans (study 6). Overall, there were significant improvements in the intervention group after 2 months for symptoms of depression, anxiety, PTSD, and relationship satisfaction for male veterans. However, when outcomes were compared to the control group, only improvements in depression and relationship satisfaction remained significant. Reactions to the workshop were positive, with participants believing that its interactive format made it memorable. They also

enjoyed the use of real world situations that they could apply to their own lives.

A 3 hour stress management intervention for hospital staff (study 19) showed the intervention significantly improved active coping and assertive behaviour in men and dependent behaviour in women at 1-3 months. However, the number of men in the intervention group who completed was very small (n=4).

An intervention providing vouchers to subsidize rental housing in low-poverty neighbourhoods looked at measures of lifetime major depressive disorder; psychological distress and behavioural problems 4-7 years after randomisation in youths aged 5-16 years old at baseline (study 33). Results suggested that male adolescents experienced harmful effects. Male adolescents in intervention families experiencing crime victimization had worse distress and more behaviour problems. It was suggested that the negative effects in boys may have been due to difficulty adjusting to changes in social networks and relationships in the new areas.

An evaluation (study 18) examined a number of men's mental health information resources produced by BeyondBlue. These resources provided tailored information to promote understanding of anxiety and depression amongst men and their family & friends, and to encourage men to take action. Approximately 1 in 8 Australian adults were reported to have seen the resources, but more females (15%) than males (12%). The materials were largely rated as useful and relevant and over two thirds of those who accessed resources thought they had improved their understanding of the issues.

KEY MESSAGES:

Personalised invite letters can be particularly effective in increasing GP attendance for boys. Short (2-3 hour) interventions have some evidence of short term effectiveness (1-3 months post intervention) in promoting resiliency in veterans and improving active coping and assertiveness behaviour for stress reduction in male hospital workers.

INTERNET/ONLINE

This category comprised 10 papers based on 3 RCTs, 2 quasi-experimental studies, 2 mixed methods designs and 1 cross sectional survey with website analytics. Half were from Australia, 2 from the USA and 1 from Canada.

A resilience training programme for sales managers (study 2) whilst enjoyable to participants, was not completed by many and did not significantly reduce distress or improve quality of life or work performance at 10 weeks post-intervention. A range of possible explanations were offered for the non-significant results. For example, it was suggested the programme might produce delayed rather than immediate mental health benefits, and therefore the failure to detect positive benefit may have been due to the data being collected before significant change occurred. Additionally, it was suggested that changes remained small because participants, as a group, were not experiencing depression, anxiety or stress prior to the intervention. External economic factors were also cited as a potential reason for the lack of significant change in work performance measures. Low participation was attributed to factors such as lack of time, and low perceived need/priority.

Two studies focused on the use of the MoodGYM programme with Australian adolescents aged 12-17 years (study 9 & 10). This programme is an interactive, internet-based CBT programme designed to prevent and decrease symptoms of anxiety and depression. It comprises 5 self-directed modules each containing information, animated demonstrations, quizzes as well as homework exercises. Data analysis in study 9 revealed that levels of anxiety amongst both males and females were significantly lower in the intervention group at the end of the programme and at 6 months follow up. Furthermore, depressive symptoms were also significantly lower at both time periods amongst males, but not females. Sex differences in outcomes could reflect different therapy preferences of males and females. It was suggested that males may prefer the systematic and logical approach of CBT for dealing with negative emotions. On the

other hand, females may prefer an interpersonal approach involving the sharing of thoughts and feelings. Analysis revealed that there was a reduction in effect from post intervention to 6 months suggesting that the full benefit might not be maintained over time and that booster sessions may be required. Notably, the data suggested that the programme may also prevent new cases of depression as well as decrease current symptom levels. It was estimated that on average 2 cases of depression could be prevented each time the programme was used with a class comprising 14 to 18 boys. Only a third of participants completed all 5 modules of the programme, suggesting that full adherence isn't necessary to gain benefit from it. The extended CBT module was reported to be one of the more important elements, but the data from the study did not reliably show which elements were most effective.

Study 10 investigated further the effect of adherence to the MoodGYM programmes on mental health outcomes using data from study 9. At post intervention and 6 month follow up significant improvements were identified for male depressive symptoms in both the high and low adherence groups compared to controls. However no significant differences between the high and low adherence groups were identified. It was considered likely that this was due to low numbers in the high adherence group resulting in insufficient power to detect a difference.

Another study (study 32) examined adherence to the MoodGYM programme amongst both male and female adolescents in two different settings ((i) school based (ii) community based). Overall, the completion rate was nearly 10 times higher in the school than community setting. Moreover, participants in the school based setting completed significantly more online exercises than those in the open access community setting. The sex of participants was found to be a significant predictor of adherence, with females being more likely than males to persist with the programme.

Two papers (study 7 & 40) focused on "Reach Out Central" (ROC) an online gaming programme to support the mental health of individuals

aged 16-25 years old. This programme is an educational, interactive game that using CBT principles to help a person develop skills for coping with stressors that may lead to mental health problems. Perhaps surprisingly given that ROC was designed specifically for males, the results showed that females benefited more from it. Significant improvements were identified amongst females only for a number of outcomes including life satisfaction, problem solving and resilience. There were increases in help-seeking for both men and women but greater for women. Males more commonly recommended help-seeking from informal rather than formal sources. The programme did not have a significant effect in terms of stigma reduction amongst either sex. Nonetheless, at the end of the programme significantly more females than males were willing to become friends with a person who was depressed. One explanation put forward for the better outcomes in females was that whilst an online gaming format may hold appeal for males, the storylines used may have been more pertinent or relatable to females than males. The fact that males expressed a preference for informal sources of help was seen to support the idea that the internet may potentially be an important way of delivering mental health information and support to males.

An online intervention (study 12) that aimed to help young people (14-25 years) make positive decisions about their mental health and wellbeing showed that use of the service by males was low (23% of 2291 responders).

A Canadian study evaluated a brief online campaign which aimed to improve the awareness and attitudes of young people (13-25 years) to mental health issues (study 26). The campaign included the use of a prominent male sports star. Overall, the evaluation showed that the campaign reached a significantly larger proportion of males than females, which was thought to be due to its sports-focus, and the fact that it was social media based. The campaign was successful at improving media literacy outcomes in the form of awareness and use of a youth focused mental

health website (mindcheck.ca), but did not have a significant effect on attitudes, personal stigma or social distance. (Personal stigma relates to an individual's beliefs about mental health issues. Social distance focused on willingness to interact with individuals with mental health issues). Results were seen to raise questions about whether social media campaigns should focus on mental health literacy outcomes rather than stigma reduction (in the form of improved attitudes and decreased discrimination). Whilst education and awareness are important elements of anti-stigma initiatives, they are unlikely on their own to result in substantial and long term reductions in stigma or social distance.

A US evaluation of the Man Therapy online mental health programme was conducted 18 months after its launch (study 42). This was described as a provocative campaign aimed at reaching men who were at most risk of suicide and least likely to seek help. However, it has been rebranded from a suicide prevention initiative to a broader mental health campaign aimed at men. It uses maladaptive ideas of masculinity (e.g. dark humour) and is said to approach issues "head on". Results suggested that users found the website accessible and engaging, with high satisfaction ratings. An evaluation of an Australian version of Man Therapy launched in 2013 by Beyondblue was reported in Study 22. This also suggested that the Man Therapy programme could have positive outcomes. In particular, it was considered to have exceeded the expected campaign reach; been cost effective and had a positive impact on the knowledge, attitudes and behaviours of men aged 30-54 years in relation to depression and anxiety. Radio and TV coverage of the campaign was found to have produced particularly good recall of brand and/or message. Analysis suggested that most visitors to the website were men seeking information about depression. Man therapy was considered to have provided a fresh perspective on their situation.

Study 22 also examined two other online initiatives developed by Beyondblue in Australia. The first was the Take Action Before the Blues Take Over campaign, which is an online/social

media programme that specifically targeted gay, bisexual and questioning men. The analysis of this campaign was more mixed than the Man Therapy programme, and provided further evidence that online programmes may have difficulty in successfully engaging males for a meaningful period of time. It exceeded the target number of visitors to the website, but the majority of individuals spent less than 10 seconds on the site and only a third clicked on a page different to the one they landed upon. Approximately, 15% of users stayed on the site for more than 5 minutes, which was seen as suggesting that when individuals engage with the site they potentially stay for an extended period of time. The other Beyondblue resource evaluated was the “Tune in Now” online toolkit aimed at the support workers of homeless men. This toolkit was designed to help support workers discuss depression and anxiety with men perceived to be at risk. Feedback from a survey of workers who used the toolkit was positive. A high proportion of respondents considered the toolkit to be relevant, easy to use and useful. Over half of the caseworkers indicated that they had altered the way they provide support to clients as a result of using the toolkit. This was considered to be somewhat of a disappointing proportion, but was attributed to the fact that caseworkers had a lack of opportunity to use the toolkit techniques rather than there being a deficiency with it. Almost all of the caseworkers would recommend the toolkit to a colleague.

On the basis of the analysis of the various Beyondblue campaigns, it was suggested that the more successful ones tended to involve more heavily individuals from the target demographic (or those closely associated to the target group) in the design of materials. It was therefore recommended that future Beyondblue initiatives aimed at specific sections of the community continue to include members of those community or their representatives in strategy development and possibly also the development of materials to maximise engagement with the programme and outcomes.

KEY MESSAGES:

- Internet and online based mental health promotion interventions showed mixed results for boys and men
 - Participation and completion of courses was often low amongst boys and men. Male participation was improved in a programme based around sport and some wellbeing outcomes were encouraging for boys aged 10-11 years participating in a strengths based (positive psychology) intervention.
 - Online gaming courses designed with boys/young men in mind showed better results for female participants.
 - There was evidence that a “provocative” programme that utilised a direct approach with dark humour and maladaptive ideas of masculinity could engage men and have positive outcomes.
- Involving the target audience (or their representatives) in the developmental stage of programmes may potentially improve engagement and outcomes.

SETTINGS

The setting based category comprised the largest number of papers (17) based on 7 quasi-experimental studies, 6 RCTs, & 2 pre/post designs. There was 1 review. Four were from Australia, another 4 from the USA, and 2 each from the UK & Germany. There was also 1 study from Canada, Japan and Norway.

A meta review examined 17 controlled evaluations of the Penn Resiliency Programme (PRP) a group based CBT intervention for targeting depressive symptoms in late childhood and early adolescence (Study 8). Outcomes were assessed at post intervention and 2 follow up assessments (6-8 months & 12 months). It is typically a school

based programme but has also been evaluated in a number of other settings including juvenile detention centres and primary care. It aims to develop skills that reduce the risk of depression in young people and was reported as being one of the most widely researched depression prevention programmes. Overall, it was found that young people who participated in the PRP reported fewer depressive symptoms at post intervention and both follow-up assessments compared with those who did not receive the intervention, but average effects were only small. Further analysis suggested that the programme was more effective at reducing symptoms in boys than girls. The mean effect size for boys was significant at both follow up points compared to only 6-8 month follow up amongst girls. When the effects of PRP were compared with an active control group no significant benefits were found, but this may be due to a lack of statistical power. Furthermore, PRP did not significantly decrease the risk for depressive disorders amongst any subgroup of participants but diagnostic outcomes were only assessed in 3 studies, and therefore once again, it is likely there was insufficient statistical power to detect a significant effect. Overall, it was concluded that there may be diagnostic benefits for boys and high symptom individuals.

A school-based body-image intervention aimed at pupils aged 10-11 years showed significant short-term improvements amongst boys in internalization of cultural appearance ideals and appearance related conversations, but these were not sustained at 3 month follow-up (study 5). It was concluded that the intervention requires refinement in order to increase its effectiveness when used with young boys. For example, it was suggested that the programme may benefit from a specific focus on boys' body image concerns and risk factors such as drive for muscularity.

Another study focused on a widely disseminated Australian school-based body image and self-esteem intervention for 12-13 year olds (study 35). A key focus of this programme (BodyThink) is on improving media literacy and the way in which media can portray an unrealistic standard of beauty, as well as addressing other risk factors for

body dissatisfaction. Analysis revealed somewhat mixed results, with boys in the intervention group having significantly higher media literacy and body satisfaction than the control group at post intervention and 3 month follow up. However, no significant effects were found on a number of risk factors for body dissatisfaction (including self-esteem) or eating disorder symptoms. Intervention group girls reported higher media literacy and lower internalization of the thin ideal, and both sexes found the intervention interesting.

A school based intervention for 11th grade students which used positive psychology, social cognitive, and relaxation approaches over 8 sessions (study 16) showed significant improvement in levels of perceived stress, state anxiety, and health promoting and stress management behaviours but appeared more useful for girls than boys.

An 8 session school delivered strength coaching/ positive psychology intervention for males aged 10-11 years (study 27), demonstrated significant increases in students' self-reported levels of engagement and hope. It was concluded that strengths-based coaching programmes may have potential in the primary school setting for mental health prevention and promotion intervention in order to increasing young people's wellbeing.

A school-based depression education intervention for males 14-16 years also aimed to increase help-seeking; reduce stigma; and identify people at risk (studies 36, 37). Analysis of the results revealed that the programme produced short-term improvements in mental health literacy. Participation also led to a number of other positive outcomes including: increased likelihood of help-seeking for depression (in particular from a professional); increased likelihood of rating a GP, a teacher and a school counsellor or nurse as helpful; increased ability to identify helpful strategies for dealing with a problem such as depression and improved attitudes towards people experiencing depression. No significant changes were found in terms of recognition of depression or improved confidence when helping others. However, it was noted that participants demonstrated a high ability to recognise

depression at the start of the programme, so there may have been a ceiling effect. The screening led to the detection of 20 at-risk boys in stage one and 31 at stage two. Students, parents and school staff found the programme acceptable and not overly intrusive.

Several other school based interventions focused on anxiety or depression did not find positive changes for boys. One school based depression prevention intervention, grounded in CBT related approaches and aimed at 13-14 years olds, showed positive intervention effects on girls' depressive symptoms but not those of boys (study 34). A universal intervention developed by Beyondblue for students starting high school (study 38) showed no significant changes in depressive symptoms or levels of risk and protective factors over the 3 years of the study. Further analyses showed no difference in outcome over time for female and male students. This intervention comprised multiple components and was implemented across a large and diverse geographical area. Concern was expressed that teacher training may have been inadequate to achieve sufficient programme fidelity across regions and ensure the intervention was delivered as planned. It also took a much greater length of time than anticipated to implement certain components, which may have affected their potential to have an impact owing to the decreased length of time students were exposed to changes. Difficulty in engaging pupils was also reported leading to the suggestion that the intervention may not have focused on the most suitable age group. It was recommended that future school based interventions are targeted at those pupils who are ready to change their behaviours and lifestyle in ways that potentially reduce the risk of depressive symptoms developing. Another CBT based school intervention for children aged 9-11 years found no intervention effects with anxiety symptoms decreasing over time regardless of whether they were in the story-reading (attention control) or the intervention group (study 29).

Two studies evaluated the use of mindfulness based stress reduction (MBSR) courses in schools with boys aged 12-13 years (study 41) and 14-15

years (study 21). Intervention group participants in study 41 who received 12 sessions of MBSR showed significantly less anxiety, less rumination, and at borderline significance, a reduction in negative coping approaches at 3 months post intervention. Conversely, there was also an increase in self-reported anger at borderline significance. In study 21, no significant difference in outcomes of interest was found between the intervention group who received 4 x 40 minute sessions of mindfulness training and controls. However, amongst individuals in the intervention group there was found to be a significant positive association between the amount of practice the boys did outside the classroom and improvement in psychological well-being and mindfulness at one week post-intervention. Most boys also reported enjoying and benefiting from the training, and expressed an interest in continuing with it in the future.

Two interventions were conducted with university based populations. Study 3 was an evaluation of a programme based on social cognition theory and focusing on self-understanding and interpersonal interactions with the overall aim of preventing psychological distress. A significant increase was reported amongst both male and female students in social self-efficacy in interpersonal relationships. In addition, there was a significant decrease in Tension-Anxiety amongst young men and also a significant increase in anger and hostility. A second university based intervention aimed to reduce stress amongst medical students (study 20). A positive effect on perceived stress was identified at 3 month follow up, with further analyses suggesting that this was due to participation in self-development groups which were led by trained group psychotherapists. There was no significant difference between men and women concerning the effect of the self-development group and the intervention had no effect on general mental distress. Consequently, it was suggested that the intervention effects were limited to specific stressors related to being a medical student.

Two studies were workplace based; one a stress management intervention (study 25) and the other a worksite wellness programme (study 28).

The former was based on psychodynamic and CBT techniques and offered to low and middle management employees (99% male). Analysis revealed significant reductions in perceived stress reactivity and sympathetic activation at 1 year follow up. Improvements were also identified for depression, anxiety and ERI (effort - reward imbalance), but did not achieve statistical significance. The worksite wellness programme (69% male) showed that physical health, mental health, and healthy behaviour were significantly improved in these employees compared to the control. The programme was effective in reducing self-reported diagnosis of depression and feelings of 'being sad a lot yesterday'. However, significantly fewer employees also reported experiencing "a lot of happiness" yesterday. The results were not sex disaggregated.

A prison intervention based on a participatory comprehensive wellness programme for recovering substance abusers showed significant improvement for depression (and smoking) amongst those who completed the programme but no change for stress (study 11).

on intervention completion and at 3 months post-intervention this was particularly so for the intervention that included a self-development group.

- Workplace based approaches seem to show promise for men
 - A CBT based intervention significantly reduced perceived stress reactivity and reduced depression and anxiety (though not at levels of statistical significance) at one year post-intervention
 - A 'wellness programme' was effective in producing both physical and mental health benefits.
- A prison intervention based on a participatory comprehensive wellness programme for recovering substance abusers showed significant improvement for depression but no change for stress at intervention completion.

KEY MESSAGES:

- Interventions within educational establishments have had varied success
- Interventions around body image have shown only minimal, short term improvements for boys aged 10-13 years.
 - Mixed sex interventions for stress and depression reduction in those aged 12-16 years showed limited significant improvements over time and were often less effective in boys.
 - Single sex interventions for stress and depression reduction in boys aged 12-16 years showed short-term (one week to 3 month) effectiveness across a range of measures including help-seeking for depression.
 - Mixed sex university based interventions for stress and anxiety reduction showed some effectiveness

INTERACTIVE/ACTIVITY BASED

This category comprised 10 papers of which there were 3 reviews, 3 RCTs, 1 pre-post design and 2 other quasi-experimental studies, and 1 qualitative study. Of the 7 individual studies, 3 were from Australia 2 from Japan, and 1 each from UK and the USA.

A meta-analysis of 10 UK studies examined the impact of 'green exercise', which refers to activity in the presence of nature (Study 4). Findings showed improvements for men and women in self-esteem with men also showing improvement in mood. Benefits were found for all green environments and the presence of water was associated with greater effects. The analysis also revealed that the largest benefit came from short engagements (5 minutes). However, it is not clear how long benefits last after activity has ended.

Similarly, an intervention in university males (mean age 21 years) examined the impact of forest bathing (taking in the forest atmosphere) (study 24).

Overall, 15 minutes in a forest environment had a significantly more positive impact than an urban environment on various psychological outcomes. For example, anxiety, fatigue and total mood disturbance all decreased significantly after forest stimuli. Conversely, participants who spent time in the forest environment also felt significantly more comfortable, soothed and refreshed.

Study 17 examined the impact of gender specific social activities for older men and women (mean age 84 years) in residential care. The analysis revealed a clear gender effect with engagement in social groups being especially beneficial for male participants. Specifically, individuals who joined a men's group that engaged in fortnightly social activities had significantly lower symptoms of depression and anxiety after 12 weeks, as well as significantly higher life satisfaction and social identification. No evidence was found to suggest that the intervention resulted in improved cognitive performance. It was suggested that groups can have positive benefits by offering a source of social support and by allowing the men to counteract feelings of marginalisation through sharing gender related experiences.

One intervention aimed at male employees (aged 30-57 years) combined comprehensive health education with hot spa bathing once every 2 weeks, along with an individualized programme once a week, for 24 weeks (study 23). Few effects were noted in mental state measures (or physical health measures) and participants had poor adherence, even in the intervention group.

An Australian football based intervention, run on school sites at the end of the day and targeting adolescents (78% male, mean age 15 years) used sport as a mechanism for building relationships and generating positive interactions (study 31). Participants showed significantly higher levels of other-group orientation. Boys in the intervention group had significantly lower scores on the peer problem scale and significantly higher scores on the prosocial scale than controls. These outcomes were associated with regularity of attendance. There were no effects on resilience, reporting of emotional symptoms or hyperactivity. However,

it was suggested that many individuals may have already possessed a high degree of resilience before the intervention as all participants arrived in Australia as refugees or as humanitarian entrants.

An intervention for male Mexican farmworkers in the US aimed to use music to reduce levels of depression, anxiety and social isolation (study 39). Significant results were not found although effect sizes were considered to show that music therapy has the potential to be an effective intervention for this population.

Four studies focused on the men's sheds approach, two of which were reviews that examined the impact of being involved in a men's shed on the health and well-being of individuals (studies 30 & 45). Whilst there remains a limited body of research in terms of outcomes, findings do indicate that the approach can have positive impacts on mental health and well-being in particular, and this includes men from culturally and linguistically diverse backgrounds, as well as those with identified mental health issues and substance addictions. It appears that the beneficial effects of sheds arise from reducing social exclusion and isolation. Participation potentially provides the opportunity to build social contacts, relationships, and camaraderie. Moreover, sheds may increase self-esteem and self-worth and provide a supportive environment in which men feel valued and comfortable sharing experiences. In addition, sheds potentially facilitate a sense of purpose and provide a venue for skill development and new learning. Overall, sheds potentially provide a unique social location, and informal learning environment that is better suited to some men than more traditional learning centres. A small qualitative study (study 13) published more recently of the lived experiences of 5 older men participating in a shed programme in Australia provided further evidence of positive health related outcomes.

Both reviews (studies 30, & 45) suggested that much of the evidence on the impact of men's sheds was generated from descriptive surveys and small qualitative studies. However, a quasi-experimental study published in 2013 also

provided additional quantitative evidence of both a physical and mental health benefit (study 14). As part of this study, health related outcomes in shed participants and non-participants were compared using SF12 and WEMWBS. After controlling for social activity, the following SF12 domains were significantly higher amongst shed members: physical functioning; role physical; general health; vitality, and mental health scales. When the WEMWBS data were analysed, the scores for all individual items of the scale and the overall total score were again all significantly higher amongst shed members than non-members, which is indicative of better mental wellbeing. Additional analysis also suggested that mental well-being was positively associated with length of shed membership. Furthermore, there was evidence to suggest that shed membership could have positive effects on mental health stigma and help-seeking. In terms of the latter, shed members were more willing to consider a broader range of sources as being suitable to approach for help.

KEY MESSAGES:

- There appears to be consistent evidence of short term mental health benefits gained from engagement with nature.
 - A meta review of data suggested activity in green spaces could improve both self-esteem and mood irrespective of duration, intensity of activity and sex and age of participants. Effect sizes were small to moderate. But important questions remain regarding how long the improvements last.
 - Similarly a study from Japan found that 15 minutes in a forest environment produced a significantly more positive effect than an urban environment on a range of psychological outcomes. However, once again the focus was on immediate effects.

- Social/group based activities appear to show promise for older men. Providing men with the opportunity to interact and engage with other men can have positive outcomes.
 - Older care home residents who joined a men's group that engaged in fortnightly social activities reported significantly lower symptoms of depression and anxiety after 12 weeks, as well as significantly higher life satisfaction and social identification.
 - There is currently limited evidence related to the men's shed movement. However, findings suggest that men's sheds can enhance self-reported health and wellbeing and promote learning/skill development.
- A multilevel football based intervention had positive impacts on peer relations, pro-social behaviour and other group orientation of teenage boys.
- An intervention comprising comprehensive health education and hot spa bathing was found to have no significant impact on the lifestyle characteristics and physical & mental health of male white collar workers. Similarly, a music based intervention failed to reduce levels of depression, anxiety and social isolation amongst Mexican farm workers, but the results did suggest it may hold potential.

OTHER

A meta-review of depression prevention programmes for children was reported in study 43. This found significant reductions in depressive symptoms in 13 of the 32 programmes evaluated. Prevention programmes were more effective when delivered to groups with a higher proportion of females. It is possible that the higher levels of depressive symptoms experienced by females

compared to males increases their motivation to engage in interventions. The impact of participant gender became significantly greater for late versus early adolescence. It was suggested that depression prevention programmes may be more effective when delivered to groups comprising females only. It is also entirely possible that current approaches to depression prevention are not particularly well suited to males owing to a limited understanding of the gender-specific risk factors for depression.

A couples-based psycho-education intervention aimed at teaching skills for coping with stress and improving relationships in low income families (study 44) showed positive changes in several stresses and stress responses. These changes were accompanied by improvements in symptoms of depression. Other outcomes including decreases in financial worries and disengagement coping were found for both sexes but with effects being especially strong for women. Men attending the men's group (and the non-attending female partners of these men) did not improve and women attending with non-participating male partners did not fare as well. The results suggest a combined couples group is likely optimal for most outcomes. Various suggestions were put forward as possible explanations for the intervention being less effective for the men's group. For example, it was suggested that without the attendance and support of their partner, men may find it difficult to make the necessary changes owing to the traditional role of females as the relationship caretaker of a family. There was also a suggestion that having a female group leader in the men's group may have produced a detrimental influence on group process. More generally, the results were considered to be indicative of the need for more father- and men inclusive parenting/relationship services.

3.2.3 EARLY INTERVENTION

In total, there were 54 papers that were focused on early intervention. These were studies in which participants had either (i) been diagnosed with a mental health condition (ii) had high scores on screening assessments, or otherwise assessed as

having a condition, or considered at increased risk of developing a problem. Studies were also included in this category if they aimed to promote help-seeking or identifying individuals with a problem.

COUNSELLING/SIMPLE INTERVENTIONS

This category comprised the largest number of papers and included a range of study designs. Overall, there were 4 reviews/meta analyses, 9 RCTs, 2 pre/post design, 1 qualitative, 1 survey based study, and 1 mixed methods evaluation. Out of the individual studies, 8 were conducted in the USA, 5 were Europe based (2 UK, 2 Finland 1 Netherland), and 1 was an Australian study.

A review published this year (study 18) examined research related to postnatal depression in fathers, which included an overview of interventions aimed at preventing or treating the condition. Only one intervention was described in detail, which was an antenatal education programme led by a male facilitator with 6 week postpartum education and support materials for men with a breast feeding partner. Fathers assigned to the intervention group had significantly lower levels of depression and distress at 6 weeks post-delivery. Social support seems to be a potentially important factor, with 1 study suggesting that fathers who perceive higher levels of perceived social support throughout the pregnancy experience significantly lower levels of depression and distress 6 weeks after the birth. The review cited 3 further studies which suggested that CBT, group therapy, comprehensive antenatal psychosocial assessment, and traditional psychodynamic therapy can be beneficial for fathers experiencing PND. Furthermore, support gain by fathers sharing experiences can also be of benefit.

Another review (study 6) focused on the effectiveness of 8 interventions that targeted co-occurring depressive or anxiety disorders and alcohol misuse. Overall, it was found that motivational interviewing and CBT interventions produced significant reductions in symptoms of depression/ anxiety and alcohol consumption. Benefits were found for brief interventions, but those of a longer duration produced the greatest

effect. In 2 studies that presented the results by sex, both males and females responded to an integrated depression and alcohol intervention, which produced better outcomes than single focused treatment in terms of depression and days drinking.

Eight studies were included in a review of one session treatment for specific phobias in children and adolescents (Study 41). Treatment comprised a 3 hour single session exposure therapy based on CBT techniques. The intervention was found to be generally effective for both males and females and different types of phobias. However, there was some evidence that the treatment worked best for females and animal phobias.

The final review (Study 47) was a meta-analysis of the adherence strategies used in past RCTs of cognitive behavioural treatments, interpersonal therapy, and psycho-education for children and adolescents with mental health problems. In total, 91% of the included studies involved CBT interventions and a majority (65%) were group based. Overall, studies that had a higher proportion of females and adolescents produced big effect sizes than those with larger proportion of males and younger children. However, the type and intensity of the adherence promoting strategies used was found to moderate the effect sizes. Analysis suggested that greater effect sizes were produced amongst males when (i) more intensive adherence strategies were used (ii) they were used more frequently and (iii) telephone promoters and in-session therapeutic strategies were employed to sustain adherence.

Three papers were based on the Time Out! Getting Life Back on Track Programme from Finland (studies 2-4). This is a psychosocial support intervention for young men exempted from military or civil service. Positive outcomes were identified at one year follow up, with psychological distress decreasing significantly more amongst the intervention group than controls. However, there was no effect on alcohol use, quality of life, problem accumulation, self-confidence or contentment. Men who participated fully in the programme were commonly psychologically

distressed and had an accumulation of problems. No other significant differences were identified between men who participated fully and other men in the intervention group. Counsellors failed to contact 21 of the 170 men in the intervention group. Analysis revealed that this group to also have accumulated a large number of problems. Thus, it may be said that the intervention did not succeed in reaching some of those in most need. The benefits of the programme in terms of reduced psychological distress may be due to the fact that it offered comprehensive support rather than having a narrower focus on one particular behaviour. Other components such as client oriented tailored support and avoiding stigmatisation when individuals sought help were also considered to be potentially key elements. One of the aims of study 4 was to identify the factors associated with implementation success when the intervention was disseminated nationwide. The factors identified included: high motivation and commitment of the stakeholders/intervention providers; successful collaboration between different sectors; managerial/organisational support and adequate training of counsellors.

Two papers were based on a RCT that compared MATCH therapy with standard condition and usual care amongst youth (7-13 years, 70% male) (Study 53 & 14). The MATCH therapy comprises evidence based treatments for anxiety (CBT), depression (CBT) and disruptive conduct (Behavioural Parent Training) as structured free standing modules. Standard condition involved the use of 3 established evidence based treatments for anxiety, depression and conduct problems. Study 53 showed that overall modular treatment produced significantly faster improvements than usual care and the standard condition on the Brief Problem Checklist and Top Problems Assessment measures. In addition, those assigned to modular treatment received fewer diagnoses than the usual care group. Outcomes for standard treatment did not differ significantly from usual care. Study 14 examined the longer term effects of the programme over a 2 year period. This study provided support

for longer term clinical benefits of MATCH, but it showed that most of the benefit occurred in the first 6 months to 1 year. After 1 year, few gains were found, but effects on average were maintained over 2 years.

One intervention (study 5) compared an adapted mindfulness based stress reduction programme with CBT for the group treatment of anxiety disorders in 105 veterans (83% male, mean age = 46 years). Both treatments produced similar improvements in principal disorder severity at 3 month follow up. CBT was more effective at reducing anxious arousal, whereas adapted MBSR was better at reducing worry and comorbid emotional disorders.

A male-sensitive brochure aimed at depressed men (aged 18-69 years) who had not previously sought help, improved their attitudes and reduced self-stigma toward counselling. In addition, the brochure improved men's attitudes and reduced stigma more than previously developed brochures. The male-sensitive brochure was also the only one to produce a significant effect for stigma reduction (Study 24). This effect on stigma was considered most likely due to the male specific content such as a direct challenge to the misconception that having depression and help-seeking are signs of weakness. Other changes to the brochure to make it more male sensitive included discussing the unique symptoms of masculine depression, and use of language more compatible with traditional masculine gender roles. The latter was considered potentially useful for creating an environment in which men feel more comfortable exploring their problems.

A gender-based motivational interviewing (GBMI) intervention for men with elevated internalizing symptoms & no recent history of formal help-seeking produced greater improvements in symptoms than help-seeking (study 51). A small effect on both depressive and anxiety symptoms at 1 month follow up and a moderate effect at 3 month follow up was found. It was reported that in clinical terms depressive and anxiety symptoms were reduced from mild to minimal in the GBMI group. Problem drinking decreased from moderate

to low in the GBMI condition, and there was also a significant small to moderate effect on stigma. The intervention had no effect on attitudes or intentions towards formal help-seeking, but did increase use of informal help-seeking (e.g. parents and partners). The authors suggested that the results highlight a male help-seeking paradox, in the sense that getting traditional men to seek formal help is difficult, but men do potentially benefit from help. GBMI that is described as "personalized feedback" to men may not carry the same degree of stigma as traditional mental health care.

An intervention from the USA that aimed to address antisocial behaviour amongst boys aged 6-11 years (SNAP, study 12) was also associated with positive psychological benefits. SNAP participants had significantly higher scores than those assigned to standard community services for the CBCL subscales of total internalizing, withdrawn-depressed, anxious-depressed but not for somatic complaints. Significant differences favouring SNAP were also found for the CSI measures of depression and separation anxiety symptoms. Effects generally held across 3 months to 1 year follow up.

A UK based qualitative study suggested that a mentoring programme could have positive impacts on adolescent boys with psychological and behavioural issues (study 19). Mentors provided a positive role model of what it meant to be an African Caribbean man. The perception of shared life experiences facilitated the development of strong emotional bonds, and boys were able to show their vulnerabilities and accept support. Indeed, one of the most significant changes was considered to be in their attitudes about self-reliance and help-seeking.

Another UK study (25) assessed the impact of a 1 day CBT self-confidence workshop on adults (80% female) with depression. At 12 week follow up, the results of this RCT showed that the workshop was effective at reducing depression and anxiety as well as increasing self-esteem. However, analysis suggested that the benefits differed by sex. In terms of depression, women gained more benefit from the workshop than men. Depression

scores were not significantly different amongst men after 12 weeks.

An evaluation of the IMPACT programme for older adults with depression was reported in study 43. This programme provided 112 older adults (72% female) with a combination of problem solving therapy and antidepressant medication. After 4 years, the severity of depression decreased for 85% of participants and nearly half gained a 50% decrease in symptom severity. Men were more likely than women to achieve a 50% reduction in symptoms and also attended fewer sessions. It was suggested that men are more responsive than women when engaged in interpersonal therapy.

The men's stress workshop provided a gender sensitive group therapy for depression that combined CBT, psycho-education and discussion of men's adherence to masculine norms. The format of the workshop was designed to improve retention of men who adhered strongly with proscribed masculine norms. The workshop was structured like a class and marketed as having a focus on teaching ways of managing stress. It was considered that men who value proscribed masculine norms may have a negative reaction to the use of the word "depression" and instead refer to their condition as "stress". Early sessions were structured to be more concrete and focused less on emotional disclosure, so not to deter men who valued emotional control and self-reliance. Study 45 reported decreases in depression severity in all 6 participants after the 8 weeks of the programme, but it is unclear whether the changes were statistically significant. All 6 men also reported a greater number of social support connections. Conversely, there was no change in conformity to masculine norms and perception of stigma increased from baseline to post workshop. The latter may have resulted from topics raised in the group discussion, and men becoming more aware that their symptoms represented more than "just stress". Feedback was positive and participants welcomed the men's focus and valued the opportunity the workshop provided to interact with other males who experienced similar pressures. Discussion of masculine norms was

considered to be one of the most helpful elements of the workshop. Men also seemed to value the general approach, in terms of the group format, group leaders' approach to topic discussion and breakdown of material.

The very long term effects (11 years) of a brief programme for children aged 3-5 years with high levels of inhibited and withdrawn behaviours were evaluated in study 46. Some positive findings were reported for girls, but boys demonstrated an inconsistent pattern of results, and no significant group differences were identified.

An intervention to strengthen the emotional self-regulation of 3rd grade children (approximately 56% male) with emerging behavioural and emotional problems (study 54) found positive impacts for both sexes on behavioural control and shyness at the post stage (4 months). Intervention group children were also less shy and withdrawn and used more assertive behaviours. Peer social skills improved for girls but not boys.

A study from the Netherlands (study 48) compared the cost-effectiveness of child-focused and parent-focused interventions for children (8-12 years old, approximately 50% male) who were identified as being high anxious from a screening programme. Significantly more participants in the child focused group (CI) had improved symptoms compared to the non-intervention group (NI). The difference between the parent focused group (PI) and NI, and CI & PI was not significant. Analysis further suggested that CI was also the most the cost effectiveness approach for boys.

KEY MESSAGES:

A number of reviews have reported positive outcomes for phobias, co-occurring depression/ anxiety & alcohol misuse, and post natal depression in fathers from interventions comprising CBT either as the sole form of therapy or in combination with other types.

- There is also evidence from individual studies that CBT and/or other forms of therapy can be successful with both men and boys in terms of reducing anxiety and/or depression, but some sex differences were noted.
- Combining problem solving therapy with medication appeared to be more effective for men than women in decreasing severity of depression. Furthermore, a child focused intervention was a more cost effective approach for reducing symptoms of anxiety in boys than girls. A CBT based self-confidence workshop was more effective at reducing depression symptoms in women than men. However, a gender sensitive, male only group therapy workshop did report decreases in depression severity, although it remains unclear as to whether these were statistically significant. An intervention addressing inhibited and withdrawn behaviours amongst very young children, failed to demonstrate long term impacts (11 years) in boys, but some benefits for girls were found.
- There was mixed evidence in terms of the effectiveness of interventions to promote help-seeking
- A mentoring programme for adolescent African Caribbean boys achieved success in changing attitudes about self-reliance, accepting support and help-seeking.
- Attitudes to seeking professional help for psychological concerns were improved by a male tailored brochure
- However a gender based motivational interviewing intervention for men did not alter attitudes or intentions towards formal help-seeking, but did produce benefit in terms of seeking help from informal sources.
- Some evidence of success in reducing stigma.
- The male sensitive brochure aimed at men with depression also reduced self-felt stigma towards counselling, and to a greater degree than 2 other publications.
- A gender based motivational interviewing approach was also found to have a positive impact on stigma.
- However, men's perception of stigma actually increased after participating in a stress workshop providing a gender sensitive group therapy for depression. This intervention was also unsuccessful in altering conformity to masculine norms.
- A review suggested that greater treatment effects in males could be produced through using various adherence strategies.

SETTINGS

This category comprised 12 papers of which 2 were reviews, 6 RCTs, 3 mixed methods and 1 pre/post evaluation. Four papers were from Australia, 2 from Canada, 2 from the UK, and 1 from New Zealand and 1 from Germany.

A meta review (study 7) of 132 school based counselling/psychotherapy treatment interventions found a medium positive effect, and girls did not outperform boys. Studies involving predominately males, predominately females, and mixed groups all had significant effects. However, same sex groups did achieve significantly better outcomes than mixed groups. It was suggested that this may be because disclosure and in-depth discussion is more easily facilitated in single sex groups.

Study 15 provided a review of outcomes from counselling in UK secondary schools. Thirty studies were included in total, most of which were a mix of humanistic (and some instances, psychodynamic) practices, based around a person-centred core sessions. A smaller number of projects offered person centred non directive counselling. Proportion of males ranged from 44%-56%, and in 87% of studies more females attended than males. Boys were significantly more likely to present with anger issues. Overall, counselling was associated with a significant reduction in levels of psychological distress with large effect sizes, but these varied depending on the measures used. No significance difference in outcomes between males and females was identified. Furthermore, the proportion of male/female participants did not impact on effect sizes.

Three papers focused on CBT based interventions conducted in schools. Study 9 focused on anxious adolescent boys who are bullied at school. Participants in the intervention group of study 33 (The Feeling Club) were children in grades 3-6 who screened high for anxiety or depression symptoms. Study 37 involved 2 interventions with children in grades 4 to 6. The first intervention involved children who had elevated anxiety screening scores. The second study took a universal approach and gave the intervention to all children in participating classes. The bullying

intervention (study 9) found to be effective for reducing the problem, as well as participants' anxiety, depression and distress and the gains were maintained at 3 months. The intervention did not enhance self-esteem, or change aggressive or avoidant responses to bullying situations. Only a third of parents attended all their sessions in this intervention citing lack of time as the main reason for non-attendance. In study 33, clinically significant improvements were found amongst both Feeling Club participants and the control group who received structured after school group activity at the end of the 12 week programme. Furthermore, there was no significant difference between the two groups. Improvements were maintained at 1 year follow up. No significant effects were found in either of the interventions comprising study 37 up to the 1 year follow up point. Control group children may have benefited from feeling included, and receiving a considerable amount of attention and relaxation. This may account for why the intervention groups may not have achieved significant improvements over controls.

A workplace suicide and early intervention programme for the construction industry (study 21) found that workers engaged positively with the after-hours crisis support phone line and case management. The emergency helpline received over 1500 calls in 28 months.

Telephone delivered CBT in an occupational setting (study 8) produced no significant improvements in anxiety or depression symptoms, but significant positive effects were identified for work productivity. Loss to follow up was high, and those failing to return data at 3 months were more likely to be male than female.

A study from Germany (Study 40) examined the effectiveness of behavioural/psych-educational group training for men aged 18 to 65 years who were chronically stressed from overworking. It was found that a 90 minute group session held twice weekly for 8 weeks resulted in significant reductions in systolic blood pressure and salivary cortisol concentration compared with the control group. There were also significant improvements in

self-reported assessments of chronic stress, anger and SF36 scores.

An Australian programme aimed to allow eligible occupational therapists, social workers, psychologists and clinical psychologists to provide mental health services under Medicare. Study 29 assessed the outcomes of 31 individuals who accessed services provided by one occupational therapist. The evaluation showed significant improvements in psychological distress from baseline to the conclusion of treatment with males benefitting more than females.

Self-help materials for treating anxiety and depression amongst male prisoners demonstrated a significant reduction in anxiety at the end of the intervention (4 weeks), which was also maintained at 4 weeks follow up (study 34). However, the authors pointed out that it remained unclear whether the positive outcome of the intervention lay in the content of the booklet or just in receiving it.

A community based therapeutic service (study 1) that aimed to address mild/moderate anxiety and depression amongst underserved Maori communities was associated with significant improvements in psychological distress. However, the engagement of men was low and remained so despite efforts to improve it. This was considered to be due to a combination of men being reluctant to access therapy and the shortage of male therapists.

An Australian initiative (Headspace) (study 42) aimed to increase the mental health service access of young people. Analysis revealed that there was an increase in the number of young people accessing mental health services which coincided with the establishment of Headspace. It was seen to have improved the access of men in particular. A higher proportion of males accessed the service compared with the general population of men who have mental health problems or who access services. The results further showed no differences in the reported service access experiences of males or females. Several reasons were identified by the young people for choosing to attend Headspace over other services. These

included a service that was easy to identify, youth friendly environment, accessibility, availability and the attitude of professionals/staff. However, young people also identified a number of psychological barriers that impacted on service access, including perceived social stigma around mental health, and negative past experiences of mental health services. The success of the initiative was attributed at least in part to it filling a recognised gap in service provision and the availability of professionals for young people to use. Headspace services were co-located with other services aimed at young people such as youth centres and internet cafes, which avoided the stigma associated with obvious attendance at mental health services. Young people also did not have to present initially with a mental health issue, rather they could self-refer to Headspace for any health or wellbeing concern.

KEY MESSAGES

- Several reviews of school based interventions of various types have provided largely positive results for both boys and girls, but there is inconsistent evidence as to whether single sex groups are more effective than mixed sex groups.
- In terms of the individual interventions examined, there was evidence from 1 study that children may benefit from school based CBT, but equally could also be helped from simply participating in structured, supervised activity programmes. Some evidence of positive effects on mental health outcomes was also found from an anti-bullying focused intervention. However, another study with children in grades 4 -6 did not demonstrate any significant treatment effects of a CBT focused intervention.

Workplace based interventions also produced mixed results.

- Behavioural/psych-educational group training showed promise in 1 study for

reducing the stress levels of overworked men, and positive mental health outcomes were also demonstrated through working with an occupational therapist. Construction workers also engaged positively with a crisis support phone line and case management.

- Conversely, telephone based CBT failed to have any significant impact on depression and anxiety, and loss to follow up was high particularly amongst males.

Two community based interventions also produced inconsistent evidence

Males largely failed to engage with a community based initiative to tackle mental health problems amongst underserved minority men in New Zealand. However, there was evidence from an Australian intervention of young men engaging effectively with services resulting in improved access to mental health support.

INTERACTIVE/ACTIVITY BASED

This category comprised 15 papers (from 12 studies), of which there was 1 review, 4 RCTs, 5 pre/post designs, 2 mixed methods design and 1 qualitative study. Six studies were from Europe (3 UK, 2 Ireland, 1 Switzerland), 3 from the USA, 2 from Australia, 1 from South Korea.

A review of 9 physical activity interventions for depression in children and adolescents (study 10) showed a small but significant effect. Single sex studies contributed the most to decreases in depression.

An intervention from the USA compared 12 weeks of vigorous exercise with a control stretching activity for treating depression in adolescents (aged 12-18 years) (Study 26, 67% male). At the post stage, depressive symptoms were significantly reduced in both conditions, but the exercise group improved more rapidly after 6 and 9 months. Both groups further improved by 12 weeks and at this points the groups did

not differ in terms of depression. Nonetheless both response and remission rates were greater in the exercise group. Adherence rates in both conditions were high, which may in part have been due to participants receiving a “small monetary compensation” for their attendance each week. However, it was further suggested that the high rates reflected the fact that the intervention was designed so that sessions could be conducted at home or another location of choice. The importance was emphasised of designing physical activity based interventions that make it as simple as possible for individuals to exercise in a manner that is enjoyable.

Men suffering from burnout who participated in a 3 month aerobic exercise training programme had significantly reduced perceived stress, symptoms of burnout (emotional exhaustion), depression, and depersonalization. The size of the effects were large (Study 20).

An evaluation of the effectiveness and cost effectiveness of the National Exercise Referral Scheme in Wales (study 38) showed there were significantly lower levels of anxiety and depression amongst those referred for mental health reasons alone, or in combination with CHD. However, further analysis suggested that the mental health benefits were only apparent amongst females.

An intervention from Ireland examined the effectiveness of a 10 week programme of integrated team sport (football) and CBT for the mental health of sedentary males and compared it with self-led individual exercise, and a control group (study 36). Analysis revealed that participants in both the football/CBT group (BTN) and individual exercise condition (IE) had significantly decreased depression scores compared with the control group at post stage and 8 week follow up. Depression scores decreased by 52% in the IE condition and by 45% in the BTN condition. The IE group also had significantly greater perceived social support than BTN at post stage and the control group at follow up, which may have been due to the non-specific effects of one-on-one staff attention and support. Researchers had more one to one interaction with

participants in the IE condition to check readings and safe use of equipment. Overall the results were considered to show the efficacy of exercise based interventions for symptoms of depression.

A related qualitative paper (study 35) reported the experiences of men who participated in the BTN. The findings were seen to support the value of gender specific mental health interventions. Participants felt that football was a positive way of engaging men in mental health initiatives, and the programme was perceived to be health enhancing, supportive as well as enjoyable.

A CBT based 11 week intervention that utilised football metaphor and venues as a way to deliver therapy for men with mental health issues found a range of positive benefits especially in relation to confidence, self-esteem and coping. Men related improvement to various key components including the therapeutic value of football metaphor, the focus on goal-setting and the mutual support developed within the groups (Study 49). The football theme was considered to have helped overcome the stigma associated with help-seeking. It was suggested that the use of football metaphor assisted in making discussion of psychological issues safer, accessible and comprehensible. A supplementary paper (study 50) explored in further detail how the use of football metaphor can support therapeutic change.

Men with alcohol dependence participated in 2 sessions of music therapy per week (30 mins) for 6 weeks (study 27). The type of music therapy varied (singing, music listening & instrument playing), with each activity conducted for 4 sessions. The results showed a significant decrease in depression, anger, anxiety and stress at post intervention. There was no significant difference in the effects of the 3 different types of music therapy.

A 10 week, 20 session psychotherapy programme for male adolescent aggression which incorporated the use of percussion exercises showed lower anger, depression and increased self-esteem, and these effects were maintained at 6 months. However, a second study that also followed up controls at 6 months found no significant difference between intervention and controls for

depression or self-esteem (study 17).

Participants in a prison art therapy intervention demonstrated a significantly greater decrease in external locus of control and depression than a control group amongst both males and females (study 22). A related study (study 23) analysed the data from this study further to examine whether there were any differences between males and females. No significant differences were identified at the 95% level.

A bibliotherapy scheme based on CBT and involving the provision of selected self-help resources and counselling support was evaluated in study 31. Findings showed significant improvements after 3 months in all the mental health status outcomes that were measured (GHQ-12 scores, Clinical Outcomes in Routine Evaluation (CORE)). No significant difference was identified between males and females on any of the outcomes. However, only 3 men came through self-referral compared to 11 woman, and the overall sample of men was relatively small (36 out of 114 participants).

A training adventure weekend followed by voluntary peer led support/integration groups (study 11) showed positive effects for men aged 19-74 years in terms of changes in depression symptoms, social support, gender role conflict and satisfaction with life. Men aged 30-44 years old benefited the most but not amongst those who participated in the peer led support/integration groups or had prior self-help experience.

A mental health first aid training project in Australia (study 44) was successful in increasing the capacity of football coaches to recognise the symptoms of depression and schizophrenia 6 months after receiving the training. Confidence to assist and support young men and their help-seeking for mental health problems also improved. As part of this study, data on mental health attitudes were also collected from players in participating clubs (70% under 25 years old). Notably, only 1 in 4 would seek help on the internet if they were depressed. On the basis of this finding, the authors suggested it may be necessary to question any automatic assumption that using the

internet will always be an effective strategy for reaching at risk groups of young men (e.g. those 15-25 years old).

KEY MESSAGES:

Exercise based interventions show promise for treating symptoms of depression and anxiety in males of varying ages.

- Framing interventions in the context of football, and a non-clinical ethos appear to be beneficially in terms of engaging men, but there is insufficient evidence to conclude that group based sport interventions are more effective than individual exercise programmes. Furthermore, not all evaluations have demonstrated mental health benefits for male participants.

Activity based intervention have also achieved success for improving the mental health of male participants.

- There is some evidence that interventions incorporating musical elements can reduce symptoms of depression and anxiety.
- Art based therapies have demonstrated effectiveness for treating depressive symptoms.
- An adventure weekend followed by voluntary peer support also reduced depressive symptoms as well as gender role conflict.
- Positive mental health outcomes in UK men were also improved after participating in a bibliotherapy scheme.

INTERNET/ONLINE/COMPUTER BASED

5 studies reported on computer/technology based interventions, of which 3 were RCTs and 2 pre/post design. Three studies were from Europe (UK, Ireland, Finland), 1 from the USA and 1 from Australia. All interventions were focused on some form of computer aided CBT.

Two studies reported largely positive outcomes for participants. A RCT from the USA (study 28) found 12 sessions of computer assisted CBT (CCAL) over 15 weeks produced significantly better improvement in children diagnosed with an anxiety disorder (aged 7-13 years, 67% males) than controls. A further group assigned to receive 12 sessions of individual CBT also achieved significantly better outcomes than controls. Gains for both CCAL and individual CBT were maintained at 3 month follow up. There was also no significant difference between CCAL and individual CBT either in terms of outcomes or patient satisfaction.

A further programme that produced generally positive results for men was the P4Well intervention (Study 30). This was an intervention conducted in Finland for stress related psychological issues, which integrated different personal health technologies with a CBT and Acceptance and Commitment Therapy. All 11 men in the intervention group felt they had benefited from the programme, and depressive and psychological symptoms were also found to have reduced. Conversely, increases in self-rated health and working ability were reported. Men found the Physiological measurements with personal feedback to be the most useful component of the intervention.

The evidence generated from the other 3 studies was more mixed.

A UK based study (study 13) explored the acceptability of "Beating the Blues", an 8 session computer aided CBT programme with 219 individuals aged 19 to 70 years old (40% male) who had depression, anxiety or both. Patients did generally report a positive experience, but post treatment, females were more favourable and reported it to be more helpful as well as expressing greater satisfaction than males. These results were highlighted by the authors as being particularly interesting owing to an expectation that men would find computer delivered therapy more appealing than a face to face format. It was suggested that the more favourable responses of females may have reflected the fact that the narrator's voice was female, and 3 out of the 5 vignettes involved

a female/female therapist. More generally, the authors highlighted a lack of research exploring gender differences in CBT for common mental health problems.

The remaining two studies both focused on the MoodGYM programme which is an interactive, internet-based CBT programme designed to prevent and decrease symptoms of anxiety and depression. One study (study 39) examined adherence to the programme amongst both male and female adolescents in two different settings (i) school based (ii) community based. As reported earlier in the section on health promotion interventions, the completion rate was nearly 10 times higher in the school than community setting. Moreover, participants in the school based setting completed significantly more online exercises than those in the open access community setting. The sex of participants was found to be a significant predictor of adherence, with females being more likely than males to persist with the programme.

The final study (number 52) was the most recently published (2014) and assessed the effectiveness of MoodGym amongst adult mental health service users (74%, females). Overall, those completers who engaged with the programme did gain some positive benefit. MoodGym was significantly more effective than waiting list controls in decreasing stress and general psychological distress, but not depression, anxiety or impaired daily function. Significantly, 85% of male participants dropped out. The authors compared the results with 8 other studies that used the MoodGym intervention. High drop-out rates amongst men in particularly have been recorded in other MoodGym studies, suggesting that they may not find the programme sufficiently engaging. Attention was also drawn to concern expressed previously that self-help CBT more generally is associated with high drop-out rates. Overall, it was concluded that the evidence for the effectiveness of MoodGym was at best mixed. For routine clinical settings, evidence supporting its effectiveness for decreasing general psychological distress is inconclusive, and there is little evidence of anxiety reduction.

KEY MESSAGES:

Evidence of the effectiveness of computer/web based therapy for improving the mental health of men and boys remains mixed.

- Some programmes have demonstrated promise in terms of decreasing depressive and anxiety symptoms. Another intervention did also show some benefit in terms of decreasing general psychological distress but appeared to have little impact on depression or anxiety

The evidence does not currently support the idea that males prefer computer based interventions to 1-1 treatment. In one study, females found the intervention more favourable and expressed greater satisfaction than males. In addition, several studies have reported a high drop-out rate amongst males in particular and certain programmes such as MoodGym appear insufficiently engaging to adult men. Amongst younger people, the use of computer based therapy in monitored settings such as schools was associated with greater compliance/adherence.

OTHER

One qualitative study from the UK (study 16) explored men's experiences and perceptions of depression and anxiety groups. It was shown that men do attend groups to gain support for depression and anxiety. The results found a strong theme of isolated men, some of whom were reluctant to discuss problems with individuals close to them, but attended group based interventions. Reported benefits of groups included peer support and reduced stigma, with the results suggesting different types of groups might be attractive to different types of men. Gender and cultural norms were commonly considered to be barriers to help-seeking.

One study (32) examined the role of the media in encouraging men to seek help for anxiety or depression. Ten news stories related to depression/anxiety were selected and the number of contacts to helplines in the weeks following publication examined. Analysis revealed a beneficial relationship between positive and affirming stories and the use of helpline services by men. The stories that appeared to have the strongest influence were about hope and recovery and featured men who other men either revered or to whom they could easily identify. These findings are consistent with social learning theory that emphasises the positive influence of role modelling on behaviour change. It was suggested that as men see respected individuals seeking help, their self-efficacy and incentive to change increases and this in turn leads to help-seeking. Overall, it was concluded that the media can play an important role in promoting help-seeking for anxiety and depression.

4. EXISTING UK PROJECTS (WP1)

4.1 APPROACH TAKEN

The previous scoping report for the Movember Foundation highlighted several databases that listed mental health and wellbeing projects. We further developed this work here, exploring these databases more thoroughly than time had previously permitted. Specifically, the 'Big Lottery' has supported a significant amount of work within the area of health and wellbeing, with some projects specific to mental wellbeing, and this was therefore a key database for identifying such projects. Other databases reviewed were: the NIHR Mental Health Research Network; the Medical Research Council (MRC) and; the Economic & Social Research Council (ESRC). Additional generic searches were completed using tacit knowledge from the Centre, MHF contacts and Google searching. Keywords such as 'men+mental health'; 'mental health projects+men' were utilised in these more generic search strategies.

4.2 GENERATED PROJECTS

From this approach, 17 projects were identified through the Big Lottery database, 0 projects through NIHR, MRC, ESRC (this was not surprising as most of the projects listed within these databases related to research into acute and enduring aspects of mental ill-health and/or were clinically focused) and 41 projects through other avenues, giving a total of 58 projects (See Table 1). Once identified, further brief information was sought about these projects (through available online links and reports and/or by direct email or phone communication) to get a feel for: whether the project was 'live' (i.e. still running), the specific target group of boys/men, and ensuring it was mental/emotional wellbeing focused in terms of promotion of wellbeing or early intervention in relation to mental health rather than about support for enduring or chronic mental health problems. A list of these projects is available from the report authors.

Table 1. Sources of UK projects

Source	Number of Projects
Big lottery database	17
NIHR/MRC/ESRC	0
Other searches	41

5. INVESTIGATIVE NETWORK CONSIDERING ‘WHAT WORKS’ (WP2)

KEY MESSAGES

- The setting an intervention is based in is crucial to creating a safe male space for engagement with boys and men. Safe settings are often those considered familiar and ‘male friendly’ – though what this means varies and needs to be understood as culturally and group specific
- Some settings stand out as appealing to certain groups: Schools for younger boys; Physical activity settings for young and middle-aged men; Workplace settings for working age men; Shoulder-to-shoulder settings for all (including older men); ‘virtual’ settings for boys and young men
- The right setting can act to reduce mental health stigma and also the stigma and discrimination experienced by marginalised boys and men
- Approaches that are embedded within communities and utilise a range of peer engagement and mentoring are particularly effective in generating ownership, facilitating trusting relationships and creating the space for disputing and re-thinking gender/masculinity
- Those involved in interventions need an array of characteristics to be most effective but having a positive and enthusiastic view about boys and men was a main core value required. The sex of those involved was not as important as having this male-positive, ‘strength-based’ view
- Activity approaches, based in areas of male interest (sport, DIY, music), were identified as an effective way to engage and sustain the involvement of boys and men. Such approaches helped overcome stigma, improved positive social engagement and acted to facilitate ‘talk’ over time
- Men often work well with direct, tangible and practical approaches that are solution-focused
- The language used within interventions is crucial and can act to facilitate or restrict engagement. ‘Male friendly’ language (appropriate for the specific group being

engaged) and avoiding the language of ‘health’ and ‘mental health’ was important

- Like settings, partnerships were often crucial to intervention success. The benefits of partnerships were: assisting early engagement by improving the credibility of a programme; extending the reach and available activities; effective use of scarce resources; increasing sustainability and growth
- Partnership working was not always straight-forward and may require work to secure ‘buy-in’ from partners and to advocate with them for a specific emphasis on boys and men.

5.1 APPROACH TAKEN

We established an investigative network of 13 key players (UK and international, focusing on the Movember Foundation’s five main countries of interest) who acted as information seeking hubs and conduits within different geographical and professional contexts. Network members were chosen based on the prior knowledge of such individuals/organisations that resided within the Centre for Men’s Health at Leeds Beckett, the Men’s Health Forum and the Movember Foundation. Network members were contracted to complete two tasks:

- 1) To identify and provide contacts/links for 2-4 projects/programmes that seem particularly successful or show good promise in mental wellbeing work with boys and men. A proforma was developed for collecting information about these projects so that there was consistency across the network and to facilitate more rapid analysis of the information provided.
- 2) To gather information from within their communities of practice (geographical or professional contexts) about what they think works, for which boys and men, within which contexts and why. In particular, which approaches seem particularly productive and for whom. Given the positions these people/organisations hold, and the relationships and networks they have within their communities of practice, this was not expected to be an onerous task.

This 'multiple hub and spoke' approach was developed to provide a manageable, efficient and effective means of rapidly gathering a broad perspective on 'what works' and in identifying specific examples of successful/promising projects and programmes from a range of contexts. Different investigative network members used different approaches to complete these two tasks:

1) To identify and provide contacts/links for 2-4 projects/programmes that seem particularly successful or show good promise in mental wellbeing work with boys and men. A proforma was developed for collecting information about these projects so that there was consistency across the network and to facilitate more rapid analysis of the information provided.

2) To gather information from within their communities of practice (geographical or

professional contexts) about what they think works, for which boys and men, within which contexts and why. In particular, which approaches seem particularly productive and for whom. Given the positions these people/organisations hold, and the relationships and networks they have within their communities of practice, this was not expected to be an onerous task.

This 'multiple hub and spoke' approach was developed to provide a manageable, efficient and effective means of rapidly gathering a broad perspective on 'what works' and in identifying specific examples of successful/promising projects and programmes from a range of contexts. Different investigative network members used different approaches to complete these two tasks. The final list of network members, their respective areas of focus and the approaches they used were as follows:

Name	Identifier	Area of focus	Methodology
Prof. Raghu Raghavan (De Montfort University)	IN1	Ethnicity	Identified relevant organisations and emailed them in the first instance, then followed up with a telephone interview. Conducted a literature search of academic articles, grey literature and also examined websites
Dr Damien Ridge (University of Westminster) Dr John Barry	IN2	Psychology	36 interviews with key informants, including psychotherapist, counsellors as well as service users and others from communities of practice

Name	Identifier	Area of focus	Methodology
Dr Andrew Smiler (Independent Therapist)	IN3	USA	A survey was conducted online which was advertised via social media, with a \$25 random prize incentive. Overall 50 people responded via the survey or through interviews. Quantitative analysis of programme content was also carried out
Hugh Norriss	IN4	New Zealand	5 telephone interviews were conducted
Dr Daphne Watkins (University of Michigan) Dr Derek Griffith (Vanderbilt University)	IN5	USA (ethnicity)	Reviewed 20 programmes, which were identified by internet searches and then ranked in relation to the network brief. The director of each selected programme was then interviewed
Prof. John Oliffe (UBC)	IN6	English Speaking Canada	Web searches, grey literature searches and academic literature searches conducted
Prof. John MacDonald (MHIRC)	IN7	Australia	Summarised the outcome findings from studies and evaluations and captured the experience of MHIRC staff
Toby Williamson (Mental Health Foundation)	IN8	Ageing men	Semi-structured interviews with experts were conducted, and then interviewees made further suggestions of people for interview and then interviews were conducted with these persons. Interviews were transcribed and agreed with participants
Chris O'Sullivan (Mental Health Foundation)	IN9	Scotland	A literature review was conducted including grey literature, and telephone interviews were also carried out

Name	Identifier	Area of focus	Methodology
Toby Williamson (Mental Health Foundation)	IN10	Boys and young men	Semi-structured interviews with experts were conducted, and then interviewees made further suggestions of people for interview and then interviews were conducted with these persons. Interviews were transcribed and agreed with participants
Prof. Gilles Tremblay (Laval University) & Philippe Roy (Université de Montréal)	IN11	French Speaking Canada	3 key informants were interviewed and a review of grey literature conducted (predominantly literature that was available only in French including expert reports and evaluation reports)
Dr Paula Carroll, Billy Grace & Dr Noel Richardson (Men's Health Forum in Ireland)	IN12	Ireland (all)	Re-analysis of 8 focus groups and 7 interviews recently conducted from the perspective of effect engagement.
Peter Baker (Independent Consultant)	IN13	Europe (including the UK)	6 Interviews were conducted, Google searches of projects and appraisal of relevant academic literature

5.2 KEY WP2 THEMES

5.1.1 ANALYSIS

Once the reports from partners were received the template documents for task one were stored ready for consideration for inclusion in Work Package 3 (WP3). The information from this task is therefore not considered further here but a full list is available from the report authors.

The information (data) collected for task two was subject to thematic analysis. All reports were closely read by two members of the team, data was coded, categorised and integrated under main theme headings.

5.2 KEY WP2 THEMES

The reports received from the 13 partners for task two totalled 138 pages and over 55,000 words. When analysed the main emerging themes were; 'safe settings', 'gender-sensitive approaches' and 'benefits of partnerships'. We discuss each of these in brief below to draw out the main elements.

5.2.1 SAFE SETTINGS

A key theme that consistently came across as important was that of the settings that interventions were delivered in or through. Paying attention to this was seen as a way to "widen the door" [Investigative Network member 10, page 97 (IN10, pg.97)]; facilitating more participation in interventions by making access easier and more acceptable for boys and men. For most, this was about creating a safe space (a phrase many used) where they could feel relaxed and comfortable:

"It appears crucial that a safe male space is created in order to facilitate work with men." [IN9]

Such safe settings were often juxtaposed to mainstream or statutory service provision settings, or even certain community venue settings, which were frequently presented as feminised or unfamiliar environments and therefore off-putting for many boys and men:

"Community facilities are predominantly used by women and therefore have become unattractive to men, particularly older men." [IN9]

This issue was also felt to be compounded for particular groups of men who had poor

experiences with such formal service settings or who had a more general distrust of formalised structures. Groups specifically identified in this way were gay men [IN9], older gay men [IN8], minority ethnic groups [IN1] [IN7], and boys and young men from deprived localities [IN10] – though this is not an exhaustive list and does not imply that there are no other groups of boys and men for whom this is also the case.

As noted in both of the above quotes, a big part of creating this safe space was about it being a specifically safe male space and setting; that is to say interventions need to be aware that locations and settings themselves are not gender-neutral and this needs to be taken into account when thinking about the work. One thing that seemed particularly important in creating such safe gendered spaces therefore was working in settings that are male familiar or 'male friendly'. This was seen to make engagement and access much easier [IN5] and:

"With respect to the most appropriate settings for working with men and boys, what is most relevant is that interventions happen in an environment that is familiar and non-threatening to them. Men and boys are more amenable to engaging in an environment in which they feel safe and can relax." [IN12]

Fundamentally, this familiarity and safety of settings acted to promote trust; something noted across a range of men's health work and evaluations as being slower to develop amongst men (and, again, we would suggest particularly so amongst socially marginalised groups of men).

"Trust is very important to men and this can begin to be built from the selection of the correct location for a project." [IN9]

Trust runs across all three themes presented, what is important here is to highlight how setting and place have a role to play in its generation. Rather than selecting a setting (as mentioned in the quote above) many interventions used what one investigative network partner termed "in-situ programme delivery" [IN7]; that is, developing interventions in settings, locations, social spaces

where boys and men already gather. Of course, given that different groups of boys and men are familiar and comfortable in different settings it is obvious that there is not a 'one-size-fits-all' setting that would work for all boys and men. Rather, settings need to be considered based on what is culturally and group sensitive:

"Settings that seemed to work best were those selected on the social and cultural identities of the men and boys they intended to serve. For example, barbershops have a historical and cultural position in the lives of many African American men and are often used as intervention settings. Similarly, the workplace and athletic venues are also settings that have served as intervention sites for mental health programmes geared toward men and boys." [IN5]

However, from the data gathered some statements can be made about specific settings that seem to be particularly effective for engaging certain groups:

- School settings for younger (approx. 5-11yrs) boys but not for older boys and young men [IN2] [IN3] [IN10] [IN12] [IN12] [IN13]

"For older boys and young men, the feedback was that they may not be as willing to use school-based interventions due to the stigma attached to seeking help and admitting to their difficulties." [IN10]

- Physical activity settings e.g. sport [IN4] [IN5] [IN8] [IN10] [IN13] particularly for younger men and or boys [IN4] [IN10]

"Many men and boys respond to services that have a physical element in which they can 'let off steam' in order to bond with others including those providing the service or support". [IN4]

- Work place settings [IN5] [IN7] [IN12]

"For older men, workplaces and community employment schemes appear to be an appropriate setting." [IN12]

- 'Shoulder to shoulder' settings which facilitate social support as well as offering the opportunity for mental health support e.g. sheds [IN4] [IN7] [IN8] [IN9] [IN12]

"The Shed is run by the men themselves with the support of Aboriginal staff. It is run very informally and men can drop in anytime for company, a chat or a cup of tea and something to eat. The Shed is a place men both trust and like to go - it is 'their place'." [IN7]

Part of what working in the right setting achieved was the ability to reduce stigma by shifting culture and 'normalising' participation in an initiative across a whole group (i.e. not just those with a mental health 'issue' or 'problem' but influencing the thinking and perceptions of all within a setting). For example, utilising the workplace as a setting:

"....can work to de-stigmatise mental health as discussions become as normal as those about physical health and sickness, and encourage an ethos of looking out for colleagues or team mates who might be having a hard time." [IN 7]

Similarly, running a support service for combat stress in a sports setting acted in the same way

"The support service works because it is not on a mental health site and there is no stigma attached to attending the group." [IN8]

The stigma that settings helped to overcome could be directly mental health related as with the examples above but could also be related to being part of a marginalised group; such as the stigma and discrimination associated with being from a minority ethnic group [IN1] or being gay [IN9]. Here, interventions directly embedded within these communities were often essential to foster and facilitate engagement.

As well as the physical settings mentioned above, an important point made by many of those consulted by the investigative network was the potential that remote or 'virtual settings' (or 'virtual communities') might offer as intervention platforms for men, particularly for the younger generation. This was often suggested as being related to men's greater desire for confidentiality and anonymity in relation to mental health (or psychosocial) concerns and to a male sense of 'control':

"The online forum allows boys and young men to express themselves in ways that they wouldn't be

comfortable with in face-to-face work.” [IN10]

“In terms of phone helplines and online help, men want a sense of being able to control their own destiny, confidentiality and anonymity.” [IN2]

Such approaches were said to help overcome the stigma associated with help-seeking and particularly mental health help-seeking. They also remove the need for those men from marginalised groups to engage directly with services perceived as discriminatory or untrustworthy:

“Online settings can serve as “communities” for boys and men, particularly those who are dealing with more stigmatized challenges regarding their mental health (e.g., depression, PTSD, etc.) and social identities (e.g., men of color, sexually marginalized men, etc.) [...] who are less likely to disclose their mental health status face-to-face.” [IN5]

They can act to engage men that may not be engaged by traditional male settings:

“For boys and young men who may find it difficult to socialise or who aren’t interested in sport or music, there seemed to be a deficit in methods in which to engage them. The online forums identified that many young men are extremely isolated and really valued having a way in which to connect with their peers.” [IN10]

...and can offer a safe space to explore, subvert or redefine male gender identity as encouraged in the online campaign #mandictionary (see <https://tagboard.com/mandictionary/178379> for examples).

However, consideration of the acceptability and effectiveness of web-based services was said to currently be lacking a firm evidence base [IN6].

As can be seen, settings were important for a range of reasons many of which were heavily tied to specific groups and social contexts. In this regard they do not stand apart from the wider issue of effective approaches taken to engage and work boys and men and it is to this that we now turn.

5.2.2 APPROACHES

The most comprehensive theme, covering a variety of issues, was that of the best approaches to take when working with boys and men.

Linked to the issues of settings, there was general recognition that the approaches taken to interventions should be embedded within the communities of boys and men they hoped to serve, showing a genuine insight into the needs of that community [IN8]. This was true across all groups of boys and men but was seen as particularly important for marginalised communities:

“Local knowledge of the community setting and the target group is essential to ensure that any intervention is culturally and environmentally appropriate” [IN12]

“Community participation is essential where a group of men and boys is marginalised” [IN7]

Again, as with settings, embedding interventions in this way was seen to provide a fertile environment for developing trusting relationships:

“Community interventions can allow organisations to develop knowledge, relationships and trust” [IN1]

As a significant part of this process of ‘embedding’, many suggested that community development approaches were required that centralised the role of the boys and men being served in interventions:

“For real ownership to be established it is vital that men are involved from the earliest stage in project development. They must set the agenda and control the project; rather than being passive participants in something that will come to be seen as worker or organisation led.” [IN9]

Several examples of incorporating such involvement were provided but most included involving local boys and men in paid roles within projects or having some aspect of peer mentoring as central to the work:

² There were some exceptions noted to this. When participants were discussing a more formal therapeutic arrangement then this differed – although, as mentioned in ‘settings’ earlier, even some therapeutic sessions had been taken into ‘male friendly’ environments. For example ‘It’s a goal’ takes aspects of formal mental health service provision into football ground settings.

“The importance of ‘home-grown’ staff and peer mentorship were often cited as a programme’s most valuable asset” [IN10]

The importance of peer involvement was very much linked to ideas about familiarity and trust but also to recognition of the role that a shared sense of identity played in the success of interventions:

“Particular client groups (prisoners and veterans) reacted much more positively to project staff when they discovered that they had shared experience. The implicit understanding and empathy that the staff member was able to show meant that there was no perceived power imbalance and that the service user could have confidence in the worker’s first-hand knowledge of the type of issues they themselves were facing.” [IN9]

In a similar way, peer mentoring was seen to play a part in helping disrupt aspects of masculinity that were seen to be damaging to mental health and wellbeing:

“The value of peer participation to get the message ‘out there’ was seen as essential. Training boys as mentors and campaigners to normalise the message and make it easier for boys and young men to seek help and speak about their difficulties is seen as an essential step in reversing the culture of boys staying silent.” [IN10]

...and instead to help participants develop or draw upon more positive aspects of masculinity:

“Programmes developed and run by men who are former participants/ clients are important to success. This kind of peer-mentoring and peer-group facilitation encourages men to work toward getting better and offers them the opportunity to help someone else (which is characteristic of hegemonic masculinity).” [IN5]

”Involving men and boys in the design of the intervention can be an empowering experience for those men and boys where they can create a sense of ownership of the intervention. This is conducive for ‘buy in’ and engagement in the intervention. This is also consistent with a strengths-based masculinities approach that reinforces participants’ sense of autonomy, control and independence.” [IN12]

Whoever the people were who were involved in interventions their characteristics, values and skills were recognised as crucial to the success of the work. Whilst it may seem obvious, having a desire, willingness and aptitude to work with men was not always felt to be the starting point for many in existing services and this created negative experiences for some boys and men and a concomitant lack of engagement:

“Too often, service providers start from a position that men and boys are to blame for their predicament and enter into the work with an agenda to fix the problem that is men or boys. Not surprisingly, men and boys will intuitively uncover this value base and misguided motivation, and either not engage or promptly disengage with the intervention.” [IN12]

It was noted that holding such views would generate a lack of authenticity that would be readily recognised by those attempting to be engaged:

“Remember that boys and men will see through staff quickly, and will know if staff are insensitive or not genuine” [IN2]

In contrast to this, ‘good’ intervention facilitators were said to be: sensitive (including gender-sensitive) [IN2][IN3][IN5][IN11]; respectful, non-judgemental and supportive [IN3]; charismatic (especially in work with young people) [IN3][IN5]; skilful and empathic [IN4][IN8]; authentic and genuine [IN6]; welcoming [IN8]; good communicators [IN8]; persistent and adaptable [IN10]; reflexive [IN12]; enthusiastic and passionate [IN12].

There was a general consensus across the investigative network member reports that the gender of those working within interventions (with the exception of certain work such as sexual violence prevention work) was not as important as holding some of the above listed values and skills:

“It is less important whether the staff are male or female, than that staff are male-positive” [IN2]

Many of the values captured in the above list of what constitutes a ‘good’ facilitator could be captured under this rubric of being ‘male-positive’.

The importance of this approach, being positive about men and boys and the assets they can bring, was underlined by most of the investigative network partners:

“Men of different ages and experiences tend to have different strengths, identifying these strengths and utilising these for programmes is a good starting point.” [IN7]

“Recognising and focusing on a man or boy’s strengths, rather than his faults and telling him how to fix them, can empower him to work and build upon those strengths.” [IN12]

Having this positive view of boys and men – a ‘strengths-based’ or ‘salutogenic’ approach - was then recognised as an important core value. Linked to this was the importance of approaches that are non-judgemental and that can implicitly challenge stereotypical male practices:

“The style or tone prevailing in the community based strategies is best described as non-hierarchical and non-shaming. This is important in that it overtly avoids one-upmanship and the competitiveness that often emerges within groups of men in other arenas” [IN6]

Having such a view of boys and men, understanding them in this way, was something that training could help facilitate and particularly training around what gender-sensitive work with boys and men entailed:

“It seems that gender-sensitive training is imperative for successful mental health programmes geared toward men and boys. Passion does not always result in gender- and situational- sensitivity.” [IN5]

Activity or ‘action-oriented’ approaches were identified by many as a particularly good way to engage and sustain the involvement of boys and men. Often activities, or subjects of male interest, were described as a ‘hook’ that could help “overcome the initial stigma of mental health” [IN9, pg.84]. The reasoning behind this was that they helped create the safe space mentioned earlier by removing any need to be too quickly engaged in ‘opening up’ emotionally:

“It is helpful if the focus of group work be on

doing activities, rather than group talking. This allows men to open up and talk gradually and naturally” [IN2]

This emphasis on activity was therefore seen not as an alternative to talking approaches but rather as being a key that could help facilitate these:

“Whilst the mental health angle in these projects may not be explicit, the rationale behind them all is that through an activity, having a base, and having supportive (and sometimes challenging) relationships, there will be an opportunity to talk about issues affecting the young men.” [IN10]

“Once the ‘doing’ activity has been established, ‘talking’ interventions can be integrated into the work.” [IN12]

The focus on activity was also seen as important in relation to creating a positive outlet for emotions and especially in facilitating social engagement, increasing male sociality, in ways conducive to improving mental wellbeing:

“Many men and boys respond to services that have a physical element in which they can “let off steam” in order to bond with others.” [IN4]

Much was said about the requirement for approaches with men to be direct and solution-focused. Participants described the importance of setting goals that related to tangible aspects of life [IN2] and of men liking a ‘directive style’ and ‘rule-based’ approaches [IN4] - although within this being cautious about “diving straight into emotions” [IN2] [IN7] was also important.

One area that came out incredibly strongly, being mentioned across almost all investigative network member responses, was the significance and importance of the language used in interventions. This was partly about making language ‘male friendly’, using humour, and formed part of the wider discussion about creating safe and trusted environments and relationships:

“People repeatedly identified the use of ‘male-friendly’ language and examples as key to building relationships between group facilitators and participants. This seems to help establish facilitators as ‘relate-able’.” [IN3]

...but was also about avoiding stigmatising language or language seen as feminised by its association with feeling, emotions etc.:

“Several projects use approaches mentioning wellbeing or tackling isolation in publicity materials and literature instead, and do not actually mention mental health at all” [IN9]

“If we’ve got a door which says ‘For Mental Health Users’, then they’re probably not going to walk through that door, if we’ve got a door which says ‘Feeling Shit? Come Here’, it’s an easier door to walk through.” [IN10]

Settings and approaches then make a huge difference to the success of interventions but these are often not enough in isolation and the right partnerships need to run alongside these, or even be part of these, to really maximise interventions.

5.2.3 PARTNERSHIPS

Whilst it could be subsumed under the previous theme heading of ‘approaches’, the issue of partnerships seems to warrant some specific attention. There is no doubt that the earlier discussion about ‘embedding’ approaches within communities often implies and requires partnerships in order for this to be facilitated. As one report put it:

“Projects cannot operate effectively in total isolation. The needs of men likely to be attracted to projects that promote good mental health are usually complex and the input of a variety of agencies is therefore required to meet them.” [IN8]

All investigative network reports provided examples of partnership working and several spelt out the range of benefits that this brings. The ‘in-situ’ nature of many interventions discussed earlier means that partnerships can facilitate “the provision of a non-stigmatising route into the project” [IN8] and the opportunity to avoid the appearance of mental health help-seeking:

“Partnerships are key, and it is well known that it is the relationship rather than the therapy modality that is most healing. It is important to reach out to boys and men in places like sport clubs, community centres, schools; or wherever men gather. Boys might want to work with a sport

teacher, rather than a counsellor.” [IN2]

As another report put it, partnerships “improve the credibility of the programme” [IN7] especially through partnership working with existing agencies that are trusted by the particular group of boys and men being engaged

“if a man is told about a project by a housing worker or an advice worker he has already established a good relationship with, he is more likely to attend” [IN9]

Extending the reach of a programme across a range of activities and/or sites was also identified as a possible benefit of partnerships [IN7][IN8] as was the issue of enabling funding and/or resources to go further and having ‘in kind’ support [IN6] [IN7][IN9][IN12]. Indeed, for some, it seemed that forging such partnerships was the only way to ensure the longevity or growth of interventions in challenging economic times:

“Increasingly, to sustain let alone scale-up health programmes, evidence and a variety of partnerships are needed” [IN6]

Yet partnerships were also recognised as not always being easy to establish and that thought needed to be put into partnership relationships and how they might develop to benefit an intervention in terms of supporting growth:

“How those partnerships work on the ground depends a great deal on the intervention and its purpose. It also depends a great deal on the skills within the group/organisation undertaking the intervention. At times a small group may feel the need to grow by an “add on” model e.g. a sporting group partnering with a health provider, or an employer partnering with a mental health support team” [IN4]

Some therefore saw part of the role of a ‘men’s health’ specific intervention to be acting as advocates for an increased focus on men and recognition of their needs amongst potential partners [IN12].

One thing that was clear is that partnership agencies had to be able to see the benefits that could accrue from such engagement in order to be persuaded to be involved; before they would give

their time and resource. For some projects, such agreement had to come in advance because of the nature of the intervention:

“Interventions in settings such as workplaces or schools require ‘buy in’ from management in those settings to allow the intervention to happen during school/work time.” [IN12]

For other interventions though their establishment and visible success could lead to organisations asking to form productive partnerships that might expand the work:

“Empire Fighting Chance describes how initially it was peer referral that brought boys to their gym. However, in time, schools started contacting them to refer pupils, asking “how are you doing this? We’ve seen a massive improvement; can we send more kids to you?””[IN10]

As well as the numerous benefits that partnerships could bring there was also an identified downside:

“Partnerships also mean more work, more meetings, more reporting – all of which needs to be borne in mind when deciding whether to partner and how many partners to get involved.” [IN7]

5.3 SUMMARY

The responses from the investigative network, offered a great depth of knowledge from the relevant communities of practice about what worked, for which boys and men, in which contexts and why. Network members found that settings are highly significant for boys and men; particularly in relation to ideas of ‘safe space’ and ‘male friendly space’. The context of the setting adds a further positive dimension to engaging men and boys, for example working with settings that are comfortable for males is key, and can often also offer pragmatic benefits in terms of accessing men and boys, i.e. going to men and boys where they are. The community is seen as important facilitator for approaches around mental health and wellbeing, and can help with the highly important aspect of building trust and ownership of projects by the participants. Those working with men and boys need to be positive, taking a ‘strength

based’ approach which views men as assets and meaningfully incorporates them in projects at as many levels as possible.

Activity, action-based work, is useful for working with men and boys. It can be a means of securing engagement in a non-stigmatising way and acts to facilitate ‘talk’ in a non-threatening manner. Language around mental health can itself be a barrier to engaging men and boys, so ensuring that the language of projects is ‘friendly’ towards men is also critical in facilitating and maintaining engagement.

Partnership working offers an opportunity to broaden the scope and reach of projects but does need careful consideration to ensure that all partners are ‘on the same page’ in terms of having a positive approach that is centred around the needs of men and boys.

6. CONSIDERATION OF EXISTING PROJECTS (WP3)

KEY MESSAGES FROM WORK PACKAGE THREE

- importance of building trust through gender-aware, male sensitive provision
- 'creating safe spaces' entails using accessible settings where targeted groups of men are likely to engage, interesting, fun activities that facilitate talk, attractive media and language, and encouraging dialogue and reflection in modes acceptable to men
- how trust, and safe spaces for men to explore options, are to be created varies by context (which groups, under what circumstances)
- peer support and mentoring is vital for creating safe spaces through trust
- programmes need to be flexible, and embody gender awareness in planning and facilitation, on basis of local need, e.g. through a range of offers
- facilitators need credibility from experience, gender awareness, and skills
- challenging stigma and exclusion involves considering intersection between gender, mental health, and possible prejudice and discrimination e.g. racism, homophobia.
- programmes need strong partnerships to enable men to access resources so they can address life issues, and to access services (e.g. early intervention) when required
- successful programmes work towards positive social change and constructively and critically engage with and challenge services
- successful programmes are grounded in core values including a social focus, concern for men as individuals, with an asset or empowerment basis
- successful programmes aim to remain organisationally grounded, close to communities and driven by concerns of men
- successful programmes also develop their skills and resources to survive and thrive
- building partnerships can involve challenging gender insensitive practices
- models for sustainability in communities include increasing representation of men with experience in organisational structures, forms of regional and local federation and autonomy, and demonstrating evidence of success
- the above themes were widespread, but no one size-fits all approach applies
- programmes vary by context in how they balance preventive inclusiveness (interventions in schools and anti-stigma campaigns) and targeting
- programmes vary in approach to language and labels in the balance struck between celebrating men 'with experience' and avoiding 'divisive' clinical terminology
- programmes vary according to group (e.g. by age, community of identity) and purpose, in the settings and range and blend of activities and talk used

6.1 APPROACH TAKEN

Information about successful and/or promising projects and programmes gleaned from WP1 and WP2 was collated. The project team developed and applied criteria for choosing 12-16 projects from these lists and worked with the Movember Foundation to apply these and make final choices. The projects were chosen on the basis that, taken together, they embody excellent aspects of mental health promotion, early intervention, and anti-stigma work. The criteria taken into consideration related to:

- Diversity (age, ethnicity, sexuality)
- Ensuring some focus on deprivation
- Ensuring some focus on specific groups of men at risk of mental health issues (veterans, men in criminal justice system)
- Geographical spread across the UK
- Non-clinical work and settings (more community based)
- Excluding mental ill-health projects/ programmes
- A range of action and talk approaches
- A mix of face-to-face and technology-centred (e.g. web-based) approaches

The following table represents the final projects chosen: [See page 50](#)

Table 3. Projects chosen for WP3

Name of project	Type of project	Location	Source	Fieldwork type
Glasgow's Helping heroes	Veterans	Scotland	Investigative network	Telephone interview
Positive prisons, positive futures	Prison	Scotland	Investigative network	Telephone interview
Kent Sheds	Sheds (older)	England	Environmental scan	Visit and face to face interview
Savera	Ethnicity	England	Investigative network	Visit and face to face interview
Akwaaba Ayeh	Ethnicity	England	Environmental scan & Investigative network	Visit and face to face interview
Opening doors	Sexuality (older)	England	Investigative network	Email Interview
Rainbow Project	Sexuality	Northern Ireland	Environmental scan	Visit and face to face interview
Sporting Memories Network	Age (older)	England	Investigative network	Telephone interview
Mind Yourself	Age (School age)	Republic of Ireland	Investigative network	Telephone interview
Young men talking	Age (Young)	Northern Ireland	Environmental scan	Visit and face to face interview
MAC UK	Deprivation (young)	England	Investigative network	Telephone interview
Mojo Project	Deprivation (working age)	Republic of Ireland	Investigative network	Visit and face to face interview
Time to change	Generic (inc. online/web)	England	Environmental scan	Telephone interview
MUTED	Generic (phone/email)	England	Environmental scan	Telephone interview
CALM	Generic (young & middle-aged) (phone, online/web)	England	Environmental scan	Telephone interview

Once selected, interviews were held with lead contacts across the fifteen selected projects. Where possible these in-depth interviews were carried out face-to-face to enable the team to also get a feel for the setting projects were delivered in and contextual features. They explored participants' views and experiences about a series of topics including: the origins of projects; their main features; aspects of delivery; the ingredients that made them successful; partnerships; staff skills; and requirements for sustainability. A process of iterative listening was then completed and data placed into an analysis framework for each of the fifteen projects.

6.1.1 ANALYSIS

These frameworks were then subject to thematic analysis to explore cross-cutting concepts and descriptions. This process involved the analysis frameworks being closely read by two members of the team, then the data being coded, categorised and integrated under main theme headings.

6.2 KEY WP3 THEMES

6.2.1 MALE SENSITIVE SERVICES - BUILDING TRUST

The interviews provided clear ideas about how to encourage men to access the projects, to feel engaged and to stay involved. One key theme is that programmes need to help men feel trust in the process. This can be achieved through gender-aware approaches, including utilising accessible settings that men feel comfortable with, designing activities that men find interesting and that potentially facilitate talk, using attractive media and appropriate language, creating safe spaces for men, and encouraging dialogue in modes acceptable to men. This is in the context of a) issues surrounding services adapting/not adapting to men's concerns about expressing vulnerability, b) stigma around the 'mental health' label.

Accessibility, it was said, can involve programmes going to locations or settings where men are, or like to be; this needs to be contextualised to take account of different male sub-groups, in different communities. Accessibility involves consideration of physical and social location in a lived community (e.g. a house in a residential street (AKW)), but also of settings for preferred lifestyle practices of male sub-groups e.g. crafts (sheds) (KS); music events/festivals that young males attend (CALM); 'saunas' (RP). Word of mouth and peer recommendation are important for recruiting men (KS, MOJO, YMT, RP). Reaching out to men (especially younger men) via electronic online communication attuned to preferred lifestyles and identities is also an important strategy for accessibility (MTD, TTC, CALM).

Part of a programme's flexibility (see organisation below) might involve developing different activities (e.g. in different men's sheds in different localities) to respond to diverse local contexts. Having more than one activity or offer perhaps makes projects appealing to more men (diversity and choice) and promotes access (KS). An example: a 'boat boys' shed focuses on skills relating to maintaining boats and going sailing, and was established in large part as members wanted to pass these skills to the younger generation. A shed at a fishing venue provides opportunity for those with a shared

interest in fishing to talk about issues beyond this shared interest. Such a flexible approach was seen as important for development of 'prevention projects' on the basis of local need; not a homogenous national product (see 'organisation' later on) (KS, SMN).

"What we're saying is it [the 'shed'] can be anything, and we give examples; it's about what works here [locally] rather than parachuting something in." (KS).

Using appropriate media effectively is important, e.g. especially with younger age-groups where projects developed a web-based presence which is appealing and contemporaneous to the target male group, and invites discrete, anonymous and unobserved, interaction with peers around shared interests, - this can be challenging as the cultural style and content need to evolve (MTD, CALM).

"I think the website helps as many people as the help line itself. A website where people go to search for help and to look for information and to kind of go away and nobody has seen them, its confidential, its anonymous, they've not even had to say anything but they can read other people's words. I think that...because it doesn't look like... where you've got a description of the issue, say OCD or whatever, and its clearly, its not got that huge great mental health hat on" (CALM)

LANGUAGE AND LABELS

Consideration of language and 'labels' is vital for engaging with men. Avoidance of potentially stigmatising language and labels has always been very important, but takes stronger and less strong forms across projects. Considerable wariness of mental health service and service user labels is generally prevalent among programmes (GHH). There is a spectrum of practice here. Trust building is encouraged, on some projects, but not others, through avoiding all (stigmatising) naming of mental health, avoiding identification with mental health services, and rejecting the label 'service user engagement'. Programmes which campaign or offer advocacy view their on-going success as underpinned by avoiding being associated, by men, with mental health services that are perceived

as stigmatising, insufficiently gender sensitive, or even racist (CALM; AKW). There can be a double stigma in some cases where mental wellbeing is implicated in social difficulties, so, for example a project working with men leaving prison prefers the term 'returning citizens' (PPPF).

By apparent contrast, some broadly non-gendered programmes, e.g. national anti-stigma campaigns (TTC), emphasise men's and women's pride in openly speaking with experience, which involves naming mental health concerns, to challenge the stigma (see below). Some programmes emphasise improving access or providing a preventative or early intervention service, within a broader mental health model (e.g. there are health professionals on the board, psycho-therapy is offered) (SAV).

"It's a mojo. I knew we couldn't call it anything to do with mental health, mental wellbeing, journeys of discovery, or any of that crap language...how do we brand it..." (MOJO).

"it is really divisive to use the service user label" "it is for all men rather than service users, not just for men who put their hand up and say they have got mental health problems" "The ethos has got to be something that every guy can feel comfortable with" (CALM).

On campaigns which aspire to be wide reaching, but with a specific target 'audience', a fun, trustworthy offer has been developed through a social marketing approach to branding, media and messaging.

"I want it to be fun, I want it to be edgy and sexy and upbeat and positive and angry or anything but fucking sad or miserable" (CALM)

Peer support is very important for trust building, engagement, and promoting wellbeing. Examples include a). partner organisations' champions supporting people who are about to 'disclose' (TTC) and b). the power of a group of men together to overcome isolation (such as older men; LGBT; or men in crisis) (SMN, SAV, GHH; RP). Peer mentoring and support on activities and in other 'group' or looser e.g. 'virtual' formats is a central theme (PPPF; TTC). This makes men feel better:

"people who connect, and simply talk to each

other, when they have a crisis are less likely to act in a desperate way as they have people to connect with... men who are better connected seem to be in a better place than men who are on their own" (KS).

Effective support can be inter-generational, or same age-cohort: "65 year olds are supporting young men to be better dads" (MOJO). To engage men effectively, most programmes have used a combination of talk and activities of some kind that were consonant with men's familiar preferences and routines for activities, and were fun. This combination, at best, helps to create a salutogenic psycho-social environment. Broadly, talk about life challenges should involve plain language (AKW, GHH). Activities can provide a physical context or a thematic framework for the talk (GHH includes a health improvement pilot based around football, with workshops about men's needs e.g. healthy eating; SMN has sporting memories, quizzes, stories, and also offers physical activity e.g. walking football). 'Doing' facilitates trust which encourages talk, including about vulnerability – "with men, the quicker we can start 'doing' the quicker we can build that trust as they see practical results." (KS)

On some projects, the activities and peer support work together to help prevent mental health issues from developing (KS); though the boundaries (between prevention and early intervention) are not absolutely clear.

"It's prevention isn't it. I think some men don't even realise they have an issue and by going to the sheds the prevention is there, so it stops it before it becomes a real big issue." (KS) "this activity is beneficial to anyone who was a sports fan, because of cognition, because of the way it promotes conversation, friendship, peer support and a fun activity that is therapeutic" (SMN)

The examples of activities that were highlighted include music (MAC UK, CALM), poetry (CALM), sport (SMN), crafts - e.g. making things in sheds; boat maintenance (KS). Social support is clearly vital across programmes in terms of overcoming isolation, (e.g. of older men), feeling part of

something, and sustaining engagement (SMN, KS). “[the camaraderie] it makes you feel part of that group, part of that family... gives them something to look forward to.” “Being seen to be part of something greater than the individual is important.” (KS).

“we know this is a good offer for engaging with men with social isolation, but it is how we reach out to them. One of the things we really want to do is to develop the social prescribing model.” (SMN)

“the biggest issues that we find impacting in LGBT people are invisibility and isolation....And the befriending project really works to, to address that...[we] take them around, show them the scene, show them where everything is, explain things to them, and really just give them the opportunity to see the opportunities that exist for making new friends, getting engaged with different events. And kind of get rid of this idea of invisibility, that there are no other LGBT people out there” (RP).

To keep men engaged, particular projects have highlighted effective processes supporting male identification. As well as making /doing things of practical use and interest; there is a more central focus on talk within some of the projects (MYS, YMT, MOJO, MTD), considered and offered in ways that are seen as acceptable to men. Talking does not have to follow traditional psychological therapy formats, but might include stories, the arts, reminiscence, male role models (not just celebrities but peers) (CALM, SMN).

“ I think that’s the difference, I think this is where we, I think, blow every myth out of the water, that the whole notion of men only talk side by side, I’ve disproven that by working with men who sit in a circle” (MOJO).

Conversations that occur within the projects can, depending on the context, be initially grounded in masculinity, making sure that talk is then perceived as relevant by those men (YMT, Mojo) “you have to look at what it means to be male...its getting in there and having the conversation” (YMT).

Talk can also take the format of allowing people to share their stories. Being part of a group must not

mean the individual man’s identity is repressed (as may have happened through distressing life-course events). Rather men should be empowered to start reclaiming their individual identities by having a meaningful social context restored - for example, for older men, through telling stories drawing on memory around a theme of shared interest or concern(sports reminiscence; personal narrative); or making or doing something of individual, specific value, that is also of interest in the community.

“The focus of the groups is to allow people to tell their own stories, and their favourite sporting memories” (SMN).

“I think it is through stories and through words that culture changes, and that men can find and listen and get the words other men are using to describe what is happening to them.” (CALM).

“By encouraging guys to write their stories down and stick them on the website you can see an attraction build up with people for reading those stories, thinking about it and sending us their stories, so there is a constant ongoing process of new stories coming and going” (CALM).

Successful programmes include safe, calm spaces for reflection (stories can be part of this) or enable a cultural space for being together to develop, rather than exclusively focusing on action and talk. In one project, working with unemployed men with men’s sheds and other opportunities for “creating male space” - “they love the cups of tea” (MOJO), men have also opted in for a range of activities with a contemplative element which can assist in resilience building “they have chosen to do yoga, and meditation, healthy eating, art based projects...they have insisted, they have written their own manifesto, of keeping the notion of wellness and resilience as their focus” (MOJO). The kind of environment which supports a safe, calm space varies according to context e.g. which men, where, under what circumstances - for example, in programmes working with young men, music can be central (CALM). In such a calm social space, often male-only, issues about male identity and possibilities for change can sometimes, in due course, be discussed with gender-sensitive insight,

although perhaps indirectly or subtly (MOJO, CALM): “its really important that there should be spaces where men can feel that they are male and male-only spaces” (CALM).

An essential element of trust building, linked to flexibility, involves programmes engaging with men in order to address everyday life problems including socio-economic aspects (for example housing, finances), prior to or alongside working with their ‘mental health’ (AKW, GHH): “we do it in a holistic way so discuss employment, housing, mental health, addition, financial; we’ve able to get them grants for training” (GHH).

Having a fit-for-purpose inclusive model where participants join in together regardless of labels has been found important to break down barriers, and build trust. Campaigns have aimed to bring together people with and without mental health concerns as a way of improving wellbeing (TTC). This social mixing is a way for building trust - of drawing in the general public, including “subconscious stigmatizers”, in conversations about mental health, with “people with experience” (so changing attitudes) (TTC). The border between prevention and early intervention can become blurred; as people with lived experience volunteer and mix with the general public (SMN, CALM).

“The campaign is very specific about getting people to talk openly about mental health; so being very specific about what you want your audience to do and what you want people with lived experience to do” (TTC).

FACILITATION

A further element of trust is the credibility of the facilitators. The leaders/facilitators should seem engaged, committed, and non-judgemental. Part of this credibility also involves the facilitator being flexible and responsive in relation to men’s voices (MYS). At the same time some programmes made it clear that role-specific skills are important, boundaries have to be maintained, for example (AKW); this can require training (SAV, CALM).

WORKING WITH MEN – FACILITATION

“You’re not getting it out of a book”; “you cannot make stuff up when its experience, you are saying

how it was and how it is, and that’s where the respect and trust is earned” (GHH)

“it has got to be earned; your whole presentation will allow you to do that” “people pick up on that quickly from doing that to get paid to wanting to make a difference in somebody’s life or in the community; you can tell the difference” “People can tell from your body language and how you come across” (AKW)

“we treat people as people; we are non-judgemental” (AKW)

Therapeutic work and mainstream health and social care are seen as feminized; male facilitators can gain credibility from “lived [male] experience” (TTC, MTD) in areas that men can emphasise with, and areas that make it easier for them to empathise with the men; and from being a role model. Having male leadership was often important to ensure the male point of view is well understood and represented, although there could be advantages in prominent female involvement (CALM). For example, Mojo discussed the need for female staff to share their ‘struggles’ with the men in their lives as a way of creating a rapport with the men they are working with. A complex area concerns deciding who are the key influencers to involve, regarding access, communication and prevention, for example involving men-only barbers shops or also hairdressers to engage partners (MTD). There is vigorous debate on programmes about the desirable gender and skills mix of staff (MAC UK). “young people often say that it’s easier to speak to women about the more emotional, maybe psychological side of things and more practically orientated conversations with men, but not exclusively so and very much dependent on the individual and their own experiences of attachment figures” (MAC UK)

“There have got to be guys at the heart of it, going ‘this is how it should be’” (CALM).

The concept of ‘co-cultural support’ was put forward: this involves considering the intersection of gender and other aspects of identity e.g. with regard to counselling (male, gay/bisexual) (RP) and advocacy (male, African-Caribbean) (AKW).

This could be extended to considerations about the age of facilitators (MYS). Underpinning this is the general idea that empathy and trust are based on shared experience; gender, cultural affinity, and age considerations should all be part of that. Co-cultural approaches in some cases by default make gender selections in their staffing choices:

“the thing about our service is you’re guaranteed a co-cultural service. Whenever you attend here, you’ll be working with other gay and bisexual men” (RP).

Some projects do stress a more traditional therapeutic model as part of their work, e.g. GHH, and RP, both of which offer counselling in-house for men. Working in-house is seen as part of being able to create ‘safe space’ for these more traditional therapy options including focus on dialogue;

“it’s in a safe and controlled environment. With the [northern location] males, they are not very good at discussing their feelings so we get that barrier down to some extent” (GHH).

Are particular forms of accredited ‘therapy’ specifically engaging for boys and men? CBT and Mindfulness were discussed (MYS; GHH). For example, a schools-based initiative delivers sessions to young people based on specific topics; “our most popular topics would be alcohol & drugs and relationships & sexuality and CBT and Mindfulness techniques”, followed by one-to-one drop in opportunities (MYS). This was seen to work well with boys, on condition that the topics were developed responsively and flexibly, involving the participants (MYS). There was a view from experience that the talk within class sessions might best be embedded within scenarios and role play, rather than being seen as chat (MYS). Overall there was no conclusive evidence to privilege one specific form of therapy. However some evidence emerged that effective programmes support boys and men to allow themselves to explore change in a positive way.

PERMISSION TO EXPLORE CHANGE

The above aspects of successful programmes, when combined with an asset-based, positive

empowerment approach (below), and with a social model of change which focuses outwards - e.g. on services and the wider environment - as well as inwards, on men’s thoughts, attitudes and feelings, appear to allow men to feel trust in a process which holds hope of change for them. Elements such as, for example, the male peer support, activities, consideration of language, focus on everyday problems in context, sharing stories, and safe space, were said to encourage men to give themselves permission to explore and perhaps reconsider their options. This exploration might, it was suggested, take account of their self-esteem, social interactions, ways of thinking and acting, lifestyles and (male) identities. By doing this, they might develop insights about what change - adapting to changed environments (e.g. for veterans; unemployed men, former prisoners), and moving forwards with resilience - might mean for themselves.

This process may be articulated in different ways, perhaps often subtle and indirect, but sometimes explicit, depending on programme aims, mechanisms, social contexts and the men. For example, a programme working with young men aged 17-25 explores masculinity through a range of creative methods centrally involving volunteers and peer-peer talk in small groups and 1-1 sessions, and including making films, and creating diaries. These approaches challenge traditional ideas, by using traditional concepts but in transformative ways, introducing terms like “mental fitness”, where speaking out becomes permitted as a sign of masculine courage –

“it’s a sign of strength to be able to see you have problems and seek help; that’s brave, that’s courageous, that’s strong”, “there are all these different forms of masculinity but it doesn’t make you less of a man” (YMT).

EXPLORING CHANGE

“Only two common things then men have is that they are unemployed, and they are motivated to change” “a session at the men’s shed tomorrow night ...they are going to identify what they might feel like if their mojo is in place, what do they need

to do on a daily, weekly, monthly basis to work towards that...they will leave with a two page plan” “they’re very different in how they think and behave and I believe it’s because they felt they have permission to be different.” (MOJO)
“they want to change their lifestyle, they just don’t know how to go about it. So we’re giving them the opportunities” (GHH)
“Man dictionary campaign is particularly about tossing around definitions, some serious, some not so serious but really pushing the ideas that we need to talk...you know what does it mean to be a guy and luring them to the website by getting them to laugh and come up with their own definitions” (CALM).

6.2.2 IMPROVING MEN’S JOURNEY TO MAINTAIN WELLBEING

An important theme is that trusted, male-accessible and engaging programmes or elements of programmes can then effectively improve the journey for some men to maintain wellbeing through addressing life issues and where appropriate accessing services. This particularly includes promoting, where this is appropriate, early intervention. For example, with male suicide prevention work, when men use a trusted, non-stigmatizing, anonymity-protected online route to talk about feeling distress, their access to a helpline, or (for younger men) web-chat (CALM), can be made quick, whereas referral to mental health services through the NHS is often slow, requiring men to feel safe to attend and to receive a diagnosis in the first place (CALM, MUTED). Action-focused project elements can also provide opportunities for signposting to other services (MUTED, MAC UK). For example, for young men formerly in prison “bringing them into mainstream services is the aim” (MAC UK). The success of such a project partly depends on it having a unique place - doing something that mainstream services are not replicating. This uniqueness is likely a reflection of working with a strong social model “we don’t want to just duplicate services that exist already for people or to kind of step on the toes of a mainstream...but we do definitely want

to work in partnership to see if we can add value through our model and through community ways of working” (MAC UK).

Developing a social prescribing model was also an ambition, so that health services partners would recognise the potential of community based early intervention programmes (SMN).

More broadly, and equally centrally, facilitating men’s journey to social inclusion is an important goal on several effective projects. This involved using a social model, providing practical support, and signposting to access much-needed resources so that men can address daily life issues such as finances or housing, which can strongly contribute to men feeling bad (PPF, AKW). Another way of promoting full inclusion is that discussed above: having groups and activities which are inclusive of wider society (TTC, CALM).

“It’s very practical stuff we are dealing with, its housing, mental health, making sure people get to their social worker...it can just be picking someone up from the gates” (PPPF).

Supporting men to build trust through engaging activities and avoiding stigmatization, and supporting their journey to maintain well-being and to social inclusion calls for national and local partnerships (TTC, SMN). For example, a project working with ex-offenders has developed a strong relationship with specific prison services to facilitate working with prisoners pre-release in areas including setting up bank accounts, has engaged with parliament to pursue structural change, and works with social services and housing services to support men to address life issues on release(PPPF).

6.2.3 CORE VALUES/ETHOS

With many of the projects, strength of feeling around their core values was evident. Retaining an approach grounded in core values or a prevailing ethos was seen as vitally important across successful programmes. Values often revolve around ideas which combine a social focus and concern for the individual, including:

- Person centred approach

- Community centred approach
- Reciprocity
- The importance of lived experience
- Empowerment
- Honesty
- Non-judgemental approach

PERSON-CENTRED

A core element of programmes' concern for values or ethos consists in showing full respect for the individual men who participate. This means taking account of their needs holistically: "we support the veterans, plus their families, plus their dependents, and we do it in a holistic way" (KS). CALM, for example, emphasised not forcing people to wear the "mental health service user hat".

"It is for all men rather than service users, not just for men who put their hand up and say they have got mental health problems" (CALM).

"The ethos has got to be something that every guy can feel comfortable with" (GHH).

COMMUNITY CENTRED

Many successful programmes explicitly outlined a community basis to their values. At least some programmes refer to roots in specific geographic communities (SAV, KS, AKW), others embedded themselves within community environments. For example, sporting memories are associated with men's sense of collective belonging with sports clubs, and the success of reminiscence projects partly comes from this community resonance (SMN). Other successful projects have a very clear sense of the community of shared identity, interest, or geography they represent (AKW, RP).

"Our job is about ensuring that mainstream and other services meet the needs of our community" (RP).

Being grounded and person- and community-centred implies that an effective programme needs to be developed and delivered in a flexible responsive way, not set up to follow funding opportunities but to follow local/regional/national need, possibly building on best existing practice (so, for example, a federation of sheds could

emerge from the existence of local sheds).

"We found that with the shed here, when we were speaking to them, they were already a shed before we came along... so it's building on things that are already happening" (KS).

RECIPROCITY/MUTUALITY

There is a strong theme of reciprocity, - "the two way street ethos" - (GHH), an aspect of a widely prevalent social model in these programmes, linked to the programmes' values and their thinking about partnership. This reciprocity includes male participants' peer mutual support - for example, mentoring or passing on skills may appeal to men who find that social contribution is salutogenic and enhances a sense of coherent, positive masculine identity. It also applies at different social levels. For example, men can contribute to sports and cultural organisations' historical collections, while sports clubs can give something back to men who supported them for all those years (SMN). Working with partners involves partners admitting that this is their challenge too; and they can both contribute and benefit. For example, big companies benefit from wellbeing in the workplace (TTC); sports museums benefit from men passing across social narratives (e.g. memories of the World Cup 1966 provided to the National Football Museum) (SMN). The concept of a fair 'exchange' expands structurally upwards in one project to 'restorative justice' (TTC).

LIVED EXPERIENCE

The idea of key members having 'lived experience' recurs widely (TTC, MTD). The ideal of people with 'lived experience' leading change was emphasised; as champions within an empowerment model (TTC), and through engaging with the public (CAL, MTD). For example, it was said, concerning anti-stigma work, it is vital to have a national campaign that the public engage with; and a campaign that empowers its secondary audience, that is, those with lived experience, to speak out and be part of a movement for change (TTC). Then, it is important to follow up with grassroots projects where individuals with lived experience are supported to lead events. Putting people with 'lived experience'

at the centre of transformative processes raises further considerations about the use of labels in engaging with men, which calls for close consideration of contexts, language and models of change. More widely, it is potentially empowering for men to be able to speak out in groups of men with similar experience (KS). Peer mentoring models are widely supported (PPPF). Putting individuals and peers at the heart of a course or programme means being flexible and responsive over pacing, direction, style etc (GHH).

EMPOWERMENT

A prevalent theme is that programmes that are asset-based can engage men with lived experience in a way that is empowering, and through this process can change their lives and impact on wider society and services. Most effective programmes involve men in developing their activities (KS). Locally grounded programmes involve users from the start in planning and developing resources and activities. Empowerment of people with 'lived experience' can be developed by having volunteers with lived experience in leadership roles; particularly by having target audience/users/members involved in planning and designing programme events, or on a programme board (SAV, MYS, MAC, GHH). "We are very person-centred, we would take the lead off the guys" (GHH). "The shed will be what the men want" (KS) "men as equal partners" (MOJO). 'Local' grounding in the way projects are set up from the start was felt to be important for this empowering approach (SAV; KS). Legitimising men's involvement in programmes is important, with an asset-based approach, starting from a positive view of strengths the men bring (KS, CALM). This then means being careful about partnerships which might undermine that approach, e.g. with partners not trusted by men.

EMPOWERMENT AND CHANGE

"The absolute core value of any anti-discrimination or anti-stigma programme we believe should be people with lived experience in leadership roles and delivering this message. It is much more effective, and is what we believe is, should be

about empowering people, not just empowering the public, empowering people with lived experience to lead that change" (TTC)

"It is advocacy as a whole...it might be they need representation at meetings; if they are not confident to say themselves in front of these professionals how they feel, we can express what they want; or empower them to have a voice because of the information and confidence building they have had in preparation for that". (AKW)

"They have contributed last year about half our income. So the user engagement, engagement of people is for me the most outstanding thing about CALM. It is the individuals who take up and say this is our charity. Those individuals might be DJs, local student, local businessmen, people in the music business, sportsmen, and they go 'this is my campaign'. Also ordinary kids at uni. going 'this is my charity. I'm doing this'. A club night or a football match or a boxing match..." (CALM)

There were also suggestions that it can be empowering for men in a safe space to give themselves permission to explore facets of identity at a remove from traditional 'hegemonic' masculine ideals: "that kind of nurturing side emerges from some of these really tough men" (MOJO). Empowerment of men means that on many of these programmes success is also gauged in their terms: men themselves verbalise this success. "A man yesterday said 'without this project my voice would not be heard. I would be in an out of the penal system' " (AKW).

Important aspects of 'ethos' were also highlighted such as: creating and living by values, commitment, user voice and rights, learning from practice, cooperation and trust in partnerships and practice. Further important values were mentioned such as honesty, being non-judgemental and working with passion; "We do what we say, and we say what we do. And we don't promise things we can't deliver. We don't sit down and paint a rosy picture..." (PPPF); "for me I think it's important that someone feels passionate about it" (MOJO).

VALUES AT THE HEART OF PROGRAMMES

“It’s about not only just creating and creating values but living by those values as well” (RP)

“Most organisations have values but we very much, everything we do is underpinned by our values and our values are underpinned by our practice” (RP)

“Being honest, being 110% above board. We have to be as we are all ex-offenders,” (PPPF)

“Commitment is key, from the Chairperson to the rest of the committee and staff” (SAV).

“First and foremost with a vision, with the right people, and importantly, more than a business plan, when this was set up informally at the time, we had a vision, with the strong voice of service users, their rights, their engagement not just tokenism; and also highlighting the gaps in the services positively, and also, highlight good practice and what has worked well” “in a partnership you do it in a cooperative and positive way, highlight where it is working well” (SAV)

“Our vision can change from month to month but our values to reduce harm to communities that will never change, ...at the end of the day we would like to make ourselves redundant there should be no need for us, but that’s a long way away” (PPPF).

6.2.4 CHANGING SERVICES; CHANGING SOCIETY

A strong theme around facilitating change is evident within the projects, and this can involve changing services as well as broader societal change.

CHANGING SERVICES

A recurrent, albeit challenging theme is that, as many ‘mainstream’ services have failed to engage with men effectively over well-being, and in some cases have engaged with men detrimentally, effective programmes can and should challenge services to change, including mental health services, and other services that affect men’s health and wellbeing, e.g. within the criminal justice system (police) and welfare systems. At the same time, many of these services are also, necessarily, partners for programmes supporting men to achieve their goals. There is a need for

effective programmes to be self-aware about their relations with partners; for example with police.

“It’s tough. It’s almost, it’s a critical friend, we would refer to it like that, it’s a critical friend” (RP).

In some cases there is a need for severe critical engagement as a pre-condition for any constructive partnership. For example, there was consideration, from a project working with South Asian men, of major barriers to working with the DWP around men with mental health concerns, concerning benefits and possible fitness for and preparation for employment (SAV). Specific criticism concerns application of the ‘fit to work test (Work Capability Assessments)’, which has been sub-contracted through DWP to Atos Healthcare, (a division of multinational company Atos), and subject to intense negative scrutiny.

“there is not enough consideration with emphasis on getting back to work, when they attend a benefit assessment, they go ‘can you walk’; there is no consideration for mental health, motivation, mood, feelings, risk: no preparation time or support for this session, and in a genuine way because it is their problem, they are not just creating; so they get scared; benefit stopped”. (SAV)

In terms of constructive, critical engagement, it was argued, on programmes specifically working with African Caribbean communities, that a restorative justice model for promoting dialogue (currently being piloted) can be effective in achieving the dual objectives of enhancing young black males’ self-esteem and bringing about changes in services that have been identified as institutionally racist (AKW, TTC). Much will obviously depend on implementation and how far the dialogue is embedded in on-going strategies for structural and attitude change.

“The uniqueness is working with a very, very isolated part of the male population, young African Caribbean men, and working to engage them and empower them to tell their story to the very professionals with whom they had previous negative experience; the police and mental health professionals in their area” (TTC)

“Both sides share their stories, the professionals

as well, so it is a proper dialogue based on a restorative justice model.” (TTC)

“The ability of mutually respectful conversation to transform people’s self-awareness really”. (TTC) In the long term, promoting necessary structural change in the mainstream implies that a project would eventually be less necessary in its current form (RP).

“Effectively, as an organisation we say we’re working ourselves out of a job. We don’t want to have to be here for the next 20 years, although we probably will be. Our job is about ensuring that mainstream and other services meet the needs of our community” (RP).

“We’ll always change, we’ll always look to change... society needs to give people a second chance, and a third and a fourth chance. What we are looking at is creating safer societies... hopefully we’ll bring people along with us who take our whole asset based approach on board”. (PPPF)

CHANGING SOCIETY

A powerful theme, reflecting a social model underpinning much of the best work, is that effective campaigns and programmes should change society, not only impacting on the attitudes and behaviour of the ‘general public’ but also of powerful and important organisations and institutions. Mental health is seen as having a complex relationship with social and environmental risk factors e.g. deprivation, unemployment, prejudice and stigma, and with social consequences e.g. with offending/reoffending behaviour, the ability of young men to integrate/reintegrate into society, and the experiences of gay/bisexual men (PPPF, GHH, MAC, Rainbow, YMT, MYS).

“We believe there is an interaction between young people and their environment, if their environment doesn’t shift then their behaviour will not improve” (MAC)

INCLUSION AND TARGETING THOSE IN PARTICULAR NEED

A challenge in defining the boundaries and priorities of a programme is to focus on

intersecting factors most likely to increase risk for a particular set of men, while not losing all focus on inclusiveness. Anti-stigma campaigns (TTC) started by targeting the ‘subconscious stigmatizers across society, with particular focus on men and women of “B, C1 and C2 demographics”, (a social marketing component: ‘insight work’ was conducted with those groups). As a result of this the campaign targeted men’s media e.g. Loaded, Rugby World. Later, on the basis of emerging evidence about levels of attitude change, they planned much more closely targeted outreach, for example involving young African Caribbean men, police and mental health professionals. The target groups of men and their social context, which influence the shape of programmes, vary greatly. A federated approach, or some other structural model allowing local flexibilities, was implemented to support local projects to target local need effectively e.g. include male carers, men with drug and alcohol issues, in different localities on the Sporting Memories project (SMN).

Not all programmes are men-only (MYS). Some effective programmes have a non-gender specific and broad target audience e.g. students in schools (MYS), the general public ‘subconscious stigmatizers’ (TTC). This is a complex area, preventative promotion work with young people, for example, should often retain a ‘society-wide’ scope, not only picking out those labelled vulnerable but also those with influence (MYS). There is always creative tension in campaigns between universal reach and targeting; both are needed (TTC). Learning on programmes can lead to strengthening the targeting of males (TTC, SAV, AKW), as well as of specific disadvantaged sub-groups e.g. Traveller Communities, with a heightened risk of suicide (MYS); African Caribbean young men, with a heightened risk of imprisonment; sectioning (AKW).

There are often advantages, it was reported, in having reasonably flexible boundaries for accepting men. For example, several projects (e.g. SMN and KS) also include men outside the main target age range - this promotes inclusiveness, and works against ageist assumptions, even while the main focus is on a particular group. Again,

not all men on Sporting Memories Network projects have dementia (SMN), not all men on Kent Sheds are veterans (KS) - although projects recognised a need to monitor boundaries and be clear about their core audience and values. Some programmes, although mainly directed at males, include females (KS); some attribute specific strengths to women in particular roles: views vary with the complexity of this.

The importance of working towards inclusion of men who may otherwise be missed due to social inequalities of provision and outreach also occurs in areas which pose particular challenges, e.g. remote, rural and older people retirement areas where older men might be particularly isolated (SMN), where particular groups require focus for inclusion e.g. LGBT (RP), or in parts of UK which pose particular challenges e.g. Northern Ireland. There are regional political challenges e.g. in Northern Ireland

“the north gets left behind quite a lot. It’s particularly difficult at the minute and some of the political context we have to deal with” (RP).

Potential gaps were also highlighted, concerning vulnerable groups of men in contexts particularly impacted by socio-economic and/or gender inequalities. These vulnerable groups include isolated older men, (SMN, RP, MOJO); unemployed (SAV, MOJO); those with drug and alcohol issues, with dual diagnosis where the health services are alleged to focus, typically, on addressing substance issues prior to addressing mental health (CALM, RP); homeless men (PPPF); young fathers in mental health support (MAC) .

Inclusive programmes promoting intergenerational work between older men and younger people can break down barriers at the intersection of ageism and gender (SMN). Campaigns which succeed in inspiring lead figures in large organisations with traditional ‘masculine’ cultural elements such as construction companies, banks, energy suppliers, to ‘come out’ about mental health can potentially impact on the experiences of employees within those organisations, and perhaps most importantly, lead to organisational change through dissolving barriers between ‘us’ and ‘them’;

with the recognition that substantial changes in organisational policy and culture must often accompany changes in individual attitudes and practice for change to be enduring (TTC).

Lobbying to change policy or practice at macro-level is a part of what many organisations do. For example, one project (PPPF) has been trying to get legislation through parliament so that prisoners are not released on a Friday as there is no support available over a weekend for those released.

6.2.5 ORGANISATIONAL APPROACHES. SUSTAINING CHANGE

The organisational approach of projects clearly plays a central role in how they are delivered. Some of the key aspects of this theme relate to areas such as scale, partnership working, flexibility (either related to organisational size, or the interactive, responsive approach embedded within the social practices they promote) and the staffing of projects.

Some of the projects discuss their organisation’s size as a positive attribute, i.e. with the concept that ‘small is beautiful’. This can be seen in terms of their wish not to be completely assimilated by social forces that block change; to remain distinct.

“We don’t want to be another cog. There are over 1300 organisations working with prisoners. I suppose we want to be the oil in the machine” (PPPF).

Similarly, by keeping bureaucracy low projects identify that they are able to invest their (often scarce) resources where they see these to be most needed (MAC). The concept of running a “tight ship” (MTD) is also proffered, again highlighting the idea that an organisation’s command of what is happening is important. Core staff numbers are often very small, even in organisations with bigger reach (SMN; PPPF, CALM).

At the same time, as mentioned in section 2 (above), supporting men to build trust through engaging activities and avoiding stigmatization, and supporting their journey to maintain well-being calls for national and local partnerships (TTC, SMN). Partnership building has been a prerequisite for success from the start (KS; SMN; TTC) and

strengthening partnerships was a recurring theme. “What makes us successful is our strong partnerships with other people” (PPPF). Effective programmes develop partnerships strategically, in relation to their aims and objectives, as well as flexibly in relation to emerging evidence of need. For example a national anti-stigma campaign includes a partnership of funders, (e.g. Government and Big Lottery); partnerships for national delivery (e.g. two large national mental health charities); partnerships with employers; partnerships with influencers such as sports clubs and marketing outlets reaching males (e.g. TalkSport radio, men’s magazines), and partnerships with community organisations working with specific groups e.g. young men in African-Caribbean communities (TTC). Partnerships need to be built and consolidated steadily in advance: “we had spent a year developing the project and interagency pieces” (MOJO). Partnership implies aligning agendas, finding champions, thinking through the impact of partnership on the project and its acceptability with men. Partnership arrangements should not compromise the organisation (PPPF). Good partnerships involve effective communication, and clarity about what each partner brings e.g. complementary skills (TTC, SMN, KS). Partnerships can be seen to be a good way of embedding a project carefully in the community in which its located (MYS, YMT, Mojo, MTD): “partners have been key to making the project work....its grounded in the communities” (YMT). Projects need partners with complementary skills to assist them to tender and to be effective in a transformed commissioning environment. (AKW, RP). “Particularly the way work is moving now. A lot of our work, our counselling work, our sexual health work, our mental health work, is directly commissioned by health and social care trusts, but a lot of the contracting now is moving on to a much wider, all-encompassing basis with the LGBT tie on then. So, rather than us trying to take on work which is outside our remit, and that isn’t directly related to what we’re trying to achieve, we need to work in partnership” (RP).

To maintain change, programmes have to learn and adapt; applying principled flexibility. They have to keep updating their offer or their response to appeal to men as social environments change and men’s lives change (CALM; MAC UK); they need to learn from organisational experience and target more effectively (MYS; TTC); and they need to develop new funding opportunities (AKW, CALM).

A theme is that organisations need to be supported to develop organisational capacity to grow to meet the scale of need (SMN), or to adapt, survive and thrive in a harsh and changing environment. ‘Growth’ is not an uncontested value: some models of expansion can be seen to conflict with being grounded, and flexible (MAC UK). The need to compete can lead to pressures to compromise core values (PPPF). For example, small voluntary organisations working with men find themselves competing with larger and sometimes private-sector profit-motivated organisations.

“We would like to take Sporting Memories to Australia, to the States, to India, to the big sporting nations” (SMN)

“The awards shows that this really resonates with people and we have got a real groundswell and momentum, we just need that capacity to grow it” (SMN)

One strongly advocated model for national campaigns and programmes might be called a ‘federated model’. This involves a programme with national reach winning or sustaining local commissions (SMN) to continue a service after initial funding runs out, implementing the training and developing the capacity required at that level, and retaining a fit-for-purpose national presence for governance, standards, shared resources, and so on (TTC, SMN). It was also said that with such a model, using regional or local leadership, learning from one region can be applied in a different one (SMN). There was also discussion of a ‘franchised’ approach (PPPF; SMN). A regional network approach was also described (KS), where projects have been embedded within a group; which could grow, perhaps by developing ‘hub’ projects. The strategic development of regional hubs and sustainable regional partnerships as well as local

groups to carry on work previously done through time-limited national funding is also seen as the way to sustain national anti-stigma campaigning (TTC). A common factor in these approaches is that any 'expansion' needs to be achieved without losing touch with local assets or losing support from within existing initiatives.

"building up regional hubs that bring together the organisations that can do this work and can find the resources and individuals with lived experience who want to champion change that aren't connected up to these groups. So building regional hubs that we won't fund but will help co-ordinate, and then providing some matched funding for events was our ideal plan for the next couple of years, and then expecting them to sustain on-going funding of local anti-stigma initiatives" (TTC)

Concerning governance and decision making, the importance of representation of men with experience in the organisation, through governing and participatory structures, was stressed (SAV, TTC). At the same time, determining the degree and nature of involvement involves complex considerations, for example some men may not be ready at a specific time to direct change in organisation (AKW).

COMMUNITY AND LEGACY

An aspect of a grounded approach is that successful programmes with a social and community model plan to leave a legacy of sustainable provision in and for communities - and so to reach more men in time, while protecting core values. Ambition to spread the legacy geographically was more pronounced in some than others.

"through the big lottery and a programme called Space and Place, we're seeking investment to actually buy a centre that will be here for the community forever" (RP).

"communities do it for themselves either through pots of local funding or through feeling empowered by our movement" (TTC).

"What has allowed us to be sustainable all this time is that we are an organisation that has got

service users at the heart; we are based in the heart of the communities, our networking strategy, people know what we do and that we do it very well" (AKW).

Continued investment in research and evaluation is advocated, so that programmes could have clear evidence of determinants of issues such as male suicide; demonstrate effective responses taking account of those determinants, and identify aspects of effective interventions (CALM, SMN, MAC). Being able to demonstrate success is a strong theme, with some discussion of what success means to programmes internally; (e.g. men's well-being, integrating well in communities; having healthy relationships with others, sharing their skills - (KS)), and recognition that funding depends on measuring success. Understandings of what success might mean and how to measure it is built into programmes' planning, and considered with individual men on the projects. Yet, this understanding includes much flexibility, responsive to community environment factors and programmes' person-centred and empowering ethos. Many successful programmes also plan to demonstrate success with appropriate measures that not only represent men's own voiced perceptions but also help to obtain further funding. For example, working with older people with memory loss, it would be good to show that the programme promotes perceived wellbeing, and promotes physical exercise, which leads to demonstrable changes in service use and better health,

"perhaps less hospital admissions, perhaps less anti-psychotic medication for those with dementia, perhaps reducing social isolation" (SMN).

Campaigns seeking to change attitudes or to prevent suicide, for example, have demonstrated success through their systematic data collection and analysis over time, concerning stigma this has involved sampling the general public, targeted group of men, and those with lived experience

6.3 SUMMARY

This chapter has reported on a range of key insights from successful projects focusing on prevention and early intervention with boys and men, and, about 'what works, for whom, in what contexts, and how'. The projects represent some of the great range of interventions on the ground, including a major anti-stigma campaign; and a rich variety of approaches in terms of scale and targeting different groups of boys and men. There is no one size-fits-all recipe for success. For example, programmes vary by context in how they balance inclusiveness (as exemplified in interventions in schools and anti-stigma campaigns) and targeting (more at-risk groups of boys and men); in the balance struck between celebrating men 'with experience' coming out proud about mental health, so challenging stigma and potentially repositioning masculinities, and avoiding 'divisive' clinical terminology to engage with men. They further vary in the types of intersection that they encourage between social setting and psycho-social safe space, and between action and talk. There is some distinction between the settings and blend of activities and talk used with older groups of men and those with younger men, as well as to engage with men 'at risk' from varied (although possibly intersecting) identities and communities of geography and interest.

Still, clear broad principles were affirmed. The importance of building trust through male sensitive social practice has been highlighted, creating 'safe spaces' through using accessible settings where targeted groups of men are likely to engage, interesting activities that facilitate talk, attractive media and language, and encouraging dialogue and reflection in modes acceptable to men. How this is done varies greatly by context. Successful projects need to be flexible and embody gender awareness in planning and facilitation. Trusted male-accessible and engaging programmes can effectively improve men's well-being by, when appropriate, enhancing their access to resources so they can address life issues, and by facilitating access to services when required. The successful projects were grounded in core values including

a social focus (e.g. addressing the intersection between inequalities, social-structural dislocation, community deprivation and gender factors on mental health) and concern for men as individuals (e.g. in coping with key transitions in their life-course, such as leaving prison, returning from military service, family bereavement, fatherhood, separation and divorce, coping with onset of memory loss, physical ill-health, migration, coming out in terms of sexuality or mental health recovery). The projects in various ways found it necessary to work towards positive social change and to constructively and critically engage with and challenge services, while also empowering individual men to explore alternatives. Programmes aimed to remain organisationally grounded, close to communities and driven by the concerns of men, while also developing appropriate partnerships and adapting their skills and resources to survive and thrive in a precarious and changing political and socio-economic environment. Models for sustainability and ensuring legacy for communities were actively explored, for example through increasing representation of men with experience in organisational structures, and through forms of regional and local federation and autonomy.

7. EXPERT SYMPOSIUM (WP4)

7.1 INTRODUCTION

Day-to-day knowledge about what works in reaching out to men and boys with regards to their mental and emotional health exists at many levels of service provision. The aim of the symposium was to tap into this tacit knowledge of health experts from academia, third sector and statutory organisations involved in policy and practice in order to inform the overall environment scan being undertaken for the Movember Foundation.

The event provided a platform for commencing aspects of knowledge dissemination from the earlier work packages into organisations that may have influence or may likely be adopters of the learning generated.

The focus of the discussions within the symposium was intended to generate ideas and suggestions about how future interventions and policy could be best implemented to improve the mental health of men and boys. The working objectives for the day were:

- to provide space to undertake some 'blue sky' thinking on what could be achieved if resources allowed
- to hone expectations based on current experience from those in the room as to what is actually achievable.
- to generate a consensus on priorities for what should be tackled as we move forward.
- to facilitate discussion on the respective roles of policy, practice, voluntary organisations and the Third Sector in meeting these priorities – i.e. what is needed to make this happen?

7.2 APPROACH TAKEN

Ethics approval was obtained for the symposium through the Leeds Beckett University Ethics approval process. Consent forms along with information sheets were sent to the delegates ahead of the event.

The day was structured (see Appendix IV for the schedule) to give a morning of presentations aimed at informing attendees of the key findings of the current study (Prof Steve Robertson), an overview of the academic base to boys' and men's mental health (Prof Damien Ridge), the perspective of the 3rd Sector (Paul Farmer, CEO MIND) and a policy perspective (Gregor Henderson, PHE Mental Health Lead). In addition there were two user perspectives from the Voices of MIND team, one representing a young man's perspective and the other an older man.

Information gathered from the key speaker and user presentations was used as the base for the afternoon session. The symposium delegates were split into three groups, each with a facilitator and a scribe with the following questions being considered:

- What are the priority groups of boys and men that should be targeted?
- What are the best settings for working with boys and men?
- What are the most effective approaches for reaching out to boys and men?
- What are the training needs for those working with boys and men?
- What are the research gaps in working with boys and men with regard to their mental and emotional wellbeing?

The comments generated through the above questions were then used in the final whole group session to identify a consensus on priorities for what should be tackled in the future with regards to mental health promotion and provision for men.

We invited over 60 people from key statutory and third sector/NGO organisations to the symposium

who had been identified through discussion within the project team, the wider network, and in consultation with the Movember Foundation (a list of those who attended the symposium can be found in Appendix V).

The day's discussions were audio recorded to facilitate analysis. The information from the three discussion groups were then subjected to thematic analysis and the themes were then subsequently independently member checked.

7.3 COMMON THEMES GENERATED FROM THE THREE GROUPS

- 1. Initiatives/services need to be responsive to men's needs**
 - All men are potentially at risk of mental and emotional problems.
 - Where possible, interventions should be tailored to the individual, however organisations should at least ask men what it is they want from the service and provide choices to suit all.
 - There needs to be recognition that many men do not have the language or understanding of the issues in many current health promotion campaigns.
 - There may be need for bespoke services for some men, but we also need to have current services adapting to be more appealing to men.
 - Reliance on a medical model is insufficient and a socially orientated approach is also needed - not as a replacement, but to add a different dimension.
 - Pre-crisis management is important, with systems and services in place to pick up early signs of mental ill health and support men who are struggling.
 - When designing initiatives/providing services it is important not to gender stereotype (either for men or for women), for example not all men are interested in sport or DIY and may not want to do activity based programmes. This risks excluding some men and making their problems worse by feeling they do not conform to the stereotypical male cultural values.
 - A good understanding of the wider social determinants of health and the impact of socio-economic factors is as important as gender for many men's problems.
 - Aggression and 'anti-social' behaviour is often an important indicator of underlying emotional and mental health problems.
 - Use of mental health terms may discourage men – this can be an issue for some initiatives that are developed by organisations strongly associated with mental health.
 - On-line provision and telephone support lines can offer ease of access, information and the anonymity that some men require to open up.
- 2. Creating an appealing environment and safe space**
 - Men need spaces to go to that are signposted as a space for men and promote a sense of mutual commonality.
 - The environment needs to welcome men with warmth and acceptance.
 - The space needs to be non-medical - men are unlikely to disclose suicidal thoughts to a GP, which is reflected by observations that many men who commit suicide have recently visited their GP.
 - The space needs to create a mutual commonality where men can feel safe, able to speak and disclose personal and sensitive information and feel confident that someone will listen to them, without judgement.
 - Finding informal settings for men to meet may involve bars; this link with alcohol needs to be handled carefully.
 - Online provision may provide a safe space for men to explore their mental health issues.
- 3. Peer support and self-help**
 - Men need to have support outside of services and initiatives which will provide help when these cannot be accessed or in times of immediate crisis, as well as promoting long-term maintenance of good mental health.
 - Peer mentoring/role models/befriending could be useful and may help reduce social isolation, as can being able to bring a friend to the services (a help-seeking legacy).
 - The use of online resources to help build real and virtual communities that can offer support to men is growing.
 - Equipping men with tools to create a plan of action, which will allow them to cope in times of crisis when they cannot quickly access external support services.
 - Men need to know that the other men accessing services are (just enough) like them to ensure continued buy-in.

-
-
4. Acknowledgement that mental health is affected by physical health and social issues
 - Physical health, particularly chronic disease and serious injuries can affect mental health. Similarly homelessness, poor housing conditions, unemployment and disability will also affect mental health.
 - Mental health interventions should not just be placed in mental health settings.
 - Evidence should be collected from interventions that are primarily designed to address these physical and social issues to establish whether they have a positive benefit of mental health. As an example, a weight-management intervention may improve self-esteem and confidence as a result of weight loss.
 5. Society and culture needs to change to improve gender equality
 - Many of men's problems and the possible solutions lie within our communities - as a society, we must ensure that men feel valued and are not simply disposable, for example by placing importance on the role of fathers in childcare so men have stronger family connections and feel valued.
 - Need to move towards a "big society" and social agendas, to re-establish communities and promote social connections for men.
 - There needs to be recognition that many men are isolated and living alone, with poor social networks and weak social capital, and this is across the lifespan.
 - There is a need for society to change the way they address men's problematic behaviours, i.e. not simply using punitive responses.
 - Cultural change is needed to make it easier for men to talk. Men can be resistant to talking about mental health, and wider society resistant to understanding that men cannot always cope with life. This resistance means it is easier for men's experience of mental health problems to go unnoticed.
 6. Intervention and education must be incorporated into early years and provided regularly throughout life, particularly during key transition periods.
 - Stigma still exists - some progress has already been made with changing the use of language relating to mental health disorders but more work needs to be done. Online resources which provide information on mental health disorders are also helping to reduce stigma.
 - Change is needed from the media, which has a significant influence on gender roles; it is currently reinforcing negative gender stereotypes.
 - Lessons need to be learnt from women's health and feminism as to how they got women's inequality issues onto the agenda.
 - Education to reduce stigma is also needed at an early age.
 - Boys and young men should be given more compassion, relationship training and the tools needed to manage crisis in their lives.
 - Emotional literacy should be taught to young men, with space for facilitated conversations throughout their schooling to help them express themselves – this may reduce aggression as a negative form of emotional expression.
 - Personal, Social, Health Education (PSHE) should be gender informed/gender sensitive, with greater access to externally supported services; 'Schools are the ultimate upstream setting which will pay off later downstream'.
 - Young men tend to approach services when they are in need, which often coincides with key transition periods in their life e.g. leaving school, changing schools, starting

³ "Big Society" is a Coalition government ideology defined as 'A [concept](#) whereby a [significant amount](#) of [responsibility](#) for the [running](#) of a [society](#) is [devolved](#) to [local communities](#) and [volunteers](#)'.

-
- work, unemployment, becoming a father, major illness, divorce, disability, widowhood, retirement. Regular support should therefore be targeted during these transition periods when they may be at an increased risk for mental health problems.
- Families need to be supported when children are in their early years, with more importance placed on the role of the father than is currently.
 - We have an ageing population – the mental health of older men is a growing area of concern, with resources, creative thinking and interventions required for preparation for retirement and on-going guidance on keeping mentally and physically fit and well.
 - More research and practice development is needed to support men with dementia.
- 7. Vulnerable groups need to be targeted**
- GBT+ men, ethnic minority men, ex-forces, men in prison and young fathers are specific groups to target.
 - There is an over representation of ethnic minority men in the criminal justice system, which may in part be due to undiagnosed / miss-managed mental health issues.
 - Preventive tools are needed for boys and men who are known to be heading for later problems, e.g. at risk groups such as those excluded from school, looked after children and those heading towards the criminal justice system.
 - Vulnerable and deprived groups are likely to have less access to resources which increases the risk of widening the health inequality between social classes, such as the homeless, migrants, and asylum seekers.
- 8. The importance of leadership figures and the state to facilitate change**
- In England, Wales and Scotland, there needs to be greater awareness of the legal requirements of the Equality Act by service providers.
 - In the Republic of Ireland the Men's Health Policy should be used as a vehicle for change.
- Sustainability, with long term effectiveness, needs to be the basis of decisions - not quick fixes and financial savings.
 - Changes need to be led by the government – they need to challenge the negative stereotypes portrayed by the media, and speak out and highlight the scale of the problem we have with men's mental health and male suicide. This needs to be echoed by significant leadership figures. Support from those in position of power and authority is likely to improve funding opportunities in this area and enable specialist services commissioned for men (i.e. support for fathers) to be accepted by everyone and seen as important.
 - Councils have a significant role in influencing local resource allocation, with greater collaboration with local health boards to ensure the importance of this issue is recognised.
 - Policy development in mental health needs to ensure it reflects men's (and women's) specific needs.
 - Commissioners need to change the way services are delivered - services are often commissioned on a short-term basis with the aim of moving people on to work/ skills programmes. These do not always allow sufficient time to build rapport and trust with each individual. These should be commissioned in ways that facilitate support for as long as the individual needs (which is the case with physical problems in health services).
 - Public health need to show increased concern for the area of male suicide – more men commit suicide compared to the number of people killed on our roads however it was felt that more funding and greater priority is placed on improving road safety than male suicide. This needs to change in order to highlight the issue and make men feel valued.
 - Workplace leaders need to ensure the culture within organisations is supportive of sharing concerns and is not adding to men's mental health problems.
 - Strong leadership is needed within the sector

to avoid a silo mentality and to promote open and constructive collaboration.

- There is a need to lobby the WHO to reinforce the need to recognise 'men's health' as an issue.

9. Training needs

- Improve training of GPs and service providers so they are more aware of men's mental health issues and more able to be able to refer to specialist support services. It may be that when they give consultations for physical problems, they also ask how people are generally feeling.
- Effective training of staff in support services (all, not just health) to ensure they use gender sensitive approaches, such as motivational and Socratic interviewing.
- Teachers should be given training in working more effectively with boys to support healthier mental and emotional development and the skills to manage health services.
- One suggestion was to train everyday people who engage in conversations and develop good relationships with clients as part of their jobs, for example taxi drivers, hairdressers/ barbers and personal trainers. Their personal relationship with people may allow them to develop conversation with men regarding mental health.

10. Research needs

- There is a lot of data available that has not been analysed. A gendered analysis is warranted.
- It is important to have a better understanding the role of masculinity and male socialisation in boys and men's mental and emotional health and wellbeing.
- How should culture be engaged with as a theoretical construct in relation to boys' and men's mental and emotional health and wellbeing?
- A cost benefit analysis of poor mental and emotional health in men and boys should be undertaken.
- Exploring the links between mental health and

the social determinants of health.

- Campaigning to NIHR and other research funders to develop programmes of research on men and boys mental and emotional health.
- All service development in this area should be accompanied by robust evaluation.
- It was also suggested that an academic unit could be established to act as a central coordinating point, which could collate the right forms of information needed by Government and society to enable change. It could also be a focus for practice development and the setting up of trials for gender transformative work.

7.4 SUMMARY OF THE DAY AND SUGGESTED FUTURE ACTION POINTS

The final session was facilitated by Gregor Henderson to enable those present to reflect on what were the key messages coming out from the day's discussions and from their individual experiences of working with men and boys. This session centred around the question 'what should be the next steps?'

It was recognised that there was still a lot to do in raising the profile of boys' and men's mental health and wellbeing. There was felt to be poor understanding of the mental and emotional needs of men and boys within society and a dearth of services that are successfully reaching out and targeting those most at risk.

There was agreement that we have been building momentum over the last 10 years in relation to boys' and men's mental health, but this requires additional impetus. For this to occur we need the support of many different voices, from the general population as well as from the Government, statutory, voluntary and third sectors. There is a need to get key players (i.e. the cabinet ministers from all departments) to hear the message and to ensure action can occur. We were reminded that will not get change by talking to ourselves, we need to convince those who are not here – by undertaking gender transformation work and also influencing those domains that already have current political buy-in.

Continued lobbying is a key component. This can be supported by the Manifesto submitted by the Men's Health Forum and further augmented by a Declaration, which prompts all stakeholders to join together with one voice, co-ordinating our action. A draft of this Declaration has been included in Appendix VI. There was also a general consensus that this should be accompanied by a series of UK wide road shows, aimed both at professionals and the general public to get the regional perspective coupled with local ownership and support. At these events the top knowledge messages can be shared and debated. There was also a proposition made as to whether we needed a men's mental

health coalition to help coordinate all the activities and to act as a central forum for advocacy on boys' and men's mental health issues.

These initiatives will help maintain the momentum – both keeping it in the public conscious and supporting organisations who are working in the field.

8. INTEGRATIVE SUMMARY AND RECOMMENDATIONS

8.1 CURRENT KNOWLEDGE IN THE FIELD (AND GAPS)

This section is divided into two parts. The first integrates and summarises information from the five work packages in order to present as succinctly as possible what is known about what works for boys and men in relation to mental health promotion, early intervention and stigma reduction. Current knowledge gaps are also identified here. The second part makes suggestions and recommendations for possible future work.

8.1 CURRENT KNOWLEDGE IN THE FIELD (AND GAPS)

Rather than repeat the totality of evidence presented in the preceding sections we focus here on drawing out the key aspects of the current state of knowledge then follow this with some identified knowledge gaps.

The settings within which interventions take place are critical to the creation of a safe space that reduces stigma and facilitates accessible engagement with men. Two related points need to be considered here to address issues of gender and diversity. First, settings need to be 'male friendly' or 'male familiar'; that is they need to be either settings where men already gather or based in 'male spaces' (e.g. sports settings, men's clubs, music venues, workplace, virtual communities etc). Second, what constitutes such male spaces varies depending on other aspects of identity such as ethnicity, age, sexuality etc. (e.g. barber shops may work well for certain ethnic minority groups, club venues may work well for younger gay men etc). Interventions should therefore ensure attention is given to the intersection of gender and other aspects of identity in the settings used.

Interventions must take a positive approach to working with boys/men. Projects need to be welcoming, to understand and empathise with the circumstances of the boys/men they engage and value what strengths they can bring to the project. This engenders trust which is vital to maintaining engagement. Incorporating the boys/men into the development and running of interventions (e.g. as project leaders, as staff, as peer mentors, on project advisory boards etc) should form part of demonstrating such values whenever possible

and contributes to reducing stigma by peer role modelling. Consultation with boys/men should be the minimum standard expected.

The style and language used can make a significant difference to successfully engaging boys/men. This has three possible component parts: first, language should be male sensitive (e.g. using 'regaining control' rather than 'help-seeking') and should avoid language some men may perceive as feminine (e.g. using 'activity' rather than 'health'); second, imagery should also be male sensitive and should promote a positive view of boys and men; third, mental health language should be avoided where possible in favour of 'male familiar' alternatives (e.g. using 'coaching' rather than 'therapy'). As well as engaging men, there is some evidence that this also reduces mental health stigma. This contrasts a little with some mainstream mental health organisations who value the importance of reclaiming mental health language.

Staff/facilitator characteristics and skills must align with interventions values and approaches. Those involved in interventions need to be able to work comfortably in male friendly settings, be genuine in having non-judgemental, male positive and empathic views of the boys/men being engaged (which will be evident in part through the style and language used) and have the skills to be able to work with boys/men in direct and solution-focused ways [NB Problem-solving (solution-focused) therapy, including CBT, has been shown to be attractive and effective for various early intervention situations for boys and men]. Having these qualities and being able to be gender-sensitive in meeting boys/men's needs seems far more important than the sex of the staff/facilitator member. Gender-sensitive training can help instil this positive view, develop these skills and thereby improve the confidence of those working with boys/men.

Male familiar activity-based interventions seem to offer promise in several ways. First, having activity as the initial, visible offer reduces the stigma of engaging, feels 'safe', and therefore acts as a 'hook' to facilitate involvement. Second, the

pleasure gained from social/group based activity promotes a sense of shared identity that has a positive impact on self-esteem and feelings of wellbeing. This experience of enjoyment also helps sustain involvement. Third, passing learning and skills on through activity-based interventions, or simply helping others, can generate a positive sense of male identity in situations where this has been compromised (retirement, redundancy etc) Successful interventions are 'grounded'. Where possible, interventions should be community embedded. They should remain close to and inclusive of the boys/men they are engaging and have a social focus alongside a positive, strength-based approach. Having this embedding can help projects engage critically but constructively with existing services and thereby help generate social change around mental health and gender. Such embedding also increases men's local social networks and reduces isolation.

Socio-cultural context. Embedding projects within a community requires awareness of the socio-cultural context of the locality and the boys/men being engaged, the inequalities that this can create and sustain and the impact this can have on mental wellbeing. For example, it is important to understand the impact of direct and institutional discrimination that certain groups face (such as minority ethnic men, gay men). However, it is also important to recognise the assets that are available within these communities of boys/men that can help facilitate successful work.

Partnerships can be crucial across all phases of intervention development and implementation. Good partnerships can: increase credibility and therefore engagement with target groups of boys/men; extend reach and available resources; aid growth and sustainability of interventions through embedding within existing, trusted community and/or statutory services. There is some feeling that mental health services are not keen to work with men's health organisations. Building partnerships may therefore require assisting other organisations in developing, and valuing, gender awareness and male-sensitive practices.

Integration of key elements. Whilst the above

components may be effective as individual elements within interventions, there seems to be a synergistic effect when these can be incorporated coherently as part of an overall intervention package. This coherent package seems to maximise a sense of ownership, engenders trusting relationships and improves the likelihood of the intervention being experienced as safe, vibrant and enjoyable. The combined effect is to create a safe space for rethinking gender/masculinity and particularly for facilitating emotional openness.

Virtual or 'arms-length' approaches. On-line and telephone support lines can offer ease of access through the anonymity they provide. Online options, including the role of virtual communities, are potentially valuable approaches for boys and young men in promoting mental wellbeing and reducing stigma.

Policy and economic context. Whilst most of the above focus on direct interventions with individual or specific groups of men it was also seen as important to recognise that the wider policy context and current economic climate play a significant role in: influencing boys/men's mental wellbeing; influencing available ways of presenting as 'male' that can impact on the ability to be emotionally expressive and thereby on help-seeking; facilitating or restricting the establishment and sustainability of the type of coherent, integrated programmes that are required.

8.1.2 KNOWLEDGE GAPS AND OPPORTUNITIES

- There is evidence from the literature that web based interventions (including web/computer based CBT) have difficulty in attracting and engaging boys/men. Yet, this conflicts with the tacit knowledge gathered from the other work packages which suggests this approach shows potential, especially amongst boys and younger men. More work is needed to examine the effectiveness of using the internet and social media to engage particular groups of boys and men, in maintaining mental wellbeing amongst these groups, and for early interventions and in stigma reduction for these groups.

-
- There is some suggestion, particularly amongst school-aged populations, that interventions around mental health promotion, early intervention and stigma reduction might be more effective, particularly for boys, when focused on single-sex approaches. This work is currently under-developed and more evidence is needed.
 - Whilst there is now good evidence of the health/mental health impact of sports and football based interventions much less is known about whether these are more effective, and more cost-effective, than individual (counselling, therapy, including IAPT) approaches. More comparative research would be useful here.
 - Whilst the qualitative evidence on the contribution of Men's Sheds projects to wellbeing is clear, rigorous quantitative research on their effectiveness is sparse.
 - There is scope for more work looking at intersectionality in men's mental health interventions. In particular, more work could be done to explore how ethnicity, sexuality and age could be best taken into account in mental health promotion, early intervention and stigma reduction interventions.
 - Given that we identified that coherent, integrative programmes seem likely to produce the best results, there is still only limited complex evaluation analysis (particularly that provide quantitative data on outcomes) available from such programmes. In part, this is likely to be because there have been few such programmes (Bradford and Preston are two such interventions; though these were 'men's health' specific but not mental health specific and both are long since finished). More evaluation work is required here.
 - Linked to this, we have only been able to identify one UK men's mental health intervention that has completed a Social Return on Investment (SROI) analysis (though we did also identify one in Ireland). Indeed, there were few examples of SROI analysis of any men's health projects/programmes. Such analysis could be extremely useful in exploring the full value of coherent, integrated programmes.
 - There remains a paucity of research on how men talk about and support others with emotional and/or mental health concerns. In particular, not enough is known about how informal, naturalistic settings can facilitate and restrict such talk and thereby impact on mental wellbeing.
 - There is insufficient information on the use/non-use of 'mental health language'. Whilst there is evidence that not using such language (using alternative terms) can assist in initial engagement with men (it may be particularly useful in mental health promotion), being able to use such language was also seen as an important part of individual men's journeys into being able to open up and talk about emotional issues and in relation to de-stigmatising mental health more generally (therefore possibly being an important part of early intervention work).
 - There remain knowledge gaps around gender and mental health stigma. We see two gaps here: First, a conceptual gap in understanding the relationship between masculinity and mental health stigma (there is currently only limited work suggesting that holding to traditional views of masculinity is associated with greater mental health stigma, this could be extended); second, an evaluation gap. Some anti-stigma initiatives (such as 'Time for Change') have commenced work on trying to understand and address the perceived links between masculinity and mental health stigma but there is significant scope for more substantive evaluation of this kind of work.
 - There is currently only limited work on the impact of policy on men's mental wellbeing in the UK and particularly of its impact on service provision within the current economic climate and with the movement of public health into local authorities. Further research here would

⁴ This is from the MOJO project that formed part of WP3 analysis
<http://qualitymatters.ie/work/mojo-project-social-return-on-investment/>

be useful for helping identify what is required to develop and sustain successful interventions from a policy perspective.

- As noted in previous work and reiterated through the work packages here, there are current gaps in the knowledge and confidence of many working in the mental health field around gender-sensitive work with boys and men (why it is important, what such work looks like in practice etc). There is a need for focused training on working with boys and men in mental health promotion, early intervention and stigma reduction that incorporates both current research evidence and experience from the field. On-going peer engagement and support, facilitated by trainers skilled in gender-sensitive work, has proven useful in prior initiatives.

8.2 SUGGESTIONS/RECOMMENDATIONS

- 1)** When commissioning interventions, funders should ensure applicants provide information to show they have considered:
 - Setting (have they considered it and in what way)
 - The extent to which boys and men from the target group will be involved in the development and delivery of the initiative. At absolute minimum there should be consultation with the target group
 - Style and approach (have they considered it and in what way; do they think about the language they use to frame their offer?)
 - Their level of gender awareness and the value they attach to a 'strengths-based' approach amongst the facilitators/staff involved (including any gender-sensitive training undertaken or planned)
 - Whether it is appropriate to have male-familiar activities as a core part of the intervention. If so, why. If not, why not
 - The embedding of the initiative into the community being served (do they intend to have an impact beyond the individual level and, if so, in what way?)
 - The partnerships that are in place or planned (why are these important, what do they bring/add)
 - Whether there is a coherence to the programme in terms of integrating the above
- 2)** Consideration should be given to expanding current 'arms-length' interventions within online and social media spaces and completing robust process and outcome evaluation of such expansion.
- 3)** School-based interventions show promise for boys and seem to align with notions about the importance of cultural change and 'upstream' activity from across the work packages. Expanding existing programmes that show promise, generating a more gender-sensitive component for boys within this expansion, and having a specific plan to evaluate mixed sex versus single sex approaches within these programmes would likely prove beneficial.
- 4)** Consideration should be given to supporting research comparing the effectiveness, and cost-effectiveness, of sports and football based interventions with individual (counselling, therapy, including IAPT) approaches.
- 5)** Consideration should be given to supporting rigorous research on the effectiveness of Men's Sheds initiatives.
- 6)** Consideration should be given to supporting research on how ethnicity, sexuality and age intersect with gender/masculinity when developing and implementing mental health promotion, early intervention and stigma reduction interventions.
- 7)** Consideration should be given to supporting robust, complex evaluations of integrated, coherent men's mental health promotion programmes and stigma reduction programme (a considerable amount of analysis has been done on early intervention programmes - though few of these have been male specific).
- 8)** Linked to the above (and something that could possibly be incorporated), consideration should be given to supporting Social Return on Investment (SROI) analysis of some existing projects/programmes.
- 9)** Consideration should be given to supporting research to better understand how men talk about and support others with emotional/mental health concerns outside of formal health settings. In particular, not enough is known about how informal, naturalistic settings can facilitate and restrict such talk and thereby impact on mental wellbeing.
- 10)** Consideration should be given to supporting research looking at the impact of use and non-use of 'mental health language' in mental health promotion and early intervention work (and its relationship to mental health 'stigma'). The work presented in this document suggests a

⁵ For example Robertson et al (2013) Men's health promotion interventions: what have we learned from previous programmes? *Community Practitioner* 86(11): 38-41 and McCullagh J. (2011) The invisible men: development of a national men's health training programme. *Public Health* 125(7): 401-6.

dilemma between the impact of language on initial engagement and its importance in early intervention and stigma reduction.

11) Consideration should be given to supporting conceptual work looking at the links between masculinity and mental health stigma and to supporting evaluation of anti-stigma work that has taken a gendered approach to work on masculinity and mental health stigma.

12) Consideration should be given to supporting research looking at the impact of policy in the development and sustainability of mental health interventions for boys/men in the current social and economic climate.

13) Consideration could be given to supporting a training programme on gender-sensitive approaches for those working with boys and men. This could take many forms but prior experience suggests that an initial two day event followed by trainer facilitated 'arms-length' peer support and an annual meeting can be effective. An approach that combined boys/men's specific expertise with mental health expertise would be ideal.

APPENDIX I - PRINCIPLES OF APPROACH ADOPTED

Social programmes 'work' by enabling participants to make different choices. Making and sustaining different choices requires change in participant's reasoning (values, beliefs, attitudes etc) and/or the actual resources they have available to them. Within a realistic evaluation framework, this combination of 'reasoning and resources' is what enables the programme to 'work' and is known as a 'mechanism'. The contexts in which programmes operate make a difference to the outcomes they achieve as different contextual factors may enable, or restrict, particular mechanisms from being triggered. This interaction between context and mechanism is what creates a programme's impacts or outcomes: Context + Mechanism = Outcome. Although programmes are context-bound, and there is variation in mechanisms deployed between programmes, it is nonetheless possible to generate insights about 'what works, for whom, in what contexts, and how' which are portable. This clearly has resonance for the current work as it is not only the change mechanisms of current interventions that need to be considered but also recognising the contexts within these mechanisms work and for which boys and men. Within both the literature review and the environmental scan it will therefore be important to consider both mechanism and context in order to draw out aspects of the 'essential elements' that could be replicated, adapted or adopted within newly developed (or developing) programmes.

APPENDIX II - SEARCH STRATEGY

Main search strategy used for searching
Pubmed database.

#8 Search (#6 NOT #7)

**#7 Search (psychoses OR psychosis OR psychotic
OR schizophrenia OR bipolar OR dementia)**

#6 Search (#1 AND #4 AND #5)

**#5 Search (Intervention [tiab] OR service [tiab] OR
services [tiab] OR scheme [tiab] OR initiative [tiab]
OR program [tiab] OR programme [tiab] OR project
[tiab] OR evaluation [tiab] OR campaign [tiab] OR
review [tiab] OR therapy [tiab] OR therapies [tiab])**

#4 Search (#2 OR #3)

**#3 Search (mental health [mesh] OR mood
disorders [mesh] OR anxiety disorders [mesh])**

**#2 Search (Mental health [tiab] OR mental well
being [tiab] OR mental well-being [tiab] OR mental
disorder [tiab] OR mental disorders [tiab] OR
psychological disorder [tiab] OR psychological
disorders [tiab] OR resilience [tiab] OR anxiety
[tiab] OR depression [tiab] OR suicide [tiab] OR
suicidal [tiab] OR emotional distress [tiab])**

**#1 Search (Men [tiab] OR boys [tiab] OR males
[tiab] OR male [tiab] OR masculinity [tiab] OR
masculinities [tiab] OR masculinity [mesh])**

NB: The search was modified for use with other
databases. Furthermore, in all databases several
additional follow up searches were also run using
supplementary terms to identify any other key
papers of interest that may not have been captured
by the main search. For example, variations of
the search were conducted in Pubmed using the
Mesh terms Health Promotion; Evaluation; Early
medical intervention. Terms such as prevention &
promotion were also utilised.

APPENDIX III - PROJECT CODES AND NAMES FOR WP3

Name of project	Abbreviation/project code
Akwaaba Ayeh	AKW
Kent Sheds	KS
CALM	CALM
Mojo project	MOJO
Young men talking	YMT
Mind Yourself	MYS
Rainbow project	RP
MUTED	MTD
Time to change	TTC
Glasgow Helping heroes	GHH
Savera	SAV
Sporting memories network	SMN
Positive prisons, positive futures	PPPF
MAC UK	MAC UK

APPENDIX IV - SYMPOSIUM OBJECTIVES AND SCHEDULE OF SESSIONS

Room: Rose Bowl 408 Portland Crescent, Leeds LS1 3HB

09.30 – 10.00	Coffee & registration	
10.00 – 10.05	Welcome and introduction from the Chairs	GH / AW
10.05 – 10.15	The Movember Foundation welcome	CS
10.15 – 10.20	Young users perspective	JD
10.20 – 11.10	Key findings from current study	SR
11.10 – 11.30	Coffee break	
11.30 – 12.00	Policy perspective	GH
12.00 – 12.30	Practice perspective	DR
12.30 – 13.00	3rd Sector perspective	PF
13.00 – 13.45	Lunch	
13.45 – 13.50	Older users perspective	DH
13.50 – 15.00	Open debate on issues raised in the morning sessions	Small groups
15.00 – 15.20	Coffee break	
15.20 – 16.00	Pulling together of key outcome from the day	AW / SR
16.00 – 16.30	Summary and conclusions from the chairs	GH / AW

AW – Professor Alan White, Co-Director Centre for Men’s Health, Leeds Beckett University

CS – Clare Shann, Global Lead for Mental Health for The Movember Foundation

DH – David Hill, Voice of Mind

DR – Professor Damien Ridge, Professor of Health Studies, Psychotherapist, Westminster University

GH – Gregor Henderson, Director of Wellbeing and Mental Health at Public Health England

JD – James Downs, Voice of Mind

PF – Paul Farmer, CEO Mind

SR – Professor Steve Robertson, Project Lead and Co-Director Centre for Men’s Health,
Leeds Beckett University

APPENDIX V - SYMPOSIUM ATTENDEES

Organisation	Forename	Surname
Men's Mental Health Research Team	John	Barry
Mental Health Leeds	Catherine	Ward
The Movember Foundation	Sarah	Coghlan
Service User (Space2)	Stephen	Cross
Service user (Mind)	James	Downs
Mind	Paul	Farmer
SPACE2	Dawn	Fuller
Mental Health Foundation (Scotland)	Isabella	Goldie
The Big White Wall	Claire	Harding
Young Minds	Damian	Hart
Muted	Ian	Hastings
Public Health England	Gregor	Henderson
Service User (Mind)	David	Hill
The Movember Foundation	Alethia	Hunn
University of Glasgow	Kate	Hunt
South London and Maudsley NHS Foundation Trust	Eli	Joubert
Royal Holloway University of London	Frank	Keating
Norfolk and Suffolk NHS Foundation Trust	Roger	Kingerlee
Men's Action Network	Michael	Lynch
Public Health England	Lily	Makurah
The Movember Foundation	Paul	Mitcheson
Surrey University	Linda	Morison
Leeds City Council	Lisa	Mulherin
CALM	Jane	Powell

APPENDIX V - SYMPOSIUM ATTENDEES

Organisation	Forename	Surname
State of Mind	Malcolm	Rae
Muted	Mat	Rawsthorne
Age UK	David	Richardson
Westminster University	Damien	Ridge
Working with Men	Shane	Ryan
Berkshire Healthcare	Richard	Scott
The Movember Foundation	Chris	Stein
Men's Minds Matter	Luke	Sullivan
Rethink Mental Illness	Dave	Swindlehurst
Men's Health Forum	Martin	Tod
Scottish Association for Mental Health	Billy	Watson
Dorking Psychology	Andrew	White
Inequality Agenda	Jennie	Williams
Mental Health Foundation	Toby	Williamson
Leeds Beckett University student wellbeing team (mental health counsellor)	Hazel	Keeley
Leeds Beckett University	Alan	White
Leeds Beckett University	Steve	Robertson
Leeds Beckett University	Brendan	Gough
Leeds Beckett University	Amanda	Seims
Leeds Beckett University	Gary	Raine
Leeds Beckett University	Esmee	Hanna
Leeds Beckett University	Mark	Robinson

APPENDIX VI – LEEDS BECKETT DECLARATION

The Leeds Beckett Declaration on the mental health of men and boys in the UK

6th November 2014

We assert that in order to improve mental health and wellbeing in the UK there is an urgent need for boys' and men's specific needs to be recognised and acted upon. All boys and men must have the opportunity to:

- Achieve the highest possible level of mental health and wellbeing
- Access equitable services that meet their needs
- Be supported by professionals and service providers who are fully aware of their gendered requirements

Boys and men have high rates of undiagnosed mental and emotional health problems that are not being identified or supported through current service provision. Boys' and men's poor mental and emotional wellbeing can lead to significant health and social issues which can affect families, society and the economic wellbeing of the UK.

To address these problems, responses are required to take account of the specific needs of boys and men.

We therefore call on the UK Government, the Regional Assemblies, providers of health services and other relevant bodies to:

- Recognise boys' and men's mental health and wellbeing as a distinct and important issue
- Raise general awareness of the mental and emotional challenges facing men.
- Tackle the stigma associated with boys and men who are struggling with their mental and emotional health
- Invest in 'male sensitive' approaches to providing health care
- Work with schools to improve the preparation of boys to meet their mental health and wellbeing needs
- Ensure that workplaces and employment services pay attention to the mental and emotional needs of the male workforce and those unemployed
- Recognise that boys and men are not a homogenous group and that their differences and diversity must be taken into account when planning and delivering services
- Recognise that boys and men may need targeting in specific settings, and that all settings should be sensitive to their mental and emotional needs
- Support the Charitable and Voluntary Sector in reaching out to boys and men
- Invest in male focused research and practice development

Name _____ Organisation _____

Signature _____ Date _____