All-party parliamentary group on issues affecting men and boys

Third Report

Tackling Male Suicide

A New 'Whole System' Approach

Our thoughts are with those men and women
who lose their lives through suicide and their families and friends

Remit of the
All-Party Parliamentary Group on Issues Affecting Men and Boys

"To raise awareness of disadvantages and poor outcomes faced by men and boys in education, mental and physical health and law;
to influence attitudes, role models, policy and legislation
that will lead to positive differences to their well-being and lives."

Publication Date: 30th September 2022

Foreword by the Chair: Nick Fletcher MP

Welcome to the third inquiry from the APPG on Issues Affecting Men and Boys. Our earlier inquiries asked "What it was like being a boy today, growing up in the UK?" and "The case for a Men's Health Strategy". Our members were asked this spring which topic they would like to explore next. Overwhelmingly, they wanted to address male suicide – an issue that affects so many people from those who lose their lives to those who are left behind.

Given the scale of male suicide, and like on so many other issues from boys' educational underachievement to male cancers and the number of men in prison, there seems to be a lack of urgency and depth in terms of political and public policy action. It is hard to explain or understand this from an equalities, societal and humanity perspective. As I have said many times before, men and women share society together, so men and boys leading positive lives with positive outcomes is also important to women and girls. We also need more action on female suicide: none of us live isolated lives.

As with previous inquiries, this one has also brought together leading international and national experts both from the world of academia and those working on the front-line to help end male suicide. Their analysis was clear: we can only tackle this by understanding and addressing the deep underlying causes at source rather than trying the address the outcomes.

They were also clear that we are currently looking at it through the wrong prism. The primary focus being a clinical view rather than one based on how most men who take this path view it. We should not place the main burden of responsibility on men themselves. Phrases like 'Man Up' 'Tough It Out' and even 'Toxic Masculinity' should be confined to the historical dustbin.

It is clear. Male suicide should be seen as a national emergency. One that has a far lower priority than it should, not just in terms of public policy and public services, but also in the eyes of society.

Of course, we want more men to talk. Many more are, every day. But as friends, family, communities, politicians and public service professionals, we all have to do better to listen, ask and act. I hope that this report gives the issue additional impetus in Westminster, Whitehall and across society so we can together reduce the appallingly high rate of male suicide.

Nick Fletcher MP (Don Valley)

Chair, All-Party Parliamentary Group on Issues Affecting Men and Boys

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(1) Executive Summary

This is the third report by the APPG on Issues Affecting Men and Boys with evidence taken from a range of national and international experts and organisations between April and July 2022.

On the basis of the evidence, the APPG has concluded that there has to be a fundamental rethink in the approach to male suicide which includes the development of a gender-informed male suicide prevention strategy in the UK. Current approaches are either not working or not working quickly enough. A new 'whole system' approach is needed.

As the statistics section shows, given that 13 men take their lives every day and each one affects 135 other people, tackling this devastating issue should be seen as a matter of urgency and action. The Government's current suicide prevention strategy and plan focuses primarily on middle-aged men and addresses the symptoms, often with tactical initiatives, rather than addressing the underlying causes and primary prevention measures. Any strategy to tackle male suicide has to be gender-informed and focus on the male-specific drivers and interventions which are effective for men. If this is not the direction taken in any refreshed suicide prevention plan, it risks not moving the dial with respect to reducing male suicide. This is not a fault of the members of National Suicide Prevention Strategy Advisory Group: their scope has to be far wider to address wider fundamental Government policy.

This view is predicated on the evidence the APPG heard that the focus has been on viewing suicide *primarily* as a mental health problem when in reality it is *largely* the outcome of a range of external issues, or personal stressors, that take many men down the path to suicide. Whilst most men who suffer from these external issues do not take this path (they can also take other paths such as addictions, obesity and poor physical healthcare), suicide is a symptom or outcome of a build-up of stressors. Suicide is a choice made by men when these stressors reach a critical level and the 'stress bucket' overflows, it is not the result either of a single cause nor of 'men not talking'. This is similar to the conclusion made in the APPG's recent report "The Case for a Men's Health Strategy."

These stressors range from a combination and culmination of issues such as relationship breakdown, work culture, employment and financial worries which are also impacted by wider issues such as social isolation, loss of belonging, the lack of male-friendly services and the lack of empathy towards men. We heard evidence that many men view suicide as a rational decision and a solution-based outcome based on their failure to fix these stressors. They often do not conceptualise their problems as being mental health problems.

There are significant differences in suicidality for different groups of men. Recognising intersectional factors is important, for example:

- Prisoners and those working in the construction industry have much higher rates;
- The male suicide rate in the North East is nearly twice as high as that in London;
- There is a huge spike in suicide of men in their late teens.

The 16 policy recommendations range from strategic measures such as the need for an overarching Men's Health Strategy with suicide as a main pillar, to the need for clear targets and responsibilities for Integrated Care Systems to reduce suicide in their areas. There is also a call for greater recruitment of men into the world of psychology and better gender-informed training for front-line professionals on the causes of male suicide. The Government's intentions with regard to the Online Safety Bill are welcomed with regard to stopping content which encourages or assists suicide.

The APPG also calls for a male positive approach to male suicide which does not place the primary responsibility on the shoulders of men, it should be on the shoulders of society, employers and public services.

Men do talk and talk about their problems – the challenge for Government, policymakers, society, employers and professionals in public services is whether they are listening, asking and acting. Evidence around middle-aged men suggests the right questions at the right time are not being asked, especially as men do not conceptualise their problems in mental health terms. Being gender-informed about how men express suicidality is vital.

We heard persuasive evidence that the current approach does not tackle the root causes and is not working. However, when the external stressors that take some men down the path to suicidality are addressed, male suicidality is significantly reduced.

This is why the APPG is calling for a new 'Whole System' approach to tackling male suicide.

To echo Professor Louis Appleby: "The data and issues we present are not dry. They are real lives. They are deaths not prevented."

Part 1: Background and Statistics

(2) Introduction/Background

Following on from the APPG's two previous reports, the members of the APPG decided to look more deeply into the issue of male suicide, which featured in those reports.

- "A Boy Today"[1] – what is life like for a boy today, growing up in the UK? This report was published in September 2021;
- "The Case for a Men's Health Strategy"[2]. This was published in February 2022.

This inquiry (held between April and July 2022) explored male suicide with a range of academic experts in the field, alongside organisations who are supporting men with mental health or suicidality. Three formal meetings were held and evidence was also taken via video interview. The evidence can be viewed online via video[3] and a summary of each can be found in Annex 1.

The Terms of Reference (what are the causes and solutions for the high number of men taking their own lives?*)* for this inquiry had a broad focus[4] on:

- Data on male suicide including within different male demographics/cohorts;
- The causes of male suicide in the UK;
- Recommendations for policies and for reducing the suicide rate.

In keeping with the previous two reports, the underlying premise was to take a male-positive approach to the inquiry rather than a negative deficit model predicated on a victim blaming/'men are faulty' framing of the issue.

Where female suicide rates are used, they are for context purposes not for 'competitive' purposes. We are concerned of course about the level of female suicide and its causes.

The timing for this report was important given that the Government finished a consultation its mental health strategy and suicide prevention plan prior to this inquiry[5]. In addition, the Women and Equalities Select Committee[6] is considering the response

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[1] APPG on Issues Affecting Men and Boys, "A Boy Today" (September 2021): https://equi-law.uk/boy-today-project

[2] APPG on Issues Affecting Men and Boys, "The Case for a Men's Health Strategy" (February 2022): https://equi-law.uk/mens-health-strategy/

[3] APPG on Issues Affecting Men and Boys, "Inquiry on Male Suicide", evidence:- https://equi-law.uk/evidence-male-suicide

[4] APPG on Issues Affecting Men and Boys, "Terms of Reference – Inquiry on Male Suicide": https://equi-law.uk/inquiry-no-3-male-suicide

[5] Department for Health and Social Care, "'Mental health and wellbeing plan (Consultation)": April 2022 - https://bit.ly/3BeXWqR

[6] Women and Equalities Committee, "Mental health of men and boys follow-up", June 2022: https://committees.parliament.uk/work/124/mental-health-of-men-and-boys-followup/

that Government Minsters gave to their inquiry on the mental health of men and boys. Over the summer, statistical bodies published their suicide figures for 2021, which all showed an increase from those reported in 2020. Lastly, whilst in post, the then Secretary of State for Health and Social Care (Rt Hon. Sajid Javid MP) gave a moving speech[7] on male suicide which included his experience of losing his brother.

The report does not go through a comprehensive literature or data review on male suicide, which is continually growing. It is telling that there is a lot of great 'writing/researching', but this is not leading to concrete policy action, which is imperative. The APPG recommends the House of Commons' Library briefing[8] on suicide.

As with the Men's Health Strategy, it is recognised that health and suicide prevention are devolved matters, so any recommendations for the Westminster Government to act upon, also would support action in the other nations in the United Kingdom.

(3) Headline Statistics

The following is a list of key statistics about male suicide (references for women's health are solely provided for context and understanding).

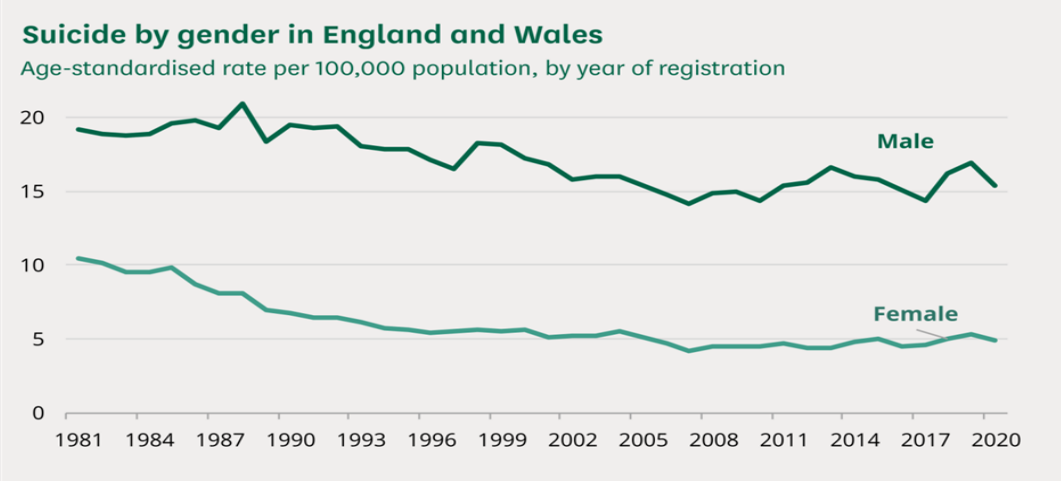
1) In 2021, 4,704 men in England, Wales[9] and Scotland[10] took their own lives. This is an increase from 4,500 registered in 2020. With 2020 figures from Northern Ireland[11] (160), this is the equivalent of 13 per day. Men make up 75% of all deaths by suicide and it is the biggest cause of male deaths under 50.

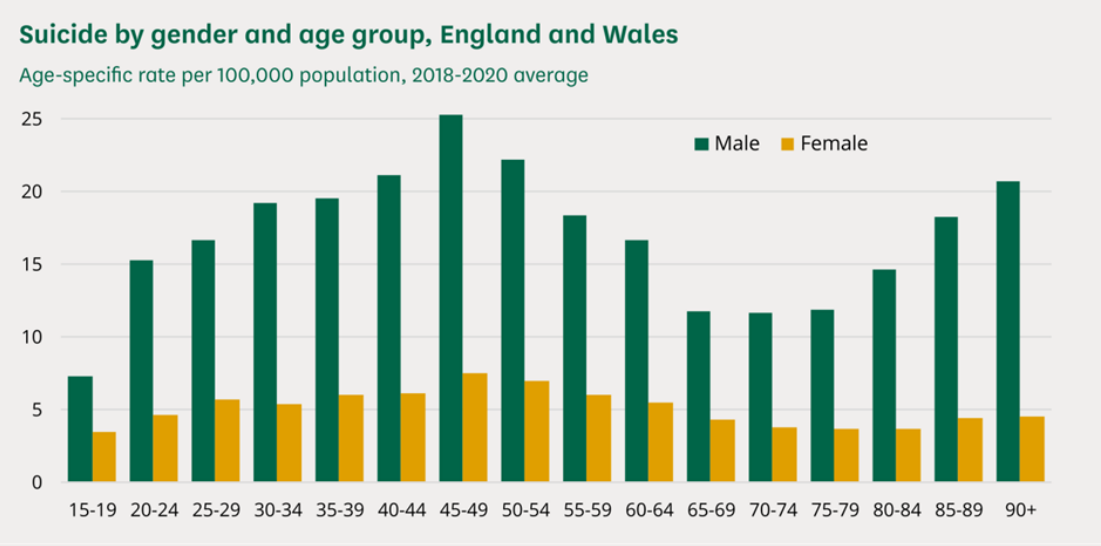
2) Whilst female suicide rates nearly halved in England and Wales since 1981 (from 10.5 per 100,000 to 5.5 in 2020), male suicide rates reduced by less than 20% (from 19.2 per 100,000 to 16.0). However, these figures are based on suicide rates rather than volumes. 3,562 men in England and Wales died by suicide in 1981, whilst 2021 the figure was 4,129[12]. The peak was 4,303 in 2019. The difference in rates and volumes is due

[7] Health and Social Care Secretary of State speech on suicide prevention, 24 June 2022: https://bit.ly/3Ow8Y4s
[8] House of Commons: "Suicide Prevention (Policy and Strategy)", January 2022: https://bit.ly/3cuM93Z
[9] Office for National Statistics, "Suicides in England and Wales", September 2022: https://bit.ly/3Sl0ZcL
[10] Public Health Scotland, "Suicide statistics for Scotland"; August 2022: https://bit.ly/3UweGYg
[11] Northern Ireland Statistics and Research Agency, "Suicide Statistics 2020", https://bit.ly/2x2ZFUB

[12] Office for National Statistics, "Suicides in England and Wales", September 2022: https://bit.ly/3Sl0ZcL

to population growth in the past 30 years. The graphs below are from the House of Commons Research Library up until 2020.[13]





3) There is also a range of intersectional issues – including age, place, race and occupation. Here is a snap shot of some key figures:

- For England and Wales, males aged 45 to 49 years had the highest age-specific suicide rate at 23.8 per 100,000 male deaths (430 registered deaths) – 7.1 per 100,000 women (130)[14];
- Between the academic year ending 2017 and that ending 2020, the male suicide rate for higher education students was statistically significantly higher (5.6 deaths per 100,000 students; 202 suicide

[13] House of Commons: "Suicide Prevention (Policy and Strategy)", January 2022: https://bit.ly/3cuM93Z

[14] Office for National Statistics, "Suicides in England and Wales", September 2021: https://bit.ly/3f35Xcm

deaths)[15] compared with female students at 2.5 deaths per 100,000 students (117 suicide deaths). The Guardian reported[16] that in the past ten years there had been 1,330 deaths with a clear and significant gender disparity - 878 (66%) were men, and 452 (34%) were women. Student suicide rates are lower than the rates for their typical age group (18-21/22);

- Men in the building trades[17] are nearly four times (see the Mates in Mind presentation) more likely to take their own lives than the average UK man, with almost nine tragedies a week;
- Rates of suicide for men in prison are three times higher than men not in prison[18];
- 11% of male victims of partner abuse (7.2% women) have tried to kill themselves.[19] Research from Dads Unlimited[20], who run the Save Dave domestic abuse service in Kent, stated that suicide prevention has become a key feature of their work, with around 40% of clients having faced suicidal ideation, rising to 55% of clients if they have been a victim of domestic abuse. The research[21] from The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) showed that 7% of middle-aged men who took their own life in 2017 had been victims of domestic abuse;
- There are regional disparities in England. In 2021, the average suicide rate per 100,000 men was 15.8 overall. However, in the North East the figure was 22.2 whilst in London it was 9.9[22]. There are national differences too. The male suicide rate in Scotland is 21.3[23].
- There is also disparities with respect to occupations seen more starkly below between those men in construction/building roles and those in administrative occupations[24].

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[15] Office for National Statistics, "Estimating suicide among higher education students, England and Wales: Experimental Statistics", 31 May 2022 - https://bit.ly/3ctzVIw

[16] Top Universities, "One UK Student Dies by Suicide Every Four Days – and the Majority are Male (4 April 2021) Why?": https://bit.ly/2o5wEmn

[17] HR News, "454 hard hats represent the number of UK construction suicides each year" https://bit.ly/3OdowLh

[18] Office for National Statistics, "Drug-related deaths and suicide in prison custody in England and Wales - 2008 to 2016" https://bit.ly/3JE8iYf

[19] ONS domestic abuse, "Findings from the Crime Survey for England and Wales: year ending March 2018": https://bit.ly/2FY8UYc - Table 14-15

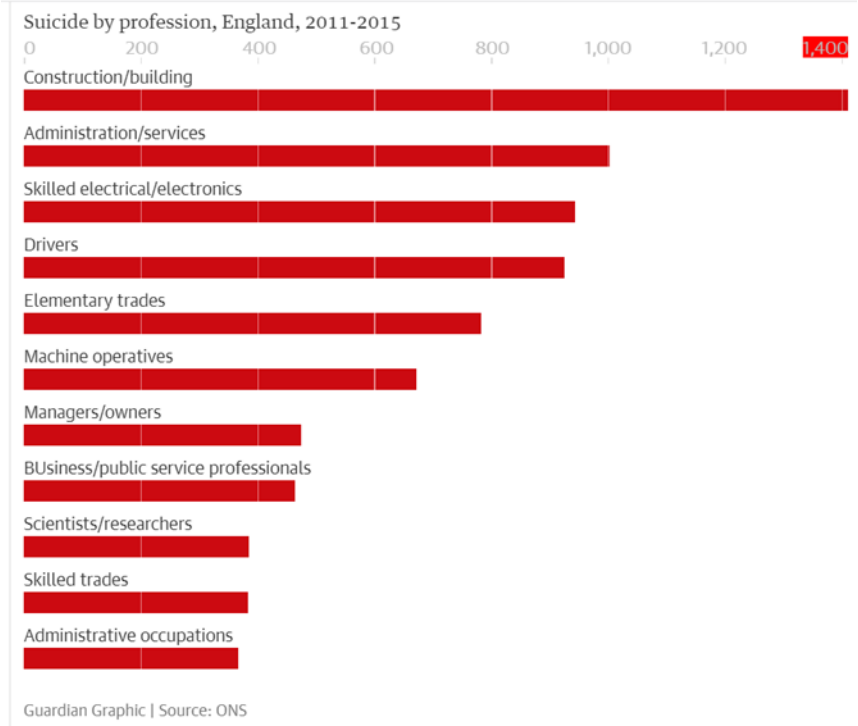
[20] Dads Unlimited, "Dads Unlimited wins GSK Impact Award": https://bit.ly/3LXpKs4

[21] The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), "Suicide by middle-aged men" (statistic featured in Professor Nav Kapur's presentation), https://bit.ly/3J4DeCi

[22] Office for National Statistics, "Suicides in England and Wales", September 2022: https://bit.ly/3Sl0ZcL

[23] Public Health Scotland, "Suicide statistics for Scotland"; August 2022: https://bit.ly/3UweGYq

[24] Office for National Statistics, "Suicide by occupation, England (2011 to 2015)": https://bit.ly/3QhHhOz



4) The research[25] from The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) on middle-aged men who had taken their own life in 2017 has a range of important statistics, for example:

- Almost all (91%) middle-aged men had been in contact with at least one frontline service or agency, most often primary care services (82%). Half had been in contact with mental health services. Contact with services ranged from within one week of death (38%) to more than three months prior to death (49%);
- Many had experienced adverse life events within three months of death, including problems with family relationships (36%), finance (30%), housing (28%), or the workplace (24%). Overall, 57% were experiencing problems with unemployment, finances or accommodation, at the time of death;
- 45% were reported as living alone; 11% had reported recent social isolation; bereavement was reported in 34% of deaths and almost a third (30%) were unemployed at the time of death; of these, almost half had been unemployed for over 12 months (47%);
- One telling statistic was that for 97 middle-aged men, the clinician's estimation of suicide risk at final service contact was recorded as "low", or "not present", in 80% of cases.

[25] The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), "Suicide by middle-aged men (statistic featured in Professor Nav Kapur's presentation)", https://bit.ly/3J4DeCi

5) Research[26] in 2015 estimated that the impact of recession meant that 878 more men had ended their life than would have been expected had the then downward trend in suicide continued. Sadly, this impacted an extra 123 women as well.

6) In England, around one in eight men has a common mental health problem such as depression, anxiety, panic disorder or obsessive-compulsive disorder (OCD)[27].

7) Despite making up 75% of suicides, men only make up 34% of those referred to Improving Access to Psychological Therapies (IAPT)[28].

8) Around 80% of undergraduate psychology students are women. Around 85% of clinical psychology trainees are women[29] and 82% of clinical psychologists are female.[30]

9) Research from the USA showed that every suicide, 135 people are affected because they knew the person[31].

10) The ONS has stated that it will soon start to include ethnicity in its suicide statistics which is vital for understanding.

Part 2: Evidence and Themes

From the evidence presented to the APPG, a number of key themes emerged, all of which point to the need for a completely new approach to male suicide prevention. In essence, a far deeper cross-governmental, public policy and strategic approach is needed that resolves the root causes of male suicide rather than individual initiatives that try to manage the 'symptoms.'

The evidence from many of the experts was that suicide should not be seen solely a mental health problem but should be seen as a potential outcome of a range of damaging externalised problems and issues, or stressors, that are causing men to take their own life.

This can be seen more broadly in men's health where outcomes such as addictions, obesity, poor physical health, poor personal healthcare and depression/anxiety are primarily caused by a range of underlying causes that need to be tackled if the outcomes are to be addressed. These underlying causes

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[26] Gunnell D, Donovan J, Barnes M, Davies R, Hawton, Kapur N, Hollingworth W, Metcalfe C, "The 2008 Global Financial Crisis: effects on mental health and suicide". University of Bristol, 2015. Guardian article - https://bit.ly/3z9Yli9

[27] Mental Health Foundation, "Key statistics": https://bit.ly/3BlJuE1

[28] Men's Health Forum, "Levelling Up Men's Health", November 2021: https://bit.ly/3t6pvVJ

[29] Centre for Male Psychology: "Why are so few psychologists male? Insights from a psychology trainee (2 September 2022)": https://bit.ly/3BfU9Qf

[30] Health and Care Professionals Council, "Breakdown by gender and modality (2018)": https://bit.ly/3PCP6Ou

[31] Julie Cerel et al, The American Association of Suicidology: "How Many People Are Exposed to Suicide? Not Six" -https://bit.ly/3zxxs94

often result from similar circumstances and exhibit themselves in different ways depending on the actual individual men. This can be said with relationship breakdown, for example. For some men it could lead to suicide, for others, it could lead to addiction or poor personal healthcare without leading to suicide.

Another overarching theme was the fact that whilst there has been increased investment in suicide prevention, there have not been any significant reductions, there needs to be wholesale change and fresh political thinking.

(4) Causes of Male Suicide

Many of the speakers (especially Glen Poole and Professor Rob Whitley) were clear that male suicide is not solely a mental health problem and significantly, should not be framed as such.

Glen Poole explained that for many men, it is a rational decision where they have tried to fix a problem(s), believed to have failed, and therefore suicide becomes another practical solution. Professor Louis Appleby also made the very strong point that men are reluctant to conceptualise their problems in mental health terms.

Both Glen Poole and Professor Rob Whitley set out that suicide is primarily caused by three intertwined issues:

- **External factors** (often referred to as stressors, antecedents or risk factors) albeit for some men their suicidality is caused by mental health problems (schizophrenia, for example);
- **Universal issues** that affect most or all men who take their own life. This sits across the stressors;
- **Transitions,** often unwelcome, in a man's life can act as the tipping point into suicidality. This was a key issue that Professor Nav Kapur also raised.

There will also be a great deal of intersectional issues affecting the three factors above such as occupation, place, class, ethnicity, disability, age and sexuality.

(A) Stressors/Antecedents

The primary stressors set out by those giving evidence are listed below and often overlap depending on individual situations. For the most part, men are suffering from a combination and culmination of them:

> Professor Rob Whitley: "Suicide is almost never a result of a single cause. We should not say X causes suicide or Y cause a suicide. Suicide, like any complex health outcome, is usually determined by a range of risk factors which intertwine. And we talk about a web of causation or multifactorial causation."

- Relationship breakdown (separation and divorce) and related issues such as family courts, CMS payments, child contact, isolation and domestic abuse;
- Financial concerns/pressures;

- Employment/Work/Unemployment (including workplace culture, redundancy, too old or injured to continue with "blue collar" work);
- Housing/Homelessness;
- Bereavement;
- Isolation/Loneliness (including being single/living alone);
- Addictions;
- Ethnicity with respect to feeling they will not be supported or believed because of their race;
- Adverse Childhood Experiences.

(B) Universal issues

- Social integration and loss of social connection;
- Loss of meaning and purpose;
- A gap in available and clearly signposted male-friendly services;
- Lack of professional/societal curiosity or empathy with respect to male wellbeing (Men do talk but who is listening/acting/asking?).

(C) Transitions/new life events

- Loss of work (and no alternatives – worsened by recession), family, relationship loss, home/homelessness, entry into the criminal justice system, sexuality, disability and bereavement and going to university/college;
- Life changes such as the transition from armed forces to civilian life or realising you are gay and being in fear of the consequence of disclosure.

The most vulnerable time for men can be when these transitions take place (when they are unwelcome).

For example, male students are most likely to take their own lives in their first year or male prisoners in the first weeks in jail.

(5) "Rational" Decisions and Rational Solutions

The evidence from Glen Poole pointed towards the view that suicide should not be primarily seen through the prism of mental health. For many men, suicide is a solutions-based and rational action or decision. In essence, they have tried to fix a problem(s) and failed. For others, they suddenly find themselves in a situation where they cannot see a resolution. Male suicide is a practical solution-based response to problems they face.

> Glen Poole: "The problems males generally see are largely practical rather than emotional; emotions subsequently follow."

On this basis, it naturally flows that to effectively reduce male suicide, there has to be better support, recognition and action with respect to external stressors, transversal issues and transitional periods. This should be the policy direction with respect to reducing male suicide.

> Glen Poole: "In general, when males can see a pathway out of their distress, suicidality reduces almost to zero. When multiple interventions are in place, they can make a significant impact."

Professor Louis Appleby also added in his evidence with respect to how men think about mental health and why they are 'missed'.

> Professor Louise Appleby: "And it's probable that men, because of embarrassment and shame and because of reluctance to conceptualise their problems in mental health terms, [they] may not present in a way that brings out the help that they need about mental health."

(6) Recognising Diversity and Intersectionality

The evidence from the speakers, and also that from the whole men and boys wellbeing sector, shows that a 'one size fits all' approach does not effectively resolve or represent male suicide. The statistics in the previous section also confirm this.

Men, and men at risk of suicide, are not one homogenous group, but when it comes to male suicide, the sole policy and narrative focus seems to be on middle-aged men – and then the caricature is one of white office-worker men.

Whilst acknowledging the suicide rate for middle-aged men is currently the highest, a focus on this group risks ignoring the fact that even young men aged 20-24 are still three times more likely to die by suicide than young women of the same age. Men who take their lives come from every demographic.

This narrowing of the focus risks ignoring the reality of male suicide, especially around occupation, place, class, ethnicity, disability, age and sexuality. It therefore requires better funding, policy, research and action in specific fields.

In terms of occupation, high risk roles include construction, farming, sea-faring and armed forces leavers ('veterans'). This sits alongside men who are unemployed and/or cannot work in their chosen field due to old age or injury. This has to be a policy and public concern. Specifically targeted policies and research is needed for these vulnerable groups. For example – why is suicidality higher in certain occupations and how is this resolved?

The same stands for regional disparity. Why is the male suicide rate in the North East nearly twice as high as that in London? What action is being undertaken to address this? Why is it so different?

(7) Men attempt suicide less

The trope that states "women make more suicide attempts than men" can often be used to minimise male suicide and set up a false competition.

The response to this was that firstly men are more lethal than women when it comes to suicide and therefore once they have made the decision, they are more decisive in carrying it out.

In addition, there is a difference between recorded/reported suicide attempts and actual attempts. Many men will make attempts but these are not recorded/reported. Glen Poole gave examples, such as a man sitting by a railway track on his own every Friday but deciding not to go through with it at the last moment. That is a suicide attempt but it would not be recorded anywhere.

(8) Changing the Narrative on Male Help-Seeking

A key underlying issue that has been raised both in this inquiry and also in the APPG's previous two reports, is the pervasive male-victim blaming narrative. It is clear that the phrase 'toxic masculinity' is damaging and adds additional stigma and barriers to male help-seeking.

This damaging narrative suggests that masculinity itself is at fault and that, if men would only talk more, this would solve their problems.

The previous two APPG reports eschewed this deficit-model and this report continues with this same approach. The key is that whilst there is a need for men to talk, and this is increasingly the case, the responsibility should not primarily rest on their shoulders. It should primarily rest on society, employers and professionals to understand better the ways men communicate, and then to listen, ask and act.

A recent Daily Mail article[32] stating that construction workers had gone 'woke' as they talk more to colleagues about the problems they face is another example of how societal narratives can be damaging and create additional barriers. On one hand men are criticised for not talking about problems ('toxic masculinity'), and then in this example they are criticised for doing exactly that ('woke masculinity'). This headline would put some men off talking because they fear being accused of being 'woke'. It is notable that this article was rightly criticised from all quarters, including from a Welsh scaffolder, Jamie Busby, whose social media video[33] went viral.

[32] Daily Mail, "UK Builders go WOKE", 19 June 2022: https://bit.ly/3Ae5T4W

[33] Wales Online, Welsh scaffolder hits back at Daily Mail over 'woke builders' claim, 22 June 2022: https://bit.ly/3pVEij3

(9) How Men Talk

A key theme throughout the inquiry has been that there is a need for society and public service professionals to better understand male suicidality and the risk factors.

When men are suicidal, they do not start talking to their GP or work colleague stating, "I want to kill myself". They will talk about the specific problems they face; work pressure, relationship breakdown, money and bereavement. They may have other symptoms such as a changing behaviour, increased drinking or gambling. These should be seen as trigger points for services and friends/family/work colleagues to start to ask what they can do to help and to listen.

Men talk indirectly about suicidality through the issues they face as set out in Section 6 and conceptualise it differently.

Men do talk and though a wide range of means, often those which are not clinical or part of 'the state', examples include:

- They take part in activities such as UK Men's Sheds (which has seen phenomenal growth), Walking and Talking groups and 'bushcraft' groups. These activities bring men together where the conversation is 'shoulder-to-shoulder' (rather than face to face) and satisfies clear human needs such as belonging, achieving and being heard;
- Anonymous/safe environments such as Andy's Man Clubs (which has also seen phenomenal growth), anonymous helplines, online groups (including Facebook) and website information;
- Men-only spaces are important where men can engage with other men on their own terms (see above) and they should not be taken away but be created. These are support services for men, by men;
- Some men manage bereavement and other crises by engaging in other activities such as setting up fundraising activities, campaigns or other practical issues. Hollie Guard is an excellent domestic abuse app created by the father of Hollie who was murdered and Dads Unlimited was created by its founders who had gone through difficult child contact issues. Andy's Man Clubs are further good example.

What is clear is the success of the informal route to support without state involvement. The success of the grassroots organisations mentioned above and many more are not only testimony to those who have created them, it also shows:

- These informal approaches have been created because the public policy/health response to male suicide and men's mental health is not working;

- Informal approaches are far more cost-effective that the public policy/health response to male suicide and men's mental health which cannot deal with the demand in a timely fashion;
- There is little formal recognition of their success (they are not mentioned in the national suicide prevention plans) and also men are not always signposted to them by local agencies because they do not fit into the formal system.

However, this should be tempered by the fact that what makes these support groups attractive is that they are not clinical or part of the system. Partly, that means they avoid the inevitable bureaucracy and control that "the system" would exert on them – also, there is no fear of disclosure that someone's details end up on an official record. It is proposed that there should be an exploration of how the voluntary sector can be supported by the public sector in partnership, whilst ensuring they remain independent of it.

Professor Louis Appleby "...it is often the Voluntary Sector that provides the setting that is acceptable to men who are who are struggling. With the voluntary sector not necessarily marking their door with health, certainly not with mental health or suicide prevention. It is a more acceptable setting for men who feel ashamed of what's happened to them. Sometimes the voluntary sector presents the reason for their service as being quite removed from mental health. It might be about sport or about social life or about men's hobbies, and that brings men in who might need to talk, who might need to find support. So this is another very important prevention partnership."

(10) Male friendly services and lack of response

Professor Nav Kapur[34] reported in the really important study he led, that many middle-aged men had actually been in contact with services but were not being seen or recognised as 'at risk', or having mental health problems.

The startling statistic from the research showed that of those men who had taken their own lives and had actually sought help and were assessed for suicidal risk in 2017, 80% had been assessed by clinicians as having low or no risk of suicide; this is troubling and an issue that must be addressed. These men are talking but who was listening? This lack of understanding of male suicidality (stressors, transversal issues and life transitions) is key, especially when presented in indirect ways.

For example, the research showed that 7% of men who had taken their own life were victims of domestic abuse but from other research in the domestic abuse sector, men who experienced domestic abuse are at least twice as likely to

[34] The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), "Suicide by middle-aged men (statistic featured in Professor Nav Kapur's presentation)": https://bit.ly/3J4DeCi

report symptoms of anxiety and depression instead[35]. Despite making up 75% of suicides, men only make up 34% of those referred to IAPT therapy.

Non-diagnosis is an issue for men. One speaker (Natasha Devon MBE) from the APPG's first inquiry "A Boy Today" set this out.

Natasha Devon MBE: "...boys' mental health conditions are less often recognised. Self-harm is often used as a barometer of mental health in young people and two thirds of admissions are girls." However, Natasha pointed to research showing that boys self-harm in atypical ways, such as getting into fights they know they can't win or punching inanimate objects (for example, walls). In other words, metrics for mental health diagnoses, are normally geared to typical female symptoms.

From as young as five years of age, girls are more likely to be diagnosed with emotional disorders. Boys are more likely to be labelled with behavioural disorders. Natasha suggested this might be down to adults having set ideas about how girls and boys should behave, resulting in misdiagnosis following individuals as they get older.

The delays in mental health referrals and one-to-one counselling for men through the NHS will be exacerbating the problem that these men want to talk but the service and support is not there. In addition, for stressors, increasing delays in family court child contact hearings for example, will lead to increased risks for fathers, especially those who are unfairly and without merit, being denied any contact with their children.

(11) Successful Approaches

Points raised throughout the inquiry and also raised in the previous APPG report on the Men's Health Strategy show the importance of services being open when men needed to use them (especially in occupations such as a construction), located where they work and ensuring communications are male friendly.

Messages should be based on explaining the problems that men face and then ensuring helplines (for example) can provide support that is accessible. Stark commanding messages such as "Men, you need to talk" are not likely to help unless it associated with a specific issue, action or reason.

It was striking to hear how hugely successful newly formed Voluntary Sector organisations (UK Men's Sheds, Andy's Man Clubs, HiS Charity and many more) have been, so what is it that they are getting right? What is the secret to their success? Five key themes emerged:

- They harness positive masculinity – including camaraderie and belonging;

[35] Hester M, Ferrari G, Jones SK, et al. «Occurrence and impact of negative behaviour, including domestic violence and abuse, in men attending UK primary care health clinics: a cross-sectional survey". BMJ Open 2015;5:e007141.

- They are based on 'shoulder-to-shoulder' communication (as opposed to the 'face-to-face' approach typified by traditional therapy or counselling);
- They recognise the need for signposting to more formal 'wrap around' intervention. For some men, talking is not enough when they are submerged with urgent practical problems;
- The male-friendly (indirect/informal) way to start the communication/talking process. Andy's Man Club's approach shows this clearly with the three questions that men are asked to talk about:
    - "How's your week been?"
    - "What's been one positive from your week?"
    - "Have you got anything that you'd like to get off your chest?"
- Tailoring interventions and support, including sourcing the real problems. As Jules Morris from HiS Charity set out as an example: "A man in his fifties may be feeling suicidal because he fears he is not fit enough to do his job. This is because of his bad back. Get him to a good physiotherapist to address his back and then he is no longer suicidal. That is the practical steps we take in supporting men who come to us. Occupational therapy can be a lifesaver".

The magic key to male suicide prevention could be built around meeting men's actual needs; recognising/accepting who they are, not who the system thinks they should be and what they should have to accept.

Part 3: Policy Solutions

The evidence from these sessions (and previous APPG reports) points to two levels of public policy solutions – overarching, strategic which require wholesale policy changes and more tactical, specific solutions.

(12) Strategic Policies

There is recognition of the increased focus and investment on suicide prevention, however, it is not reducing male suicide at a significant pace.

The evidence clearly points to a fundamental strategic rethink at all levels; political, public service, societal and socio-economic. This is rather than a revised suicide prevention plan (albeit welcome) which, with its range of actions, will not sufficiently address the root causes and missed opportunities.

The current suicide prevention plan has a section on reducing middle-aged male suicide which relates to gambling clinics/research, screening interventions, communication campaigns and more funding for helplines. Any new suicide prevention plan that takes the same approach risks having the same limited, if any, effect. This is not a fault of the National Suicide Prevention Strategy

Advisory Group; the political scope has to be far wider to address fundamentals of wider Government policy.

The clear conclusion is that at a strategic level, there needs to be a range of policy solutions, including:

1) **Men's Health Strategy**: To tackle men's health and suicide, an overarching strategy has to be in place with a key strategic pillar being male suicide. As set out, men's poor health is driven by a range of external stressors and life events and that men will exhibit this through addictions, obesity, poor physical health, poor personal healthcare, depression/anxiety, risk-taking and suicide. These conditions can act as pathways to suicide.

   To reduce male suicide, the policy focus must recognise, tackle and limit the negative impact of stressors and life events. Resolving these will likely reduce male suicide far more than tactical actions and plans.

   Tackling male suicide should form a key part of the forthcoming White Paper of Health Disparities.

   The APPG has reported previously on the need and mechanism for a Men's Health strategy. Continual delays in putting this into practice are delaying overarching gender-informed, positive action and solutions.

2) **Cross Government Approach**: Allied to the above, a range of interventions are required. This is not just a Department for Health and Social Care responsibility; a deeper and holistic Government approach is needed.

   A range of other departments clearly have a role and the current suicide prevention plan outlines this, for example:

   - Ministry of Justice (family courts and prisons);
   - BEIS (employment and occupations);
   - HM Treasury (economy);
   - Education (training and skills);
   - DLUCH (local government and "levelling up");
   - Ministry of Defence (veterans);
   - Home Office (domestic abuse/sexual violence/forced marriage).

   Reforms and changes in these departments should include male suicide prevention as an aim. Long-term savings made through reducing male suicide should also be included in budget calculations.

3) **Minister for Men's Health and Wellbeing**: A glaring issue with respect to male suicide, male health matters and wider men's wellbeing issues more widely is that there is no one Minster with responsibility. This is why such little progress on male wellbeing is being made. There are four

equalities minsters, a women's health minister and a women's health ambassador yet not one has a clear responsibility for men.

If the Government is serious about tackling men's health, there has to be clear Government accountability, otherwise male suicide and men's health will continue to fall between the cracks because it is nobody's responsibility.

4) **Increased funding:** There has to be more investment in mental health and suicide prevention, not only from the clinical side but also to deal with issues such family court delays and increased skills training for the over 50's, which will deal with the underlying causes of male suicide.

5) **Specific responsibilities of the Office of Health Disparities (OHS) and Integrated Care Systems (ICSs)**: Targets should be placed on the OHS and ICSs to reduce male suicide and to ensure that ICSs are required to set out in their local plans specific workstreams with SMART objectives with respect to male suicide prevention. Targets are crucial alongside benchmarking with other countries where there has been a positive impact through targeted interventions.

6) **Male-friendly narrative**: The Government through a mental health strategy, suicide prevention plan and also through a men's health strategy has responsibility for setting the right tone. This should be a male-positive tone that eschews male victim-blaming or placing the primary responsibility on the shoulders of men when it should be on the shoulders of society, employers and public services. This includes not using the term 'toxic masculinity' in any policy or communications.

(13) Tactical Policies

Alongside a range of strategic policies, there are a number of tactical policies that should fit under them or are cross-Government issues that need to be addressed.

7) **Increase the number of male psychologists**: Current figures show that over 80% of registered psychologists are female and the undergraduate numbers have consistently been over that figure. It is vital this is addressed to ensure that there is an increase in male psychologists who will have the lived experience and the relatability of being men.

8) **Male psychology modules**: Only one university in the UK (Sunderland) has a male psychology module as part of its psychology degree[36]. This needs to be addressed urgently so that all psychologists ascertain a better understanding of men's issues.

[36] University of Sunderland, "Sunderland launches world's first male psychology module": https://bit.ly/3pYjpUk

9) **Fund more research projects covering diverse male groups:** The Government should commission a programme of granular research with respect to the diverse range of men who take their own lives. This should include regional and occupational differences (with commensurate action plans) and the spike in late teenage boys/early twenties' men.

10) **Support the Voluntary Sector with resources and informal partnerships**: To continue with their phenomenal success, charities such as Andy's Man Club, UK Men's Sheds and HiS Charity should be supported with finance, gifts in kind and included in care pathways, *but not controlled* by the Public Sector.

    Some, such as UK Men's Sheds, need support with core central costs (which is hard to receive) because, without a central coordinating body, the local branches will not be as effective or well-governed. Other organisations just need access to community centres; many enlightened local councils provide facilities for free on given days, other less enlightened ones demand fees.

11) **Gender-informed training and male-specific diagnostic tools:** The training of professionals, especially GPs, accident and emergency teams and social services should be gender informed about male related issues that lead to suicide. This will support greater professional curiosity and the asking of the right questions.

    There are also male-specific mental health diagnostic tools available which have shown to be successful. These need to be researched and actively considered for wholesale adoption.

12) **Communications campaigns should be male positive**: These should not be predicated on the command that "Men Should Talk", they should be male positive and make sure they are action-led, signposting to services/professionals who will listen without judgement. They should also be targeted at where men go, not where people think they should go.

13) **Providing free training for workers in high-risk sectors**: This is vital as they will be trained to spot and talk to colleagues at risk, such as in the building industry, or military. The hugely successful Mates in Mind is focussed on supporting the construction industry around primary prevention measures and culture change. The Lion Barber Collective trains barbers and hairdressers around male mental health. Such groups should be funded as part of a suicide prevention plan.

14) **Construction procurement policy**: There should be mandatory mental health sections on procurement frameworks in the construction industry so that it is viewed and addressed as on par with Health & Safety compliance. This could be rolled out into other high-risk occupations too.

15) **Improve construction industry regulations:** There should be mandatory mental health sections on procurement frameworks. Suicide, whether inside or outside of work, does not currently trigger a RIDDOR[37] to HSE for disclosure in the construction industry, when clearly it should do.

16) **Ensure equal recognition of male suicide in potential domestic homicides**: The current Tackling Domestic Abuse Plan[38] urges police officers that when assessing suicides/unexplained deaths with relation to potential domestic abuse, they think "particularly [about] females". This phrase should be removed as it is contrary to the equal application of policing towards individuals and men.

[37] Health and Safety Executive," Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013": https://www.hse.gov.uk/riddor/

[38] Home Office, "Tackling Domestic Abuse Plan", March 2022: https://bit.ly/3Skkcfb

Part 4: Conclusions and Recommendations

(14) Conclusions

After hearing from national and international health experts during this inquiry, it is clear that a new approach is needed with respect to reducing male suicide in the UK. It should form a key pillar of the Men's Health Strategy. There are also clear strategic and tactical levers that the Government, policy makers, health bodies and others should act upon to raise the profile of tackling male suicide. It should be treated it as a national emergency.

The evidence clearly suggests this new approach should not view male suicide as primarily a mental health issue. It is solution-based, focusing on and tackling underlying causes of male suicide, including:

- relationship breakdown;
- employment;
- workplace culture;
- finance;
- bereavement.

Continued increases in investment around suicide prevention will not achieve results unless this structural change is put in place. Addressing the political, public service, societal and socio-economic factors is vital.

The evidence also suggests a new gender-informed approach should be one that better understands male help-seeking and signs of distress. Rather than look for obvious signs, such as direct disclosures, it should look at the causes and issues that can take a man down the path to suicidality. This means a sea change in thinking and attitudes in public services and their professionals. Professional curiosity has never been more important. Healthcare professionals should be encouraged to proactively enquire how someone is feeling, especially in the known higher risk occupations.

Lastly, men do talk. They just talk differently to women and not always in a clinical setting. The phenomenal successes of informal voluntary groups which have sprung up in the last decade are testament to that. Their success is built on a positive male-centric approach that does not judge men but supports them in their own language and on their own terms. They should be supported but not controlled by state bureaucracy.

Male suicide is devastating for these men and those they leave behind. Placing the primary burden of responsibility on their shoulders and not on the shoulders of society, employers and public services is an approach that is not acceptable, nor fair. It is vital that a New Whole System Approach to Male Suicide is developed.

(15) Policy Recommendations

1	The creation of a Men's Health Strategy in England with a specific male suicide prevention strategy and plan forming a key pillar.
2	The Government to take a far deeper cross governmental approach to male suicide and tackling the underlying causes. This includes relevant departments having male suicide reduction as an aim.
3	A Minster for Male Health and Wellbeing to ensure there is Government accountability for delivery in reducing male suicide and wider health and wellbeing issues for men.
4	Specific responsibilities and targets for the Office of Health Disparities and local Integrated Care Systems (ICSs) for reducing male suicide.
5	The Government and policy makers to lead on creating a more positive male-friendly narrative with respect to male help-seeking and suicide.
6.	Tackling Male Suicide must be a key issue that is addressed in the Government's forthcoming White Paper on Health Disparities in England
7	The Government to work with universities and the British Psychological Society to increase the number of male psychologists and male students studying psychology degrees.
8	Universities to embed male psychology as a core part of their psychology curriculum.
9	The Government to commission a programme of research projects covering diverse male groups.
10	Local government and ICSs to support informal male support groups with resources and signposting without taking them over. This may include free access to community centres of example – and this should form part of the local community's suicide reduction strategy.
11	A programme of gender-informed training for GPs, the NHS, local councils and police with respect to understanding the male related issues that lead to suicide. This will also support greater professional curiosity.
12	The Government to fund free training for workers in high-risk sectors to look out for colleagues at risk, such as in the building industry, or military. In addition, there should be support for initiatives such as Mates in Mind, HiS Charity and the Lions Barber Collective.
13	Government and all public body communications campaigns with respect to male suicide and mental health to be male positive and targeted at where men go, not where people think they should go.

14	Mandatory mental health sections on procurement frameworks in the construction industry. This could be rolled out into other high-risk occupations.
15	Suicides at work to be disclosed as a RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations).
16	Revise wording on domestic homicides and suicide within the Government's Domestic Abuse Plan.

Appendices

Appendix 1: Speaker Summaries

(1) Glen Poole (Chief Executive of the Australian Men's Health Forum)

This is a précis of the evidence that can be viewed via this video[39]

Introduction

Glen is a global leader in the field of men's health and male suicidality and has spoken to the APPG before, including on the need for a Men's Health Strategy.

With respect to male suicide, his general view was that society and the medical profession felt:

- Male suicide is a mental health issue;
- Men are not as good as women at talking about their feelings, or about their mental health;
- Men do not seek help.

For those men with long term depression or long-term mental health problems who are suicidal, without doubt, the best intervention for them is psychological or psychiatric where much good work is being done. However, when research data is considered, it's a complete misanalysis of the problem of male suicide.

Men are blamed for not reaching out and getting help with their mental health, but that is not the help they are looking for or often need. The problems men generally see are largely practical rather than emotional; emotions subsequently follow.

Causes

Research shows some important differences between male and female suicide. Generally, the majority of women who die by suicide have a diagnosed mental

[39] Glen Poole: https://bit.ly/Poole-suicide

health issue; the majority of men do not. There are a range of issues and stressors/antecedents that put men on the road to suicide. In almost all cases there is at least one other serious social or psychological distress that is going on in a suicidal man's life, including problems with:

- Relationships;
- Money;
- Jobs/Employment;
- Law;
- Addictions;
- Trauma, including unresolved trauma from childhood;
- Bereavement.

When men are unable to cope with the distress and cannot find a way through, it becomes a 'rational' decision to them take their own life. Suicide for them is a solutions-based approach to deal with a problem(s) they face, as all other solutions in their view have been exhausted.

As policy responses are focussed on mental health interventions, it is a common failure to diagnose suicide properly – especially with respect how men express suicidality. Usually, men do not say "I am feeling suicidal", or "I need to talk about my feelings".

They are instead focussed on expressing and dealing with external issues (not the internalisation of those issues) and on what action can be taken to fix the problem. The average male who is thinking of taking his own life will also usually be socially isolated and disconnected – including those who have recently become so. They will present with issues such as:

- Dealing with a former partner;
- Dealing with the police and courts;
- Unable to see his children;
- Lack of awareness of rights;
- Homeless, with nowhere to sleep;
- Getting too old for blue collar work, possibly also dealing with diseases such as arthritis;
- Made redundant.

Some men develop their own 'healthy coping mechanisms'. Others are not so healthy and may turn to alcohol and/or drugs - a sign that a man might be suicidal is often that they are suddenly drinking more than they normally would as a coping mechanism.

Solutions

Glen called for a multi-agency approach across the public, private and voluntary sectors, where risk factors can be reduced to manageable levels. In general, when males can see a pathway out of their distress, suicidality reduces almost to zero.

When multiple interventions are in place, they can make a significant impact.

Examples of successful interventions include:

- Dealing with underlying causes;
- Public awareness campaigns;
- Training of professionals, such as GPs, to be gender informed about male related issues that lead to suicide;
- Reduction of the ease of taking large quantities of over-the-counter drugs (for example paracetamol);
- Fencing off hotspot locations with co-located signs that offer helpful information;
- Harnessing positive masculine attributes by training up workers in high-risk sectors to look out for colleagues at risk, such as in the building industry or military;
- An increase in the number of male psychologists and better promotion to men as a career;
- The funding of Voluntary Sector agencies that promote positive male messages and activities such as [in the UK] Men's Sheds, Andy's Man Club and HiS Charity[40].

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(2) Professor Nav Kapur (Head of Suicide Research, Manchester Metropolitan University)

This is a précis of the evidence that can be viewed via this video[41] and ground-breaking report on Middle Aged Men[42]

Data

Professor Kapur spoke about his report about suicide for middle-aged men. This report highlighted a number of key issues especially with respect to death by

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41 Professor Nav Kapur: https://youtu.be/t3eZDyivGKs

42 The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH): Suicide by middle-aged men (statistic featured in Professor Nav Kapur's presentation), https://bit.ly/3J4DeCi

suicides during 2017. It describes the stressors/antecedents of suicide, barriers to accessing services, and a range of recommendations.

Almost all (91%) middle-aged who have died by suicide had been in contact with at least one frontline service or agency, most often primary care services (82%). Half had been in contact with mental health services. It is therefore too simplistic to say men do not seek help. He said that we should focus on how services can improve the recognition of risk and respond to men's needs, and how services might work better together.

A stark fact arose is that 80% of those who took their own life and had been risk assessed by a clinician but were deemed to be 'low-risk' or 'no risk'.

Professor Louis Appleby added in his evidence (see below) with respect to this same research that "So they were they were in contact with services and if we put this positively, there were opportunities for prevention, but that prevention didn't happen. And so it raises the question as to contact for what, what were they there for and what happened to them. And it's probable that men, because of embarrassment and shame and because of reluctance to conceptualise their problems in mental health terms, may not present in a way that brings out the help that they need. It may also be that our services are not sufficiently vigilant about the people who present to them not talking about mental health or suicide, but nevertheless at risk."

For the minority (9%) of men who were found to be out of contact with any supports, there are several examples of local and national Voluntary Sector initiatives aiming to reach this group.

The research found high rates of key risk factors compared to their incidence in the general population. 30% of men were unemployed, and a fifth (21%) were divorced or separated. Over a third (36%) reported a problem with alcohol misuse and 31% reported illicit drug use. Overall, 57% were experiencing economic problems – unemployment, finances or accommodation – at the time of death.

More than half (52%) of men who died had a physical health condition, most commonly circulatory system diseases, such as hypertension. Services needed to be aware of the importance of physical ill-health as a factor in suicide risk and that help-seeking for physical health problems may be an opportunity for prevention. Suicide prevention for men in mid-life requires a range of public health, clinical and socio-economic interventions.

There is a comparatively low rate (5%) of engagement with talking therapies, which was evident among the men who were studied, despite the higher than expected rate of contact with services that was found. This is consistent with data showing women are twice as likely as men to finish a course of IAPT and are more likely than men to seek help through psychological therapy. Professor Kapur recommended psychological therapies suited to the needs of men should be offered.

4% of men in mid-life who died by suicide had previously self-harmed, 7% in the week prior to death. He emphasised that recognition of risk by services after self-harm is vital, as further self-harm may involve a method of greater lethality such as hanging. Men use far more lethal methods than women.

Reasons

The research showed that suicide for men is based on a combination and culmination of adversity factors that act as stressors/antecedents:

- Long standing risks (adverse childhood experiences);
- Build-up of adversity (unemployment, physical harm, isolation, bereavement/alcohol/drugs);
- New stresses/life events (relationship breakdown, financial problems, work, housing, isolation and contact with justice system).

Recommendations

There are a number of approaches to take which included:

- There is a vital role in prevention particularly for primary care, A&E, the justice system and mental health services. There should be focus on how these services can improve the recognition of risk and respond to men's needs and how services might work better together;
- Economic adversity, alcohol and drug misuse and relationship stresses are common antecedents of suicide in men in mid-life. Prevention requires a range of public health, clinical and socio-economic interventions;
- Middle-aged men who seek help for their mental health sometimes remain untreated. In particular, psychological therapies suited to their needs should be offered;
- Around half of the men who died were known to have self-harmed. Recognition of risk by services after self-harm is vital, as further self-harm may involve a method of greater lethality such as hanging.

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(3) Professor Rob Whitley (Associate Professor in the Department of Psychiatry, McGill University)

(Author of *Men's Issues and Men's Mental Health: An Introductory Primer, 2021*)

This is a précis of the evidence that can be viewed via this video[43]

Background

Men account for around 75 to 80 percent of completed suicides. These statistics are stable across most Western jurisdictions: Canada, the US, UK, Australia and

[43] Professor Rob Whitley: https://youtu.be/LP7bDf6RxQc

New Zealand. There was a period of declining rates of suicide in the late 1980s and 1990 but since around 2006-2008 rates of male suicide started increasing again.

There has been a lot of investment in attempts to try and help prevent suicide and male suicide in particular, but the fact that the rates are increasing (and not declining) indicate that we do need a new approach.

Overall Causes

Professor Whitley stated that suicide is almost never a result of a single cause and that we should not say X causes suicide or Y cause a suicide. Suicide, like any complex health outcome, is usually determined by a range of risk factors which intertwine. We talk about a web of causation or multifactorial causation. There are well researched and well-established risk factors and these include:

- **Mental illness.** Men with a mental illness have a much higher risk of suicide than men without mental illness. Schizophrenia is probably the mental illness with the highest risk, but also depression, post-traumatic stress disorder, anxiety, eating disorders. The other mental illnesses also have a high risk;
- **Separation and divorce**. Divorced men and separated men have a higher risk of suicide than non-divorced married men and unmarried men. This is especially the case where the divorce involves separation from children. There's still a social stigma associated with divorce. There can be financial issues for men involved because they often have to support, in a way, two households. They support their own household and then have to pay contributions to the mother to support her household;
- **Job loss and unemployment**. This is a risk factor especially amongst blue collar men and a lot of manual workers, men who work in manual trades. When men lose a job, it is usually an unwanted transition, the same as a divorce or a separation, and it has financial, social and psychological consequences. Obviously, it means lost income and lost social support that comes with work. Work gives meaning, purpose, structure and routine. Being unemployed typically means monotony, boredom, social stigma and loneliness. The statistics prove that blue collar men, less educated men, manual workers, when they lose a job and when they have a long period of unemployment, they have a higher risk of suicide.

Transversal/Universal Issues

Professor Whitley explained that there are some transversal issues that sit across those three risk factors above:

- **Social integration and social connection:** If you are unemployed, if you have a mental illness, if you are a recently divorced father who is living in a bedsit away from your children, men will typically be lacking some level of social integration and social connection;

Meaning and purpose: Work gives many people including men meaning and purpose in life. Men who the primary breadwinner at the head of a household, being a good father, a good husband, someone who is leading the family, can also bring a lot of meaning and purpose. Divorced and/or unemployed men can often be lacking in that meaning and purpose. People with mental illness may also find it hard to establish that in the first place;

- **A gap in services:** we know that unemployed men, men who are divorced and divorced men with mental illness have higher rates of suicide. They have these issues and find such transitions very difficult to cope with. However, there are no or very few male sensitive services, very few services tailored to the male experience which tap into the male proclivities to help one another out, to take action, to look for solutions and to work together to try and solve the problem.

Solutions

There are many different types of healing and certainly there is not a 'one size fits all' solution for people who are undergoing mental stress or mental issues. The official mental health system typically offers a limited suite of options, usually medication and talking therapies. However, there is a range of options:

- **Medication and Talking Therapies:** This is a quick fix and does not necessarily solve underlying issues. Second is talking therapies or psychotherapies, which are certainly very helpful but have very long waiting lists;
- **Reform of family law:** This should be considered as a part of a male suicide prevention strategy, because so many suicides are linked to what's happening after separation and divorce;
- **Shoulder-to-Shoulder/Action programmes.** There have been many programmes which have tried to base themselves on shoulder-to-shoulder programmes. In addition, programmes which involve an action more than just simply "talk to me, tell me about your feelings" are successful as men like to engage in activities. They like to go in the garden, they like to repair bikes. They like to go for a walk;
- **Recovery colleges**. Recovery colleges are like an adult education college where people with mental health issues can go and learn new skills and take courses;
- **More focus on the negative impact of unexpected life transitions and provide appropriate supports**. Losing a job, suddenly getting divorce, bereavement, leaving the military can be risks. These life transitions, some of them are unexpected, can be very difficult times in a man's life, and there is not really any appropriate support beyond a few peer support organisations here and there, which again are doing a valiant job and trying to help, often underfunded and under-supported. We need

more services and more help for at least the men who are undergoing these sort of events;

- **We need a strengths-based rather than a deficit-based approach to men's mental health**. Professor Whitley explained that we need to build on the strengths of men having mental health issues and mental distress, rather than berate them or judge them and use phrases like 'toxic masculinity', 'male privilege' or 'patriarchy'. Many men who have had mental health issues have been very good family members and good employers. They have been good citizens. They have learnt many skills in their life and they are now undergoing an issue or a problem and we need to identify those strengths and build on their strengths instead of taking a judgemental, singularly victim blaming approach.

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(4) Professor Louis Appleby (Professor of Psychiatry at the University of Manchester)

(Also, Director of the National Confidential Inquiry into Suicide and Safety in Mental Health. Chair of the Government's Advisory Group on the National Suicide Prevention Strategy)

This is a précis of the evidence that can be viewed via this video[44].

Professor Louis Appleby's team at the University of Manchester (including Professor Nav Kapur above) have been leading academic research into male suicide. The other main research hub is the Suicidal Behaviour Research Laboratory at Glasgow.

Professor Appleby's detailed evidence presented a number of figures on recent risk and also some trends over the last several years. In addition, he highlighted causal factors and priorities for prevention, a number of these were covered by Professor Kapur's evidence and one important point that Professor Appleby made, we have added into his evidence so that it flows.

Professor Appleby also made some really important points on intersectional groups.

In 2007, a few years into the first suicide prevention strategy, England had the lowest suicide rate on record for England, and records began in 1861. It rose and then fell back in 2017. The reason for the rise in between 2007 and 2017 is, "suicide rates are very sensitive to economic circumstances and is one of the main drivers of suicide and this period is between the financial crisis". It particularly impacted men in their fifties. He also stated that it is, "a particularly

[44] Professor Louis Appleby: https://www.youtube.com/watch?v=Rr6Uoy3_JPQ&t=1035s

important concern as we move into a period of economic stresses just now with the cost-of-living crisis, bringing difficult news for many people."

There has been a further rise post 2017 which was owing to how suicide was concluded at coroner's inquests, "The standard of proof was lowered. And so if you lower the standard of proof required, then inevitably you put the numbers up".

Trend Data

He highlighted a number of really important pieces of trend data:

Twenty years ago, the biggest cohort of men taking their own lives, were men in their thirties. Now it is men in their fifties. However, this is the same group of men, they are just twenty years older. So for middle aged men at the moment is a confluence of two concerning factors historically high suicide rates in that particular group of people, even though they've aged during that time, and a greater sensitivity to economic hardship.

The last time men over 75 had the highest suicide rate was 1994 but it is now one of the lowest. Something has changed for older men. Their lives have become safer, less vulnerable to suicide. It is probably due to a number of factors. Those suicide effect is caused by one thing. But it would be hard to put aside the fact that health care for older people and including mental health care has been greatly developed during the last three or four decades.

There has been a very substantial fall in the suicide rate in mental health patients. It is around 70 deaths per 100,000 people per year so it still relatively high and equates to aroid 8-900 suicides by male mental health patients every year. This fall has occurred for a number of factors, one of them is that we now have far more people under mental health care and that mental health services have become safer, particularly for men.

The increase of the internet was raised by Professor Appleby as a concern with respect to middle aged men – who find out how to take their own lives. The research found 15% of men who died by suicide had used the internet in ways that were suicide-related, most often searching for information about suicide methods. He recommends online safety should be part of any prevention plan for men at risk of suicide.

There has been a continual increase in the number of young men taking their own lives and that this has growing trend for men in their late teens to take their own lives since 2010. New research being conducted shows it spikes sharply for men in their late teens "a very rapid escalation".

Professor Appleby explained that "Something is happening in the lives of young people, and we need to try and understand what it is. We were able to identify in the report some early experience families with mental illness or substance misuse or domestic violence, experiences of abuse and neglect and maybe being in care. There are also signs of online risk. So again, this point about using the Internet in a way that presents a risk, not just social media, but also searching

for methods of suicide." He also added that for young LGBT+ people bullying and intimidation was present. It shows that social prejudice is an important factor.

Professor Appleby also made the point about the importance of ethnicity with respect to suicide prevention. The Office for National Statistics for the first time has published this data and there are different rates between different groups. In most cases, those from ethnic minorities do not have higher suicide rates than white British males, however, with one exception being people of mixed or multiple ethnicities.

Professor Appleby also raised the importance of the growing voluntary sector and that was a need for partnership with it. He stated that, "it is often the voluntary sector that provides the setting that is acceptable to men who are struggling. With the voluntary sector not necessarily marking their door with the words 'health', certainly not with mental health or suicide prevention, it is a more acceptable setting for men who feel ashamed of what has happened to them. Sometimes the voluntary sector presents the reason for their service as being quite removed from mental health. It might be about sport or about social life or about men's hobbies, and that brings men in who might need to talk, who might need to find support. This is a very important prevention partnership".

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(5) Oli Vikse (Project Development Champion, Andy's Man Clubs)

This is a précis of the evidence that can be viewed via this video[45]

Andy Man's Clubs (AMC) have been a tremendous success and sit alongside other organisations and initiatives such as UK Men's Sheds.

The first club was formed in Halifax in 2016 in West Yorkshire by Luke Ambler in response to his brother-in-law's suicide. The first club saw nine men attend. Now across the UK, there are 103 clubs with 1,800 attending every Monday night. He stated that when you create the right environment, men do come. There are also online sessions for those who cannot reach a physical venue.

The key reasons men are attending and are concerned about are:

- Finances, including financial insecurity;
- Relationship breakdown;
- The related impact of the above with respect to contact with children;
- Bereavement (including if a family member/friend has taken their own life).

[45] Olli Vikse: https://bit.ly/3S2rrIA

Each AMC is run by a facilitator who is a volunteer who themselves have attended an AMC session at a point where they were struggling. Each AMC session is confidential and starts with a series of questions:

- "How's your week been?"
- "What's been one positive from your week?"
- "Have you got anything that you'd like to get off your chest?"

It is described as a community and many meet up separately for other engagement opportunities such as walking/running groups, football, rugby, mountain biking. They also run stalls at galas and deliver presentations to local businesses.

Awareness is generated through their website, social media, local newspapers, radio, TV, delivering presentations to businesses, working in partnership with other organisations, posters, billboards and MPs.

Men who need more tailored support are referred to specialist services.

When asked about what support AMCs needed from the state – the answer was clear that it's promotion, signposting and support for venues. Nothing more. AMC's do not want to be part of the 'state' or 'state-based intervention' else it loses the structured informality and authenticity that is so key. It also risks undermining the anonymity of the clubs.

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(6) Jules Morris (Chief Executive, HiS Charity)

This is a précis of the evidence that can be viewed via this video[46]

HiS Charity takes a holistic approach and is meant to bridge a gap in the mental ill-health service.

What HiS does first and foremost is to provide a nurturing and holistic support service. They are a supplementary service and not a clinical service, they are a service that meets a person's human needs.

In order for a person to feel whole, their five basic needs must be met:

- Love – to be cared for;
- Belonging – to feel part of something;
- Achievement – to have a sense of making a difference;
- Being heard – to feel useful;
- A purpose – a drive.

[46] Jules Morris: https://bit.ly/3OyCuX2

The charity supports men with the tools to enable them to deal with their own mental ill-health with a tailor-made package and team around them who ensure their needs are met. They adapted the Abraham Maslow theory, which puts forward that people are motivated by five basic categories of need:

- Physiological - food, clothing & shelter;
- Safety - protection & financial security;
- Love and belonging - friendship & family bonds;
- Esteem - self-respect & personal growth;
- Self-actualisation - self-fulfilment.

They do not simply offer counselling; they tailor the package for the individual. For example, they recognise that depression can be triggered by pain and so may enlist the help of an osteopath, or whatever is appropriate.

Similar to other initiatives such as Andy's Man Club, they have spawned a variety of activity groups such as boxing, fishing and mindfulness.

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(7) Des McVey (former Consultant Nurse and Psychotherapist, Whitemoor prison)

This is a précis of the evidence that can be viewed via this video [47]

Des explained that men in prison are nearly four times more likely to take their own life than the general male population. The most concerning time is for prisoners on remand and the first few weeks of a sentence. Post-release, men are eight times more likely to take their own life after than the general population.

The range of contributory factors that heightened suicide risk for men in provision are:

Prior to custody male prisoners face a range of experiences:

- Unresolved childhood trauma;
- Being from disadvantaged communities;
- Having to be stoical to survive;
- Difficulty in regulating emotions / impulsive;
- Increased rates of mental health problems;
- Higher levels of shame, sadness, fear and hopelessness;
- Coping strategies that impact deleteriously on mood;

[47] Des McVey: https://bit.ly/3cz2NiB

- Less likely to be in a stable relationship.

During custody, male prisoners face a range of experiences:

- Prison is traumatising;
- Adjusting and transitioning to prison life;
- Dislocation from family / friends / children;
- The uncertain time frame of the sentence and how long they will be in custody;
- Poor prison conditions;
- Inconsistent prison regimes;
- Bullying by other prisoners;
- Failure to create communities or build support;
- Poor quality mental health services;
- Lack of respect for contribution of health personnel;
- Lack of purpose.

Male mental health problems for prisoners are exacerbated by prison staff issues:

- Lack of mental health training;
- Too low staff numbers;
- Lack of transparency and Lack of accountability.

Recommendations:

- Reserve prison for only the most dangerous;
- Improving the prison fabric, higher staff levels and improved training and improving the quality of prison staff;
- Professionalise officers and governors;
- Encourage compassionate enquiry.

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(8) Sarah Meek (Managing Director, Mates in Mind)

This is a précis of the evidence that can be viewed via this video[48].

Mates in Mind is a charity that was initiated by Health in Construction Leadership Group (HCLG). It has a board of trustees working within the industry. It is aimed

[48] Sarah Meeks: https://www.youtube.com/watch?v=kqWjd-QoNao

at supporting the mental health of those who work in the construction industry, either through being directly employed or through self-employment/freelance.

Men in the construction industry are over three times more likely to take their own life than other men.

Mates in Mind in partnership with the Institute of Employability Studies have conducted research with those in the construction industry who worked for SMEs. This is a largely invisible group. One third said they suffered anxiety. This was especially the case with: painters, decorators, plasterers, joiners, electricians, plumbers and landscapers.

The main causes of anxiety were: workload, business partners/colleagues, pressure at work, family/relationships and financial pressures/debt.

The research showed that:

- Over 50% find talking about mental health "extremely difficult";
- Two-thirds feel the stigma of mental health stops people talking about it;
- 40% would not dare to discuss mental health with a colleague;
- Only one third said their GP is easy to talk to about mental health;
- Most would speak to a close friend or family member.

The main recommendations were:

- Mandatory mental health section on procurement frameworks;
- Statutory funding to support this high concern industry;
- Support for young people and new entrants into the industry – consider the skills gap and the future of construction;
- Suicide should require a RIDDOR disclosure.

Sarah identified three main types of help:

- **Primary prevention**: stopping mental health problems before they start e.g. incorporating mental health & wellbeing policies into the workplace;
- **Secondary prevention**: supporting those at higher risk of experiencing mental health problems e.g. providing MH awareness training to managers & staff and how to spot signs/what to do etc;
- **Tertiary measures**: helping people living with mental health problems at a time of need e.g. employee assistance programme, helplines, apps, mental health first aiders.

(9) Dr John Barry (co-founder of the Male Psychology Section of the British Psychological Society):

(Co-author of *Perspectives in Male Psychology: An Introduction, 2021*)

Dr Barry recognised that any robust response to the issue of male suicide will require cross agency working, including psychologists, police, health and prison services and so on. In particular, the work of the family courts should be included, following a review of their working practices.

Accepting suicide is a complex, multifactorial issue, Dr Barry pointed out that one of the biggest current risk factors is connected to relationship breakdowns and the family courts. Research shows that men who are divorced are twice as likely to die by suicide than those who are not.

There is a lot of evidence that demonstrates that stable relationships are very good for mental health. Therefore, it is not surprising to find that relationship breakdowns and divorce have a really severe impact on men's lives. Less well researched is the issue of contact with children following family breakdown. However, some recent research looking at the impact of family breakdown and family court issues found that by far the biggest problem is access to children. There is some good research data available about the relationship between male suicide and family breakdown, but more needs to be done in this area.

Related to the above is society's attitudes to masculinity. There is a sort of male gender blindness and a negative attitude to masculinity in some areas of society. There is a lot of talk about concepts such as 'toxic masculinity' and 'the patriarchy'. Whilst there are things about masculinity that could be improved, as in all matters, research shows that emphasising positive male attributes improves men's wellbeing. A demeaning approach runs the risk of becoming a self-fulfilling prophecy. Dr Barry produced a survey a couple of years ago and found that 80% of respondents said that they were concerned, very concerned or worried about the effect that negative views about masculinity, as depicted in the media, might have on boys.

His recent survey of 4000 men in the UK and Germany found that men's mental wellbeing is significantly negatively impacted by the belief that masculinity itself is toxic.

Whilst there are bad men and bad fathers, we should be mindful that some of the worst behaviours that the men do are done by men who've been traumatised in childhood or have been abused in some way. This is not to absolve them from responsibility, but this point illustrates there is an empathy gap that men have to deal with. However, it is wrong to assume men don't care about their children, this narrative about men needs to be addressed.

It should be recognised that men often do seek help from therapists, but they tend to prefer to fix whatever it is that is making them distressed rather than talk about their feelings. When there appears to be no solution for men who lose contact with their children, they are devastated. They are going off and killing themselves. They are self-medication with alcohol, a sort of slow suicide.

Overall, Dr Barry explained five levels that impact men and how they engage with the world they live in:

Dr Barry calls for:

- procedures within family courts to be urgently investigated and problems addressed if male suicide is to be reduced;
- more research to be done to understand the impact of divorce and parental separation;
- more research to look into the effects of projecting positive aspects of masculinity to help men and boys.

Annex 2: Evidence Sessions

Information and recordings of the evidence sessions can be found at: https://equi-law.uk/inquiry-no-3-male-suicide/

The recordings are also available: APPG YouTube channel[49]

[49] APPG YouTube Channel: https://bit.ly/3vkTSrx

Annex 3: Terms of Reference

The terms of reference for this inquiry can be found at: https://equi-law.uk/inquiry-no-3-male-suicide/

Annex 4: Authors and Secretariat

This policy report has been authored by:

- Mark Brooks OBE, Policy Advisor to the APPG on Issues Affecting Men and Boys: www.mark-brooks.co.uk
- Mike Bell and Christopher Badley, Equi-Law UK (who also act as the secretariat): www.equi-law.uk

To contact the APPG, please email: Mike Bell: mike@equi-law.uk

Further information about the APPG including its membership, can be at: https://equi-law.uk/appg-menboys/

Annex 5: Support Organisations

If you have been affected by the information in this report, please contact support organisations including:

Samaritans: https://www.samaritans.org/

Papyrus: https://www.papyrus-uk.org/