PUBLICFIRST

Tackling The Stigma

Using the power of sport to support men's mental health

Contents

Executive summary

How best to provide diagnosis, support, and treatment for those suffering from mental health problems has emerged as a pressing policy question. While traditionally, mental health has been considered a lower priority than physical health, a welcome concerted effort has been made in recent years towards 'parity of esteem'. That means valuing physical and mental health equally. Politicians, clinicians, and campaign groups have directed considerable effort at tackling the stigma associated with suffering from mental health problems. For their part, responsible businesses and employers have also recognised the importance of supporting the mental health of their workforce and taken action to do so.

As an indication of the growing priority being placed on tackling mental illness, former UK Prime Minister Theresa May identified poor mental health treatment as one of her 'burning injustices' that she was committed to tackling upon entering Downing Street. During her tenure, she announced a £2.3 billion annual real terms increase in mental health care spending, as well as a raft of measures to better support prevention of mental health issues among young people.

At the same time, there have been a growing number of reports suggesting an increase in mental health issues, particularly among the young[1]. The recognition of the need to better support mental health is overdue. However, it is also the case that we have not yet identified a 'silver bullet' in tackling mental health problems. There remain 'hard-to-reach' groups who are less willing to discuss, seek support, or engage in treatment for mental health issues, chief among them are males from the lowest socio-economic groups – in common usage, working-class men[2].

That reluctance to seek support has real costs, both social and economic. Mental ill health is estimated to cost the UK economy somewhere in the region of £70bn-£100bn a year. Furthermore, suicide is the most common cause of death for men aged between 10-49[3].

1 Pitchforth, J., Fahy, K., Ford, T., Wolpert, M., Viner, R. M., & Hargreaves, D. S. (2019). Mental health and well-being trends among children and young people in the UK, 1995–2014: analysis of repeated cross-sectional national health surveys. Psychological medicine, 49(8), 1275-1285.

2 We use the term 'working-class' to mean NRS social grade C2/D/E

3 ONs (2018). Suicides in the UK: 2018 registrations. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations

Finding ways to better support working-class men experiencing mental health issues is therefore an important policy priority. How do you help a group of people that experiences problems, but has been historically reluctant to seek help?. To explore ways to answer this problem, *Kindred* supported *Public First* to produce this report – which is centred upon a new survey of 4,000 people across the UK to identify potential gateways to reach working-class men about mental health issues.

At the outset, we should make clear that this report has not been written by clinicians or experts in the treatment of mental health. Nor has it been written as a defence of the betting and gaming sector. Rather, we have tried to offer a contribution to the debate on how to improve existing mental health problems based on a public policy analysis and on detailed, original opinion research of the general public – many of whom declare varying forms of mental health challenges. The focus of our research has (very deliberately) been on what are defined as the 'common mental health disorders' (i.e., anxiety and depression) and mild expressions of those disorders rather than more those conditions which require more significant clinical interventions. In short, we have examined those issues where a public policy response is reasonable, rather than those more serious and complex issues which must rely much more heavily on the clinical community.

The detailed survey we conducted confirmed existing academic research, highlighting that those in lower socio-economic groups are disproportionately likely to suffer from mental health issues. While men are less likely to be aware of symptoms of depression, or to seek treatment as a result, working-class men sit at the intersection of these two groups. As such they are both less likely to be at risk of mental health issues, but are less likely to seek treatment for them. However, the research also highlighted a potential way to reach this group. The polling found that working-class men are considerably more likely to follow sports than other social groups, and football in particular. They are also much more likely to consider sport to be an important part of their lives and the local community.

The survey showed:

- 33% of working-class men are unaware of the symptoms of depression (compared to 23% among everyone else);
- Among those who indicated they had experienced symptoms of depression, 43% of working-class men say it had no effect on

their work life compared to half of the rest of the sample;

- 28% of working-class men said symptoms of depression had no effect on their social life compared to 35% of the rest of the rest of the sample;
- 61% of working-class men identified as a fan of a specific sports team, compared to 49% of everyone else;
- 47% of working-class men considered their team to be important to their life, compared to 35% of everyone else.

Previous academic research has suggested the importance of reaching out to working-class men 'on their own terms' through partnership-based group work approaches. It is out of the scope of this report to understand exactly why, but from existing research we can hypothesise that this reflects a 'pride' felt by many men from traditionally working class communities. Small scale studies have suggested that sports-based interventions, and in particular those delivered through football meet this test and overcome some of the aversion to help-seeking behaviour among men. Taken together with the compelling findings of our policy research, which highlight how important football is to the lives of working-class men, it appears that interventions delivered through, or in partnership with, football clubs have real potential to reach working-class men suffering from the common mental health disorders. *Team Talk*, a programme delivered by Derby County Community Trust, and supported by *32Red* (a *Kindred* brand) is one such scheme, which shows early promising signs of being able to support men with mild mental health conditions.

Initial evaluations of this scheme show real promise in improving men's mental health. There is now the potential opportunity for other football clubs to replicate this scheme in their local areas. While more evaluation over the long-term is needed, the evidence from *Team Talk* suggests that by working in partnership with local NHS commissioning groups through 'social prescribing' and greater funding from corporate sponsors, football clubs have the chance to make a real contribution towards improving the wellbeing of their fans and local communities.

We recognise that the role of the betting and gaming sector has been a high profile political topic in recent months and that a number of politicians have argued against the industry's role in sport, along with other industries such as food and drink. However, given there are clear signs that by using sport and football as both a way to

engage working-class men and address mild mental health issues, programmes such as this can help to overcome some of the stigma surrounding mental health and men's reluctance to engage.

The structure of this report is as follows: Chapter 1 summarises evidence from the Office for National Statistics (ONS) and other sources on the prevalence of mental health issues and gender/socio-economic variations. Chapter 2 explores the existing literature and research around 'help-seeking behaviour' among working-class men, and effective approaches to reaching them. Chapter 3, upon which much of our analysis sits, presents the findings of *Public First's* detailed new polling, with a focus on working-class men's experience of mental ill health and the potential importance of sport to reach this group. Chapter 4 provides an overview of the work and impact of *Team Talk* as a case study and potentially replicable model to better reaching working-class men. Finally, Chapter 5 explores the costs of mental ill health and the consequent positive benefits of tackling it through schemes such as these.

Through this report we seek to inject some ideas that policymakers might consider in conjunction with their discussions with clinical staff and mental health specialists. We make tentative conclusions for policymakers and mental health specialists to discuss in what is becoming, at long last, a more serious public conversation on what is an extremely important health and social issue.

Chapter 1

Mental health in the UK, trends, and variations

Background

Every week in the UK, one in six adults experience a symptom of a 'common mental health problem'[4] categorised as depression and the different anxiety disorders. Nearly half of all adults say they have experienced a mental health disorder at some point in their lives and a third have received a diagnosis.

Over the past 20 years, there has been an increase in reported mental health problems among women, while reported rates among men have remained stable. This is particularly true of young women. 26% of women between 16 and 24 years report experiencing the common mental health disorders, compared with 9% of men their age. However, there has also been an increase in reporting of common mental health disorders in those aged 55 to 64 years.

Suicide is the leading cause of death in men aged between 10-49 years[5] and the demographic with the highest suicide rate is men aged 45 to 59 years[6].

Gender and Mental Health

There are a number of gender differences reported in both the prevalence of mental health problems and the types of problems experienced by men and women.

Women are more likely to report suffering from common mental health disorders[7]. Depression has been found to be between 1.5 and 2.5 times more prevalent in women[8]. Boys and men are more likely to be diagnosed with autism[9], with an incidence of around 1.5% versus 0.25% of women and girls. However, there is some evidence

4 Mental Health England (2016) 'Fundamental Facts About Mental Health 2016' Retrieved from https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf

5 Mental Health England (2016) 'Fundamental Facts About Mental Health 2016' Retrieved from https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf

6 Office for National Statistics. (2017). Suicides in the UK: 2017 registrations: Registered deaths in the UK from suicide analysed by sex, age, area of usual residence of the deceased and suicide method. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2017registrations

7 National Collaborating Centre for Mental Health. (2011). Common Mental Health Disorders: The NICE Guideline on Identification and Pathways to Care. National Clinical Guideline Number 123.

8 Waraich, P., Goldner, E. M., Somers, J. M., & Hsu, L. (2004). Prevalence and incidence studies of mood disorders: A systematic review of the literature. Canadian Journal of Psychiatry, 49(2), 124-138.

9 McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.

to suggest that this may be a result of women being better able to 'camouflage' their autism[10].

Men also have much higher rates of alcohol dependence with as many as a quarter of men aged 16-60 years drinking dangerous amounts[11]. Analysis of NHS data shows that of 10,000 British people, about 17.1 men and 7.6 women present with alcohol dependence annually[12], with the highest rates of dependence among those between 35 and 54 years old.

Women and girls make up 62% of all hospital admissions for intentional self-harm[13]. They have a higher rate of suicide ideation[14] and they are much more likely to attempt to commit suicide[15]. However men are three times more likely to actually commit suicide[16]. Suicide is the biggest cause of death for men aged between 10 and 49. This highlights the catastrophic impacts of leaving mental health conditions unaddressed. This trend is consistent across most countries, except for China where women have a higher suicide rate[17] and in Eastern Mediterranean countries where the ratio between men and women is roughly equal[18].

There are hormone-based explanations for women having higher rates of anxiety[19] and depression[20]. However, there is also evidence to suggest that depression is being underdiagnosed in men because the diagnostic criteria favour a more typically female expression of depression. When male-specific screening tools are used, the disparity in prevalence diminishes[21]. This is especially problematic because men who exhibit male-typical (rather than traditional) symptoms of depression are less likely to seek help[22].

Men also have a higher propensity for violence. Across different

10 Lai, M. C., Lombardo, M. V., Ruigrok, A. N., Chakrabarti, B., Auyeung, B., Szatmari, P., ... & MRC AIMS Consortium. (2017). Quantifying and exploring camouflaging in men and women with autism. Autism, 21(6), 690-702.

11 Ibid.

12 Thompson, A., Wright, A. K., Ashcroft, D. M., van Staa, T. P., & Pirmohamed, M. (2017). Epidemiology of alcohol dependence in UK primary care: Results from a large observational study using the Clinical Practice Research Datalink. PloS One, 12(3), e0174818.

13 Winter, J. (2015). Provisional monthly topic of interest: Hospital admissions caused by intentional self-harm. Health and Social Care Information Centre. Retrieved from content.digital.nhs.uk/catalogue/PUB19222/prov-monthes-admi-outp-ae-April%202015%20to%20August%20 2015-toi-rep.pdf [Accessed 23/08/16].

14 Canetto, S. S., & Sakinofsky, I. (1998). The gender paradox in suicide. Suicide and Life□Threatening Behavior, 28(1), 1-23.

15 Very Well Mind (2019). Rates and Statistics for Suicide in the United States. Retrieved from https://www.verywellmind.com/suicide-rates-overstated-in-people-with-depression-2330503

16 Ibid.

17 Hawton, K. (2000). Sex and suicide: Gender differences in suicidal behaviour. British Journal of Psychiatry, 177(6), 484-485.

18 Värnik, P. (2012). Suicide in the world. International Journal of Environmental Research and Public Health, 9(3), 760-771.

19 Maeng, L. Y., & Milad, M. R. (2015). Sex differences in anxiety disorders: Interactions between fear, stress, and gonadal hormones. Hormones and Behavior, 76, 106-117

20 Albert, P. R. (2015). Why is depression more prevalent in women? Journal of Psychiatry and Neuroscience, 40(4), p219– 221

21 Zülke, A., Kersting, A., Dietrich, S., Luck, T., Riedel-Heller, S. G., & Stengler, K. (2018). Screening instruments for the detection of male-specific symptoms of unipolar depression – A critical overview. Das Gesundheitswesen, 80(8/9), P-67.

22 Call, J. B., & Shafer, K. (2018). Gendered manifestations of depression and help seeking among men. American Journal of Men's Health, 12(1), 41-51.

cultures, men commit more crimes than women[23], including more violent crimes[24]. Poor mental health can be linked to violence although it is not via a direct link, except for in cases of schizophrenia and bipolar disorder[25]. Instead the causation is further removed with poor mental health linked to alcohol and substance abuse[26], and alcohol abuse has an established link with violence[27].

Consequently, while reported rates of depression indicate that it is more prevalent among women, this is likely in part because of both underdiagnosis and the fact that men are less likely to seek help for depression. Furthermore, the evidence is clear that the consequences of leaving mental ill health among men unaddressed can be catastrophic, with men experiencing higher rates of alcoholism, violence, and suicide.

Socioeconomic variations

To consider differences between depression rates and social class requires a clear definition of social class. For the purposes of this study, we use social groups C2/D/E to define 'working-class' (a short-hand for non-professional workers). It is very easy to see how depression can impact a person's ability to work, perhaps leading to lower incomes, a more challenging experience of formal education and more difficulty seeking employment. In many ways there is a natural vicious cycle explicit in this association; those who are out of work and struggling to get by on limited income are likely more exposed to the stressors we might expect to contribute to depression. Previous literature has indicated greater complexity than this.

Assari demonstrated that the protection from Major Depressive Episode (MDE) by higher Socio-Economic Status (SES) is not consistent across groups of individuals. For example, he found that higher income appeared to have a stronger positive effect for women, as well as a number of interactions with ethnicity[28]. There is also some evidence that those near the middle of the social hierarchy suffer higher rates of depression (and anxiety) than those at the top

23 Walker, J.T. & Maddan, S. (2013). Understanding statistics for the social sciences, criminal justice, and criminology. Burlington: Jones & Bartlett Publishers. p. 99. ISBN 978-1449634032

24 Rowe, D. C., Vazsonyi, A. T., & Flannery, D. J. (1995). Sex differences in crime: Do means and within-sex variation have similar causes? Journal of Research in Crime and Delinquency, 32(1), 84-100.

25 Rowe, D. C., Vazsonyi, A. T., & Flannery, D. J. (1995). Sex differences in crime: Do means and within-sex variation have similar causes? Journal of research in Crime and Delinquency, 32(1), 84-100.

26 Jane-Llopis, E. V. A., Jané-Llopis, E., Matytsina, I., Jané-Llopis, E., & Matytsina, I. (2006). Mental health and alcohol, drugs and tobacco: a review of the comorbidity between mental disorders and the use of alcohol, tobacco and illicit drugs. Drug and Alcohol Review, 25(6), 515-536.

27 Boles, S. M., & Miotto, K. (2003). Substance abuse and violence: A review of the literature. Aggression and Violent Behavior, 8(2), 155-174.

28 Assari, S. (2017). Social determinants of depression: The intersections of race, gender, and socioeconomic status. Brain Sciences, 7(12), 156.

or bottom[29]. However, there are a number of other potential factors (e.g., long working hours relating to more depressive symptoms among women, and working weekends across genders[30]).

However, all this considered, there is little doubt of an association between lower SES and greater risk of depression. Children and adults living in the lowest 20% income bracket in Great Britain are between two and three times more likely to develop mental health problems[31]. There is a general and consistent finding of greater ill-health among those in lower social groups[32-33] - and specifically depressive symptoms[34]. A systematic review of 23 countries found that socioeconomically disadvantaged young people are three times more likely to develop mental health problems than their peers from socioeconomically advantaged families and their mental health was shown to improve in cases where the family's socioeconomic status also improved[35]. Even when controlling for socioeconomic status, poor quality housing and a lack of amenities also correlate with poor mental health[36].

Investigations into the direction of causation have tried to establish whether lower socioeconomic status results in higher depression rates or whether depression results in a lower socioeconomic status, suggest that socioeconomic status has a greater effect on mental health than the reverse[37].

Low parental education specifically was associated with a risk of child depression while parental and child depression was not predictive of future occupation, education, or income. This is supported by Hudson, who found that economic stress is a likely reason for the impact of SES on mental health, and demonstrates little evidence of movement into less favourable communities and employment conditions among patients[38]. However, this lack of 'downward drift'

29 Muntaner, C., Borrell, C., Benach, J., Pasarın, M.I., et al. (2003) The associations of social class and social stratification with patterns of general and mental health in a Spanish population, International Journal of Epidemiology, 32(6), 950–8

30 Weston, G., Zilanawala, A., Webb, E., Carvalho, L. A., & McMunn, A. (2019). Long work hours, weekend working and depressive symptoms in men and women: Findings from a UK population-based study. Journal of Epidemiology and Community Health, 73(5), 465-474.

31 Ibid.

32 Acheson, D. (1998). Independent inquiry into inequalities in health: Report. London: HM Stationery Office.

33 Erikson, R., & Torssander, J. (2008). Social class and cause of death. European Journal of Public Health, 18(5), 473-478.

34 Joinson, C., Kounali, D., & Lewis, G. (2017). Family socioeconomic position in early life and onset of depressive symptoms and depression: A prospective cohort study. Social Psychiatry and Psychiatric Epidemiology, 52(1), 95-103.

35 Reiss, F. (2013). Socioeconomic inequalities and mental health problems in children and adolescents: A systematic review. Social Science and Medicine, 90, 24–31.

36 Jones-Rounds, M.L., Evans, G.W., & Braubach, M. (2013). The interactive effects of housing and neighbourhood quality on psychological well-being. Journal of Epidemiology and Community Health, 68, 171–175.

37 Ritsher, J. E., Warner, V., Johnson, J. G., & Dohrenwend, B. P. (2001). Inter-generational longitudinal study of social class and depression: A test of social causation and social selection models. British Journal of Psychiatry, 178(S40), s84-s90.

38 Hudson, C. G. (2005). Socioeconomic status and mental illness: Tests of the social causation and selection hypotheses. American Journal of Orthopsychiatry, 75(1), 3-18.

of patients is limited to those with common mental health problems, not those with more severe mental health conditions requiring hospitalisation.

Further supporting this direction of causality, from socioeconomic status to mental health, one estimate indicated that the 1999 introduction of minimum wage legislation in the UK led to an improvement on recipients' depressive symptoms comparable in magnitude to the effect of antidepressants[39]. As such, we propose the following: that SES has an impact on mental health, and that mental health can have sudden and intensely damaging effects on an individual's SES through, for example, hospitalisation, or more obviously, suicide.

Overall, the most deprived regions of the country have higher suicide rates than wealthier ones; the North East and Wales have the highest rates and the South East and London have the lowest. However, it appears to be a region's relative position that matters more than its absolute prosperity. Thus, wealthy countries have higher rates of anxiety than poorer countries[40] and more equal societies have lower rates of mental illness[41] and better wellbeing overall[42]. Unemployment and job insecurity are closely associated with an increased suicide risk[43], especially among men, but there is less of an impact in areas of widespread high unemployment. This further supports the conclusion that relative, rather than absolute, prosperity has a greater impact on mental health.

Summary

There are clear observed differences in rates, type, and severity of mental ill health between men and women. While women are more likely to report symptoms of common mental health disorders, rates of alcoholism and suicide are higher among men. It appears to be clear that there is a real problem of underdiagnosis among men, leaving mental health problems unaddressed until they turn into more severe problems down the line.

Differences in prevalence also emerge between social groups. The most socially disadvantaged groups, particularly in areas of high inequality, are more likely to experience mental health problems than

39 Reeves, A., McKee, M., Mackenbach, J., Whitehead, M., & Stuckler, D. (2017). Introduction of a national minimum wage reduced depressive symptoms in low-wage workers: A quasi-natural experiment in the UK. Health Economics, 26(5), 639-655.

40 World Mental Health Survey Initiative (2005). WMH Historical Overview. Retrieved from https://www.hcp.med.harvard.edu/wmh/index.php

41 The Resolution Foundation (2011). The Spirit Level: is income equality the sole solution? Retrieved from https://www.resolutionfoundation.org/comment/the-spirit-level-is-income-equality-the-sole-solution/

42 G. Bangham, Happy now?: Lessons for economic policy makers from a focus on subjective well-being. Resolution Foundation, February 2019

43 NHS (2015). Unemployment and job insecurity linked to increased risk of suicide. Retrieved from https://www.nhs.uk/news/mental-health/unemployment-and-job-insecurity-linked-to-increased-risk-of-suicide/

men. The direction of causation appears to be from lower SES to poorer mental health.

Working-class men then sit at the intersection between these two groups. They are both more likely to experience mental health issues because of their social background, but less likely to have these problems diagnosed and detected, leading to potentially catastrophic consequences, such as addiction, violence and suicide. In short, working class men present some important challenges to those making and influencing public policy in the broad healthcare space.

Chapter 2

Help-seeking behaviour and tackling stigma

Having explored the differences in prevalence and severity of mental health problems along gender and socio-economic lines, this chapter considers the literature on help-seeking behaviour. It explores what existing research has told us about differences in help-seeking behaviour between men and women, suggested causes of this variation, and what interventions are most successful in overcoming the reluctance of working-class men to seek help.

Help-seeking behaviour

Help-seeking behaviour is action taken by those suffering from mental health problems to access diagnosis, treatment, and support. Existing literature makes it clear that men are less likely to seek help for their depressive symptoms than women. A study in North America found that men seek counselling services approximately half as frequently as women do[44]. This is consistent with variations in men's willingness to seek treatment for health problems in general. Men are also less likely to seek help for physical conditions and injury (for example, researchers in Sweden[45] found a delay between the discovery of a testicular lump and treatment-seeking). Indeed, it was found that those women who did not visit a doctor tended to be healthier than those who did, but the same was not true for men[46]. This is indicative of a disconnect between the need for, and use of, medical assistance among men. This help-seeking gap between men and women appears to be even greater for emotional problems and depressive symptoms[47].

It has been suggested that the help-seeking gap is caused by adherence to a traditional masculine gender role[48], necessitating 'stoicism' and 'inexpressiveness'[49]. When men are interviewed about why they had delayed seeking help for testicular cancer, they largely cite an unwillingness to be perceived as weak, hypochondrial, or

44 Wills, T. A., & DePaulo, B. M. (1991). Interpersonal analysis of the help-seeking process. Handbook of Social and Clinical Psychology, 162, 350-375.

45 Sandén, I., Larsson, U. S., & Eriksson, C. (2000). An interview study of men discovering testicular cancer. Cancer Nursing, 23(4), 304-309.

46 Jacomb, P. A., Jorm, A. F., Korten, A. E., Rodgers, B., Henderson, S., & Christensen, H. (1997). GP attendance by elderly Australians

47 Möller-Leimkühler, A. M. (2002). Barriers to help-seeking by men: A review of sociocultural and clinical literature with particular reference to depression. Journal of Affective Disorders, 71(1-3), 1-9.

48 Seidler, Z. E., Dawes, A. J., Rice, S. M., Oliffe, J. L., & Dhillon, H. M. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. Clinical Psychology Review, 49, 106-118.

49 Möller-Leimkühler, A. M. (2002). Barriers to help-seeking by men: A review of sociocultural and clinical literature with particular reference to depression. Journal of Affective Disorders, 71(1), 1-9.

lacking in masculinity[50]. In one study, 64% of men agreed with the statement that 'minor illness can be fought off if you don't give in to it'[51]. Among young men in particular, studies have suggested that they do have health concerns, but are afraid to ask for help because it is 'embarrassing or unmanly'[52]. Furthermore, men may seek to address mental health concerns through coping mechanisms more in tune with these perceived masculine norms, for example in heavy drinking[53].

Many studies have found an association between belief in masculine gender roles and attitudes towards seeking treatment (termed *Male Gender Role Conflict*)[54]. The harms caused by these beliefs are potentially twofold, as indicated by Good and colleagues[55]. They find that restriction-related beliefs (what men should not do) informed help-seeking attitudes. However, achievement-related beliefs (i.e., what men are supposed to do) were associated with higher incidence of depression itself. This indicates that men who have a strong belief in male gender roles are both at an increased risk of avoiding medical help and of depression itself. 'Double jeopardy', as the authors refer to it.

These traditional values appear to be more common in working-class communities[56]. For example, when *Mind, the mental health charity*, ran a resilience-building mental health intervention for unemployed middle-aged men they found that some of them were afraid of the stigma that would be attached. One man said he thought people would think he was a 'mental case' for getting involved. Another said if he saw someone with a Mind t-shirt, the first thing he would think was *'he's a bit unstable keep away from him'* [57].

Tackling the help-seeking gap

So how can we help this 'hard-to-reach' group? The sorts of interventions more likely to be welcomed by men has been the target of much research. Typically, men appear to prefer therapeutic relationships which are based on partnership rather than paternalistic

50 Chapple, A., Ziebland, S., & McPherson, A. (2004). Qualitative study of men's perceptions of why treatment delays occur in the UK for those with testicular cancer. British Journal of General Practice, 54(498), 25-32.

51 Sharpe, S., & Arnold, S. (1998). Men, lifestyle and health: A study of health beliefs and practices. Unpublished research report (R000221950).

52 Robinson M. (2001). In: Davidson, N., & Lloyd T. (eds.). Promoting Men's Health: A Guide for Practitioners London: Baillière Tindall.

53 McConatha, J. T., Leone, F. M., & Armstrong, J. M. (1997). Emotional control in adulthood. Psychological Reports, 80(2), 499-507.

54 Thompson, E. H., Pleck, J. H., & Ferrera, D. L. (1992). Men and masculinities: Scales for masculinity ideology and masculinity-related constructs. Sex Roles, 27, 573-607.

55 Good, G. E., & Wood, P. K. (1995). Male gender role conflict, depression, and help seeking: Do college men face double jeopardy? Journal of Counseling and Development, 74(1), p70

56 Clements, B. (2014). The correlates of traditional religious beliefs in Britain. Journal of Beliefs and Values, 35(3), 278-290.

57 Steen, M. R. S. R. M., & Day, G. R. R. Doing and rethinking. Building resilience with men.

care[58]. Group-based workshops rather than individual interventions also appear to be more popular for men. As a general point, interventions which are targeted are much more effective than interventions which are general and given to a multitude of different individuals. Largely this has been evidenced through targeted interventions towards non-majority groups, but it appears to be equally applicable to other groups who resist seeking help[59].

The evaluation of *Mind* resilience programmes (referenced above) found that for many men, having activities in a non-stigmatised location was more successful. Equally, team-based practical activities, traditionally associated with men helped to overcome stigma. For instance, a football session combined with a coping skills course proved successful. A participant described its appeal: *'One; because I like playing football and Two; because I'm interested in learning life skills and I wanted to learn to cope better with my daily structure of life.'* [60]

Other programmes which utilise football as a means to deliver health interventions have previously been trialled with some success. A national programme of men's health delivered in and by English Premier League football clubs was shown to have twofold success. It was not only successful in encouraging healthier behaviour, but it reached and engaged individuals who did not typically consult a GP or use health information services[61]. One participant taking part in a weight-loss programme in Scotland delivered through 'Football Fans in Training' described why the programme worked for him as follows: *'The good thing was, straight from the start, we all had something in common with each other. Rather than being sixteen strangers, we'd all something in common, and that was the club and a love for it.'* [62] A randomised controlled trial of the same programme found that the football-focused scheme could help men to lose a clinically important amount of weight and importantly reached high-risk men across social groups who were not attracted to other schemes[63].

The 'It's a Goal' intervention based a community mental health project within a local football stadium, utilising football as a

58 Seidler, Z. E., Dawes, A. J., Rice, S. M., Oliffe, J. L., & Dhillon, H. M. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. Clinical Psychology Review, 49, 106-118.

59 Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. Psychotherapy: Theory, research, practice, training, 43(4), 531.

60 Ibid

61 Zwolinsky, S., McKenna, J., Pringle, A., Daly-Smith, A., Robertson, S., & White, A. (2012). Optimizing lifestyles for men regarded as 'hard-to-reach' through top-flight football/soccer clubs. Health Education Research, 28(3), 405-413.

62 Pringle, A., Zwolinsky, S., McKenna, J., Daly-Smith, A., Robertson, S., & White, A. (2013). Effect of a national programme of men's health delivered in English Premier League football clubs. Public Health, 127(1), 18-26.

63 Hunt, K., Wyke, S., Gray, C. M., Anderson, A. S., Brady, A., Bunn, C., ... & Miller, E. (2014). A gender-sensitised weight loss and healthy living programme for overweight and obese men delivered by Scottish Premier League football clubs (FFIT): A pragmatic randomised controlled trial. The Lancet, 383(9924), 1211-1221.

metaphor[64]. Participants in the programme showed a marked improvement in wellbeing. They were able to demonstrate that the use of football language helped make therapeutic ideas more accessible. For instance, some of the participants engaged in discussion of the mental health issues experienced by professional footballers which helped them to understand the dangers of leaving mental health concerns unaddressed. One participant said that the programme was accessible to him *'because it's a "blokey" thing'.*

Although this intervention was relatively small-scale, it did directly benefit the target group of individuals. The majority of the participants were unemployed men, and the researchers found some qualitative evidence for the participants moving towards employment and educational opportunities. A larger sample is needed to demonstrate the effectiveness of the programme in having a measurable impact on employment. However, as discussed above, it is crucial to target interventions to maximise cut-through and success, and football provides a potentially useful targeting vehicle.

Summary

Existing empirical research suggests that gender norms are a key factor in the difference in help-seeking behaviour between men and women. Men are reluctant to access mental health services because of perceived stigma and the notion that asking for help is 'unmanly'. However, the programme evaluations discussed in this chapter show that team-based programmes, focused around activities traditionally masculine activities - specifically sport and football - can be a more effective channel to reach working-class men. There is reason to believe that similar schemes and programmes could greatly help the difficulties around reaching and benefiting male mental health in the UK.

64 Pringle, A., & Sayers, P. (2004). It's a goal!: Basing a community psychiatric nursing service in a local football stadium. Journal of the Royal Society for the Promotion of Health, 124(5), 234-238.

Chapter 3

Public First Polling Research

In order to supplement existing research on the prevalence and distribution of mental health issues, and to better understand the potential for sports and football-based interventions for 'hard-to-reach' groups, *Public First* conducted a nationally representative opinion poll of 4,010 UK adults on their experiences of mental health issues.

Methodological Note

To avoid the challenges of the self-report gap on depression, the poll asked respondents about the symptoms of mental ill health. To do this, we took a multi-pronged approach to examining depression rates including both the Centre for Epidemiologic Studies Depression Scale Revised (CES-D-10-R; CES-D) and NHS Symptoms. The CES-D-10-R is a screening tool for depression which asks participants to report on a four-point scale the extent to which they have experienced 10 depressive feelings or behaviours over the past week. A score of over 10 on the CES-D is typically used to indicate depression. Participants were able to opt out of taking the CES-D prior to starting it and during its completion, allowing those who would feel uncomfortable doing so to avoid it.

We do not propose that these measures should take the place of standard diagnostic practice and any study focused on depression rates should use a more rigorous methodology. However, they do allow us gain an indicative insight into broad societal trends. For the reporting of significance below we utilise independent samples t-tests for CES-D scores, and "N-1" Chi-squared tests for percentage comparison, in line with Richardson, 2011[65].

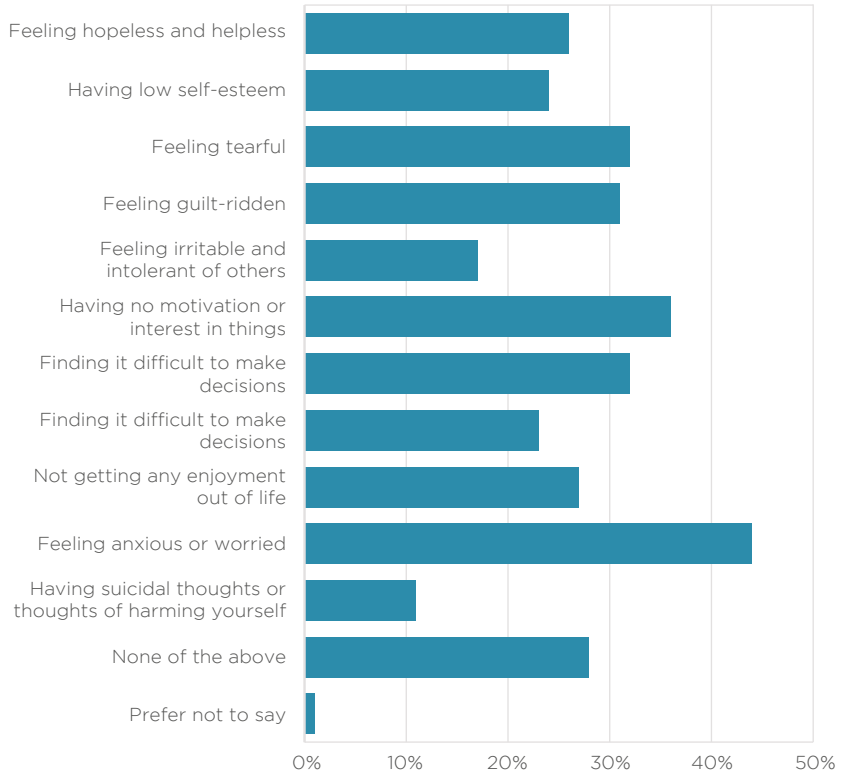
Prevalence of mental health issues

Two-fifths of the public (40%) reported having suffered from the symptoms of mental ill-health in the past 12 months, with 27% having been clinically diagnosed with a mental health issue. 11% said they had suffered symptoms but had not been diagnosed. When we directly asked how people would rate their mental and physical health on a

65 Richardson, J. T. (2011). The analysis of 2× 2 contingency tables—Yet again. Statistics in medicine, 30(8), 890-890.

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of the time (3-4 days)	All of the time (5-7 days)
1. I was bothered by things that usually don't bother me	☐	☐	☐	☐
2. I had trouble keeping my mind on what I was doing	☐	☐	☐	☐
3. I felt depressed	☐	☐	☐	☐
4. I felt that everything I did was an effort	☐	☐	☐	☐
5. I felt hopeful about the future	☐	☐	☐	☐
6. I felt fearful	☐	☐	☐	☐
7. My sleep was restless	☐	☐	☐	☐
8. I was happy	☐	☐	☐	☐
9. I felt lonely	☐	☐	☐	☐
10. I could not "get going"	☐	☐	☐	☐

Would you say that you have experienced any of the following things in the last 12 months?

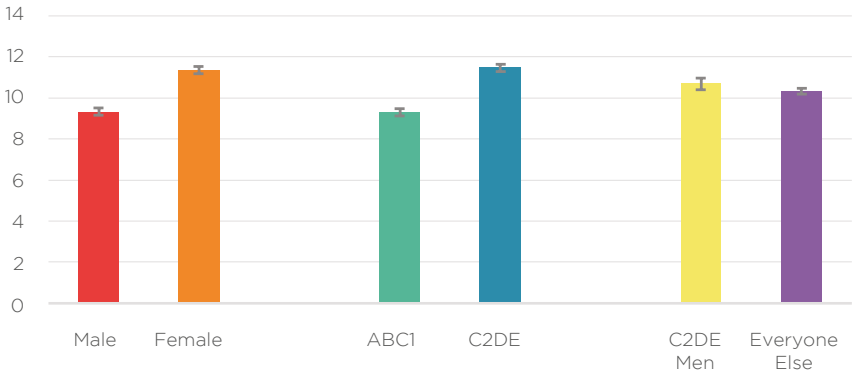


5-point scale, we find that people tended to rate their mental health higher than their physical health, averaging a score of 3.75 across the country compared to 3.5 (*p<0.0001*, paired samples t-test). In percentage terms, 64% say their mental health is Quite or Very good, compared to 57% for physical health.

On the surface, awareness of clinical depression symptoms is high, with 63% of the UK claiming to be aware of these symptoms. Awareness is highest among the younger portion of the sample (18 - 24 year olds, 76%), and lowest among the oldest (65 year olds and over, 55%, *p<0.0001*). This age pattern also maps onto symptom prevalence (those who say they have experienced the symptoms of a mental health condition) with a steep drop off from 18 - 24 year olds (61%) to 25-34 year olds (47%, *p<0.0001*) and the lowest rates among those 65 and older (20%). In line with this, when given a list of NHS symptoms only 8% of 18-24 year olds select none of the above, compared to 53% of 65 and over (*p<0.0001*). Age is not the focus of this report, but our results indicate that researchers investigating mental health should pay attention to the youngest in the UK.

Those in the C2DE social class, commonly defined as 'working-class', tended to score higher on the CES-D (11.47 compared to 9.31, *p<0.0001*). Alongside this, 28% of people in C2DE said they had had symptoms of a mental health issue they thought might require treatment, but decided not to, compared to 23% of ABC1 (*p<0.0001*).

Comparison of Scores on the CES-D-10-R for Different Demographic Groups



In line with existing research, we found statistically significantly higher scores among women on the CES-D (11.37 compared to 9.34, *p<0.0001*). However, we also found evidence to support the idea that men are more reluctant to engage in help-seeking behaviour

with 26% of men scoring over 10 on the CES-D saying they had not suffered from symptoms of a mental health condition, compared to 19% of women (*p<0.005*).

All of this supports the existing consensus that men and women differ in their response to mental health issues, with men both less likely to acknowledge they are suffering from depression, and less willing to seek help even when they indicate they are suffering from symptoms.

Working-class men

Working-class men sit at the intersection of the two trends – less likely to score highly on the CES-D in line with men more generally, yet more likely to score higher because of their social grade. Consequently, we found no significant difference in CES-D scores between working-class men and the rest of the sample (10.69, 10.32, p=0.12). When we compare Working Class Men to men in higher social grades (ABC1) we find their CES-D score significantly higher (10.69 compared to 8.4, *p<0.0001*), and when we compare them to women in lower social grades (C2DE) we find them to score significantly lower (10.69 compared to 11.98, *p<0.0005*).

Chart: Comparison between Working Class (WC) and Middle Class (MC) Women (W) and Men (M) on average CES-D scores, with p-values indicating significant differences between groups as measured by independent-samples t-tests.

		WCW	WCM	MCW	MCM
	Mean Score	**11.98**	**10.69**	**10.48**	**8.4**
WCW	**11.98**	-	p<0.0005	p<0.0001	p<0.0001
WCM	**10.69**	p<0.0005	-	n.sig	p<0.0001
MCW	**10.48**	p<0.0001	n.sig	-	p<0.0001
MCM	**8.4**	p<0.0001	p<0.0001	p<0.0001	-

Our research highlights a trend in scores on the CES-D demonstrating the relative importance of both gender and social grade. It is worth noting here that while uptake of the CES-D in our sample was high (85% opted in to completing it) there were naturally individuals who did not respond. We do find that working

class men were slightly less likely to opt in to this question battery (83% compared to 86%, *p<0.05*), and also that those who earlier said they had suffered from the symptoms of a mental health issue were more likely to complete it (9% opted out compared to 17% of those who said they have not suffered with the symptoms, *p<0.0001*). This would indicate that the overall scores we find may be higher than if we had required response on this question. However, we can find no evidence that opting out disproportionately affected the CES-D scores of a particular group (for example, working class men who opted out were no more likely to have earlier stated they suffered with symptoms than those who opted out among the rest of the sample - 3% and 4% respectively).

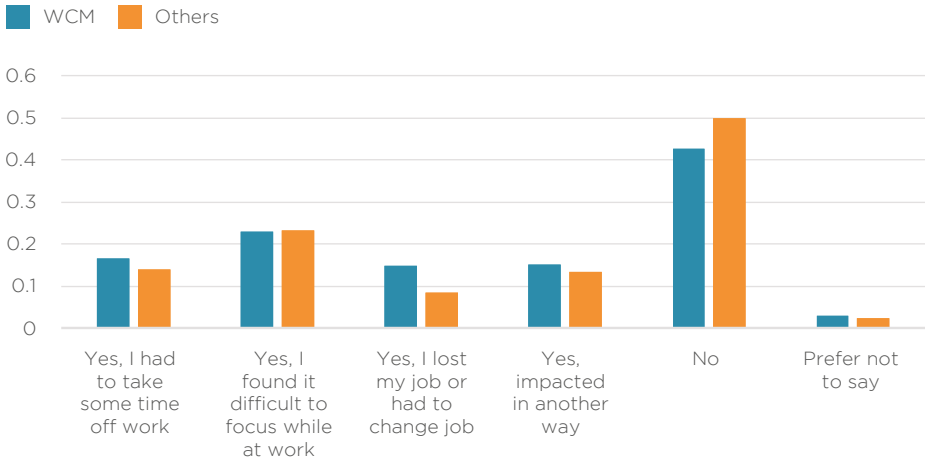
Despite having a score on par with the aggregated rest of the sample, when presented with a list of NHS symptoms of depression, 34% of Working Class Men indicated they had experienced none of them, compared to 27% in the rest of the sample (*p<0.0001*). Equally, when asked directly if they had suffered from the symptoms of a mental health issue, 34% said yes compared to 41% of the rest of the sample (*p<0.0005*). This helps to explain why we see them to be significantly less likely to be diagnosed with a mental health issue (23% compared to 27%, *p<0.005*). While the overall rates of diagnosed mental health condition differ between these groups, this would appear to reflect the differences in reported prevalence of symptoms, which in turn conflicts with the depression rates estimated with the CES-D. Put more simply, men who exhibit symptoms of depression are not acknowledging they have those symptoms and therefore are not being diagnosed. As such, it appears that the issue is getting working class men to acknowledge and understand when they suffer from the symptoms of depression, and on that basis engage in help-seeking.

Furthermore, among those who had experienced symptoms, 43% of working-class men said it had no effect on their work life, compared to half of the rest of the sample (*p<0.05*). 28% said it had no effect on their social life compared to 35% in the rest of the sample (*p<0.05*).

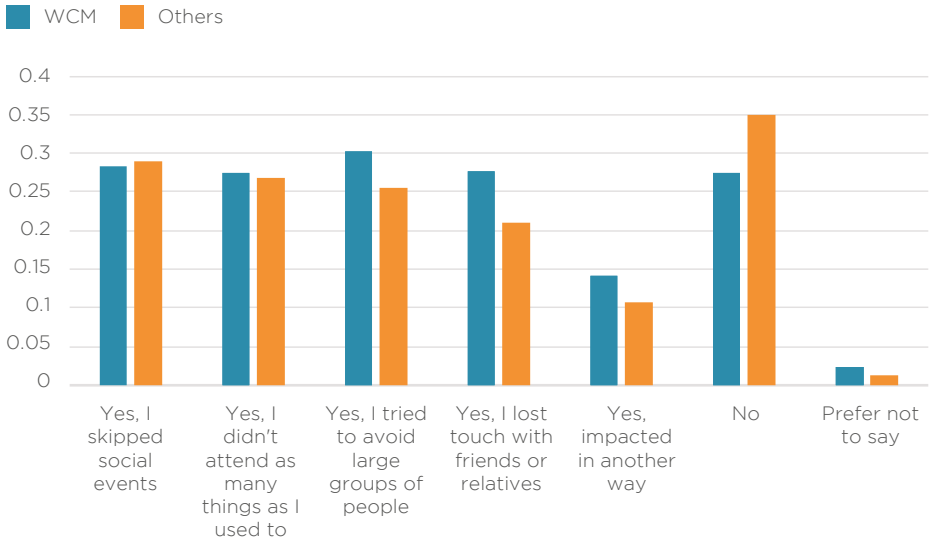
What emerges here is that, while the prevalence of depression among this group is no different to the aggregated rest of the sample, they are less willing to report experiencing symptoms and, where they do have symptoms, appear to suffer more as a result of them. This is perhaps indicative of a higher threshold for acknowledging depressive symptoms and the consequent greater severity of the impact of these symptoms.

Working-class men were also less aware of the symptoms of mental health issues (54% compared to 66% in the rest of the

Was your work life impacted by any experiencing of the things you selected in the last question?



Was your work life impacted by any experiencing of the things you selected in the last question?



sample, *p<0.0001*), and less likely to say they have suffered with the symptoms of a mental health issue (34% compared to 41%, *p<0.0005*). Taken together, this reinforces existing literature on gender and class disparities, and reinforces the need for specifically targeted efforts to address mental health issues among working-class men.

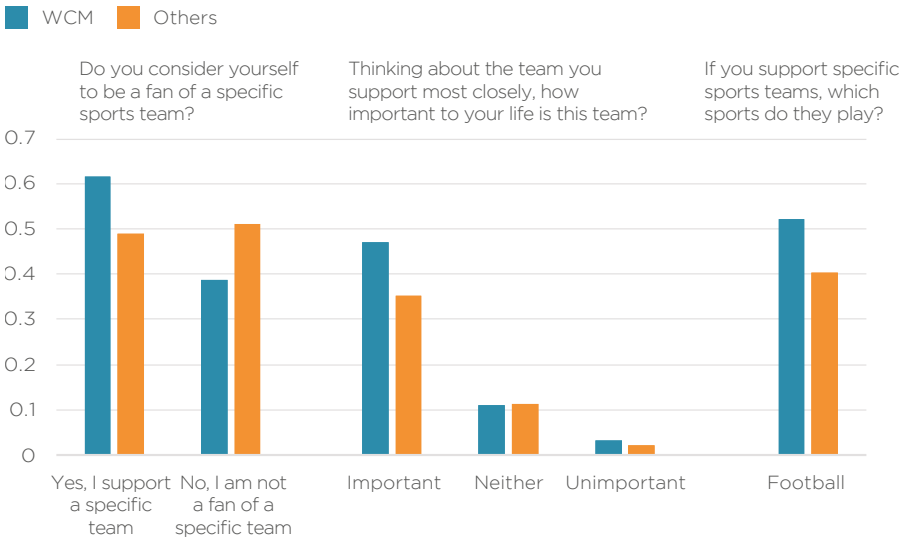
Football as a solution

Our polling also investigated the perceptions and importance of football in UK society. Watching professional football is an important part of UK culture. Of those who said sport was an important part of their life, 84% were football followers and 72% talked to their friends and family about their support for that club. Across the whole sample, including those who did not regard themselves as sports fans, 58% said that the local club was an important part of the community as a whole, and among those whose support for a team was an important part of their life, this rose to 80%.

We find that 40% of the UK watches live broadcast sports on television at least once a week (12% daily), 53% of men and 28% of women (*p<0.0001*). 1 in 5 people in the UK attend a live sports event a couple of times a month or more (20%), 26% of men and 13% of women (*p<0.0001*).

In line with the limited existing studies on the role of sport and sporting institutions, our polling indicated that football can provide a way to reach working-class men and tackle mental health. 61% of working-class men identified as fans of specific sports teams, compared to 51% across the sample *(p<0.0001*). Over half (52%) of this group listed football as a sport with a team they supported compared to 40% of the rest of the sample (*p<0.0001*). 40% were football fans of a specific team and considered the team to be important in their lives compared to just 29% of everyone else (*p<0.0001*). This provides a clear indication that working-class men in this sample were more interested in football and more passionate about it.

Sports Fanship among Working Class Men



Summary

Taken together, this polling confirms existing research on the difficulties of reaching men with traditional mental health-based interventions. The research highlights how, while not altogether different in their experiences of depression when compared to others, working class men appear to be less forthcoming with their symptoms and more likely to suffer social and economic consequences as a result.

However, the polling also highlights the role of sport as a potential route to reaching working-class men. It was clear from the polling the importance many working-class men placed on sport and football in particular. Given the aforementioned success of targeted interventions for specific groups, football presents a rare opportunity for successful and novel solutions to the issues surrounding male mental health. The results of this research reaffirm that such solutions could ultimately have a widespread effect, with football displaying support among a majority of the target group.

The next chapter uses the example of *Team Talk* as a case study for what a successful football-based mental health intervention can look like, and its potential as a model for others to adopt.

Chapter 4

Models for moving forward

Football has a unique reach among British sports. It is the nation's favourite sport, and our polling confirmed that football clubs are important anchors in the communities they are based in.

As our polling confirmed, working-class men were more likely to find football an important part of their life – and were more likely to actively and passionately follow a specific team throughout a season. Therefore, the challenge is how to harness football as an opportunity to tackle mild mental health issues, and how to overcome the barriers to help-seeking behaviour among working-class men in particular. As Chapter 2 highlighted, programmes that utilised football as a means to deliver health interventions showed promising signs of success. But to date, these have taken the form of isolated short-term projects rather than larger sustainable programmes.

In Derby, there is a new structured and long-term programme utilising football to tackle men's mental health problems. It provides an important case study for what programmes designed to reach working-class men could look like.

Context

Derby is a growing city, but it is also a city that faces challenges in common with many Midlands and Northern towns and cities. Prosperity is unequally distributed. The more deprived areas in Derby have life expectancy of 12.4 years and 8.9 years lower for men and women respectively than the national average. 64% of adults are overweight. And Derby has higher than England's average for depression-recorded incidents, and a higher than average rate of depression and anxiety prevalence.

'Team Talk'

In 2018, Derby County Community Trust piloted a project - *Team Talk* - that aimed to support men who suffer from mild mental health problems across the city. Following further investment from *32Red,* the project was launched as a fully-fledged scheme in April 2019. The programme is targeted at men who suffer from mild mental health

issues. Using the role of the football club as a community hub, and offering a safe, secure space where men can talk about their feelings with other like-minded men, the project seeks to combat the stigma associated with mental ill health by harnessing the power of football and the support of Derby County.

The objectives of the project are:

- To improve confidence and self-esteem;
- To direct people to appropriate partners for help if problems are more severe;
- To improve daily coping strategies; and
- To reduce the stigma around mental health.

Case Study: Harley

"My name is Harley Hollinshead, and I have attended *Team Talk* since it began in June 2018 and have been an active member and supporter for a year; a male only mental health group ran by Derby County Community Trust.

Team Talk operates every Monday between 6 and 8 o'clock in the evening. The first hour is very relaxed with many of us playing table tennis, getting a hot beverage and having a general talk. The second hour consists of a more structured conversation where we speak about different topics each week.

I first got involved with *Team Talk* as I was under a lot of stress; this was really playing havoc on my sleeping patterns along with my temper. The hardest part was entering through the doors, but what a fantastic decision it was for me. It has given me a completely different outlook on life in just this small space of time.

Since I have been attending the group, I've started to live my life in a new way. I am more understanding and patient, and not just in my personal life but also professionally.

I have become more understanding when different situations arise and have grown in empathy. I prefer to listen than to talk in the structured talks but will add something if I believe it will help another's situation in the group. I also like to have one-to-one chats as everyone operates differently and it allows me to act as a mentor for others."

The model works in the following way:

Recruitment

The project is not advertised as a mental health scheme. Instead, it invites men to visit a neutral location, to places they know, trust, and importantly, feel a connection with - for instance some sessions take place nearby Pride Park, Derby County's home ground. The sessions are advertised as places for men to talk and make acquaintances with like-minded people. Participants are recruited through a number of different channels:

Self-referral: Derby County Community Trust use social media and direct advertising during Derby County matches to advertise the existence of the project – allowing individuals to refer themselves or friends and family to the course.

Agency referral: The team at Derby County Community Trust work with partners in the mental health sector across Derby including the Royal Derby Hospital, Derby University, Derby City Council, local Mind coordinators, and other interested parties to identify participants that might benefit the most from the project.

Local GP surgeries: Working with local GPs in Derby, *Team Talk* staff help identify patients that are struggling with their mental health and signpost them to sessions across the city.

Session structure

Sessions run once a week for two hours across multiple locations in the city. A mixture of fully-trained staff and volunteers focus on making people feel comfortable and able to open up and talk.

The sessions aim to give participants a ‘safe space’ to chat, socialise, and participate in leisure activities such as table football, cards, and games consoles. This creates a relaxed atmosphere where people can meet others who may be experiencing similar mental health issues. There are also opportunities for participants to attend other sessions hosted by Derby County Community Trust including exercise classes and football.

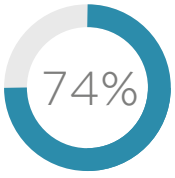
Alongside the activity sessions, the scheme has opened a second, ‘chatty room’, for discussion. This room allows people to speak directly with other participants or trained staff and has proved beneficial in opening the conversation about mental health among participants. Those facing more severe problems can find advice about where best to seek help and are signposted to more targeted interventions if necessary.

Luke Wilkinson, who heads up the *Team Talk* project in Derby, explains why it is so important. ‘The focus on mental health, especially for men, is getting greater and we want to be backing the movement as much as we can. A lot of work in the UK focuses on physical health but we want to be able to provide the same services for mental health too.’

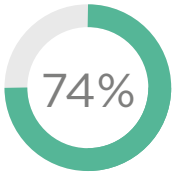
Measuring progress

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) is used when participants first arrive to identify a base level of the individuals’ mental health, as well as assessing if they are suitable to participate in the project or are in need of more focused support. Participants then feedback on the project weekly by sharing their opinions with the staff as well as undertaking evaluation questionnaires throughout the project that allow staff to track improvement in mental health. The results have been incredibly positive. Throughout the first 6 months of the project, the following outcomes have been achieved:

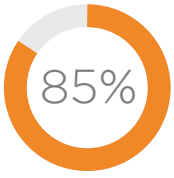
Positive increase in mental health



Increase in physical activitiy



Positive increase in general well-being



Project growth

Derby County Community Trust continue to expand the project. By developing a relationship with Derby City Council's People's Service, the *Team Talk* scheme will expand into the Derwent area of Derby. This community is one of the most deprived areas of the city, with higher levels of poor mental health and low-income families. By working closely with Derby City Council, the scheme has identified that there are a number of fathers accessing services in Derwent with mild mental health issues, who would benefit enormously from the *Team Talk* approach.

A further hub has also launched in partnership with Derby University to tackle mental health issues among students. *Team Talk* staff had a presence at Freshers Week, and *Team Talk* information was placed in all student accommodation welcome packs. The Student Union and the university's GPs are heavily involved in the development and referral to the programme.

Case Study: Daniel

Client Name: Daniel
Length on programme: 11 months
Age: 37

Daniel suffered from depression and anxiety for a number of years prior to him starting *Team Talk*. His wife has also been suffering from mental illness for around 10 years, which subsequently began to influence Daniel's mental wellbeing.

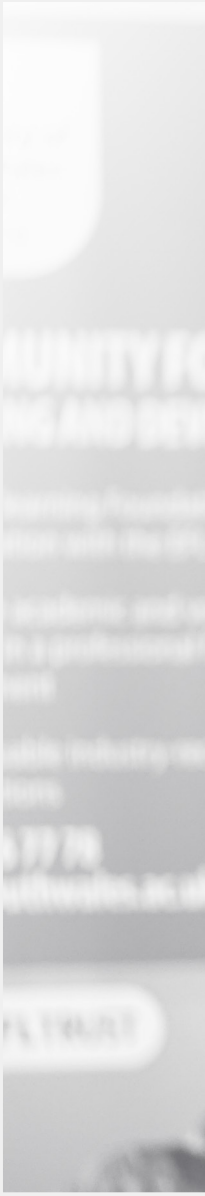
Daniel was visiting his wife in hospital, when he got talking to someone else on the ward. The conversation led to them discussing the positive effects *Team Talk* had on the his life, who suggested that they attend the session together.

Although Daniel was a little anxious at the thought of attending *Team Talk*, he felt comfort in the fact that he had some support from someone who was already attending and the positive feedback he had provided Daniel during their discussion.

Daniel attended the first session, at which he pointed out the session was nothing like he expected. Staff were non-judgemental, he had a choice to whether he wanted to share his thoughts and feelings or not. He also found the atmosphere at the venue was relaxed, there were games to get involved in and also a room where he could talk to staff and the wider group as and when he wanted. Staff at the session were always reassuring to the blokes, outlining it was a safe place to talk.

Daniel has taken part in a number of activities; he always gets involved in the table tennis on a Monday night and attends the monthly football session. As a result of *Team Talk* Daniel has also joined a charity football team, where he plays football (something he loves) whilst at the same time raises money for charitable causes - the next match is to raise money for ex-service personal.

Daniel outlined what a positive impact *Team Talk* has had on not only his own mental and physical health but has also helped him to give back



to his community and other people who are going through a similar situation. He has also recently undertaken mental health training so he can begin to help others.

Summary and potential development

The *Team Talk* model has continued to develop since its initial launch in 2018, and is one of the most structured interventions of its kind to be implemented. The tailored approach to targeting men – by harnessing their passion for football and sport – has proved successful based on initial results, and is likely to see hundreds of men across Derby improve their mental health. With *Kindred Group* – of which *32Red* is a brand – committing to fund similar projects across all their sponsored clubs in the UK, there is potential for

growth in schemes of this kind.[66]

Furthermore, the success of this project highlights an opportunity for other football clubs, sporting organisations, and their sponsors to undertake similar projects. The power of football to reach across communities and audiences is significant. While football clubs and their sponsors should continue providing funding for projects such as *Team Talk,* there is the potential for a boost in 'social prescribing' - and for NHS Clinical Commissioning Groups to play their part too.

In 2013, West Ham United's Foundation became one of the first football clubs to be recognised as a health service provider – as part of a wider project undertaken by the NHS Newham Clinical Commissioning Group.[67]

The '150Club' scheme – run in partnership with NHS Newham Clinical Commissioning Group (CCG), Newham Council and the 150Club partnership (made up of West Ham United's Foundation, activeNewham and the Staywell Partnership) – is an innovative 24-week programme offering local residents at risk of diabetes or cardiovascular disease a wide range of tailored physical activities to help combat the diseases. The project uses the power of West Ham United's brand in Newham to empower local people to take greater control of their own health through 'social prescribing'.[68]

Taking its name from the recommended amount of 150 minutes of exercise people should take per week, the '150Club' is part of a wider bid to tackle high rates of diabetes and cardiovascular disease in Newham by helping people to stay healthier. This initiative, known as the Newham Community Prescription Scheme, was first piloted in a number of Newham GP practices in 2013. Now, GPs across the borough can refer patients aged 18 years and over who are at risk of developing diabetes or cardiovascular disease to the '150Club'.

Community based projects such as the '150Club' – where the local Clinical Commissioning Group took an innovative approach to service delivery – have proved to be a huge success, with the

66 Kindred (2019). A new way of sponsoring – giving back to the community. Retrieved from https://www.kindredgroup.com/news--insights/2019/a-new-way-of-sponsoring--giving-back-to-the-community/

67 West Ham United FC (2019). 150 Club. Retrieved from https://www.whufc.com/club-foundation/health/community-prescription

68 NHS England (2017). Social Prescribing. Retrieved from https://www.england.nhs.uk/personalisedcare/social-prescribing/

scheme recently passing the 500 participant completion mark,[69] as well as winning a *BT Sport Industry Award* in 2018 for 'Community Programme of the Year' [70].

This innovative approach is a new way forward in mental health service delivery. Through deeper partnerships between local NHS CCGs and football clubs via a stronger commitment to 'social prescribing', delivery of schemes such as *Team Talk* can tackle the barriers that working-class men face with seeking help, leading to improved mental health outcomes for men across the UK.

69 West Ham United FC (2019). Zabaleta celebrates 500 completers of West Ham's award-winning 150Club programme. Retrieved from https://www.whufc.com/news/articles/2019/august/16-august/zabaleta-celebrates-500-completers-west-hams-award-winning

70 NHS Newham Clinical Commissioning Group (2018). Newham's 150 Club win BT Sport Industry Award. Retrieved from https://www.newhamccg.nhs.uk/news/newhams-150-club-win-bt-sport-industry-award/65373?ignore=newhams-150-club-win-bt-sport-industry-award&postid=65373

Chapter 5

The potential benefits

The moral imperative of tackling mental ill health is clear. But there are also real social and economic benefits to be gained from tackling mental ill health. The UK's Chief Medical Officer[71] has estimated that mental illness costs the UK in the region of £70-100 billion per annum, equivalent to 4.5% of GDP. Separate OECD findings corroborate this figure, putting the cost at 4.1% of GDP. These findings are unsurprising because those experiencing mental illness have much lower employment rates or productivity.

The Chief Medical Officer's report suggests that those with severe mental illness are four times more likely to be unemployed and for those with common mental disorders the rates are double. Research from Oxford Economics suggests that in the region of 180,000 people are prevented from joining the labour force because of mental ill-health. However, these 'direct' labour market costs are compounded by an estimated additional 93,000 people forced out of the labour force in order to care for someone with a mental health problem, with a further 27,800 reducing their working hours for the same reason.

For those who remain within the labour market the impact of mental ill-health remains considerable. Data from the ONS[72] suggests that alongside this, 15.8 million working days were lost in 2016 due to sickness absence related to mental health. Other sources put these figures even higher with the Sainsbury Centre for Mental Health[73] calculating that 70 million days were lost. 'Presenteeism' [74], which is when people turn up to work while they are ill (making them both less productive and causing more ill-health and exhaustion which results in a loss of productivity) was also suggested to cost £15.1 billion a year to businesses, often costing more than absenteeism as it is more common among higher paid staff.

Depression alone has been associated with a cost of £7.5 billion a year by Kings Fund[75]. So even a 2% decrease in depression rates could be

71 Davies, S.C. (2014). Annual Report of the Chief Medical Officer 2013. Public Mental Health Priorities: Investing in the Evidence. London: Department of Health (2014)

72 The ONS (2016). Sickness absence in the UK labour market: 2016. Retrieved from https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/sicknessabsenceinthelabourmarket/2016

73 The Centre for Mental Health (2010). The economic and social costs of mental health problems in 2009/10. Retrieved from https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/Economic_and_social_costs_2010_0.pdf

74 The Centre for Mental Health (2007). Mental Health at Work:Developing the business case Retrieved from https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/mental_health_at_work.pdf

75 The King's Fund (2008). Paying the Price: The cost of mental health care in England to 2026 Retrieved from https://www.kingsfund.org.uk/sites/default/files/Paying-the-Price-the-cost-of-mental-health-care-England-2026-McCrone-Dhanasiri-Patel-Knapp-Lawton-Smith-Kings-Fund-May-2008_0.pdf

worth up to £150 million to the economy. It could equally reduce the number of sick days by 300,000 taking the more conservative estimate of mental health sickness days from the ONS[76]. While taking a further conservative estimate of £75-£80 per individual as the cost of a day of sickness absence, the cost benefit to businesses directly would be £22.5 million. This moderate improvement could also put around 5000 people back into the workforce, by helping both those who suffer with mental health issues and those who take time off to care for them. With more sizeable impacts on depression rates, the benefit scales heavily. Oxford Economics estimated that UK GDP in 2015 could have been over £25 billion higher than it was without the economic consequences of mental health problems to individuals and businesses.

Of course, economic costs are not the only societal costs caused by mental illness. Research from Oxford University[77] suggests that serious mental illness reduces life expectancy by 10 to 20 years which is a greater reduction than that caused by heavy smoking. There is no reliable or up-to-date data on the prevalence of mental health in prisons. The most commonly used estimate is that 90%[78] of the prison population are mentally unwell, but this figure dates from 1998 and uses a broader definition of mental illness than many clinicians would recognise. However, there is a widespread consensus that rates of mental ill health are higher among those in prison and that efforts towards reducing offending, and rehabilitation must tackle mental health issues.

Summary

There are large and intertwined social and economic costs of mental ill-health. As such, tackling mental health problems not only benefit the individuals concerned but also wider society family, with only small reductions yielding considerable benefits at scale. Given that existing schemes are failing to reach a significant part of the population there is a clear imperative to find new solutions that do. As such, the return on investment from schemes that tackle men's mental ill health could be great. More firms which provide sponsorship for sporting activities should consider supporting these schemes as part of their corporate social responsibility activities. For their part, local and national Government, as well as clinical commissioning groups should back these schemes and make it as easy as possible for them to operate.

76 OECD/EU (2018), Health at a Glance: Europe 2018: State of Health in the EU Cycle. OECD Publishing, Paris/EU, Brussels, https://doi.org/10.1787/health_glance_eur-2018-en.

77 Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: a meta-review. World Psychiatry, 13(2), 153-160.

78 National Audit Office (2017). Mental Health in Prisons. Retrieved from https://www.nao.org.uk/wp-content/uploads/2017/06/Mental-health-in-prisons.pdf

Conclusion

The greater awareness of (and support for) mental health conditions in recent years is undoubtedly welcome. What was once seen as a taboo topic, with a very particular social stigma attached, has now become a priority for policymakers and employers.

Yet despite this growing social acceptance and awareness, traditional routes that support mental health problems are failing to reach working-class men. Given the high individual and social costs of mental ill-health, which appear to be heighted in working-class men, it is clear that a new approach is needed *Public First's* polling supports the hypothesis that the use of sport and football in particular is a fruitful way to engage working-class men. The *Team Talk* scheme provides one model for how this can be done by meeting men on their own terms, through institutions and football clubs, which have particular significance to them.

As the *Team Talk* model expands, more in-depth analysis of its contribution to tackling mental health over the longer term, and in a wider range of contexts will be necessary. But the early promise and results of this research should encourage other partners to invest in similar schemes.

There is growing recognition of the benefits of so called 'social prescribing' and the Government has recently launched a new National Academy of Social Prescribing to gather evidence on this growing area of health care. This is a welcome recognition that schemes such as those involving sport can go a long way towards improving wellbeing, alongside more traditional clinical interventions.

By working together, corporate sponsors, football clubs themselves, and local NHS commissioning groups, have an opportunity to work together to tackle both the direct mental health problems that working-class men experience, but also the very real barriers to them seeking help.

Case Study: Jimmy

Client Name: Jimmy
Date joined: May 19
Age: 60

Jimmy has suffered from depression and anxiety for most of his life, but it wasn't until his mid-40s he was actually diagnosed. He has always had cycles of low mood swings but following a bereavement and divorce a few years ago, this got worse.

Jimmy attended group work therapy in the early days of his diagnosis but felt this was not the best option for him, as it tended to be more 'doom and gloom' rather than supporting him through his issues. He also found that he was later unable to attend any kind of group work activity and the most people he was comfortable with was two or three people. Psychological (IATP) services were a help whilst he attended, however at the end of this support his mental health issues continued to spiral.

Jimmy wasn't aware he needed to do anything about his mental health as he felt he was in a cycle that he just had to live with. However, he then saw the video of Frank Lampard at a *Team Talk* session and recognised that he needed to do something about it, and that *Team Talk* might be able to help him.

Jimmy turned up to the first session extremely anxious about coming and sat in his car for the first 15 minutes to build up courage to get through the door. When he finally got inside it was something completely different to what he expected. The room was set up with games, guys were chatting and laughing, and staff were really welcoming and there was a 'really calm atmosphere about the entire thing'.

At this session he was then invited to play on Pride Park pitch the following week.

"I was so excited to be asked to play on the pitch. I remember going to the Baseball Ground when I was younger and to get to actually play at Pride Park was amazing. I am 60 had not played football for over 20 years and had to borrow kit from anyone and anywhere. I ran around as much

as I could, pulled a muscle, was tired, but at the end sitting in the changing rooms all I could think of was *Wow I can still play football*.

"I have now joined the Everybody Active programme through the Trust where I can exercise more, play walking football and lose weight at the same time."

Jimmy now attends weekly sessions and feels comfortable in a group situation with the others, he recognises he is not the only one who suffers from mental health issues and also recognises what a positive impact he has within the group around supporting others who are experiencing similar thoughts and feelings. His love for football has had a massive impact on his attendance and he "feels comfortable to attend sessions which are associated to the one thing he loves – football."

"At the moment *Team Talk* provides me with everything I need and the tools to help me look after myself. Without seeing that video I honestly don't know where I would be today. I am still not 100% but feel the slide of depression has come to a holt. I no longer feel isolated and feel I am happy to take part in activities and initiate conversations with others."

Acknowledgements

This report was peer reviewed by Dr Mark Griffiths, Distinguished Professor of Behavioural Addiction at Nottingham Trent University

PUBLICFIRST

11 Tufton Street
London
SW1P 3QB

T: 020 368 72761
E: contact@publicfirst.co.uk

www.publicfirst.co.uk