

The State of Men's Health in Leeds: Main Report

Professor Alan White, Leeds Beckett University
Dr. Amanda Seims, Leeds Beckett University
Robert Newton, Leeds Beckett University & Leeds City Council



Institute for
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1 Executive summary

By examining the state of men's health in Leeds this report offers an introduction to the main issues facing boys and men with regard to their physical and mental health and wellbeing. The report primarily explores: (1) key causes of mortality in men; (2) men's use of services; and (3) key intersectional factors, social determinants and lifestyles which impact on men's health. Due to the broad scope of this topic it was not possible to provide a detailed picture for each area of concern, however by recognising what is happening to our male population in the city's localities we can identify where there are the biggest challenges for men and where further work can be completed in attempt to overcome these. To the author's knowledge, Leeds is the first city in the UK to explore the health issues and health behaviours of its male population.

Overall we see a city with great variance in the health and wellbeing of its men, with areas of high deprivation seeing very different health challenges than for men living in the more affluent suburbs. Men typically have higher levels of preventable premature death and chronic ill-health compared to women, and Leeds is no exception. There needs to be a concerted effort made to address the causes of the health challenges men face. To tackle men's physical and mental health, action is required both at the structural level of service provision, in reaching out and targeting men more effectively, and also at the societal level addressing the social determinants of health.

1.1 The male population

There are approximately 410,000 males living within Leeds; with 18% aged 0-15 years; 69% aged 16-64 years; and 13% aged 65 years or over. Projected estimates for 2035 indicate that the largest increase in the Leeds' population will be among males aged 65 years or over (an increase of around 46% from 2015). Leeds is diverse in ethnicity and age: in 2011, over 50% of the male population in five Middle Layer Super Output Areas (MSOAs) were of non-white ethnicity, and in some MSOAs 20-25% of their male population were aged 65 years or over. In 2011, over 50% of men across Leeds aged 65 years or over felt their disability or long-term condition limited their daily activities, increasing to over 70% in some MSOAs.

1.2 Health status

In Leeds we still have a higher number of men dying prematurely, with about 20% of all male deaths occurring before the age of 65 years as compared to 12% of female deaths in Leeds and 19.5% of male deaths nationally. Life expectancy at birth in Leeds (2011-2013) was 78.9 years for men and 82.4 years for women. In 2010-2012, the all-cause mortality rate of death for males of all ages in Leeds was 39% higher compared to females and was 65%¹ higher for males aged under 75 years compared to females aged under 75 years. Median male hospital inpatient admission rates in Leeds for major non-communicable diseases were typically at least double that of females.

1.2.1 Circulatory disease

Circulatory disease was the primary cause of mortality for males in Leeds (all ages) and the second largest cause of mortality for males aged under 75. The number of males in Leeds registered as having coronary heart disease (CHD) was equivalent to 4% of the male GP registered population and 59% higher compared to females. Hypertension prevalence among males between 25-64 years of age was greater compared to females, and hypertension was the most commonly diagnosed condition among men (and women) as a result of a health check (77% of all persons diagnosed with a health condition).

¹ Erratum: this figure as amended on the 26th October 2016

1.2.2 Cancer

Cancer was the primary cause of mortality for males aged under 75 years and the second largest cause of mortality for males of all ages. Cancer prevalence was generally similar for males and females (4% and 3% of the male and female GP registered population), however prevalence was greater in males aged 65 years or over (21% of males vs. 15% of females). Overall cancer mortality was 44% higher for males (all ages) as compared to females, with men having higher incidence rates and mortality for the majority of non sex-specific cancers.

1.2.3 Respiratory

Respiratory disease (excluding pneumonia and influenza) is the third largest cause of death in men in Leeds, with great variation depending on socio-economic factors. Men have a 41% higher mortality from respiratory disease than women.

1.2.4 Accidents

The overall mortality for accidents was 60% higher in men as compared to women, mostly as a result of road traffic accidents, but also included accidents in the home and in the workplace.

1.2.5 Suicide

The male suicide mortality rate in Leeds was nearly five times that of females. The rate for years of life lost due to suicide for men aged 15-74 years in Leeds was 28% higher compared to the rate observed across England and Wales, but the female rate in Leeds was similar to the female rate observed nationally.

1.2.6 Diabetes

The number of men in Leeds registered as having diabetes was equivalent to 5% of the male GP registered population and 23% greater compared to females. Men were more likely to be diagnosed with diabetes as a result of a health check compared to women (13.8% of men diagnosed with a health condition following a health check compared to 11.5% of women). This demonstrates the importance of engaging men with health checks at an early age to allow time for appropriate intervention prior to the development of chronic disease.

1.2.7 Mental health

Fewer males were registered with a common mental health disorder compared to females, but a similar proportion were registered with a severe mental health disorder. Around 6% of the male GP registered population (aged 18+) were registered with depression, however prevalence was almost double this in some areas of Leeds. More men compared to women were registered with schizophrenia, paranoia and psychotic disorders. Of the 6% of men (aged 16-64) in Leeds claiming Employment and Support Allowance (ESA) and the 1% claiming incapacity benefit, around 50% of cases were associated with mental and behavioural disorders although the scope and severity of these disorders were not known. Median mental health inpatient admission rates were higher for males compared to females. Across Leeds Clinical Commissioning Groups (CCGs), the number of mental health bed days was greater for males compared to females and the gender difference was much higher than observed nationally.

1.3 Lifestyle and preventable risk factors

1.3.1 Alcohol

Alcohol-specific mortality for men in Leeds was 16% and 25% greater than male rates seen regionally and nationally and Leeds was ranked 264th out of 326 local authorities for male alcohol-specific mortality. Of the GP registered population aged 16+ years with alcohol consumption recorded, males were more likely to consume a level of alcohol that was deemed as an increasing risk or higher risk of harm to their health compared to females (20% of males vs. 12% of females with alcohol consumption recorded respectively). Just over 5% of men aged 50-64 years with known alcohol consumption were classified as at a higher risk of harm from alcohol, however in some MSOAs this was as high as 11-19% of men in this age group. We do not know the level of alcohol consumption for over half the 16+ years GP registered population in Leeds and in some areas it is not known for over 80% of men. Male admission rates for alcohol related conditions were double that of women, and were far greater than male regional and national figures.

1.3.2 Overweight

Of the GP registered male population in Leeds with weight recorded, nearly half (approximately 152,000 out of 318,000 males recorded) were considered overweight or obese (48% of males vs. 45% of females recorded) although this was as high as 62% of males in some affluent areas. The proportion of overweight or obese males increased continually from age 25 years onwards. We do not know weight status for approximately 22% of the male GP registered population in Leeds - in some areas of Leeds, weight was not known for 30-40% of the male GP registered population in that area. Between the ages of 16-64 years, the proportion of this male population without weight recorded is typically double compared to females.

1.3.3 Smoking

Smoking status was well-recorded by GPs across Leeds. Approximately 26% of the male GP registered population with status recorded are registered as smokers (compared to 19% of females recorded), although in some areas within Leeds the proportion of male smokers was over 40%. Smoking was most common among men aged 25-49 years - this was also the age group with the largest gender difference.

1.3.4 Sedentary lifestyle

Around 30% of the male GP registered population (aged 16-74 years) in Leeds with activity status recorded were classed as 'inactive', however in some areas this was over 40% of males assessed and as high as 52% in one MSOA. Overall a higher proportion of men assessed in Leeds were classed as 'active' compared to women (29% vs. 21% of women assessed), however the gender difference reduced with increasing age. Physical activity status for 77% of the male aged 16-74 years population in Leeds is unknown (compared to 75% of the female population), however this proportion is far higher in younger age groups; a clear increase in recording activity status of males (and females) over the age of 50 years was observed, possibly as a result of NHS health checks.

1.4 Social determinants of men's health

Men in less affluent areas of the city have significantly worse health than those living in the wealthier suburbs, with the majority of this inequality attributed to the standard of their education, living conditions and employment.

1.4.1 Education

In 2011, there were areas of Leeds where over 30% of working-age men had no qualifications and more recently, over 70% of boys in some areas of Leeds were not achieving five or more grade A-C GCSEs including English and maths; this may have a significant impact on their ability to secure employment.

Educational attainment was generally worse for boys compared to girls across the school years, however attainment for both sexes was worse compared to national figures. Approximately 69% of Looked After Children (LAC) accessing alternative education provision were boys and the proportion of male LAC achieving a good level of development in the Early Years Foundation Stage Profile or achieving five or more A-C grades at GCSE including English and maths was similar to, or worse than, boys in the poorest performing areas of Leeds.

1.4.2 Housing

Approximately 17% of men over 16 years live alone. Men are not typically seen as a vulnerable group with regard to housing need and this is resulting in some high rise flats having 75-80% male residents, creating areas of social isolation. The majority of the city's homeless are male.

1.4.3 Employment

In 2011, more men compared to women were unemployed or long-term unemployed, and the gender gap for both was greater than observed nationally. In 2011, men were more likely to be self-employed compared to women and more likely working long hours. More men were working in 'routine' and 'higher managerial, administrative and professional' occupations compared to women.

1.5 Accessing health and lifestyle services

Fewer males compared to females completed NHS health checks and screening for bowel cancer and chlamydia however males were more likely to receive a positive diagnosis for disease when they did. Only 30.5% of Healthy Lifestyle Service users were male. The most common health goal chosen by men was for physical activity; very few set a goal for reducing alcohol consumption and they were less likely to set 'weight loss' as a goal compared to women. Men were less likely to use weight management and smoking cessation services compared to females, although those males engaging were somewhat more successful than females. Although the number of males registered with the 'Leeds Let's Get Active' scheme more than doubled in the second year of the programme, female membership was still 50% greater. Approximately 72% of drug and alcohol service users over 2011/2012 were male. Males were less likely to have a planned exit compared to females and only men had unplanned exits due to a prison sentence. In 2013/2014, 63% of those undergoing treatment for alcohol addiction were men.

In 2010-2011, the number of males accessing NHS specialist mental health services in the Leeds Metropolitan District was lower than females (35% greater use by females). Men were less likely to be referred into Improving Access to Psychological Therapies (IAPT) services through NHS Leeds CCGs and less likely to complete a treatment over a recording period compared to females.

It is noticeable that there are limited services available aimed at men who are either the victims or perpetrators of abuse.

1.6 Conclusion

The report points to a city that has great potential to improve its overall health and wellbeing. The report commends previous and current approaches used in Leeds to target men, and proposes detailed strategies as to the way forward in order to address the unmet needs of men.

2 Introduction

Leeds is the third largest city in the UK and has aspirations to be the Best City for Health and Wellbeing by 2030 (Leeds City Council, 2013). The health of the male population was highlighted as a gap in the Joint Strategic Needs Assessment (JSNA) for Leeds 2012 and as an area for development by the Health and Wellbeing Board and the Public Health Leadership Team.

This report is an introduction to the health, wellbeing and social challenges facing men and boys in Leeds. The purpose of this research was to ensure that current public health provision is reaching out and targeting those men most in need and to help guide future commissioning decisions. It is anticipated that the evidence provided in this report will be used by the Health and Wellbeing Board in Leeds to highlight Men's Health as an area of focus in the forthcoming Joint Health and Wellbeing Strategy 2016. The evidence in this report can also be used by all partners in the city to develop more gender sensitive services. To the author's knowledge, Leeds is the first city in the UK to explore the health issues and health behaviours of its entire male population.

The three documents offer different perspectives: (1) 'The State of Men's Health in Leeds: Main Report', gives a detailed overview of the main issues facing men with regard to their health and their use of services; comments from the interviews, an analysis of the policy documentation; examples of good practice from elsewhere; and sets out key recommendations and suggestions for best practice that can be used to guide future commissioning decisions; (2) 'The State of Men's Health in Leeds: Data' report (Seims & White, 2015) gives the detail behind the analysis with a wide range of information covering the health of men and boys and the context within which they live and how they engage with services. Where possible, the data has been presented at the level of the 107 Middle Super Output Areas (MSOAs) across Leeds; and (3) 'The State of Men's Health in Leeds: Factor Analysis Report' (West *et al.*, 2015) presents the results of a detailed statistical examination of the main health challenges facing men within Leeds.

Box 1: How to read this report

- The research approach used to produce this report is described in section 3 '*Research approach*'
- The main health issues and causes of mortality for men in Leeds are highlighted in section 4 '*Health status of men in Leeds*'
- Section 5 '*Understanding men*' provides an insight into the socialisation of boys and men which influences their behaviours and attitudes towards health and explores how these change across the various life stages and their impact upon health and the risk of chronic disease with age.
- Section 6 '*Intersectional factors and social determinants that impact on men's health*' describes factors which indirectly affect health – these include demographic factors which are unalterable, social determinants and other life experiences and situations which impact upon health such as fatherhood and caring responsibilities.
- Comments from the interviews are interspersed throughout the report.
- Key figures are included throughout the report to highlight the main issues affecting men's health in Leeds however the reader should refer to sections within the data report for additional figures and data (stated in the footnotes of this report), including the top ten MSOAs with the greatest concern.
- Examples of good practice used to specifically target men are described in section 11 '*Examples of good practice in men's health – local and national*'
- Key recommendations for service providers are stated within each relevant section
- General recommendations for service providers are stated in sections 13 '*Recommended action for supporting specific groups of boys and men*' and 14 '*General guidelines for working with men*' and suggest potential strategies for engaging and supporting men
- General recommendations relating to council operations are stated in section 15 '*Recommendations for the Council*'

2.1 Aims and objectives of the study

The primary aim of the research was to frame available data and intelligence related to men's health in Leeds to inform commissioning decisions and therefore help shape the development of services for men.

The objectives of the study were to:

- conduct an analysis of current health and wellbeing data to identify gender differences and evaluate the effect of geographical area and various intersectional and other social determinants of health and wellbeing
- conduct a review and analysis of Leeds City Council's health and wellbeing policies to establish whether these state the need for the provision of male-specific services and/or strategies for improving the health and wellbeing of men in Leeds
- collate existing academic literature demonstrating gender inequalities for health and best practice for engaging men in services
- interview health and wellbeing stakeholders for Leeds to develop an understanding of the process and information used in the commissioning of services and identify current problems faced with engaging men
- establish sources of additional information and data which may be available to enhance this process
- develop guidelines for best practice in commissioning services which aim to enhance the engagement of men and narrow the gender gap for health equality in Leeds

3 Research approach

The approach adopted for the study comprised of five main components:

- a review of existing literature on men's health and service interventions
- an analysis of current policies
- interview data from key council stakeholders
- a general analysis of routinely collected health, socio-economic and service use data
- a secondary factor analysis of health data to identify areas of concern

The study was given ethics approval by Leeds Beckett University.

3.1 Literature review

A review of existing literature was used to highlight issues relating to men's health and wellbeing, to understand how men generally use services and identify strategies for engaging men in services. This information is presented in a separate report. The findings from the literature review are presented throughout this report and integrated with data from the 'The State of Men's Health in Leeds: Data' report (Seims & White, 2015), and data from Commissioner interview transcripts.

3.2 The analysis of current policies and practices within the City of Leeds

Health policies from within Leeds were analysed to identify current strategic thinking on men and their physical and social health and wellbeing. This included an assessment of how men are portrayed within current Leeds City Council and Health Service provision. The findings from the policy analysis are presented in section 12 '*Policy Context – Local and National*'.

3.3 Interviews with key council stakeholders

Key stakeholders and Commissioners of health and social care services from the Council and NHS were interviewed to determine their perspective on the state of men's health in Leeds, their views on how men use services and what information they needed to develop services for the future. Nine interviews were conducted, recorded and transcribed. A pragmatic analysis was undertaken of the interview data to extract the key topics and issues and to identify any cross-cutting themes. The findings from the interviews are integrated into the narrative within this report and not included as a separate section.

3.4 Analysis of routinely collected health, socio-economic and service use data

A descriptive analysis was undertaken of key data relating to the health and wellbeing of men in Leeds.

This comprised a review of:

- Demographic data
- Mortality and morbidity data
- Lifestyle data
- Service use data

Data sources accessed for the study were:

- Publically available 2011 Census data for Leeds through NOMIS²
- The Leeds Observatory³
- Health & Social Care Information Centre (HSCIC)⁴
- Office for National Statistics (ONS)
- Public Health England

² http://www.nomisweb.co.uk/census/2011/data_finder

³ <http://observatory.leeds.gov.uk/>

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- Local GP audit - provided by Leeds Public Health data team; and
- Service use data

Where available, data were analysed using the 2011 MSOA⁵ classification across Leeds. Where possible, adult population age groups were evaluated at 16-24 years, 35-49 years, 50-64 years and 65+ years.

Where Census data were analysed, proportions were calculated as a percentage of the England and Wales, Leeds or MSOA population obtained from the 2011 Census (using all residents in households and communal establishments). Where GP audit data were analysed, proportions were calculated as a percentage of Leeds or MSOA population obtained from the October 2014 GP registered population. Where a specific age group population was chosen, this is stated within the report text.

Disease prevalence taken from GP audit data represents individuals who had received a diagnosis from their GP and therefore may not represent the total number of males and females in Leeds who have undiagnosed conditions. Thus, the term 'known' prevalence is used where these data are presented throughout the report.

For each category of lifestyle prevalence (e.g. smoking, alcohol, physical activity), prevalence was calculated as a proportion of males and females who had been asked for this information by their GP (and therefore not as a percentage of the complete GP registered population). The proportion of males and females in Leeds who had not been asked for this information was calculated as a percentage of the complete GP registered population.

For the majority of the health data the Direct Standardised Rate (DSR), which is per 100,000 of the population, was used. It is important to note that disease prevalence and mortality were not always present in every MSOA.

Tables, histograms, bar graphs, line graphs and pie charts are used to present the data. Where possible, the top ten MSOAs with the greatest concerns were identified for each topic – these can be found throughout the data report.

3.5 Factor analysis report

A secondary analysis of the key health issues facing men in Leeds has been undertaken. There are three components to this work:

1. Background influences and data choices
2. Creation of the indicators from individual aspects of men's lives
3. The combination of these through a factor analysis.

This work is being presented separately to this report.

3.6 Limitations

The study was intentionally broad in its scope, providing an introduction to the complex issues affecting men's health in Leeds. This overview approach limited the detail that could be provided for each issue and prevented focused examination of the many different groups of men, including gay men, disabled men, and men from different racial and cultural backgrounds. Additionally, the remit did not include engaging with the many providers of services or other stakeholders which also meant that the voices of men and those working directly with men in Leeds were not directly heard.

⁵ Leeds is broken down into 107 Middle Super Output Areas (MSOA), each representing a population of about 5,000

There have been significant difficulties in accessing data for the study, mostly as a result in the barriers put up by the change in legislation following the move of Public Health from the NHS into Local Authorities. There is an absence in our report of some key data that were not accessible during the review period, these included:

- GP registered population – GP audit data based on this population is limited to only those residents in Leeds who are registered with a GP in Leeds and does not include those registered with a GP elsewhere.
- Domestic Violence – a copy of a brief report on domestic violence was available, but very little raw data. The gender split of the data on the number of incidences was only available at ward level.
- Drug and alcohol service use - male usage and type of substance abused data were not available at MSOA level and age of service users was unknown.
- Potential years of life lost – this is in the process of being calculated for Leeds, but data were not available for this report in our time frame for completing the study
- Lung cancer screening – there is no national lung cancer screening programme offered to ‘at risk’ groups⁶. The Leeds ‘Got a Cough? Get a Check?’ campaign currently offers free lung cancer screening to individuals aged over 50 who are experiencing possible related symptoms, however data to show engagement and outcome were not available.
- Mental health – data were not available to evaluate GP referral patterns following diagnosis, mental health service use and outcomes disaggregated for gender and MSOA.
- Council housing use – in one council housing location (Armley 1), factors such as marital status, household composition, benefit status and arrears owing were collected, however these data were not available for all tenants in Armley 1 or for any other council housing location and data were not gender segregated.
- Prisoner and offender data – there were no data on ex-offenders with regard to the health issues we identified within the study. This limited our ability to show the health consequences in this vulnerable group.
- Physical activity levels – self-reported activity levels recorded by the GP may not accurately reflect actual activity levels in men.

⁶ The Department of Health has funded a study to determine whether a national screening programme in people aged 50-75 is of benefit. <https://www.ukhs.org/what-is-the-ukhs.html>

4 Health status of men in Leeds

This section explores gender differences in life expectancy and mortality and highlights the main health issues affecting men in Leeds.

4.1 Life expectancy⁷

Life expectancy at birth in Leeds (2011-2013) was 78.9 years for men and 82.4 years for women. Although there has been a faster improvement in men's life expectancy than women's over the last 10 years in 2013 we still had a higher number of men dying prematurely with about 20% of all male deaths before the age of 65 years as compared to 12% for women and 19.5% for males nationally (Figure 1). Currently, men living in the affluent suburbs of Leeds generally enjoy long lives with relatively good health, and have a life expectancy far greater than men living in deprived areas the inner city.

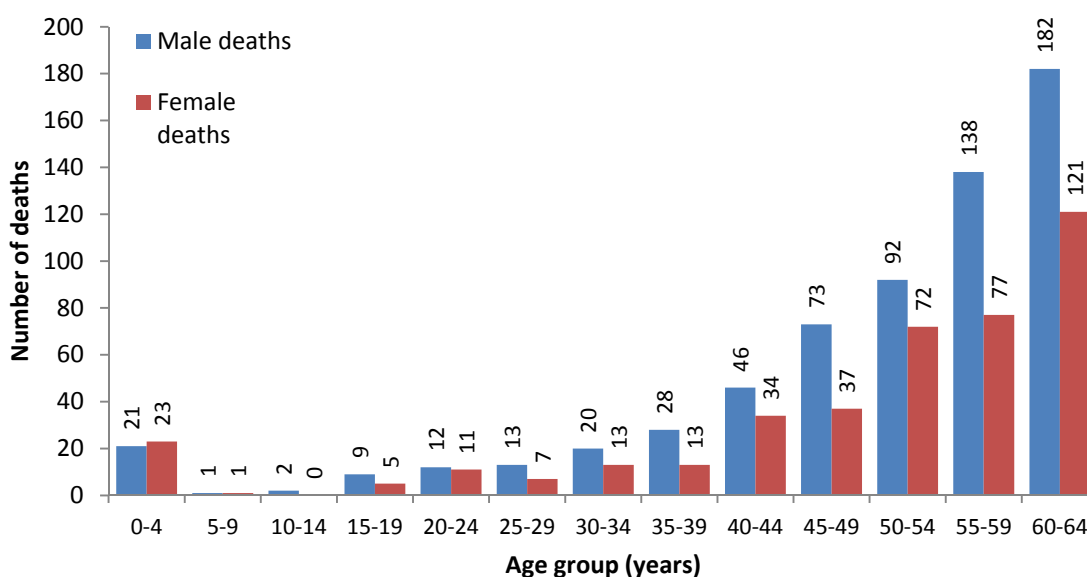


Figure 1. Number of male and female deaths in Leeds for the under 65 year age groups (from Seims & White, 2015)

4.2 Mortality⁸

There are many health conditions that impact on men and women differently, with higher levels of overall mortality and premature mortality seen in men than for women. In 2010-2012, the all-cause mortality rate of death for men under 75 years of age in Leeds was 65%⁹ higher than for women¹⁰. Rates for the main causes of mortality in males and females in Leeds are shown in Figure 2 (all ages) and Figure 4 (under 75 years). Circulatory disease and cancers were the primary and secondary cause of mortality for males (all ages) and cancer and circulatory diseases were the primary and secondary cause of mortality for males aged under 75 years. Circulatory disease and cancer were also the top two causes of mortality for females (both all ages and under 75 years) but rates were lower compared to males.

The ratio of male rates of mortality compared to females across conditions are in Figure 3 (all ages) and Figure 5 (under 75 years). Although suicide was a low cause of mortality compared to circulatory disease

⁷ Please refer to 'The State of Men's Health in Leeds: Data' sections 5.2 'Life expectancy' and 5.3 'Morbidity and Mortality' for further detail and analysis of data

⁸ Please refer to 'The State of Men's Health in Leeds: Data' sections 5.2 'Life expectancy' and 5.3 'Morbidity and Mortality' for further detail and analysis of data

⁹ Erratum: this figure was corrected on the 26th October 2016

¹⁰ Leeds mortality data presented in this section were obtained from http://observatory.leeds.gov.uk/Leeds_Health/

and cancer, this showed the greatest gender difference with almost five times as many men dying as a result of suicide compared to women (Figure 3 and Figure 5).

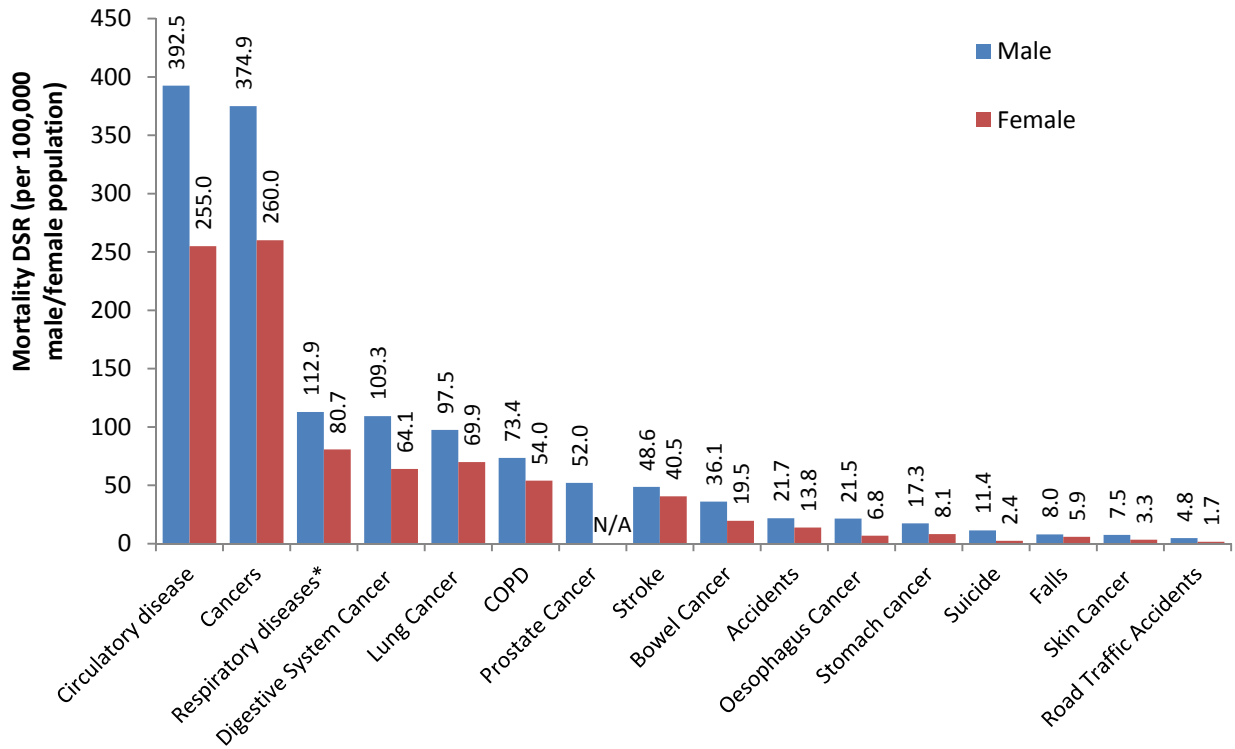


Figure 2. Mortality rates (DSR) for males and females (all ages) in Leeds, 2010-2012
*Excluding pneumonia and influenza

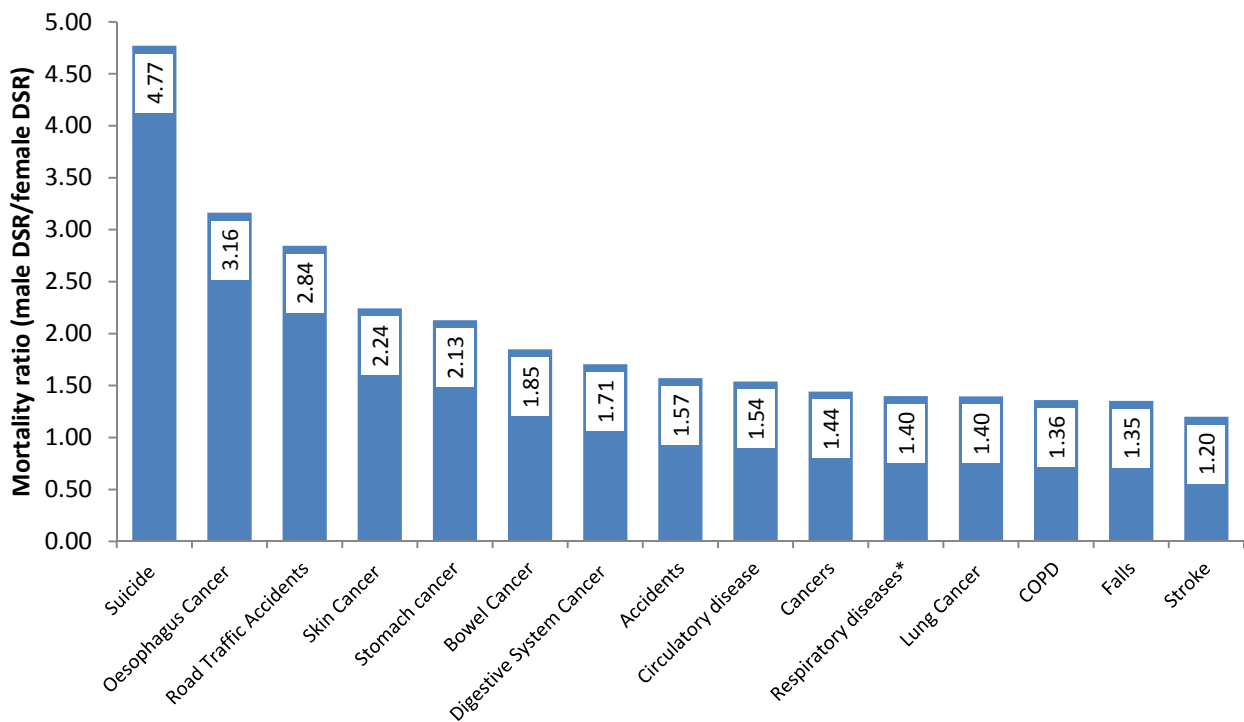


Figure 3. Mortality ratio (male to female) across common causes of mortality for men in Leeds (all ages), 2010-2012 (calculated from data in Figure 2)
*Excluding pneumonia and influenza

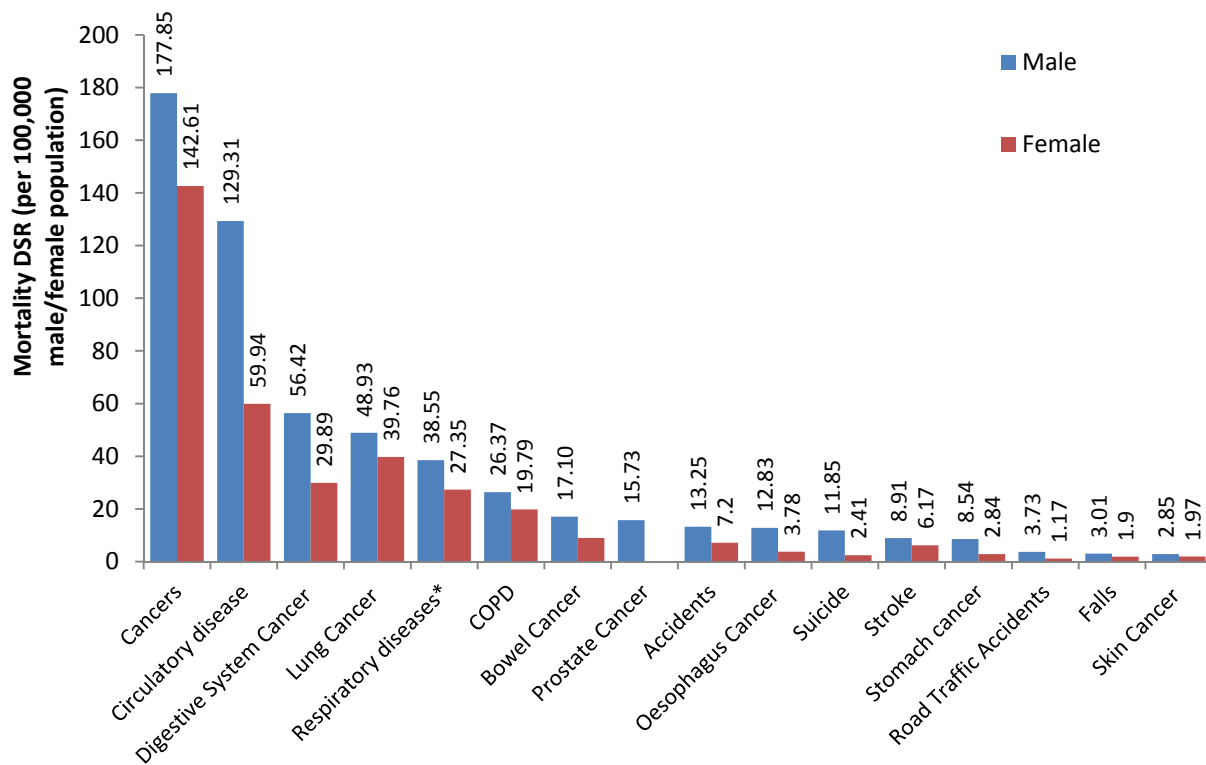


Figure 4. Mortality rates (DSR) for males and females (under 75 years) in Leeds, 2010-2012
 *Excluding pneumonia and influenza

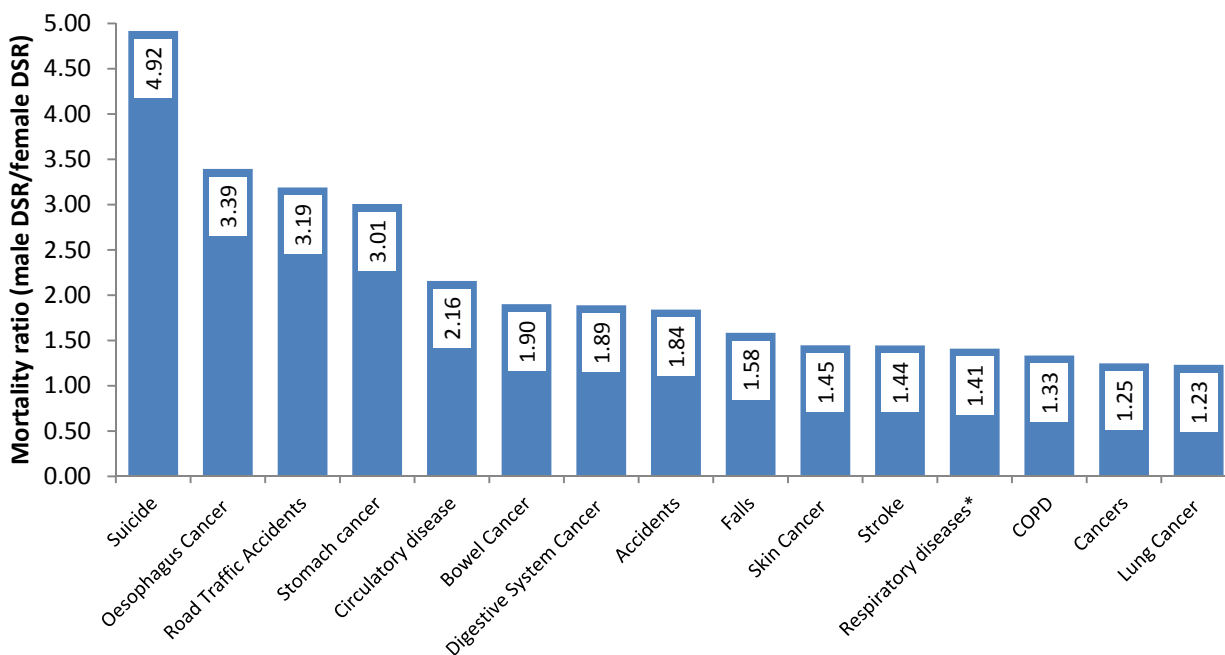


Figure 5. Mortality ratio (male to female) across common causes of mortality for men in Leeds (under 75 years), 2010-2012 (calculated from data in Figure 4)

With improvements in diagnosis and treatment, many of the health challenges facing men now go on to become long-term conditions. The following sections cover the prime health conditions facing men within Leeds.

4.3 Cardiovascular disease¹¹

Men generally have higher rates of premature death and morbidity as a result of cardiovascular disease (EC, 2011; GBD, 2014). In some MSOAs in Leeds, over 20% of men (aged 25+ years) have been diagnosed with hypertension – the top ten ranked MSOAs with high prevalence ranged from 22.3% to 27.8%, with the highest being in Swillington, West Garforth and Little Preston. In 2014, nearly 6% of men (aged 25+ years) in Leeds were known to have coronary heart disease (CHD) and the number of men registered with CHD was nearly 60% higher compared to women (Figure 6). The large disparity between the cardiovascular deaths in males between the more prosperous areas of Leeds as compared with the less well-off areas demonstrates that many of the deaths are avoidable. The difference between men and women is in part due to pre-menopausal women having a biological advantage over men with regard to their heart health (Bhatnagar *et al.*, 2015).

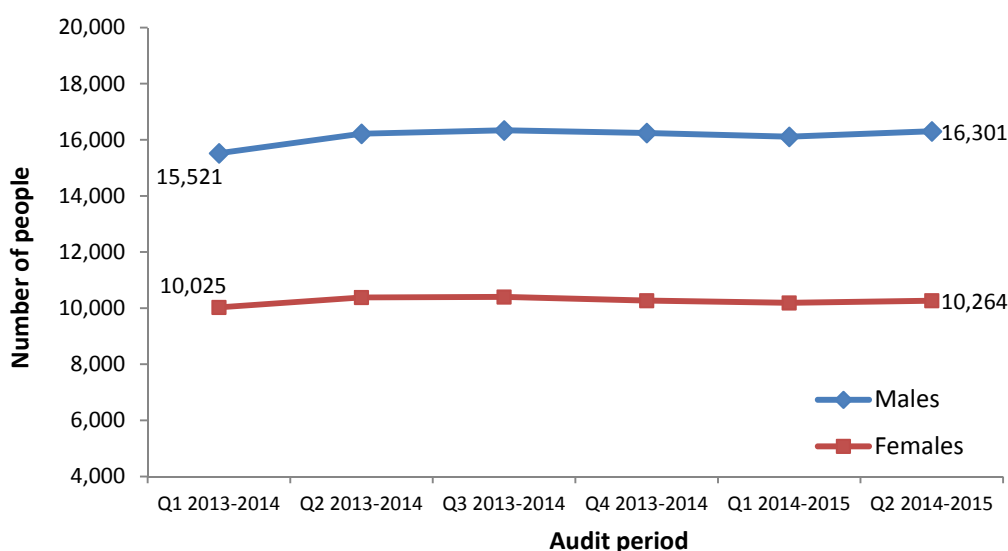


Figure 6. Number of males and females in Leeds registered with CHD across the most recent six audit quarters (from Seims & White, 2015)

In the top ten ranked MSOAs, CHD prevalence in men aged 25+ years ranged from nearly 8% to over 11%, with the highest in Swillington, West Garforth and Little Preston. In men aged 65 years or over, prevalence of CHD was 22% vs. 13% in females of this age, and the total number of men aged 65 years or over with CHD was 36% higher compared to women of the same age. The median CHD inpatient admissions (2009-2011) DSR across Leeds for males (under 75 years) was more than double compared to women, with the highest rates in Wetherby East, Thorp Arch and Walton.

Circulatory disease mortality (all ages) across 2010-2012 was 44% higher compared to women (392.5 vs. 255.0 respectively) and 15% higher compared to England and Wales (341.8). Male circulatory disease mortality (all age) in the top ten ranked MSOAs ranged from 317.8 to 2,112.9¹², with the highest in City Centre. Circulatory disease mortality in men (under 75 years) was almost double that of women, (129.3

¹¹ Please refer to 'The State of Men's Health in Leeds: Data' section 5.3.2 'Cardiovascular morbidity and mortality' for further detail and data analysis

¹² There is some doubt throughout the report on the data relating to City Centre as the life expectancy is very low and the DSRs for nearly all conditions very high and out of kilter with the rest of Leeds. This may be an artefact of undertaking calculations against a standard population as this area has an unusual population structure, with the majority aged in their twenties and thirties.

vs. 59.9). In the top ten ranked MSOAs men's rates of mortality ranged from 169.7 to 301.5, with the highest being in Burley [more than double the overall rate observed across Leeds as a whole (Figure 4)]. The median circulatory disease inpatient admissions (2009-2011) across Leeds for males (under 75) was almost 46% higher compared to females.

Stroke mortality across Leeds in 2010-2012 for all ages was 20% higher for men compared to women (DSR of 48.62 vs. 40.5 respectively). In the top ten ranked MSOAs stroke mortality for men (all ages) ranged from 48.0 to 84.3, with the highest being in Harehills – Comptons, Sutherlands and Nowells. Stroke mortality (2010-2012) was 44% higher in men in Leeds under the age of 75 years compared to women (DSR of 8.9 vs. 6.2 respectively). Stroke mortality rate for males (under 75) in the top ten ranked MSOAs ranged from 22.6 to 42.4, with the highest in the MSOA of Broadleas, Ganners, Sandfords. The rates for the top five ranked MSOAs were four times higher compared to the city wide rate (Figure 4).

4.4 Cancer¹³

Men tend to have higher rates of incidence and premature mortality from those cancers that should affect both sexes equally (for instance, stomach cancer, pancreatic cancer, leukaemia); nationally, men have a 56% higher incidence rate and a 67% higher risk of dying compared to women. This increased risk persists when all cancers are considered (i.e. including breast and testicular cancer), with men having a 14% higher incidence rate and 37% higher death rate (CRUK/NCIN, 2013).

This increased risk has also been noted globally (Tan *et al.*, 2013; EC 2011; Cook *et al.*, 2011; White *et al.*, 2010) and the reasons are not fully understood (Edgren *et al.*, 2012). What is known is that there may be a small survival advantage in women (Micheli *et al.*, 2009), but the large variation in cancer incidence and mortality between different groups of men point more towards socio-cultural factors. Men have historically higher levels of smoking (Parkin, 2011a), higher alcohol intake (Parkin, 2011b) and diets lower in fruit and fibre (Parkin & Boyd, 2011a) and higher in processed and red meat (Parkin, 2011c), and are more likely to have worked in carcinogenic environments (Rushton *et al.*, 2012). There is also a suggestion that men may be slower at responding to cancer symptoms and therefore at greater risk due to having more advanced cancer, although this has a weak evidence base as discussed later under the section on screening.

This increased risk is seen within Leeds; over 2010-2012 the cancer mortality DSR across Leeds was 44% higher for men (all ages) compared to women (374.9 vs. 260.0 respectively). The male DSR was 9% higher compared to England and Wales (344.4) and there was a similar difference between women in Leeds and women nationally (a rate of 235.5). Cancer mortality in the top ten MSOAs ranged from 307.2 to 412.3¹², with the highest in City Centre. In men aged under 75 years, the cancer mortality rate in 2010-2012 was 24% higher for men than for women (177.85 vs. 142.61 respectively). The male (and female) DSR was 10% higher compared to England and Wales (161.3 and 129.6 for males and females nationally). Cancer mortality rate for men aged under 75 years was highest in the MSOA of Cross Green, East End Park and Richmond Hill (a rate of 243.8) and was almost 40% higher than the rate observed across Leeds as a whole (Figure 4).

The top five MSOAs ranked with the highest cancer mortality rates for males (all ages) were ranked relatively low for cancer prevalence (aged 25+). This may be due to higher rates of heavy impact cancer, such as lung cancer, in the poorest MSOAs.

Within Leeds the main Public Health focus is on three cancers – Breast, Lung and Bowel. Though men can get Breast Cancer the two cancers that have specific relevance for men are bowel cancer and lung cancer, both of which are seen to have a higher incidence and mortality in men. Lung cancer mortality

¹³ Please refer to 'The State of Men's Health in Leeds: Data' section 5.3.3 'Cancer morbidity and mortality' for further detail

DSR for men across Leeds (all ages) in 2010-2012 was 40% higher compared to women (97.52 vs. 69.87 in women) and 28% higher compared to men in England and Wales (76.0). Male lung cancer mortality rates (all ages) in the top ten ranked MSOAs ranged from 100.0 to 143.7, with the highest in Halton Moor, Wykebecks. Lung cancer mortality DSR across Leeds (under 75) in 2010-2012 was 23% higher in men compared to women (48.93 vs. 39.76) and 21% higher than the male rate for England and Wales (40.3). Lung cancer mortality rates for males (under 75 years) in the top ten ranked MSOAs ranged from 64.7 to 99.9, with the highest in the MSOA of Gipton South. The rates for the top five MSOAs were approximately double compared to the city-wide rate (48.9). Cancer screening and uptake is explored later in section 10 '*Men accessing General Practice and screening services*'.

Men are at an increased risk of developing bowel cancer, with men nationally having nearly a 60% higher incidence at all ages, and a 46% higher incidence in the 15-64 age range, with a 65% higher rate of mortality for all ages and a 58% higher mortality rate in the 15-64 age range (CRUK/NCIN, 2013). Bowel cancer mortality DSR across Leeds (all ages) in 2010-2012 was almost double for men than women (36.0 vs. 19.5 in women). Male (all age) bowel cancer mortality rate for the top ten ranked MSOAs ranged from 35.1 to 52.1, with the highest in the MSOA of Belle Isle South. Bowel cancer mortality DSR across Leeds (under 75) in 2010-2012 was also almost double for men than for women (17.1 vs. 9.0 respectively). Bowel cancer mortality rate for males (under 75) in the top ten ranked MSOAs ranged from 19.9 to 42.9, with the highest in the MSOA of Crossgates and Killingbeck.

The incidence of prostate cancer is increasing in men, mostly as a result of an ageing population, but also due to better awareness of the condition and earlier diagnosis. Despite an increase in prevalence however, the actual mortality rate (52.03 per 100,000 men of all ages for 2010-2012 for Leeds) has remained mostly unchanged, suggesting that treatment is more effective and that some identified cancers were not life-limiting. Prostate cancer mortality rates (under 75) for males in 2014, in the top ten ranked MSOAs ranged from 24.6 to 50.1, with the highest in the MSOA of Brackenwood and Gledhow, The rates for the top five ranked MSOAs were 2-3 times higher than the city-wide rate (15.7). Prostate cancer is known to be more prevalent, with a higher death rate in men from Black ethnic groups¹⁴, but specific data on mortality in Leeds for this group of men was not available.

The overall numbers for testicular cancer deaths are low [57 in the UK in 2013 (ONS, 2014c)] but this cancer is also on the increase nationally (Le Cornet *et al.*, 2014). There is an issue of getting early diagnosis and treatment as this is entirely curable and there are still examples where men have delayed presenting with the disease and had worse outcomes (Mason & Stauss, 2005). Over the period of 2010-2012, around 30 men were diagnosed with testicular cancer in Leeds each year¹⁵.

Although breast cancer is mostly seen in women it is important to recognise that men can also develop this disease (Ly *et al.*, 2012) and that more men die each year of breast cancer (86 deaths across England & Wales) than die from testicular cancer (ONS, 2014c). The incidence of breast cancer in men is increasing through a possible link with the increased prevalence of obesity in men (Humphries *et al.*, 2015). Men who have breast cancer have been found to have particular difficulties due to the social stigma of having a 'woman's cancer' and also due to the lack of male focused support (Ruddy & Winer, 2013; Andrykowski, 2012).

4.5 Respiratory disease¹⁶

Respiratory disease mortality DSR (excluding pneumonia and influenza) across Leeds (all ages, 2010-2012) was 40% higher for men compared to women (112.9 vs. 80.7 respectively). Respiratory disease

¹⁴ <http://www.ncin.org.uk/view?rid=2991>

¹⁵ From 'Cancer Analysis System, snapshot CAS1403', data provided by the team at <http://www.cancerresearchuk.org>

¹⁶ Please refer to 'The State of Men's Health in Leeds: Data' sections 5.3.4 'Respiratory disease morbidity and mortality' for further detail and analysis of data

mortality rates for men (all ages) in the top ten ranked MSOAs ranged from 109.4 to 250.0 with the highest in the MSOA of City Centre¹⁷. Respiratory disease mortality DSR across Leeds for those under 75 years of age (2010-2012) was 41% higher for men compared to women (38.55 vs. 27.35 respectively). Respiratory disease mortality rates for men (under 75) in the top ten ranked MSOAs ranged from 69.0 to 260.4 with the highest in the MSOA of City Centre. The rates for the top five MSOAs were at least double the city-wide rate (38.6).

In 2014, the overall proportion of the male population with Chronic Obstructive Pulmonary Disease (COPD) was similar to that of females (approximately 2% of the population), with prevalence proportionally higher in the male population aged 65 years or over (9.7% of males in that age group vs. 8.5% of females respectively). The proportion of males aged over 25 years with COPD in the top ten ranked MSOAs ranged from 4.3% to 6.4% which was more than double that observed for males across Leeds (1.85%). The highest proportion was in the MSOA of Belle Isle North (133 men).

The COPD mortality DSR across Leeds for all ages (2010-2012) was 36% higher for men compared to women (73.4 vs. 54.0 respectively). Chronic obstructive pulmonary disease (COPD) mortality rates for men (all ages) in the top ten ranked MSOAs ranged from 86.6 to 250.0, with the highest in the MSOA of City Centre. COPD mortality DSR (under 75) across Leeds (2010-2012) was 33% higher for men compared to women (26.4 vs. 19.8 respectively). In the top ten ranked MSOAs ranged from just over 47 to about 260 per 100,000, with the highest in the MSOA of City Centre. The rates for the top five MSOAs were at least double the city-wide rate.

Men's increased risk of dying from respiratory disease is mainly a result of historically higher rates of smoking or working in hazardous environments. With changes in smoking prevalence in men and the decrease in heavy manufacturing and mining, and an increase in the use of protective equipment in the workplace there will be a reduction in the forms of chronic lung conditions seen previously over time. Men tend to have higher rates of death due to pneumonia in their younger years due to homelessness, aspiration pneumonia and through HIV (EC, 2011).

Data for tuberculosis (TB) incidence was not available for this study, but nationally men have double the rate of death as compared to women (ONS, 2014c) with men accounting for 58% of cases nationally and trends matching those of migration (PHE, 2014). Identifying at-risk males is an important public health issue, with some migrants arriving with latent TB and developing the full disease during their stay. They are also more likely to be suffering from Multi-Drug Resistant TB and extensively drug-resistant TB. Men who may be the most at risk can also be the most reluctant to come forward, and those that do, the least likely to adhere to treatment regimens (EC, 2011).

4.6 Accidents¹⁸

Deaths from accidents are generally falling within the UK due to stringent health and safety legislation at work, road safety measures, and a more risk-aware society (EC, 2011). Despite this, men are still more likely to be involved in an accident and to be killed either at home, at work or on the road. In the main part, this is due to being more likely to be in occupations that put them at risk, more likely to complete home DIY or through greater likelihood to be driving. It has to be acknowledged that there is also an element of bravado and inability for some men to recognise the hazard.

The accident mortality DSR across Leeds in 2010-2012 (all ages) was 60% higher for men than women. Accidents were also more widespread across the city for males compared to females, with 89 MSOAs reporting a male rate for mortality from accidents compared to 81 MSOAs reporting a rate for females.

¹⁷ See note #17 above regarding high rates relating to the City Centre

¹⁸ Please refer to 'The State of Men's Health in Leeds: Data' sections 5.3.7 'Accidents' for further detail and analysis of data

The top two MSOAs with the highest DSR for accident mortality in men (all ages) were Little Woodhouse and Belle Isle South.

4.7 Mental health¹⁹

From recent 2014 data it can be seen that approximately 18% of adult males in Leeds had a common mental health disorder, with prevalence greatest in the 50-64 year age group (23.4% of males in that age group).

The most common disorders were anxiety and depression. The highest prevalence of anxiety in males was in the MSOA of Otley (14.0% of men aged 18+) and was similar to the city-wide prevalence for women (14.8%). The highest prevalence of depression in males was in the MSOA of Morley West (12.9% of men aged 18+) and was similar to the city-wide prevalence for women (12.5%). In Leeds, 0.4% of men (aged 18+) were registered with Post-Traumatic Stress Disorder (PTSD), with the largest proportion being in Lincoln Green and Ebor Gardens 1.32%, which is four times higher than the city-wide rate for males.

Common disorders with the greatest increase (over a six-quarter period) in prevalence amongst men were anxiety, with a 16% increase and PTSD (14%). The greatest increase in females were also seen for anxiety (14%) and PTSD (11%).

In 2014, just over 1% of adult males in Leeds had a severe mental health disorder, with the prevalence greatest in the 50-64 year age group (1.56% of males). The most common disorders observed for adult males were bipolar affective disorder and schizophrenia (Figure 7). Schizophrenia was the most common severe mental health disorder amongst males and the number of men registered with this condition was 35% higher than the number of females. Paranoia and psychotic disorders and were more prevalent in males compared to females (41% and 32% greater respectively).

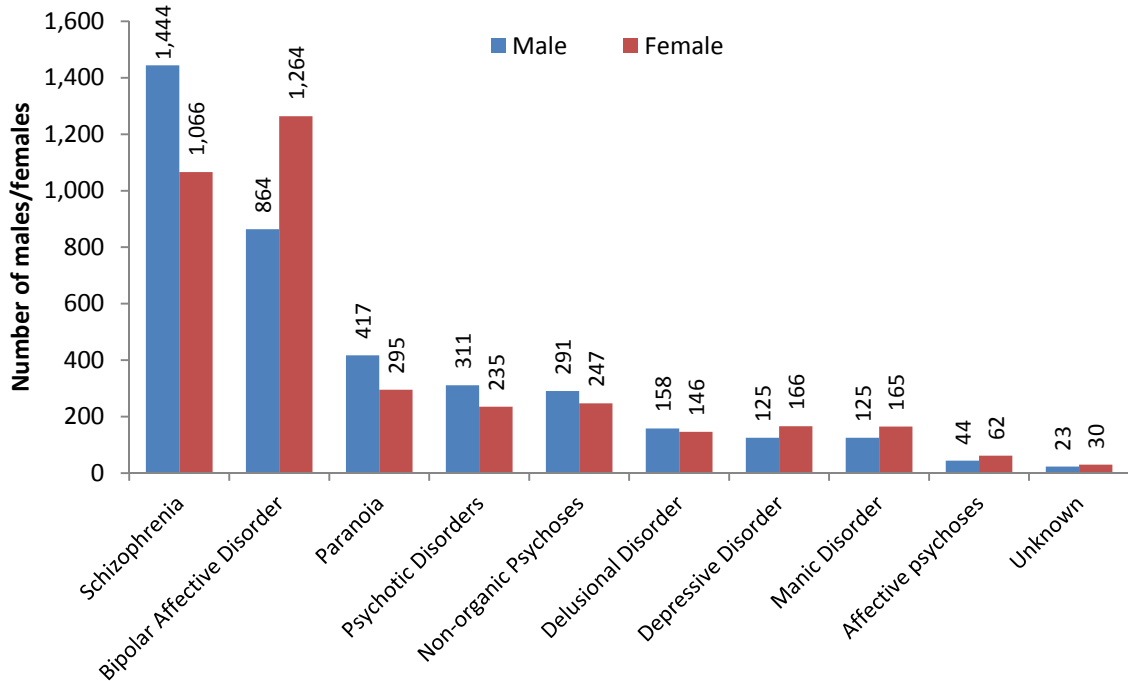


Figure 7. Number of males and females in Leeds registered as having a severe mental health disorder by type of disorder, Q2 2014-2015 (from Seims & White, 2015)

¹⁹ Please refer to 'The State of Men's Health in Leeds: Data' sections 5.3.8 'Mental health' for further detail and analysis of data

National data also show that the number of males in contact with mental health services is less than that observed for females, however the number of men admitted to hospital was greater compared to females and a higher proportion were as a result of referrals from the courts.

Mental health is discussed in further detail in section 8 'Mental Health'.

4.8 Suicide²⁰

Men's higher rates of suicide are a global concern (Tan *et al.*, 2013; Pitman *et al.*, 2012; EC, 2011). During the recent recession, increasing rates of male suicide have been seen in those countries most affected, such as Ireland, Italy and Greece (Antonakakis & Collins, 2014; Corcoran *et al.*, 2015; Pompili *et al.*, 2014). In the UK suicide rates have been increasing and this is also replicated within the Leeds area (Barr *et al.*, 2012).

In 2010-2012, the suicide mortality rate across Leeds (all ages) was nearly five times higher for men compared to women (11.4 vs. 2.39 respectively). The calculated DSR for years of life lost due to mortality from suicide (age 15-74 years) for men in Leeds was 28% higher compared to the DSR for England and Wales however this difference with the national figures was not observed for females²¹.

The top two MSOAs with the highest rates of suicide mortality in men (all ages) were Burley (56.2) and Armley, New Wortley (38.8). In 2010-2012, suicide mortality rates for men (under 75) in the top ten ranked MSOAs ranged from just under 25 to over 56 per 100,000 with the highest in the MSOA of Burley. The rates for the top ten MSOAs were at least double the city-wide rate.

The MSOA of Armley, New Wortley was listed in the top 10 ranked MSOAs for high rates of male suicide mortality (2010-2012) and high male hospital admission rates for self-harm (2009-2011). These men who self-harm could therefore be a group of men that could be targeted in hospital by getting them into services that may minimise future suicide attempts (Hawton *et al.*, 2015).

The Leeds report on suicide (Leigh-Hunt *et al.*, 2010) noted that overwhelmingly, the main cause of suicide was a loss of something: having to leave the family home and now sofa surfing; having long term health conditions; facing employment difficulties (unemployment, bullying or stress at work) and/or divorce and loss of contact with children. A lot of men were also noted to be in complicated relationships and leading chaotic lives. These negative life events result in a low in their resilience that can culminate in suicide. The report recognised a growing problem for older men resulting from a lack of focused services, poor social capital and networks and social isolation. This same pattern is not seen in women, who are generally thought to be better at using services and having better social support networks.

Male suicide is discussed in further detail in section 8 'Mental health'.

4.9 Diabetes²²

There has been a significant rise in the incidence of diabetes, increasing by 60% in the last decade and set to increase year on year (Diabetes UK, 2015), with 23% more known²³ male diabetics compared to known female diabetics in Leeds (Figure 8). Most of the increase is in obesity-related type 2 diabetes

²⁰ Please refer to 'The State of Men's Health in Leeds: Data' sections 5.3.6 'Suicide' for further detail and analysis of data

²¹ Taken from 'Years of life lost due to mortality from suicide: directly standardised rate, 15-74 years, 3-year average' (2011-2013). Available from <https://indicators.ic.nhs.uk/webview/>

²² Please refer to 'The State of Men's Health in Leeds: Data' sections 5.3.2.2 'Diabetes prevalence' for further detail and analysis of data

²³ This data reflects the number of males and females diagnosed with diabetes through their GP and may not represent the total number of males and females who have undiagnosed diabetes.

and is strongly associated with overweight and obesity, with men more likely to develop the more damaging visceral fat. The consequences of diabetes worrying, as it is a key cause of avoidable deaths and long-term ill-health conditions such as heart disease, kidney failure, blindness and erectile dysfunction and it also increases the risk of cancer (Karet 2012; Diabetes UK 2013; Inoue *et al.*, 2006; Shamloul & Ghanem 2013).

In 2014, diabetes prevalence was over 5% in males as a whole, however in the top ten ranked MSOAs this ranged from 6.6% to 8%, with the highest in the MSOA of Swillington, West Garforth and Little Preston. Diabetes prevalence was highest in males aged 65 years or over, where 18% of males in this age group have the condition (Figure 8). Male (under 75) admission rates to hospital (2009-2011) were 33% higher for men than for women across Leeds, with the highest rate of admission being in Bramley Whitecote.

Across Leeds 46% of all males with diabetes are over the age of 65 years, but the predisposing factors will have been set in place over the previous decades, such that preventative programmes need to be delivered earlier in the lifespan.

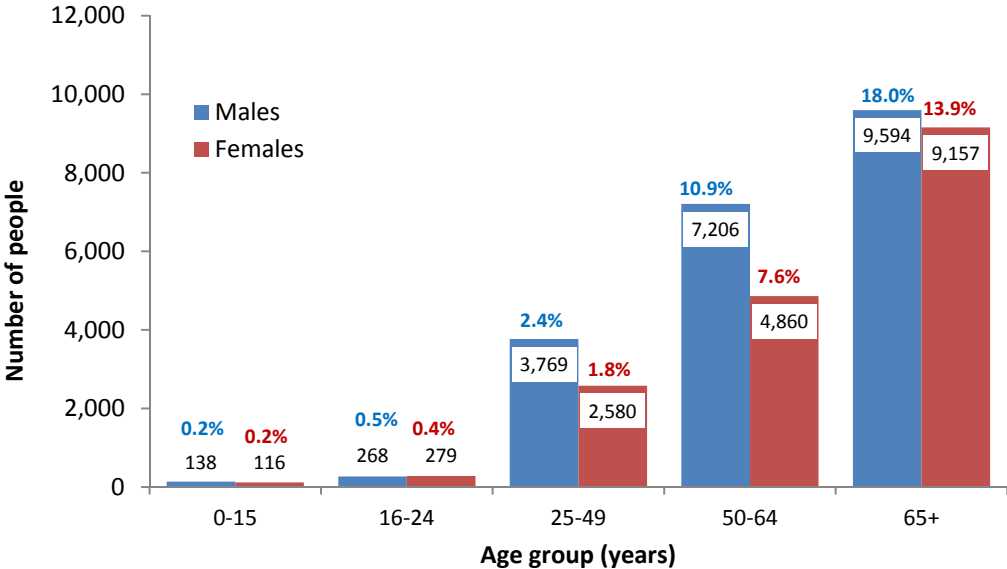


Figure 8. Diabetes prevalence (total and as a percentage of age population) for males and females in Leeds across age groups in Q2 2014-2015 (Seims & White, 2015)

4.10 Self-assessment of health²⁴

Despite the lower life expectancy, higher mortality and prevalence of chronic disease observed in men, data from 2011 indicated that they were generally less likely to rate their general health as ‘bad’ or ‘very bad’ compared to women [6.3 % and 6.7% of the male and female 16+ age population respectively], however in some MSOAs over 10% of men rated their health as ‘bad’ or ‘very bad’. In those aged 50-64 years, groups, men were more likely to rate their health as ‘bad’ or ‘very bad’ compared to women [9.8% of men in this age group compared to 9.3% of females (Figure 9)] however this trend was reversed in the 65 years age group, where women were more likely to rate their health as ‘bad’ or ‘very bad’ (16.6% compared to 15.9% of males).

²⁴ Please refer to ‘The State of Men’s Health in Leeds: Data’ sections 5.1 ‘Self-assessment of health’ for further detail and analysis of data

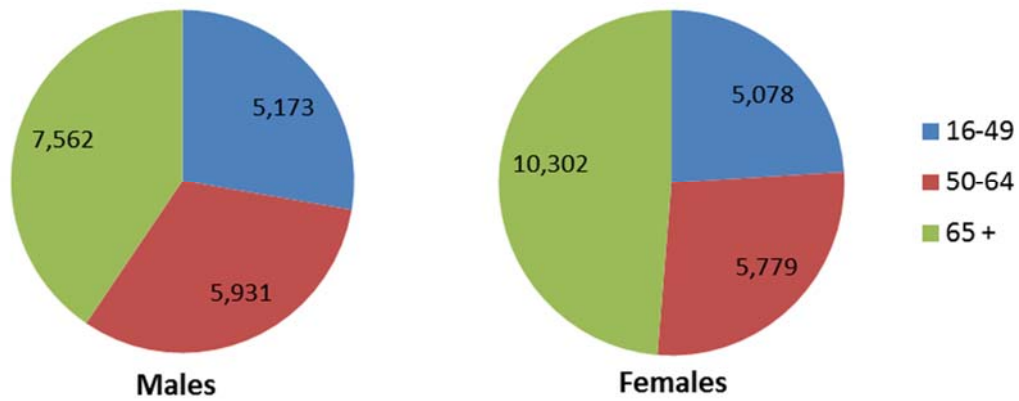


Figure 9. Number of males and females in Leeds rating their health as 'bad' or 'very bad' by age group
 (from Seims & White, 2015)

To tackle men’s physical and mental health, action is required both at the structural level of service provision in reaching out and targeting men more effectively, and also at the societal level addressing the social determinants of health. The effectiveness of these actions can be greatly enhanced by understanding men’s behaviour and the societal constraints within which they exist. This is discussed in the following section.

5 Understanding men and their health

The following sections describe the biological factors that affect how the male body differs from the female body and also the effect of social pressures on boys and men which influence health-related social determinants and lifestyle behaviours.

5.1 Being born a male

The building blocks of sex difference are the XY chromosome in men and the XX chromosome in women,²⁵ creating many anatomical and physiological differences between men and women that are beyond the reproductive system. From birth, boys have health challenges that differ from girls in many ways. There are more congenital disorders and developmental disorders that affect boys, with a greater incidence of delayed reading, stammer, attention deficit hyperactivity disorder, Tourette's Syndrome, autistic spectrum disorders, hyperkinetic disorders and disruptive behaviour disorder (Breeman *et al.*, 2014; Kraemer, 2000). These can all negatively impact on their educational attainment and social development, which is not helped by boys being more likely to be excluded from school due to conduct problems (Whear *et al.*, 2013).

As adults sex-differences are still as important. The immune system is seen to be more pronounced in women, playing an important role in the excess incidence of autoimmune disorders in women, but also having a protective effect in cancer development and survival for women (Sun *et al.*, 2012; Bouman *et al.*, 2004; Restif & Amos, 2010; Micheli *et al.*, 2009). Cardiovascular disease is more prevalent in younger men as a result of the cardio-protective effect of female sex-hormones, though obesity and diabetes have been found to remove this benefit in premenopausal women (Ren & Kelley, 2009). There are also marked anatomical and physiological differences between the male and female heart (Fazal *et al.*, 2014; Campbell *et al.*, 2011; Papakonstantinou *et al.*, 2013). Men tend to deposit their fat intra-abdominally, with an increased risk of the associated diabetes, hypertension and high cholesterol [metabolic syndrome] (Tchernof & Després, 2013). Boys have a higher prevalence for asthma than girls before puberty, but women have a higher level than men until post menopause reflecting both the difference in lung structure in the young and the influence of the sex-hormones (Postma, 2007; Carey *et al.*, 2007).

Although these biological differences may exist, there are far greater disparities that exist between men, dependent on socio-cultural and environmental factors. It is therefore important to recognise the nature of how men are socialised and the effect of the social determinants as much as the anatomical and physiological sex differences in order to understand men's health within a city such as Leeds.

5.2 Growing up as a boy and living as a man

Boys and men are bombarded with messages as to how they should behave and what attributes they should possess. This process starts from birth; the way boys and girls are treated helps shape the way they see the world and also how society treats them, with their clothes and toys giving a very visible display of their gender. These early experiences of social conditioning, coupled with the effect of schooling (Mac an Ghail & Haywood, 2012; Mac an Ghail, 1996) can lead to what Pollack (1999) calls the "Boy Code"- a set of unwritten 'rules' about how boys think others expect them to behave: including "be tough," "don't cry," and "go it alone,". How each boy acts in public is carefully watched by their friends and peers as a signifier of their masculine identity and such 'policing' can limit their ability to learn valuable life skills. An example of this is that although girls seemed to be allowed to develop a breadth of language with regard to emotions, feelings and relationships, boys' freedom to be as open has been found to be much more restricted (Frosh *et al.*, 2002).

²⁵ Recognising that there are people with other genetic variants that can cause different sex related disorders.

On entering adulthood, this social pressure continues with men historically expected to be the main breadwinner, to be in control, trustworthy, able to provide and protect, to be a good father, and be a loyal partner. These expectations can be very damaging as they are mostly built on stereotypes and give unreasonable pressure on men to live to a set of values that are often misplaced and unattainable. This goes across the spectrum of men's lives, with those that are trying to live up to these goals creating both stress and strain and the feelings of failure when they are not lived up to. This is compounded by what would have been seen as a 'traditional' way of living is now absent for many men, with a new reality of unemployment, fragile partnerships, and poverty.

This is reflected in the number of vulnerable young men in society that are living chaotic lives, sometimes as a result of drug and alcohol abuse (Nayak, 2006), but often through complex social pressures and a lack of a social role. This was found in Harland's inner city Belfast study who found that many boys and young men are desperate for a sense of belonging and acceptance, with a turmoil beneath their 'tough' persona (2009 p1):

"[the young men] clung desperately to narrow and contradictory interpretations of masculinity, believing that men should be powerful, strong, brave, intelligent, healthy, sexy, mature, and in control of every aspect of their lives. In reality, however, their lives were full of 'contradictions' as most young men felt powerless; feared the threat of daily violence; were labelled 'stupid' in school; did not pay attention to their health needs - particularly their mental health; had limited sexual education; rarely asked for support; and felt they were perceived by adults as being 'immature.'"

Similar young men are found across the UK and though they do not easily conform to health messaging they are still in need of a nurturing and caring environment. Coles *et al.* (2010) reported that men, especially young men and men from low socio-economic groups, often described themselves as forgotten and not taken seriously by health services – a finding shared by many other studies on men.

The majority of men live happy and contented lives, but poor physical or emotional health can threaten this masculine identity and create difficulties for those men who feel that such 'weakness' will make others see them as being 'less of a man'. These social pressure can also make it difficult for some men to negotiate their health and health behaviour in positive ways. For instance, there are men who consider being a smoker (Hunt *et al.*, 2004; Bottorff, Seaton *et al.*, 2014; Okoli *et al.*, 2011), and a drinker (de Visser, 2007) as important signifiers of manhood, such that the meaning of smoking and drinking goes beyond the addictive nature of tobacco and alcohol to a deeper meaning of who you are within your peer group.

With more emphasis on personal, social, health and economic (PSHE) education in schools there is a much greater understanding of alternative lifeways, such as sexual differences and boys are developing skills to navigate their lives more effectively. Nevertheless social pressure to conform means that health care services will have to recognise the impact of masculine identity on how services are viewed and consumed.

6 Intersectional factors and social determinants that impact on men’s health

Men (like women) are not a homogenous group; we cannot paint a single picture of men’s health and expect it to be representative of all men. Preventable ill-health is generated as a consequence of key intersectional factors²⁶, such as age, ethnicity, cultural group, sexuality and disability and a raft of social determinants²⁷ relating to marital status, education, employment, socio-economic status etc.

6.1 Demographic profile of males in Leeds

According to the 2011 Census data, there were almost 368,000 males living in Leeds, however recent GP audit data shows that there were approximately 410,000 males living within Leeds in October 2014. Some of the intersectional factors mentioned earlier are unalterable and some create different challenges for male health; these include age, ethnicity, any disabilities and sexuality. The key demographic data with regard to these factors (within the confines of the data available at time of completion) are outlined below.

6.1.1 Age²⁸

Across Leeds, 18.1% of the male population are aged 0-15 years; 68.8% aged 16-64 years; and 13% over 65 years, with some MSOAs having more younger men and few older men, whereas others had a higher proportion of their men in the older age groups. This alters the health challenges faced (highlighted earlier in section 5 ‘Understanding men and their health’) and what services may be the most useful. The ten MSOAs with the greatest proportion of boys (aged 0-15 years) ranged from 23.9% to 29.1% of the total male population, with the highest being in Seacroft South. The MSOA with the lowest proportion of boys was City Centre (1.9%). The proportion of working-age men (16-64 years) in the top ten ranked MSOAs ranged from 77.4% to 97.3%, with the highest being in the MSOA of City Centre. The MSOA with the lowest proportion of working-age men years was the MSOA of Bramham, Boston Spa and Clifford (57.3%). The proportion of older men (65+ years) in the top ten ranked MSOAs ranged from 21.4% to 25.7%, with the highest being in the MSOA of Swillington, West Garforth and Little Preston. The MSOA with the lowest proportion of older men years was the MSOA of City Centre (0.79%)²⁹.

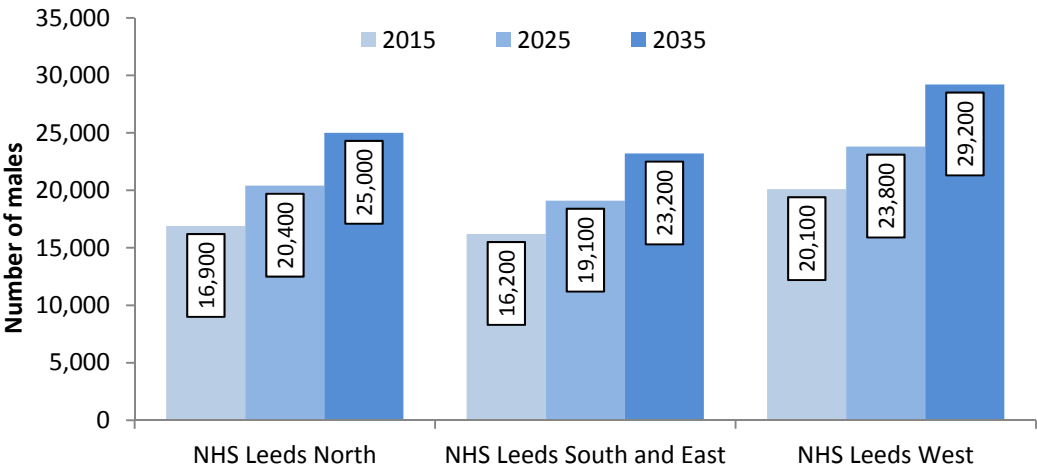


Figure 10. Population projection for males aged 65 years or over in Leeds 2015-2035 (from Seims & White, 2015)

²⁶ Intersectional factor reflects the diversity of issues that affect a person’s life that are not alterable by choice.

²⁷ Social determinants relate to the conditions in which people live and the social and economic factors that can impact on their health - these are changeable.

²⁸ Please refer to ‘The State of Men’s Health in Leeds: Data’ section 2.1 ‘The male population’ and 2.2 ‘population change for Leeds’ for further detail and analysis of data

²⁹ Leeds City Centre has a very unusual population, with the majority of those living in the heart of the City being in their 20’s and 30’s. This makes calculations on life expectancy and other calculations relating to death rates etc. very uncertain.

The age profile of males has changed over the years with an increasingly aged population (up by 10.2% between 2004-2013), and this is set to continue, with the projected estimates for 2035 (Figure 10) indicating that the largest increase in the Leeds' population will be among males aged 65 years or over (an increase of around 46% for males and 33.7% for females from 2015). Those classified as older adults now span a wide range of ages and we are entering into new territory with older, older men (those aged over 85 years) being more prevalent. It is also projected that by 2035 there will be approximately 400 more boys in the 0-4 year population of Leeds compared to current figures.

6.1.2 Ethnicity³⁰

Ethnicity can have specific effects on physical and mental health. For instance prostate cancer is three times more prevalent in African Caribbean men than in Caucasian's (Kheirandish & Chinegwundoh, 2011), diabetes is a greater risk in South Asian men at a lower level of visceral fat (Waugh *et al.*, 2013), and a higher rate of BME men coming into contact with mental health services via adversarial or crisis related routes (Robinson *et al.*, 2011).

According to Census data (2011) 84.5% of the male population in Leeds were classed as White, 2.7% Mixed/Multiple ethnicity, 8% Asian/Asian British, 3.5% Black/African/Caribbean/Black British and 1.3% 'Other'. The MSOAs with more than 50% of their male population classed as non-white were Harehills Triangle (84.3% non-white), Harehills (65.0%), Chapeltown (64.9%), Lincoln Green and Ebor Gardens (57.8%) and Beeston Hill (56.0%).

The young male population (0-24 years) in Leeds is generally more ethnically diverse compared to older generations, with approximately 20% of their population of non-white ethnicity compared to 5% in the 65 years age group. However, ethnic composition within age groups differs widely across the city with approximately 70% of the male 50-64 year population in Harehills Triangle being of non-white ethnicity, compared to around 0.5% of males aged 50-64 years in the MSOA of Wetherby West.

6.1.3 Disability³¹

Disability comes in many different forms and can have a marked effect on physical and emotional health and wellbeing and can be from birth, acquired through accident or through long term chronic health problems.

According to the 2011 Census, around 18% of males and 21% females (aged 16+ years) in Leeds had a long-term health problem or disability that limited their daily activities by a little or a lot. This was similar to England and Wales (19% and 23% of men and women).

In 2011, 8% of men in Leeds aged 16-49 years felt their daily activities were limited (by a little or by a lot) as a result of their disability or long-term health condition, although in the MSOA of Seacroft North this increased to 16% of men aged 16-49 years. Across Leeds, 25% of the 50-64 age population were limited due to their disability or long-term condition, but in the MSOA of Lincoln Green and Ebor Gardens this rose to almost 43% of men aged 50-64 years. Approximately 52% of males aged 65+ years felt limited by their disability or long-term condition, with the highest proportion being in the MSOA of Otley (83%).

³⁰ Please refer to 'The State of Men's Health in Leeds: Data' section 2.3 'Ethnic minority men in Leeds' for further detail and analysis of data

³¹ Please refer to 'The State of Men's Health in Leeds: Data' section 2.4 'Disability and long-term health conditions' for further detail and analysis of data

In the 16-64 year age group, 6% of men in Leeds felt their daily activities were limited a lot by their disability or long-term condition, however almost 12% of men in this age group in Seacroft North and in Harehills – Comptons, Sutherlands and Nowells felt limited a lot by their disability or condition.

6.1.4 Sexuality

Sexuality is a protected characteristic under the Equality Act and as such should be considered in the provision of all services. According to ONS Sexual Identity in the UK report (ONS, 2014d) for 2012, 1.5% of the whole UK male population saw themselves as 'gay' with 0.3% 'bisexual'. There are also men who have sex with men (MSM), who do not necessarily see themselves as gay, but have their own health risks. The ONS acknowledge that it is very difficult to determine the total number of men who may be transgendered or experiencing gender variance (ONS, 2009).

The issues relating to ones sexuality goes beyond the sexual act (Manthorpe & Moriarty, 2014; Gough & Flanders, 2009; Dickson-Spillmann *et al.*, 2014; Balán *et al.*, 2013; Gates, 2013; Fallin *et al.*, 2015) and cannot be adequately covered in this report, but where appropriate comment can be made it has been included in the text.

The Council does not hold any data to show the number of gay, bisexual and transgender men living in Leeds.

6.2 Social determinants of men's health

The social circumstances in which a person lives are related to educational attainment, housing, employment, poverty and marital status. These factors have a profound impact on overall health and wellbeing and focusing on these may have a greater impact on health than by focusing on health per se (Deaton, 2002). The clustering of factors that influence men and their health have to be recognised and tackled as a whole; focusing on single items negates the complexity of the broader picture.

However, not all focus should be on the most vulnerable, as there are issues and problems with men's health throughout the social strata. The idea of "proportionate universalism" has recently been suggested as a possible policy direction in the Marmot report for tackling inequalities more equitably:

"Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism." (Marmot Review Team, 2010, p15).

6.2.1 Educational attainment³²

A good education can have a significant positive effect on health and wellbeing, increasing the likelihood of paid employment and a less risky lifestyle. The longer a child is in education, the greater the benefit, with those continuing into tertiary education more likely to get a better job and be healthier (Viner *et al.*, 2012; Wilkinson & Marmot, 2003).

Across Leeds many boys are missing out on this valuable start in life. The proportion of boys in Leeds in 2013 achieving a good level of development (44%) in the Early Years Foundation Stage Profile (EYFSP) and level 2 key stage 1 reading (83%) and writing (77%) was lower compared to girls and compared to boys nationally. For these three indicators of educational attainment, the MSOAs of Harehills; Harehills Triangle; Bramley; Harehills – Comptons, Sutherlands and Nowells; Halton Moor, Wykebecks; and Belle Isle North were repeatedly ranked amongst the ten MSOAs with the lowest proportion of boys achieving these standards. This gender gap on essential reading and writing skills at such an early age may have a

³² Please refer to 'The State of Men's Health in Leeds: Data' section 3 'Education' for further detail and analysis of data

long-term impact on boys' ability to achieve high educational attainment at later stages compared to girls.

In 2013, the proportion of boys achieving three or more higher grade GCSE passes including English and Maths (52.4%) was lower compared to girls (63.0%) and compared to boys nationally (55.7%). In some MSOAs across Leeds only 20% of boys are achieving this standard. The MSOAs of Harehills and Halton Moor, Wykebecks were ranked in the lowest achieving MSOAs for GCSEs in addition to being ranked in the lowest achieving MSOAs for EYFSP and key level 2 assessments, though it needs to be noted this is not a longitudinal study and therefore the current data cannot be directly matched.

Approximately 69% of LAC accessing alternative education provision were boys, and the proportion of male LAC achieving a good level of development in the early Years Foundation Stage profile (23%) was similar to that observed in the lowest five ranked MSOAs in Leeds (19-26%). The proportion of male LAC achieving five or more A-C grades at GCSE including English and maths (14%) was less than observed in the lowest ranked MSOA in Leeds (20.9% in Harehills for boys).

Across Leeds, approximately 15% of males (16-64) had no qualifications in 2011, however the top ten ranked MSOAs with the highest proportion ranged from 30% to 37% of males with no qualifications, with the highest being in Halton Moor, Wykebecks.

Beyond mainstream education is the issue of health literacy and how well an individual has been prepared to care for their own health and that of others. This is not related to reading ability per se, but to the understanding of the basic concepts of health (Peerson & Saunders, 2009; Nutbeam, 2000; Choi & Dinitto, 2013). Men are thought to have lower levels of health literacy than women due to a socialisation process that tends to assume health is a female issue, which historically affected the likelihood of boys being educated about their health. This had an additional effect of boys' engagement with health messaging and their ability to fully comprehend health campaigns.

6.2.2 Housing³³

Housing links with community engagement, and community spirit and having a stable living environment of good quality can help create a positive place to live and grow. Poor housing can have marked physical and emotional consequences, with damp, cold and unsanitary conditions leading to an increased risk of infections, respiratory conditions and stress amongst other health conditions (Pevalin *et al.*, 2008).

Housing stock within all cities is a problem. Getting the right mix of private home ownership, council tenancy and private renting is important, as vulnerable adults can be greatly affected by both the type and location of accommodation. Social housing is typically more affordable, and often offers a better housing standard and provides greater security of tenancy compared to private renting. Social housing is primarily offered to vulnerable people such as those with severe health problems, lone parents with dependent children and those on very low incomes. The Commissioners noted that men up to the age of 35 years are typically not seen as vulnerable compared to women and can only receive housing benefit at the shared housing rate and therefore end up in bed-sits or shared housing.

The introduction of the bedroom tax and the system of housing allocation has impacted on where young single unemployed men are being housed, with more now being located in the high rise blocks of flats than previously. The Commissioners have noted that this is creating a new problem, where these mostly white young men are suffering from low self-esteem, depression and social isolation.

³³ Please refer to 'The State of Men's Health in Leeds: Data' section 2.5 'Housing composition and tenure' for further detail and analysis of data

Approximately 17% of men aged 16+ lived alone in Leeds in 2011. In the top ten ranked MSOAs with the highest proportion this was as high as 28.2 to 42.0% of men, with the highest being in the MSOA of Lincoln Green and Ebor Gardens. Across Leeds as a whole approximately 16% of men in Leeds aged 16+ lived in social housing³⁴ in 2011, however in the top ten ranked MSOAs this was as high as 39.4% to 59.1%, with the highest being in Halton Moor, Wykebecks.

In April 2015 there were blocks of council-owned high-rise flats in Leeds where 75-85% of residents were males, with the largest number being in The Heights, Armley (85.0%). The highest proportion of residents within these complexes were aged between 31 and 60 years of age, with a higher proportion of men in these age groups compared to women (Figure 11).

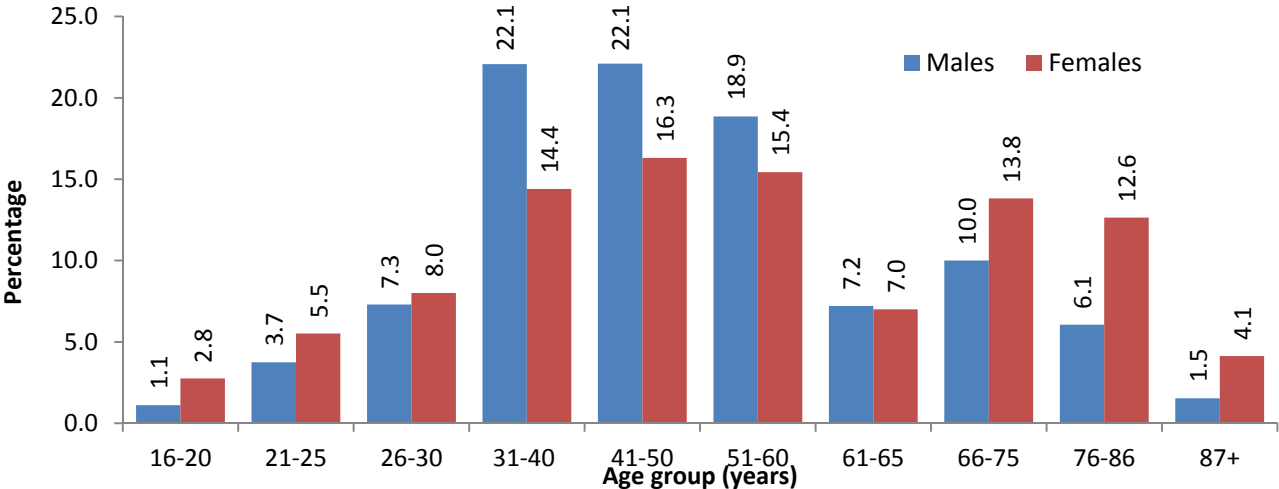


Figure 11. Percentage of men and women living in council owned high-rise flats in Leeds by age group (from Seims & White, 2015)

The 2011 census data showed that 127 men (aged 16+) were living in a privately owned hostel or temporary shelter for the homeless which is almost double the number of females (64). It is estimated by the Commissioners that there are about 12 men who are rough sleeping across the city. They have chaotic lifestyles and struggle to attend appointments. Many fail to engage with services, have frequent Accident and Emergency visits with head injuries, but are considered below the threshold for mental health services as they are seen to have sound mental capacity.

There are excellent services already provided for vulnerable men on the streets, including the York Street practice and 3rd Sector provision – Simon on the Streets and The St Georges Crypt. In the last two years the Crypt has run a set of events to coincide with Men’s Health Week, which have been very welcome by the men. Throughout the year a Physiotherapist from Leeds Beckett University, attends the Crypt to offer support to the men. What is apparent is that these men would not have access to these services if they did not go out to the men.

There are a hidden group of men with multiple exclusion homelessness (MEH), who are not yet on the streets, but leading displaced lives due to being asylum seekers, early migrants, or sofa surfing as a result of having to leave the family home or ending their time in child care (Fitzpatrick *et al.*, 2012). This group don’t usually appear in hostel or official figures and are therefore difficult to quantify.

³⁴ Rented from the local council or a not-for-profit housing association approved and regulated by Government.

6.2.3 Employment³⁵

Work still maintains a central role in many men's lives; the expectation for many boys and young men entering into adulthood is that they will get a stable job, with a living salary and be able to provide for a family. This is not the case for many men and this is creating a difficult transition into a new reality.

Unemployment carries many serious health risks for men (Strandh *et al.*, 2013; Hammarström & Janlert 2002; Gulliford *et al.*, 2014). In the Lambeth & Southwark study, unemployment sat alongside divorce as the two main issues with regard to the health of men in those London Boroughs (Robertson, Zwolinsky & Raine, 2013). The number of unemployed men in Leeds, in 2011 was 68% higher compared to females, a gender difference much higher than nationally where 48% more men were unemployed compared to women. The number of unemployed men was equivalent to 5.6% of the male Leeds population, however the top ten ranked MSOAs with the highest proportion ranged from 10.8%-15.7%, with the highest being in Beeston Hill.

In 2011, 2.7% of men aged 16-64 in Leeds were classed as long-term unemployed, which was greater than observed across England and Wales (2.2%). The gender gap was also greater in Leeds compared to national data with 60% more men in Leeds classed as long-term unemployed compared to women versus a gap of 32% nationally. The top ten ranked MSOAs with the highest proportion of men (16-64 years) who were long-term unemployed ranged from 5.1% to 7.5%, with the highest being in the MSOA of Ebor Gardens.

In 2011, 2.4% of men in Leeds aged 25+ had never worked which was higher than men nationally (2.1%). In the ten highest ranked MSOAs this was as high as 5.2% to 8.2%, with the highest being in Harehills Triangle. It is important to note that this MSOA was also consistently ranked amongst the top five MSOAs with the worst educational attainment for boys. Poor educational attainment may hinder future employment opportunities – the top ten ranked MSOAs with a high proportion of long-term unemployed men also typically had a high proportion of men with no qualifications, which supports this point. In the MSOA of Lincoln Green and Ebor Gardens, approximately 30% of men aged 16-64 had no qualifications.

Working brings not only earnings, but also social status, shapes social roles, fosters social participation and is a major factor in self-image and self-esteem (Davis, 2014). Jahoda (cited in Paul & Batinic 2010) identified other key latent functions of work:

- The imposition of a time structure on the waking day – ‘traction’
- Shared experiences and contacts outside the home
- Linking an individual to goals transcending his own purpose – ‘sense of purpose’
- Personal standing and identity – ‘status’

The work environment is rapidly changing, with its loss of heavy industry and manufacturing and the increase in men undertaken what was historically seen as women's work within the service industry. The opportunities for full time permanent physical work where men can use their physicality are disappearing. The Working Class/Blue Collar, Heavy industry & manufacturing, often had harsh working conditions, but gave men a sense of pride and of a sense of place and belonging. It also brought younger men and older men together, where intergenerational support could be established. It is now much rarer for young men to have contact with older men within the workplace and society as a whole.

Those in work may be in transient or vulnerable employment or on zero hours contracts, which increase stress and the risk of financial difficulties. The number of long-term unemployed has also risen. It is also important to note that the recent recession has seen an increase in the number of suicides in both

³⁵ Please refer to ‘The State of Men's Health in Leeds: Data’ section 4 ‘Economic activity’ for further detail and analysis of data

working age men and older men, which may be due to exposure to multiple disadvantage, severe financial constraints and little prospect of improvement (Davis, 2014).

In 2011, those men in work (employed and self-employed) were more likely to be working full time, with nearly 10% of men in Leeds over the age of 16 years working over 49 hours a week compared to 3.2% of women (Figure 12 and Figure 13). The top ten ranked MSOAs with the highest proportion of male employees (aged 16+ years) working long hours (49 or more hours a week) ranged from 10.4 to 13.3% of men, with the highest being in Bardsey, East Keswick, Collingham, Linton and Harewood. For many men there is not the option of working flexibly, with fixed times for starting and finishing work, and they may be vulnerable to job loss if too much time is missed. This poses challenges in being able to support family life and also for accessing services out of office times.

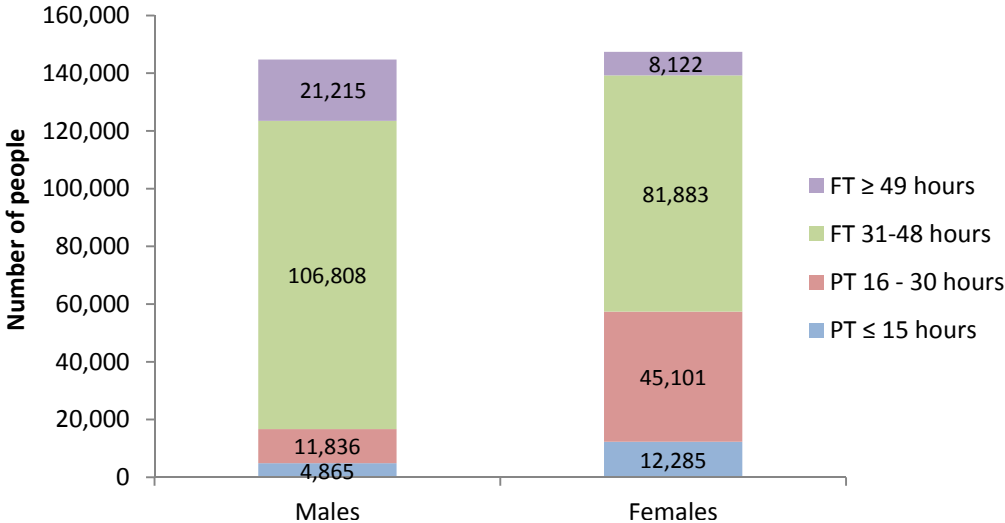


Figure 12. Hours worked by male and female employees (from Seims & White, 2015)

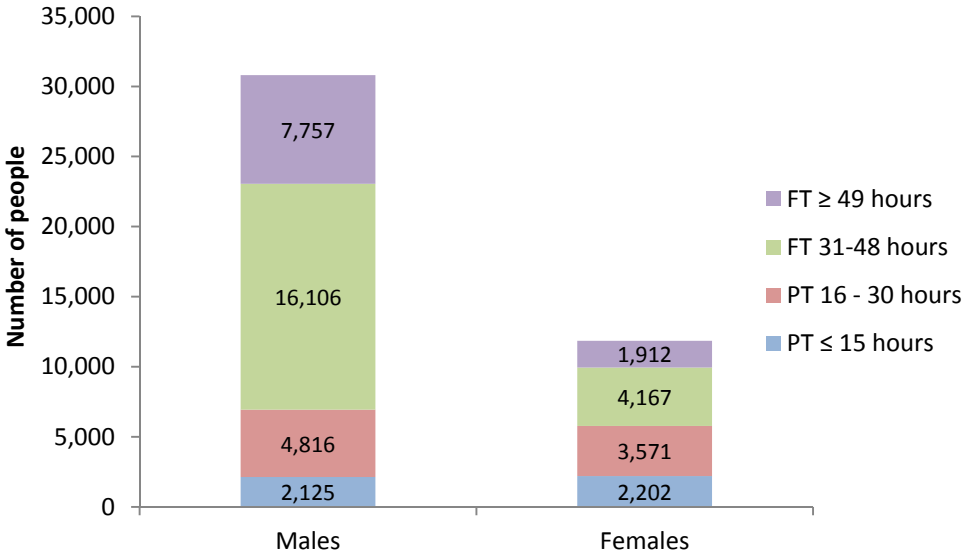


Figure 13. Hours worked by self-employed males and females (from Seims & White, 2015)

For many men, work is being found to be increasingly stressful as a result of:

- Demand-control issues – high demands with low control leads to high job strain
- Job insecurity
- Psychological harassment (such as bullying)
- Low social support at work
- Organisational injustice
- Effort-reward imbalance (LaMontagne *et al.*, 2014)

Most men on completion of their day's work are returning home to their families to take their share of child-care responsibilities. The work-home interface is also taking its toll on men's mental health:

- Fulfilling caring responsibilities
- Financial worries
- Relationship breakdown and loss of contact with children
- Increasing loneliness and isolation

For many men their contact with old friends diminishes as their responsibilities increase. Most social networks and social capital within a family lie with the female partner, such that on divorce or separation many men find themselves isolated. Losing employment or the ability to play sport etc. increases this isolation as not many men retain friendships with 'mates' as they no longer have the ability to share common experiences (McDonald & Mair, 2010).

In 2011, 4.0% of men (aged 16+) were economically inactive due to long-term disability or illness, however the top ten ranked MSOAs with the highest proportion ranged from 7.4% to 10.1%, with the highest being in Belle Isle North. In 2014, 5.7% of men (aged 16-64) in Leeds claimed Employment and Support Allowance (ESA), however the top ten ranked MSOAs with the highest proportion ranged from 10.9 to 13.0% of men, with the highest being in West Hunslet and Hunslet Hall. The most prominent underlying condition was mental and behavioural disorders, accounting for almost 50% of males claiming ESA. In 2014, 9.9% of men aged over 65 claimed attendance allowance in Leeds, however in the top ten ranked MSOAs this ranged from 14.7 to 25.8% of men in those areas.

6.2.4 Poverty³⁶

There are well-established links between poverty and health, with the Marmot report highlighting that men generally have higher rates of premature death when experiencing social and economic hardship (Marmot Review Team, 2014). Although women in England are generally more likely to be at risk for mental illness compared to men, deprivation has a large impact upon the risk of mental illness, with similar proportions of men and women in the poorest quintile at high risk of mental illness (23% and 25% respectively, compared to 9% and 10% in the richest quintile)³⁷.

The welfare state is designed to help those most in need of support. In 2014, across the city of Leeds 2.8% of men claimed Job Seekers Allowance (JSA) compared to 1.4% of women. However, the top ten ranked MSOAs with the highest proportion of men claiming JSA ranged from 9.4% to 17.3%, with the highest being in Beeston Hill. In 2011, 2.7% of men in Leeds were classed as long-term unemployed which was higher than women in Leeds (1.6%) and men nationally (2.2%). However the top ten ranked MSOAs with the highest proportion of long-term unemployed men ranged from 5.1% to 7.5%, with the highest being in Lincoln Green and Ebor Gardens.

A study conducted by Insight on the men in Wortley as a follow on to the Suicide Audit asked men about their challenges. These men reported many difficulties such as not being able to use legal aid to seek access to their children, being employed on zero hour contracts, having lots of debt and not being able to afford their own home, car, or even current popular technology such as a basic smart phone. One Commissioner noted this despair:

"I'm wondering that surely must have an impact and you know we know links to debt and mental health, poor mental health... the haves and the have nots, the materialistic stuff around having that car or that pair of trainers or that smart phone. And a lot of the men who the insight work's engaged with within the pub in Wortley and Armley, a lot of them didn't have smart phones and we're saying

³⁶ Please refer to 'The State of Men's Health in Leeds: Data' section 4.4 'Benefits claimed' for further detail and analysis of data

³⁷ Health survey for England, DH; the data is the average for 2008 and 2009; England; updated March 2011

‘oh we’ll send you this app and we’ll send you that app’ and it’s like ‘I haven’t even got a smartphone, I’ve got a basic bog-standard one, that’s how crap I am’”.

This lack of access to a mobile phone or being limited to pay as you go phones (PAYG) with no internet access further limits work and educational opportunities as it is hard to apply online for jobs or search for jobs. Funding cuts mean libraries are closing or limiting their hours so that for some men it is difficult or in some cases, impossible to access the internet.

6.2.5 Marital status and relationships³⁸

Nationally there is a trend for men to stay at home longer and to enter into legal partnerships³⁹ later; nationally the proportion of people aged 30-49 years who were single increased from 24% in 2001 to 31% in 2011 (ONS, 2014b).

Men who are in stable relationships tend to have better health than unmarried men and those men who become divorced, separated or widowed often experience a major deterioration in their physical and emotional health (Umberson 1992; Williams & Umberson 2004; Shor *et al.*, 2012). A recent study on men’s health in Lambeth & Southwark found that there were two specific groups of men to be conscious of with regard to their health, with one being the unemployed and the other those divorced and widowed (Robertson, Zwolinsky & Raine, 2013). When men lose their partner, suicide rates go up, as does depression, alcohol and smoking, and these men are more likely to face social isolation and die prematurely (Hosseinpour *et al.*, 2012; Fitzpatrick *et al.*, 2012).

The peak for divorce for both men and women is in the 40-44 year age range, with men slightly outnumbering women (ONS, 2012). Separation can have a profound effect on men as it is usually instigated by the women (ONS, 2012), requiring the man to leave the marital home and the children tending to stay with the mother (ONS, 2012). There are also financial implications for the male, through child maintenance and divorce settlements. Financial pressures on men can persist into second marriages, leading to depression and further marriage difficulties (Hiyoshi *et al.*, 2015).

The data from the 2011 Census for Leeds shows that divorced men are typically aged 30-59 years and that approximately 10% of this age group are divorced, however in the ten MSOAs ranked with the highest proportion of divorced men this ranged from 13.2 to 16.0%, with the highest being in the MSOA of Belle Isle North.

With the increasing life expectancy in men and women nationally, there are more older married couples and lower numbers of widows as compared to 2001⁴⁰. There has been a rise in divorce in couples over the age of 60 years, with a national increase from 1.6 per 1,000 married men in 1991 to 2.3 per 1,000 married men in 2011 (ONS, 2013c). This may be due to increased age of marriage, improved life expectancy giving greater potential for divorce in older age, or those who are divorced co-habiting rather than re-marrying, thus staying ‘divorced’. In an American study, the rate of divorce was found to be 2.5 times higher in remarriages versus first marriages, with greater financial security in working women, people living longer lives and a loss of stigma in being divorced as the main factors involved (Brown & Lin, 2012). The generation of men now entering retirement have mostly been socialised to be very self-contained with their emotional expression, with the social isolation caused by the loss of their partner having the potential to cause hidden suffering (Bennett, 2007; Canham, 2009).

³⁸ Please refer to ‘The State of Men’s Health in Leeds: Data’ section 2.6 ‘Marital status’ for further detail and analysis of data

³⁹ Marriage, civil partnerships etc.

⁴⁰ Taken from http://www.ons.gov.uk/ons/dcp171776_325486.pdf

6.3 Other key issues affecting men

6.3.1 Men as carers⁴¹

The loss of much of the traditional employment opportunities for men, and a much more level playing field for job opportunities between the sexes, coupled with a general decline in men participating in further and higher-education, means an increasing pressure on men to find a place for themselves within society. One of the key findings from the Role of Men in Gender Equality study (Scambor *et al.*, 2013; Scambor *et al.*, 2014) was that there are a greater number of men engaged in high levels of unrecognised care for family, friends and relatives; this is broader than fatherhood, though there is recognition that more men are taking on the primary responsibility for their children. A finding from the report was that there is an emerging ‘caring masculinity’ that is helping men from all walks of life to engage in a more gender-equal society.

In 2011, approximately 8% of males and 11% of females in Leeds were providing unpaid care. Carers were predominantly aged between 25 – 64 years of age (Figure 14). The 50-64 year age group had the highest proportion of its population providing unpaid care (17.3% and 23.6% of the total male and female population in that age group respectively).

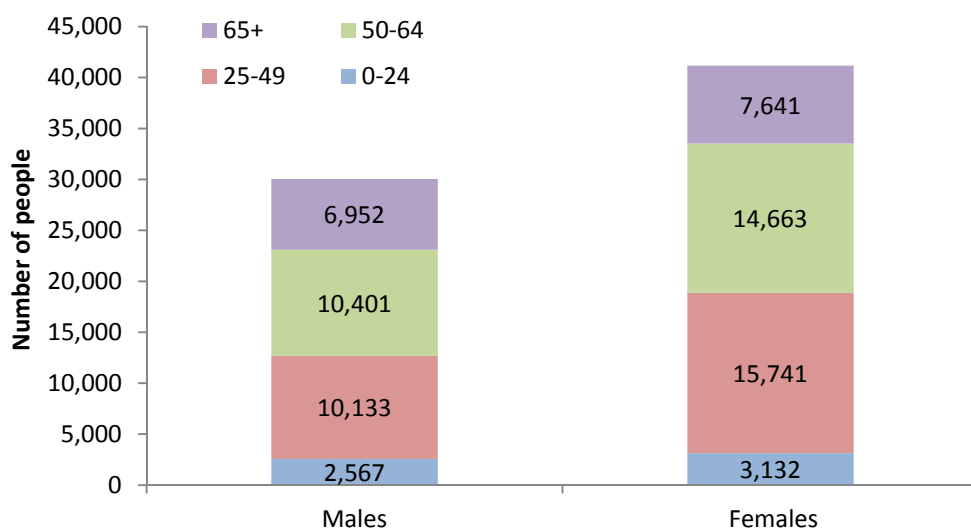


Figure 14. Number of males and females providing unpaid care in Leeds across age groups (from Seims & White, 2015)

Across Leeds in 2011, approximately 3.4% of men (aged 25-64) in Leeds were providing 20+ hours of unpaid care, although the top ten ranked MSOAs ranged from 4.6% to 7.0%, with the highest being in Belle Isle South.

Though many men accept their caring role, there is a high cost of caring for a sick or infirm relative or friend, which is physical as well as emotional. The Commissioners have noted that men are less likely to make themselves known as a carer and they acknowledge that at present there is not as much support for male carers as there is for female carers. This view has been supported by what little research has been conducted on men as carers. A recent systematic review on barriers and facilitators in male carers accessing formal and informal support (Greenwood & Smith, 2015) showed that though men were committed to their role it was often their decision not to access support – they were ‘proud’ to care without formal support (p5). They also found that when they did have access to informal and formal support they found it very beneficial, whether it was professional or voluntary. The main barriers to accessing services were: insufficient information, poor awareness of services and service costs.

⁴¹ Please refer to ‘The State of Men’s Health in Leeds: Data’ section 2.8 ‘Provision of unpaid care’ for further detail and analysis of data

6.3.2 Fatherhood⁴²

The role of fathers within families has had a lot of attention over the past decade, with much research undertaken on the positive impact the father can have on the overall wellbeing of their children and also the positive effect children can have on men's mental and physical health (Coakley 2013; Higham & Davies 2013; Zaroni *et al.*, 2013; Twamley *et al.*, 2013; Featherstone & Fraser 2012; Settersten Jr & Cancel-Tirado 2010; Shirani 2013; P. Morgan *et al.*, 2011). An engaged father has a reduced likelihood of divorce or separation and has a positive effect on the mental well-being of their partner (Twamley *et al.*, 2013). Older men benefit both physically and mentally when they are able to retain contact with their grandchildren (Bates & Taylor, 2012). There has been a strong governmental push to build on this recognition, with funding support for projects that engage men in their fathering role (Big Lottery, 2012).

The recent European Commission Role of Men in Gender Equality report (Scambor *et al.*, 2013; Scambor *et al.*, 2014) noted the emergence of 'caring masculinity' as a positive development. In many families the man is now taking a much greater part in child care, including the stay at home dad, and across Leeds there are over 2,200 men who are lone parents with dependent children, with some also maintaining a full-time working position.

There is a growing worry over the mental health problems some fathers encounter in the months following birth (estimated at between 5% to 10% of new fathers), with depressive symptoms' scores for resident fathers increasing on average by 68% during the first five years following the birth. If undetected, this can have a negative effect on the entire family and lead to increased risk to mother, child and the man (Garfield *et al.*, 2014; Smith *et al.*, 2013). Paternal post-natal depression is more prevalent in men who have a previous history of mental health problems and those with substance abuse issues, and is strongly related to poorer socio-economic circumstances (Tuszyńska-Bogucka & Nawra, 2014).

First-time young fathers can also suffer psychological difficulties, especially when they themselves have had a vulnerable background (Boyce *et al.*, 2007). A recent study of young fathers identified a greater risk in those who become a parent before the age of 25 developing serious health problems and a greater likelihood of dying prematurely due to the combined stress of being a father, partner and breadwinner at an early age (Einiö *et al.*, 2015). It is noticeable that the Leeds City Council Website for teen parents⁴³ has limited information for young fathers. All the support and guidance is aimed at the young mother apart from a link to the Families Need Fathers webpage, which is aimed more at helping in situations where families are at the point of breaking down.

In a recent Leeds report, where fathers of Looked After Children were known, a higher proportion of them misused alcohol/drugs compared to the mothers, with 64% of these men not engaging with support services (Bane, 2013).

6.3.3 Ex-servicemen

It is estimated that there are about 3.8 million ex-service personnel in England (approx. 9.1% of total population) (Woodhead *et al.*, 2009), with the majority making a successful transition back into society. There are however, studies suggesting that those who have seen active service may have risk factors for offending and also be more likely to have unmet physical and emotional health needs (Lyne & Packham, 2014).

⁴² Please refer to 'The State of Men's Health in Leeds: Data' section 2.7 'Lone fathers' for further detail and analysis of data

⁴³ <http://www.leeds.gov.uk/youthInformationHub/Pages/Are-you-a-teen-parent.aspx>

Armed service engagement has been linked to mental and emotional health problems, with higher levels of homelessness, suicide and domestic violence (Lyne & Packham, 2014). Ex-service personnel have high rates of health problems such as musculo-skeletal, cardiovascular and respiratory disease. Alcohol and smoking rates are also seen to be higher, with smoking cessation more difficult if the habit was started during active service (Brown, 2010).

Medical notes from the army are not shared with the civilian health service. Most servicemen who have been on a commission tend to be de-registered with their home GP and dentist after a three-year period away. Both these factors can impact on the visibility of health problems and their likelihood of being followed-up post discharge.

It was hoped that data could be provided on this group of men, but the information was not available. Better tracking of ex-servicemen so longer term support can be offered should be considered.

6.3.4 Offenders

Being in prison brings specific health and social challenges, with offenders more likely to smoke, misuse drugs and/or alcohol, suffer mental health problems, report having a disability, self-harm, attempt suicide and die prematurely compared to the general population (NOMS, 2014). The Prison Reform Trust have also noted that over 200,000 children had a parent in prison at some point in 2009, which was greater than those affected by divorce, highlighting that the social implications of prison go beyond the individual (Prison Reform Trust, 2014).

7 Lifestyle behaviours affecting men's health

There are strong links between lifestyle factors and health and wellbeing, with many of the causes of men's higher rates of premature death and morbidity being preventable if problematic lifestyles can be moderated. Men tend to have poorer diets, are more likely to take illegal drugs, engage in unsafe sex and have greater risk taking on the roads and at work. Though more women have low physical activity levels, there is a silent majority of men who are also living sedentary, inactive lives. There are very strong links between lifestyle and the wider social determinants of health, such that some problems are difficult for individuals to manage alone; for instance smoking is strongly linked to deprivation, poor educational status and those unemployed or working in routine or manual occupations (ONS, 2014a). Many of these lifestyle risk factors do not exist in isolation, such that there is also a clustering effect where the overall effect is amplified (Zwolinsky *et al.*, 2012).

Although there are many aspects of women's lifestyles that are worrying, it is men who overall still have greater numbers that smoke, drink and are overweight, with the suggestion that most of the city's key targets on healthy lifestyles are not being met due to the health behaviours of men. It is notable therefore that in 2013-2014, only 30.5% of Healthy Lifestyle Service users were men and of the 257 visits by male users, only 3.5% of visits were associated with setting an alcohol reduction goal – this is of particular concern given the high mortality associated with alcohol consumption amongst men in Leeds. The most common goal set was related to physical activity (47.5% of all visits by male users). Men were also less likely than women to set a goal for healthy eating or weight loss

Some men's propensity for risk-taking is augmented by male socialisation, targeted marketing by tobacco and alcohol companies and the influence of the media (Cranwell *et al.*, 2015). Working with men in a more effective way to address their health behaviours can only be part of any solution. There are deep structural issues that also need to be tackled alongside working with the men themselves. The most successful public health initiatives over time have been through state intervention and legislation - sanitation, clean water, health and safety in the workplace, road traffic legislation, reduction of lead in fuel, replacing coal gas, and more recently the introduction of smoking bans, are by far the most effective ways of improving the nation's health. Finland had the highest levels of male premature cardiovascular death in Western Europe until legislation was introduced to reduce the salt and fat content in the manufacture of their food; it now has one of the lowest levels of Cardiovascular Disease (CVD).

7.1 Smoking

7.1.1 Smoking prevalence⁴⁴

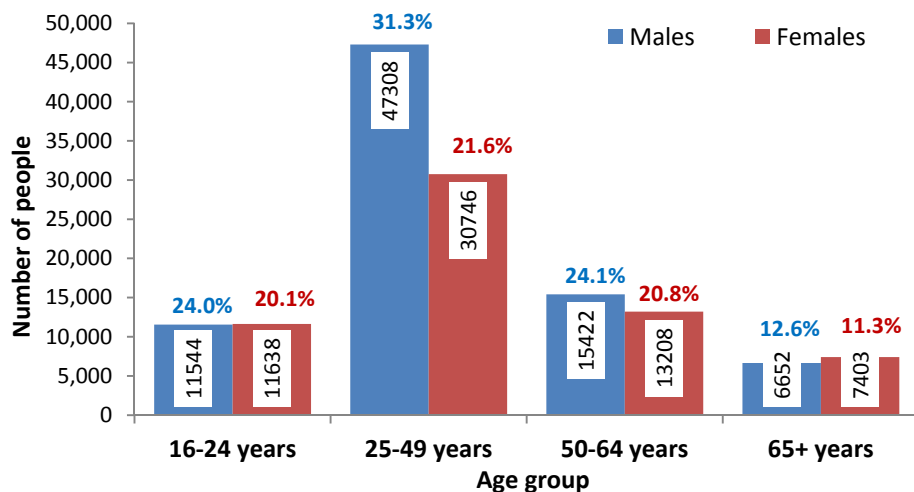
Male mortality rates from smoking-related deaths has declined in recent years alongside a decrease in the number of men smoking (HSCIC, 2015b).

However, there are still a substantial number of men who smoke, and smoking is still the biggest contributory factor for premature death and morbidity in men, accounting for 40-60% of the sex difference in premature mortality (McCartney *et al.*, 2011). The high levels of deaths from smoking-related cancers and cardiovascular mortality still warrant concern.

In Leeds smoking status is known for a high proportion of males (94%), however this is less than for females (98%). Of those captured, 26% of males were classified as smokers, however in the top ten ranked MSOAs this ranged from 39.0% to 43.1%, with the highest being in the MSOA of Beeston Hill.

⁴⁴ Please refer to 'The State of Men's Health in Leeds: Data' section 6.2 'Smoking prevalence' for further detail and analysis of data

The greatest prevalence of smokers are in the 25-49 year age group, which also has the largest gender difference (Figure 15).



N.B. Percentages show numbers as a proportion of each age group recorded

Figure 15. Number of male and female smokers in Leeds across age group (from Seims & White, 2015)

What is not known within Leeds is the prevalence of other forms of tobacco usage, such as chewing tobacco and snuff, and pipe smoking which can increase cancers of the oral cavity, larynx and associated organs (IARC, 2012).

7.1.2 Smoking cessation and service use⁴⁵

There is still limited evidence on the long-term effect of the smoking ban (Jones *et al.*, 2015) or e-cigarettes on smoking cessation (West *et al.*, 2015; Grace *et al.*, 2015). It is therefore important not to rely on these approaches to tackle the high numbers of men who still smoke and there is still need to consider how smoking cessation services can be developed. Interviews with the Leeds Commissioners support the importance of finding successful smoking cessation interventions, with a number of different approaches being adopted across the city. They note however that it is becoming increasingly difficult retaining smokers in the service as although they may attend about 40% fail to set a quit date.

The Leeds smoking cessation service has been recognised nationally as a beacon of good practice and commended as one of the highest performing in the country (Leeds City Council, 2011). Despite this focused attention, generally the number of men engaged with smoking cessation services in Leeds over 2013/2014 was equivalent to approximately 3% of known male smokers in the city. It is encouraging to see that in the top five MSOAs with the highest proportion of known male smokers, 246 men were registered with smoking cessation services in 2013-2014, however this was a small proportion out of the 6,340 known smokers across these areas. Men in Leeds also engaged less with smoking cessation services compared to women (41% men vs. 59% women), however on a more positive note, a greater proportion of visits made by men were associated with setting a quit date compared to women (54% of male visits vs. 43% of female visits) and men were more likely to have a successful quit (69% of male quits set vs. 67% of female quits set). These quits were self-reported and carbon monoxide test results were not available - earlier data from the Leeds service indicated that 77% of self-reported quits were confirmed through the results of a carbon monoxide test. Success for males occurred primarily with a closed group intervention (46% quit rate of those who entered the system), followed by Plus One Clinic (38.2%) and One-to-One Support (37.6%).

⁴⁵ Please refer to 'The State of Men's Health in Leeds: Data' section 7.3.4 'Smoking cessation services' for further detail and analysis of data

It is reassuring that some men are engaging with this service, however as more men are smokers, services need to consider how they may increase male engagement further; targeting men during early years of smoking may result in greater long-term health benefits if abstinence is maintained throughout later years.

7.1.3 Targeting smoking

The most compelling evidence in terms of quitting smoking, is an individual seeking support from their General Practitioner, with an abrupt halt to smoking supported by nicotine replacement therapy (NICE, 2012). Men nationally have a better success rate at quitting smoking than do women, but they are less likely to want to try, with fewer visits to their GP with regard to their smoking behaviour. The challenge is to get the individual to a stage where they wish to stop and for them to maintain their abstinence, which requires a concerted effort in reaching out and targeting men and offering the support they need once they abstain.

The meaning of smoking differs between men and women and there are benefits to acknowledging and building on this understanding (Bottorff *et al.*, 2014). Smoking patterns also differ greatly by ethnicity and there are new challenges with the number of new migrants from Eastern Europe where there are high levels of male smoking. It is not possible to fully explore this issue here, but there is a need for services to recognise the different forms of masculine behaviour in Eastern European men and to find new ways of reaching out to these men (Aspinall & Mitton, 2014).

Focusing campaigns on individuals' day-to-day lived experiences can help individuals to manage their complex relations with peers. For instance workplace interventions have been found to be effective at helping employees to quit smoking, with the benefit of having a large group of smokers in one setting. There is a workplace scheme underway in Leeds to target local refuse collectors to help them stop smoking, however no other details were available as to how this is progressing. A Cochrane review of workplace interventions found that group therapy programmes, individual counselling, pharmacotherapies and multiple intervention programmes aimed mainly or solely at smoking cessation all had significantly increased cessation rates as compared to no treatment or minimal intervention controls (Cahill & Lancaster, 2014). The Post Office invested £46m in health initiatives and were able to show a £277m return on their investment over a three year period through improved productivity and reduced sickness absence rates (Marsden & Moriconi, 2008). Spouses were encouraged to join their partners on smoking cessation groups as evidence suggests it is more effective if both partners quit at the same time.

smoking in the home and in cars can be a major source of passive smoking for children and there is a large benefit to be had in targeting new fathers (Bottorff *et al.*, 2014). Smoking in men who are trying to conceive has also been found to be problematic, with heavy smokers having a low sperm count (Joo *et al.*, 2012). By building on the man's desire to be a good father and to safeguard their children there is a greater motivator to stop smoking.

There are some groups of men that need specific approaches to reach out and target them. For example men who start to smoke whilst in the armed services have been found to be particularly resistant to cessation programmes due to the meaning of the smoking act as a form of bonding with colleagues (Feigelman, 1994; Brown, 2010). Gay men and MSM also tend to have higher rates of smoking (Holloway *et al.*, 2012; Dickson-Spillmann *et al.*, 2014), but have been found to have a similar desire to quit as found in heterosexual population (Fallin *et al.*, 2015). Stonewall note that messaging about smoking cessation is often not focused onto the gay community, which reduces its effectiveness (Guasp & Taylor, 2012).

7.1.4 Recommendations

- Better data is needed on tobacco usage – GPs should ask about ‘tobacco use’ not whether people smoke or not. For example, do they smoke filter tips, roll-ups, pipe, e-Cigarettes or chew tobacco? This would enable more specific guidance on quitting and to identify possible future health concerns (i.e. oral cancer, or un-known consequences of e-Cigarette usage).
- Community and workplace campaigns for quitting smoking should be instigated, building on the positive consequences and addressing gender-related influences.
- Gendered school-based initiatives should be considered, with those focused onto boys, building on social competency and alternative masculine identity-based work
- Linkage of smoking cessation with physical activity based initiatives
- Targeted interventions should be considered, including those directed at fathers and grandfathers, men who have sex with men and migrant men

7.2 Drugs and Alcohol

7.2.1 Drug and alcohol abuse⁴⁶

Substance misuse causes a substantial level of disruption in the lives of those affected and their families. We have focused on alcohol misuse within this report due to the lack of data available on drug misuse in the city.

Alcohol is implicated in many of the health and social challenges men face. Alcohol remains a significant cause of physical and emotional problems in men, with many accidents and illnesses linked to alcohol, and is one of the leading causes of morbidity and mortality in young men (Probst *et al.*, 2015). The physical effects include its role in developing liver disease and it has been estimated that alcohol is responsible for between 3.6% and 8% of new cancers in men in the UK (Parkin 2011b; Schütze *et al.*, 2011).

Nationally there is a decrease in overall alcohol consumption, but this has occurred differently between the age groups, with young men aged 16-24 who have had more than 8 units on at least one day, dropping from 32% to 22% between 2005 and 2012. However, in older age groups the decrease in the number of men consuming more than 8 units on at least one day is lower, with men over the age of 65 showing no change in alcohol consumption. The 25-44 year age group has the highest overall proportion of heavy drinking (24%), with older ages having a more sustained drinking pattern through the week as opposed to the more occasional but heavy drinking of the young (ONS, 2013a).

GP recorded alcohol consumption is currently not known for just over half the population in Leeds (54% of men and 56% of women). The top ten ranked MSOAs with the highest proportion of men (aged over 16 years) with no record of alcohol consumption ranged from 67.5% to 85.4% of the male population in those MSOAs, with the highest being in the MSOA of Harehills Triangle (3,531 men with no record).

Approximately 20% of males in Leeds aged 16 years and over with known alcohol consumption, consumed a level that was deemed as increasing risk of harm to their health or a higher risk of harm to their health (Figure 16). Males in the 50-64 year age group had the highest proportion of their population at increasing or higher risk due to alcohol consumption (26%), which is an older age group to the National pattern. Approximately 21% of these men were at increasing risk, however in the top ten ranked MSOAs this ranged from 25.2% to 27.7%, with the highest being in Yeadon - Henshaws, Southway, Westfields.

⁴⁶ Please refer to ‘The State of Men’s Health in Leeds: Data’ section 6.3 ‘Alcohol’ for further detail and analysis of data

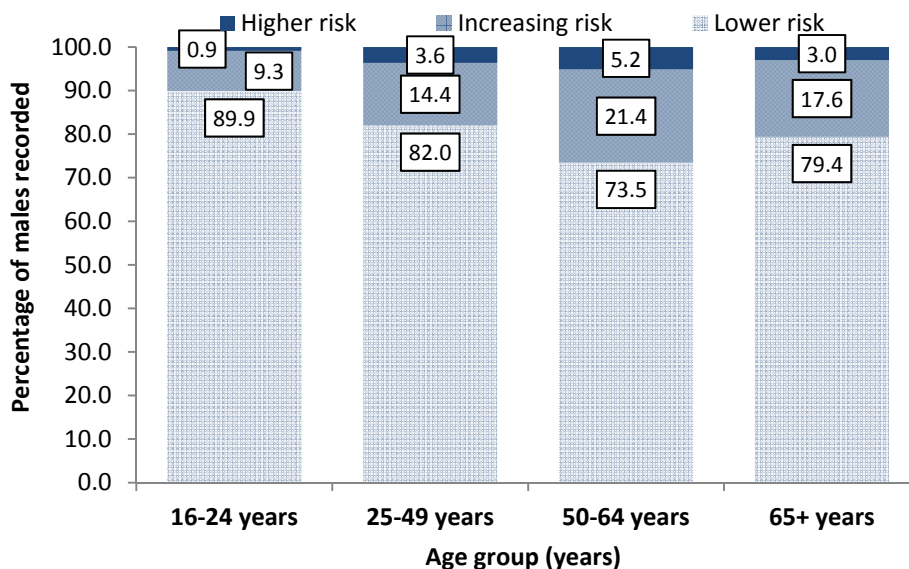


Figure 16. Percentage of males classified as lower, increasing and higher risk for alcohol consumption across age groups (Q2 2014-2015) (from Seims & White, 2015)

In 2013, the DSR for male hospital admissions due to alcohol-specific conditions was 21% greater in Leeds than the national rate. In 2013 the Leeds male hospital admission rates due to alcohol-specific and alcohol-related (broad and narrow) conditions were more than double seen for females. Male admission rates for alcohol-specific conditions and for alcohol-related conditions (broad and narrow) were respectively 21% and 10% higher in Leeds than nationally. Over 2010/2012 alcohol specific mortality in Leeds for males was 16% greater than the regional rate and 25% greater than the national rate for males. Compared to other lower-tier local authorities in England, Leeds was ranked in the highest 20% for male alcohol-specific mortality.

7.2.2 Drug and alcohol service service use⁴⁷

Within the city of Leeds current alcohol reduction services are based on the Leeds Drug and Alcohol Strategy and Action Plan, 2013-2015 (Leeds City Council, 2014). Key outcomes of this include educating people as to the risk of drug use, improvement of treatment services to enable them to respond to needs within every community and ensuring support for vulnerable children and families to reduce the risk of family breakdown.

A comment from one of the Commissioners noted the necessity in reaching out to men affected by drugs and alcohol early:

“... around the drug and alcohol services 40% of people accessing those services are coming through the criminal justice route and they tend to be men more than women. It might be that men aren’t getting the help they need and they’re getting to the point where they’re being mandated to access rather than self-selecting to access”

In Leeds, 72% of drug and alcohol service users over 2011/2012 were male. Of those registered with the service, 68% entered that year. Of the males exiting the service that year, 25% were planned exits (vs. 39% planned exits for female users). Of those exiting the service, 3% of men had unplanned exits due to a prison sentence (no females exited due to prison). Over 2012/2013, 44% of male users engaged in drug and alcohol services abused both opiates and crack – this was higher than observed across England (31% of male service users). Over 2013/2014, 63% of those undergoing alcohol treatment were men

⁴⁷ Please refer to ‘The State of Men’s Health in Leeds: Data’ section 7.6 ‘Drug and alcohol services’ for further detail and analysis of data

(1,526 out of 2,423 in treatment) and 63% of successful completions were men (388 out of 623 successful completions).

7.2.3 Targeting drug and alcohol abuse

BARCA Leeds ran 'Platform'⁴⁸, which was a specialist drug and alcohol service for young people, but it was not possible under the remit of this study to explore how effective this intervention was at reaching out and targeting men. This service has now been replaced with Forward Leeds⁴⁹.

A systematic review undertaken by Probst *et al.*, (2015) was focused onto alcohol-related deaths and makes the recommendation that those workforces where there is a permissive approach to alcohol need to be targeted, as they are much more likely to lead to an employee's use of alcohol at work and problem drinking. A further systematic review of alcohol interventions amongst workers in male-dominated industries also noted that screening for risky alcohol use and targeted programmes can be effective (Lee *et al.*, 2014).

Entrenched drinking cultures from the Eastern European countries may be exacerbated by the difficult living conditions some early migrants find themselves living in once they arrive in the UK (Rehm *et al.*, 2007; Britton & McKee 2000; EC 2011). Illegal migrants, which are most often male, will be outside of normal health service provision and may be unwilling, or unable, to access the available support services.

As with smoking, MSM are purported to have higher rates of heavy drinking and more alcohol-related disorders, but there is a scarcity of research on this area to provide any robust evidence of effective interventions (Wray *et al.*, 2015). This excess within the gay community has been questioned and an American study found more similarities than dissimilarities with heterosexual men (Gilbert *et al.*, 2015). Interventions that are specifically aimed at gay men have a greater degree of resonance within the gay community, but MSM don't always associate themselves as being gay and therefore may miss out on such support (Wray *et al.*, 2015).

7.2.4 Top recommendations

- Targeted interventions at those men who are known to be at increased risk, including those who are unemployed or recently divorced / widowed, migrant men, gay men and those men who have sex with men.
- Alcohol consumption was not known in many men aged 16-24 years – monitoring drinking habits in the young would enable earlier guidance to help address emerging problems.
- Campaigns aimed at older men and those who are living in the wealthier suburbs should be considered
- Workplaces should be less tolerant of alcohol and drug related issues, with the possibility of greater use of screening considered
- Specific campaigns aimed at offenders and ex-servicemen should be investigated

7.3 Physical activity and sedentary behaviour

The health implications of low levels of physical activity (PA) have been long known, with increased risk of cardiovascular disease, becoming overweight, poor bone health and premature mortality being some of the consequences (Gulsvik *et al.*, 2012; Kohl *et al.*, 2012). There is now additional concern over the high levels of sedentary behaviour that is also evident within the population. This concern is

⁴⁸ <http://barca-leeds.org/what-we-do/platform-young-people%E2%80%99s-drug-alcohol-treatment-services>

⁴⁹ <http://www.forwardleeds.co.uk/>

independent of meeting government targets for PA (Varney *et al.*, 2014; Thyfault *et al.*, 2014), as the health risks remain, even when meeting the recommended levels of PA (Biddle *et al.*, 2011).

Although it is well recognised that women have lower levels of PA overall, it is also the case that the majority of men are below the recommended levels for good health, with recent data showing that typical self-reported gender differences in PA may diminish when activity is electronically monitored (Eastwood, 2013).

There are also an increasing number of men who are living very sedentary lives. In part, this is due to the changes in society where the loss of traditional heavy industry and manufacture and the conveniences of a modern day existence have markedly reduced the day-to-day graft, which increases in leisure time activity cannot replace (Ng & Popkin, 2012). Men are more engaged in service industries and office-bound jobs, including call centres, with long periods of sitting with minimal physical effort. There are also many more men out of employment or working part-time hours than previously, which has a marked effect on levels of PA (Van Dyck *et al.*, 2010). Contrary to the belief that unemployed men have more time for leisure activity, their actual level of sedentary behaviour increases, mostly due to the lack of funds, social support and networks necessary to engage in regular exercise (Zwolinsky *et al.*, 2012). There is also a depressive effect as a result of poor self-esteem.

Men with mental health problems gain greatly from more PA with good examples emerging from sport-based settings (Darongkamas *et al.*, 2011; Pringle & Sayers 2004).

Older inactive men who are living sedentary lifestyles are also more likely to become lonely and socially isolated and have a feeling of disconnection from the rest of society, leading to depression and increased risk of mortality (Casey *et al.*, 2011; Steptoe *et al.*, 2013).

7.3.1 Physical activity status⁵⁰

Unfortunately PA status [as assessed through the GP Physical Activity Questionnaire (GPPAQ)] is only known for 23% of males aged 16-74 years in Leeds (Figure 17).

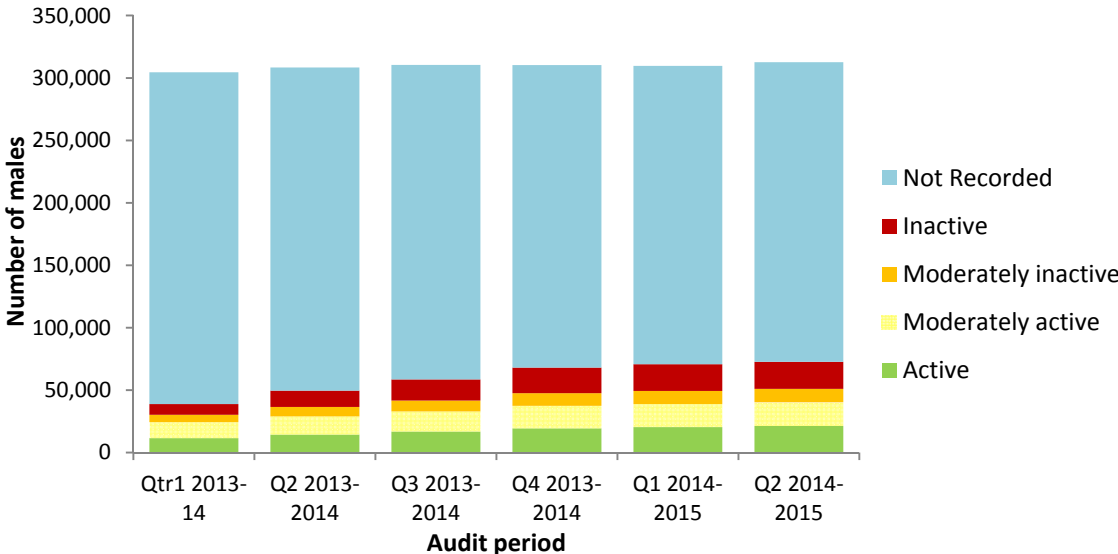


Figure 17. Number of males aged 16-74 years across GPPAQ classifications or with no record of GPPAQ in Leeds (from Seims & White, 2015)

In the top ten ranked MSOAs, the proportion of men with no GPPAQ record ranged from 83.1% to 96.6%, with the highest being in the MSOA of Little Woodhouse (6509 men aged 16-74 with no record).

⁵⁰ Please refer to 'The State of Men's Health in Leeds: Data' section 6.4 'Physical activity' for further detail and analysis of data

Of those with a GPPAQ record, 30% of males aged 16-74 years were classed as 'inactive' (Figure 17), however in the top ten ranked MSOAs, this ranged from 40.2% to 52.2%, with the highest being in the MSOA of Hyde Park, Burley. Although 29% of men aged 16-74 were placed in the highest category of 'active', in the lowest ten ranked MSOAs this ranged from 16.7% to 20.0%, with the lowest being in Beeston Hill.

7.3.2 Use of physical activity programmes⁵¹

Leeds Let's Get Active (LLGA) is a programme to encourage inactive people to do at least 30 minutes of PA once a week. Those who register with this scheme have free access to gym and swim sessions at council leisure centres for one hour per day (off-peak and at restricted times) and an additional hour per day at four leisure centres. Free community activities such as health walks, dance and beginner running groups are also provided. Members of this scheme can also access paid sessions at the council leisure centres.

Across Leeds, 2.7% of men aged 16+ were registered in the LLGA scheme. In the highest ten ranked MSOAs, the proportion of men registered ranged from 4.77% to 7.44%, with the highest being in Armley, New Wortley, indicating that men in deprived areas are engaging with the programme.

The number of males registered with LLGA more than doubled in the second year of the programme, however female membership was still 50% greater (Figure 18). The scheme has been successful in engaging the 16-24 year age group which had a 3.5-fold increase in male membership in the second year. The large increase in membership in this age group is very positive as engaging people in PA in early years may lead to life-long benefits if maintained.

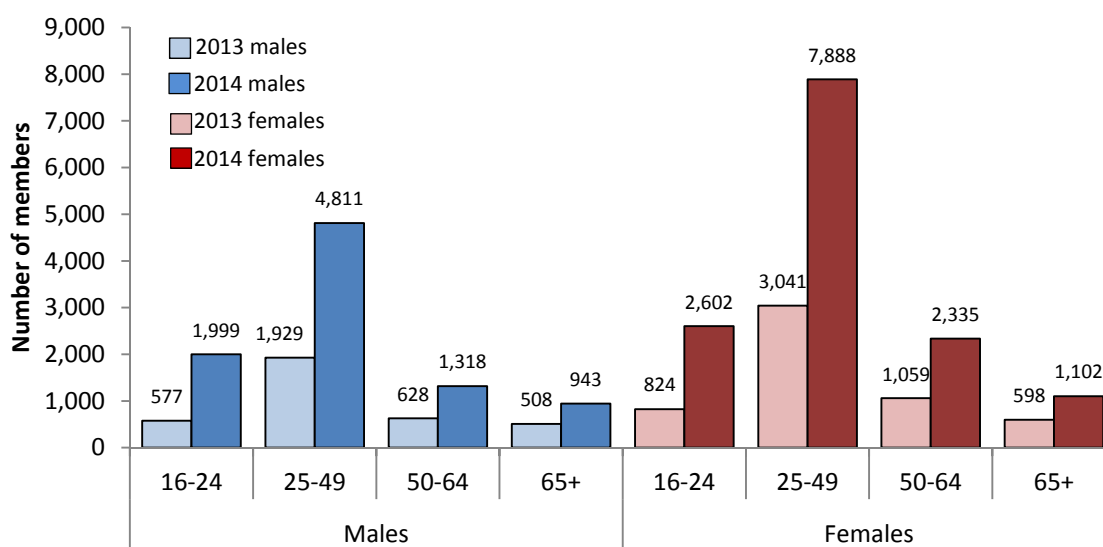


Figure 18. Number of male and female members registered on the Leeds Let's Get Active Scheme by age for 2013 and 2014 (Seims & White, 2015)

Male members of LLGA predominantly used gym facilities (58% of all visits) and were less likely to swim or use fitness classes compared to women but more likely to use racket sport facilities. It is worth noting however that there are generally few male only PA opportunities, with swimming sessions an exception but these are limited and only provided at two council leisure centres (13 provide women only sessions).

Approximately 70% of male LLGA members attended free LLGA sessions over the year - 6,321 male members attended a total of 62,469 free LLGA sessions. The free LLGA sessions are typically scheduled

⁵¹ Please refer to 'The State of Men's Health in Leeds: Data' section 7.3.1 'Leeds Let's Get Active programme' for further detail and analysis of data

during working week days, which may limit usage by men who are typically more likely to work full-time and longer hours compared to women.

It is difficult to gain a true understanding of PA levels in Leeds as those who are not engaging with the LLGA scheme may be involved in community sporting activities, have private gym membership or be a member of the council gym⁵².

7.3.3 Engaging men with physical activity programmes

There has been some success in getting men of all ages more active when targeted interventions have been put in place that are designed to appeal to men of different ages (White *et al.*, 2014). Initiatives found to be effective with men require regular feedback, access to self-monitoring tools, elements of social support, variety in activities and a degree of friendly competition (George *et al.*, 2012). A systematic review of physical activity interventions in disadvantaged communities found that multi-component adult group-based interventions that are supported by behaviour change theoretical frameworks were the most effective in increasing participation (Cleland *et al.*, 2012).

Using sporting settings can be a good way of getting men back into physical activity as they can have an affinity to a club (Parnell *et al.*, 2015). However the experience from the Premier League Health initiative was that people attending the sessions may not have been previous supporters or even be supporters from different clubs. The attraction was the availability of an interesting intervention that had the added benefit of being run by a high profile club (White *et al.*, 2012). The Premier League Health initiative involved the employment of a Health Trainer over a 3 year period to work with young males. They used the 'power of the club badge' to recruit 'at-risk' young men, 80% of which were not meeting PA guideline targets, into a variety of different exercise opportunities (Pringle *et al.*, 2011). Interviews with those running the initiative and the men taking part suggested that the success of the intervention was in part due to it being tailored to their needs (for example, including badminton classes at midnight for South Asian men who worked on the taxis and in restaurants), was in setting they valued, and was fun (White *et al.*, 2012; Pringle *et al.*, 2013; Robertson, Zwolinsky, Pringle *et al.*, 2013).

A noticeable feature of the Premier League initiative was the effect it had on wider lifestyle issues than just increasing physical activity levels. Of those men who completed the evaluation questionnaire more than 9 out of 10 men presented at least one negative health behaviour and approximately 8 out of 10 men reported combinations of lifestyle risk factors associated with an increased risk of non-communicable disease. At follow up 7 out of 10 men made at least one positive change to their health behaviours and almost 1 in 4 men reduced the number of harmful lifestyle risk factors they presented for non-communicable disease, 5% reduced two or more.

Walking is a popular way of getting men active and has the added benefit of tackling social isolation in the older man (Hunt *et al.*, 2013). 'Men's Sheds' and gardening-based interventions have the advantage of decreasing sedentary behaviour in men (Milligan *et al.*, 2013). Walking football and touch rugby have also been found to be very popular with older men and those worried about the effect of injury on their capacity to work. Though this has not had any formal evaluation it is gaining a lot of support around the country with 434 Walking Football United teams now registered⁵³. There is also 'slipper soccer' for older men with dementia or unable to engage in outdoor activities⁵⁴.

There has been a concerted effort to engage women in sport and physical activity across the city, one example is the 'This Girl Can' campaign which has had a large media presence – but it is noticeable that there has been no equivalent campaign for males. Sportivate provides funding to develop projects that

⁵² Service use data for the Leeds Council Bodyline scheme was not available

⁵³ <http://www.walkingfootballunited.co.uk/>

⁵⁴ <http://oldermenswellbeing.co.uk/2015/09/16/slipper-soccer-a-kick-about-for-older-gentlemen/>

will engage 11-25 year olds who are inactive, however the scheme is prioritising women and girls aged 19-25. The Active Lifestyles team in Leeds currently offers free sessions across the Council's Leisure Centres targeting women; the Women (and girls) Into Sport and Physical Activity (W.I.S.P.A) offers a range of free activities from tennis, dance and circuit training to pamper sessions and works with local third sector organisations to engage its target group. It has been noted that women are more likely than men to take advantage of non-gender-sensitive community PA interventions and by attendance they typically outnumber men 2:1 (Pringle *et al.*, 2010).

7.3.4 Recommendations

- City-wide initiatives to increase PA should consider the male perspective and include discussions with employers
- PA based opportunities should be created to allow men to become less sedentary and to expand their social networks
- Target men through 'male only' activities by reviewing the provision at each leisure centre, i.e. is there interest in more male only swimming sessions or male only circuit training classes for example?
- PA programmes should be used as a way of engaging men on wider healthy living issues, such as smoking cessation, diet, weight, and safe drinking.
- Offer PA programmes which can include both father and child
- Those men identified as having mental health difficulties or being socially isolated should be offered support to engage in PA based initiatives

7.4 Overweight, obesity and diet

There is still a tendency within society to see being overweight and weight loss as predominately a female issue, despite the higher number of men who are overweight, with a more negative impact through their tendency to have visceral fat (Tchernof & Després, 2013). This intra-abdominal fat increases the risk of the metabolic syndrome (diabetes, hypertension and high cholesterol), fat-related cancers, dementia and sleep apnoea (Aben *et al.*, 2012; Eckel *et al.*, 2010; Hildreth *et al.*, 2012; Parkin & Boyd, 2011b; Jordan *et al.*, 2014) and erectile dysfunction (Shamloul & Ghanem, 2013). Despite this excess, men are less likely to be recruited into weight loss initiatives or provided with clinical support. The recent data (2013/14) on finished admission episodes with a primary diagnosis of obesity for England and Wales showed 6,746 episodes for women and 2,578 for men (HSCIC, 2015a).

In addition to the problem of being overweight, men tend to have less nutritiously balanced diets, with above the recommended levels of dietary cholesterol and saturated fatty acids and lower levels of polyunsaturated fat, carbohydrate and fibre. They also have higher than advised salt and other mineral levels, which adds to the negative health consequences (EC, 2011).

Male socialisation is also an issue, as food and diet tend to be seen as a female concern by men and therefore they are reluctant to engage with decision-making around their diets (Gough & Conner, 2006; Gough, 2007). For many men, their food intake is managed by their parents or partners with their limited involvement. Young men living alone are particularly noted for their poor food choices, which is compounded by poor food knowledge, lack of ability to cook and competing priorities (Kelly & Ciclitira, 2011).

A further emerging issue with regard to men and their weight lies in the push for muscularity. Normal weight boys have been found to see themselves as underweight and their 'dieting' is in order to increase body mass, not decrease it. A study undertaken by McCreary & Sadava found that 28–68% of normal weight boys felt they were underweight, while 30-67% of normal weight girls felt they were fat (McCreary & Sadava, 2001). This wish to have a muscular body is now emerging as a new health concern

as boys and young men actively seek to bulk up their bodies with protein drinks and other food supplements and increased risk of steroid use (Van Hout & Kean 2015; Eisenberg *et al.*, 2012).

7.4.1 Prevalence of overweight and obesity⁵⁵

GP audit data for weight classification had captured data for 78% of the male population in Leeds which is less than captured for the female population (86% of females captured). In Horsforth Central, weight classification was only known for approximately 61% of the male population. The proportion of males in Leeds without a record of weight classification was much higher compared to females in the 16-24 year age group (24.6% of males in this age group compared to 13.8% of females), 25-49 year age group (23.9% of males vs. 8.7% of females) and 50-64 year age group (11.0% of males vs. 5.8% of females). The high proportion of men aged 50+ years who are overweight or obese suggests that recording weight at an earlier age may reduce the risk of obesity in later years, and subsequent risk of associated disease.

Of those males who have a BMI classification, 48% were above what was considered a normal weight range for their height [overweight, obese I, obese II or morbidly obese] compared to 45% of females. Approximately 30% of males with weight recorded were classified as overweight (not obese), which was higher than females [24% (Figure 19)]. However in the top ten ranked MSOAs this ranged from 36.2% to 41.1%, with the highest being in the MSOA of Bardsey, East Keswick, Collingham, Linton and Harewood. Nearly 17% of males with weight recorded were classified as obese (all categories) although this was lower than females (21%). In the top ten ranked MSOAs for males this ranged from 21.6% to 24.0%, with the highest being in the MSOA of Morley West.

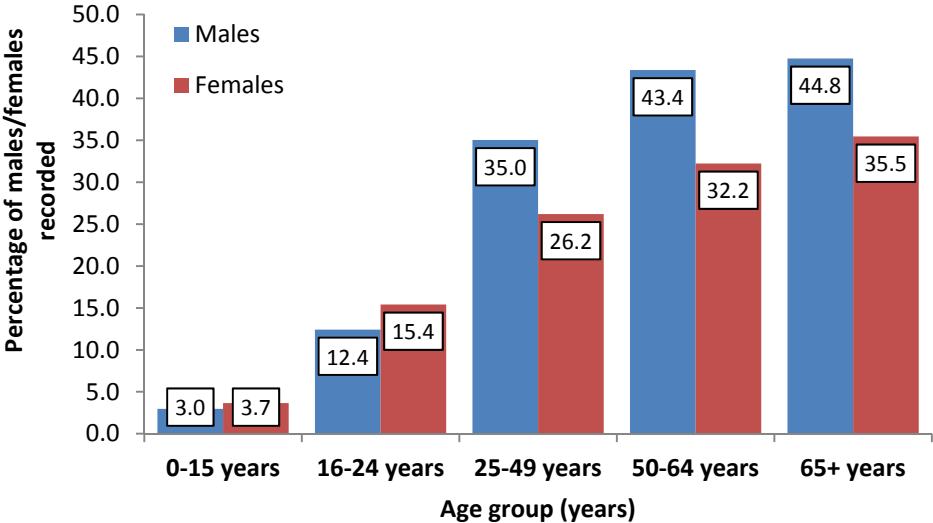


Figure 19. Percentage of males and females in Leeds classified as overweight (as a proportion of males and females with recorded data) across age group (from Seims & White, 2015)

With regard to weight it is important to note that approximately 22% of the male population with weight recorded were classified as underweight. However in the top ten ranked MSOAs this ranged from 28.9% to 37.1%, with the highest proportion of underweight males in Seacroft South. Underweight was most prevalent in boys aged under 16 (84% of boys).

7.4.2 Use of healthy eating and weight management services⁵⁶

Male weight problems are much less likely to be identified and acted upon. Female weight is more likely to be monitored as it is linked to reproductive health issues. Weight management advice is less likely to

⁵⁵ Please refer to 'The State of Men's Health in Leeds: Data' section 6.1 'Weight classification' for further detail and analysis of data

⁵⁶ Please refer to 'The State of Men's Health in Leeds: Data' sections 7.3.2 'Weight management services' and 6.3.3 'Ministry of Food programme' for further detail and analysis of data

be given to men within General Practice, such that they are less likely than women to be advised to diet or lose weight during a GP consultation (Bleich *et al.*, 2011). Men are also much less likely to be prescribed weight-loss drugs and fewer men end up being referred for bariatric surgery (Mold & Forbes, 2013). Less than 15% of referrals to the commercial weight loss groups are men (Jebb *et al.*, 2011) and nationally men account for only 23% of attendees at NHS weight management services.

Within Leeds, weight loss is managed by 'Weigh Ahead'⁵⁷, which is run by the Leeds Community Healthcare NHS Trust; they also have a 'Watch it'⁵⁸ family weight loss service also run by the Leeds Community Healthcare NHS Trust. In the first quarter of this year (Q1, 2015), only 27% of those registered with weight management services were men. Only half of these men had weight recorded, however a larger proportion of men lost weight compared to females (60% vs. 46% respectively), with a typical weight loss of 1-3% of initial weight (Figure 20).

The number of men participating in the Ministry of Food programme⁵⁹ peaked in 2013-2014, with 89 men, however only 28% of these men resided in 'deprived areas'.

The recent Football Fan's in Training (FFIT) trial of men's weight loss services run in conjunction with the Scottish Premier League demonstrated that men who have traditionally been seen as hard-to-reach will engage in weight loss initiatives and successfully lose weight and sustain that loss. At 12 weeks the intervention group had lost on average 5.8 kg as compared to 0.4 kg in the comparison group and at 12 months the weight loss was still 5.6 kg for the intervention group and 0.6 kg for the comparison group (Hunt *et al.*, 2014). There were also dietary improvements that were sustained over the 12 months and the men reported higher levels of physical fitness.

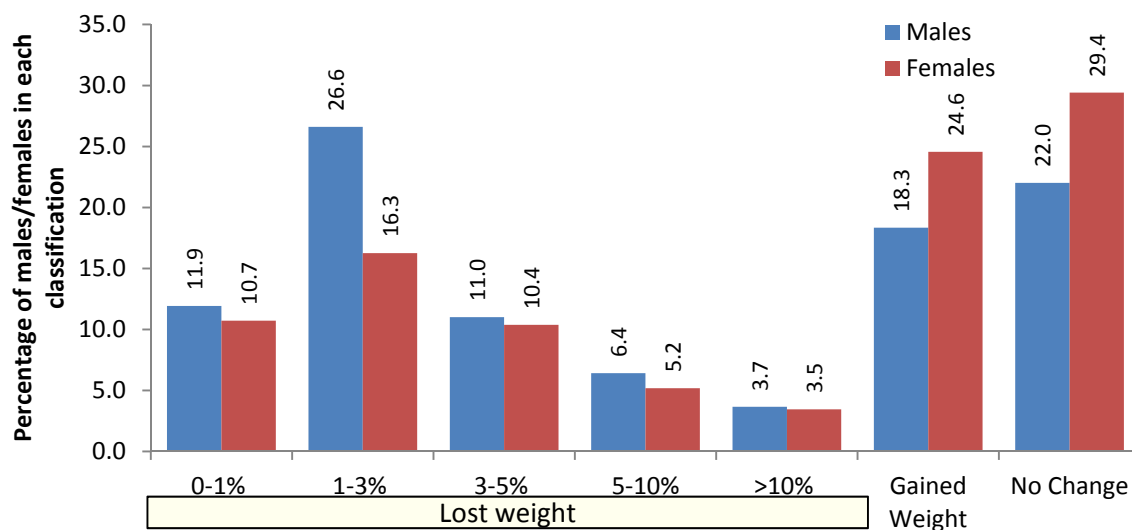


Figure 20. Percentage of males and females who lost, gained or did not change their weight (Seims & White, 2015)

The 'SHED IT' male only gender-targeted weight loss maintenance programme (Lubans *et al.*, 2009; Collins *et al.*, 2011; P. J. Morgan *et al.*, 2011; Morgan *et al.*, 2013) in Australia received 600 enquiries within a one-week period, demonstrating the high appeal of this type of programme. Men either received a resource pack focused on key weight loss messages such as 'don't drink your kilojoules' and 'reduce sitting time' or a website user guide and the resources package. Both groups showed significant weight loss, decreased calorie consumption and increased PA at the three month follow-up assessment.

⁵⁷ http://www.leedscommunityhealthcare.nhs.uk/our_services_az/weigh_ahead_adult_weight_management_service/

⁵⁸ http://www.leedscommunityhealthcare.nhs.uk/our_services_az/watch_it_family_weight_management_service/

⁵⁹ This is an eight-week course designed to teach cooking skills and healthy eating strategies.

NHS Leeds Community Healthcare Adult Weight Management Service was commissioned by the Department of Health to run a men's only weight loss group with the Leeds Rhinos during their 2010 season. It ran for 12 weeks with 12 men taking part. The average weight loss was 2.4 kg, compared to 2 kg at other weight loss groups, with an average waist loss of 4.3 cm at the Leeds Rhinos' course, compared to 3.25 cm normally. The attendance and completion were higher than other courses, with 12 men signed up and 10 completing the course. The commissioning of this service was not repeated once this trial funding by the DH was completed.

Local authorities around the country are running men only weight loss groups. Wigan has an on-going men's weight management programme called 'Trim Down Shape Up'. Evaluation⁶⁰ of this service has been undertaken by Leeds Beckett University. Over the first 20 months, it was noted that 91% of those applying for this 'male' weight loss service were women. The programme was modified to fit to a more male appropriate format, which had a marked effect on getting the men to attend. Once the men were recruited, the group camaraderie was the dominant factor that motivated retention. They were also motivated to continue as a result of losing 5% of their weight in 12 weeks. Kirklees have now also set up a men's only weight loss group at the Huddersfield Football stadium.

7.4.3 Engaging men with healthy eating and weight management services

The largest assessment of men's weight loss interventions was undertaken by Aberdeen University in 2014 (Robertson *et al.*, 2014). This comprised separate systematic reviews on clinical effectiveness; cost-effectiveness; qualitative evidence on interventions for treating obesity in men, and men in contrast to women, and the effectiveness of interventions to engage men in their weight reduction. They identified a set of important factors that should be considered in setting up new services:

- Men were more likely to benefit than women if PA was part of the intervention
- Reducing diets, coupled with PA and behaviour change were the most effective combination
- Though fewer men were recruited onto weight loss interventions, once they were on they were more likely to lose weight
- The perception of having a health problem (e.g. being defined as obese by a health professional), the impact of weight loss on health problems and desire to improve personal appearance without looking too thin were motivators for weight loss amongst men.
- Men prefer more factual information on how to lose weight and more emphasis on PA programmes
- Interventions delivered in social settings were preferred to those delivered in health-care settings
- Group-based programmes showed benefits by facilitating support for men with similar health problems, and some individual tailoring of advice assisted weight loss in some studies
- Generally, men preferred interventions that were individualised, fact-based and flexible, which used business-like language and which included simple to understand information
- Preferences for men-only versus mixed-sex weight-loss group programmes were divided.
- In terms of context, programmes which were cited in a sporting context where participants have a strong sense of affiliation showed low dropout rates and high satisfaction
- Although some men preferred weight-loss programmes delivered in an NHS context, the evidence comparing NHS and commercial programmes for men was unclear
- The effect of family and friends on participants in weight-loss programmes was inconsistent in the evidence reviewed - benefits were shown in some cases, but the social role of food in maintaining relationships may also act as a barrier to weight loss
- Evidence on the economics of managing obesity in men was limited and heterogeneous.

⁶⁰ <http://www.ukhealthforum.org.uk/prevention/case-studies/?entryid92=32167>

The Men's Health Forum have recently completed a guide for weight loss in men, in conjunction with Public Health England, based on the findings of the Aberdeen study (MHF/PHE, 2015).

7.4.4 Recommendations

- Investment in male weight loss services, with specific targets for recruiting and retaining men for all weight loss providers
- Support for services aimed at physical activity/weight loss should be developed with the key teams in the city (Rhinos, Carnegie, Leeds United)
- Male-only weight loss options should be made available, with options of programmes that involve a physical activity component
- Men over the age of 20 years should have their weight recorded to give earlier warning of being overweight and increased options for advice and referral onto weight loss programmes
- Discussions should be had with schools and colleges with regard to addressing boys and young men's male weight concerns – including being underweight or overweight, and the rise in body-building.

7.5 Sexual health⁶¹

It is important to note that nationally, sexually transmitted infections (STIs) are most prevalent in heterosexual men under the age of 25 years and in men who have sex with men (MSM), and across all the STIs there is a year-on-year increase in incidence (PHE, 2015).

MSM are particularly noted to be at increased risk of sexually transmitted diseases, accounting for the majority of infected males across the country. This has additional importance when coupled with their increased risk of Hepatitis A and C and HIV (Yin *et al.*, 2014). Data from 2013 showed that 29% of the Leeds population aged 15-59 who were diagnosed with HIV were MSM (Yin *et al.*, 2014). A modelling exercise in the UK has identified that HIV transmission is most likely in younger men who are highly sexually active, living with asymptomatic undiagnosed HIV (Punyacharoensin *et al.*, 2015). It is this group that needs to be targeted to get their diagnosis confirmed and preventative measures put in place, but this requires careful consideration of the rationale behind why men put themselves and others at risk (Balán *et al.*, 2013).

PHE reported that national detection rates for Chlamydia are still 1.8-2.1 times higher in females and that detection rates among males aged 20-24 were 1.5 to 2.5 times higher than among males aged 15-19 years (PHE, 2015). They advocate embedding chlamydia screening for 15-24 year olds into a variety of community settings to increase uptake. In Leeds although fewer males are screened for chlamydia, a higher percentage test positive (13.3% of males tested compared to 9.5% of females).

There has been a recent push for human papilloma virus (HPV) vaccination in boys to help increase herd immunity within the population. This will benefit women who are at high risk of anal and cervical cancer and other HPV related diseases, but it will also benefit gay men who are at risk of anal cancer and heterosexual men at risk of oral cancer. The HPV virus can be transmitted across the vulva to the mouth during oral sex and is thought to be behind the rising rate in oral cancer in men (Dunne *et al.*, 2006; D'Souza *et al.*, 2014; Stock *et al.*, 2012).

⁶¹ Please refer to 'The State of Men's Health in Leeds: Data' section 7.5 'Sexual health' for further detail and analysis of data

7.6 Clustering of health behaviours

There is a clustering effect seen with many of the problematic health problems, such that men who smoke also drink and men who are inactive are also overweight with high levels of sedentary behaviour and are more likely to also have a poor diet (Zwolinsky *et al.*, 2013).

This tends to suggest that targeting single health behaviours will be less successful than targeting multiple factors, for instance combining smoking cessation with increasing exercise is seen to have an added benefit (Ussher *et al.*, 2014). For many of the most problematic health behaviours there may also be a strong element of underlying mental health problems, either diagnosed, undiagnosed or hidden. This means that a wider level of support may be needed than just smoking cessation advice, for instance.

Men's health behaviours also rarely operate in isolation of the wider family; if the man smokes his partner will most likely smoke as well and a man's female partner often manages his diet. This suggests that complex relational issues are at play in changing lifestyles. Interventions using an integrated approach involving both partners may be more successful. Clustering can also occur around different patterns of living, such as seen in those men who have been through military service or offender's institutions.

8 Mental Health

Poor mental health can affect all aspects of men's lives, including their feelings of personal worth and relationships and employment, but men's mental health is a complex area. More men commit suicide, yet greater numbers of women are diagnosed with anxiety and depression - women are greater users of counselling services and have higher rates of referral to IAPT services, yet a higher proportion of men are diagnosed with psychosis and admitted to hospital with mental health problems and have more bed days than women.

In Leeds there have been important reports on mental health, including the 'Mental Health and Wellbeing in Leeds: An Assessment of Need of the Adult Population' (Eaton *et al.*, 2011) and the 'Audit of Suicides & Undetermined Deaths in Leeds 2008-2010' (Insight, 2014). These reports note that poor mental health and wellbeing are associated with a broad range of adverse outcomes, including higher levels of health risk behaviours such as alcohol and drug misuse, smoking, and experience of violence and abuse (Shorey *et al.*, 2012; Schuch *et al.*, 2014; Wilkins 2010). If these individual outcomes are taken as a proxy for mental health, it is possible to get a different picture of the challenges facing the male population, as for all of these outcomes, male rates are higher. The European State of Men's Health report (EC, 2011) suggests that though men may not be appearing in mental health data, their high levels of alcohol, drug taking, aggression, offending and self-harm may be a better indicator of their emotional wellbeing. Nationally there are also a growing number of boys aged 17-19 years who self-harm – with one Commissioner noting that this increase tends to get missed due to the focus being on the higher numbers of girls that self-harm. The argument that the current diagnostic criteria are not suitable for men and we need to find better metrics is getting stronger (Morison *et al.*, 2014; Ridge *et al.*, 2011).

The Commissioners have noted a number of specific mental health risks for men across Leeds, with a worry that there will be greater problems in the future. There is a strong link between mental health problems and poverty, and this is being compounded by recent changes in legislation, for instance the bedroom tax is driving a lot of young white men into one bedroom flats and high rise flats where no-one else wants to live. This group of men have been found to have low self-esteem, low self-worth and be at risk of depression and suicide. There are additional stressors in having limited accommodation, with a knock-on effect of causing problems for children's access (for example creating a barrier so children are unable to stay with their father, or children's primary carers not wanting to send children to their father's accommodation), leading to a self-perception that they have failed again. A worrying feature was noted by one Commissioner, that these men are not being identified as having specific needs until quite late:

"These men are mostly invisible unless they are a nuisance – they don't flag up on anyone's system."

Despite the strong link between poverty and mental health, some of the more affluent areas of Leeds are among the top ten MSOAs with the highest male prevalence of common mental health problems. Some possible explanations for this is that these men may be more aware of mental health problems and therefore more likely to recognise symptoms and articulate these to their GP. If men in the more deprived areas are not presenting to their GP or are unable to identify symptoms of mental health problems then they will not receive a diagnosis and subsequent suitable treatment.

The Commissioners reported that women seemed to be better at recognising their mental and emotional health problems and were more willing to approach the doctors or available services in times of need. They also noted that when men do present at their GP, it is more likely to be regarding a physical health problem or problems with sleeping rather than presenting with anxiety or low mood. They also suggested that men don't feel comfortable seeking help for their mental health needs, especially in the ten minutes available at the GPs, and that there is a lot of low mood and anxiety across the city that is missed.

The Commissioners reflected on the possibility that GPs are not being trained to spot men's signs of mental distress, and were more focused onto physical issues. However, a key finding from the Leeds suicide audit (Leigh-Hunt *et al.*, 2010) was that many of the men that committed suicide were not known to be at risk. This suggests that there may be a large number of men that are not engaging with health and social care services until their problems are more severe.

The survey completed as part of the MIND report (2009) on men's mental health found that men were almost half as likely to talk to friends about their problems as women (29% of men compared to 53% of women) and that 31% of men would talk to their family about feeling low compared to 47% of women. The National Children's Bureau also reported that only 10% of men aged 16+ would access health services early and of their own accord if experiencing an emotional or psychological issue and 19% would avoid accessing health services at almost any cost (Hamblin & Kane, 2015b).

Between 2008/2009 and 2010/2011, the number of males accessing NHS specialist mental health services in the Leeds Metropolitan District had increased by almost 14% but the number of females accessing services was still about 35% greater. Approximately 63% more females were referred into Psychological Therapies (IAPT) services through NHS Leeds CCGs (Q1-Q3 2014-2015) compared to males. Approximately 83% more females finished a treatment during this period compared to males. The number of bed days for males was 58% greater compared to females across all of the CCGs in Leeds, with about 60% of all bed days being associated with males; this gender difference was greater than observed nationally (only 46% greater for males compared to females).

The challenges facing men with regard to their mental health extend into the stigma or possible implications of being identified as having a mental health problem, these include (Möller-Leimkühler, 2002):

- The fear of loss of status
- Loss of control and autonomy
- Incompetence
- Dependence
- Potential damage of identity

These were reinforced in a more recent survey undertaken by CALM (Welford & Powell, 2014), which found that 42% of men felt the need to be the main breadwinner in the household, 29% higher than women, and that 29% of men worry that if they lost their job their partner would see them as less of a man.

Two voluntary sector organisations in Armley and Wortley did some insight work on mental health in men and found that there were still traditional views held by the men in their sample, such as:

- 'Man up'
- 'Take your hard knocks'
- 'Take it inside'

Ironically, Leeds and York Partnership Trust has run a men's mental health campaign called 'Man Up?'⁶², where men were supported to talk about their 'MENTal' health. A 'crisis card' has been produced following on from the insight work funded by Public Health, with men at risk in West Leeds, which identified the need for a resource to be kept in the 'back pocket'. This is currently a city-wide resource carried by police and frontline staff, however funding is not secured for 2016/17.

The recent Clinical Commissioning Group audit of the Leeds and York Partnership NHS Foundation Trust mental health services identified that the Single Point of Access (SPA) for services was found to be

⁶² <http://www.leedsandYorkpft.nhs.uk/membership/ManUp>

effective (Quality Care Commission, 2014). The feedback from patients using the services was positive and it was noted that intensive short-term crisis support of patients was praiseworthy, as was the Leeds Liaison Psychiatric Service for Older People. The Mental Health Audit also recognised the importance of targeted interventions and many of their proposed initiatives will have direct relevance for men:

- improving early identification of drug taking to reduce drug-related deaths
- screening for prisoners at entry for alcohol and mental health problems
- identifying mental health issues for the Lesbian, Gay and Bisexual community in non-mainstream settings
- expanding screening in brief interventions for harmful/ hazardous drinking in GP and A&E departments

An interesting observation from the Commissioners was that many of the men that engage with mental health support groups are older men, and that they are coming to act as a 'peer supporter' rather than as a client. The impression given is that they are needing help themselves but feel more comfortable engaging through the guise of helping others. A further observation by the Commissioners is that men who access 'survival from trauma' groups usually arrive later in their lives than women do, suggesting a longer period of their lives where issues have not been addressed.

8.1 Engaging men with mental health and wellbeing services

There are some key messages emerging on men's mental health needs and how they are under-recognised within current mental health provision. To help prevent the many adverse consequences of poor mental health it is important to consider more targeted interventions.

8.1.1 Recommendations for supporting boys and men with regard to their mental and emotional health and wellbeing:

- Addressing mental health and behavioural disorders in men needs to be prioritised due to the high numbers unable to work – unemployment creates strain on employment services and also increases the risk of social isolation
- Funding should be secured for the 'Crisis Card' initiative. The use of the card should be extended to target spaces men are known to use i.e. housing agencies, employment exchanges, GP waiting rooms, workplaces etc.
- All services that come into contact with men should have preparation to deal with men's mental and emotional health needs
- More linkages should be made between the police and mental health services, with embedding of community psychiatric nurses within the police force, street triage and greater education of the police with regard to men's mental health issues
- Addiction services need to ensure that men's mental health is assessed and managed as part of the package of support offered

9 Domestic violence/abuse

The 2014/15 'Leeds Domestic Violence and Abuse Strategy and Action Plan' has as its vision:

"Leeds is a city that has a zero tolerance approach to domestic violence and abuse, where individuals, families and communities are supported to reach their potential and lead safer, healthier and happier lives."

Domestic violence/abuse was defined in the Leeds Scrutiny Report on Tackling Domestic Violence and Abuse (Leeds Scrutiny Board, 2014) as 'the abuse of power and control over one person by another, which can take many different forms, including physical, sexual, emotional, verbal and financial abuse.' (p12). The full extent of domestic violence and abuse is not known, but spans across all sectors of society and has a damaging effect on all concerned. Nationally the ratio of female to male victims of domestic abuse is placed at about 4:1, and traditionally the main focus has been on supporting female victims of male perpetrated violence and abuse, and on protecting children within families where abuse is occurring. But it is important to note that men can both be the perpetrator and victim of domestic violence (Hamel, 2009), that there are also men who are trying to protect their children from abusive mothers and that they may need guidance as often they have been victims of abuse themselves (Zanoni *et al.*, 2013).

According to the Leeds Domestic Violence report (Leeds Scrutiny Board, 2014) the location of domestic violence seems to be prominent in the wards of Burmantofts, Gipton and Harehills (over 50% of incidents fell across 9 wards). The report recommends more complete analysis of spatial and temporal incident patterns to identify specific local areas or communities that have more concentrated issues, or areas with under, or over, expected levels of reporting.

The same report stressed that effective management and engagement of perpetrators was required and although they do signpost to national organisations, there doesn't seem to be anything in Leeds. They state:

"During our inquiry we heard directly from individuals that had perpetrated domestic violence and abuse and sought help themselves in addressing their behaviour towards their partner but found it difficult to find out discretely what support options were available to them locally".

A consultation exercise (Featherstone & Fraser, 2012) on fathers and domestic violence, identified that there was an increasing amount of work targeting men as there is a realisation that prevention has to be a key aim - men who are excluded from home without any form of remedial support, move on into new homes where the problems are replicated. They also noted that it was unfair to rely on women to protect children from violent men. However they did recognise difficulties due to a number of factors, which included the absence of a strong evidence-base for current interventions and a lack of policy.

They reported that there were those interventions that were focused onto men as perpetrators (such as the Respect programme) and those that were trying to stop men being violent by moving them towards being non-abusive fathers (Caring Dads). Respect have a marked ideological problem with the Caring Dads approach in dealing with domestic violence, but the consensus of the expert meeting seemed to be that an integration of the two approaches was optimal.

They also suggested any programmes need to take into consideration the co-occurrence with other health problems, such as alcohol dependence (Smith Stover *et al.*, 2011) and mental health problems (Shorey *et al.*, 2012) and their inability to understand their children's behaviour and needs (Bunston, 2013). Men who are violent often have histories of being abused themselves or having suffered trauma, with high levels of post-traumatic stress disorder (PTSD) present (Shorey *et al.*, 2012). This links with the risk posed to children as the Leeds report on Looked After Children found, those children at greater risk

of abuse or harm came from 33% of families that had the 'toxic trio' of: domestic violence, substance abuse, and poor mental health (Bane, 2013).

It has been noted, however, that it is difficult to get men engaged in perpetrator programmes. In a study conducted in the North East of England on those projects least successful in engaging men four key reasons emerged (Donovan & Griffiths, 2013):

- work with perpetrators was not within the remit of partner agencies
- when it was part of their remit, it was through a criminal justice lens
- agencies such as children's services claimed to work with families, but in practice this meant mothers and children only
- female practitioners felt unsafe about engaging with perpetrators, especially when this was in a domestic setting

They recommended that social workers and others working in this area have additional training to improve skills and confidence in working with abusive men.

There are many men in families where there are child protection issues, both as a result of maternal and/paternal abuse. A strong motivational factor for working with men is their desire to be a 'better dad' (Stanley *et al.*, 2012). Fatherhood is an important transition point for many men, with recognition that many problematic aspects of men's behaviour can be tackled at his point. When children were also supported, they identified changes in the father that would benefit the children; changes in the father-child relationship and changes in the child's functioning.

Other interventions that are effective at helping men become less abusive or aggressive have found that keeping men in the family longer, with support, can have great benefits for the children and also for their partner, with very positive longer term effects on the child's development and educational attainment reported (Featherstone & Fraser, 2012; Fatherhood Institute, 2014). The Fatherhood Institute (2014). warns that by excluding fathers too soon can result in children demonising or idolising them, suffering distress, anger and self-doubt and may lead to increased health problems However it is also noted that the needs of the child's safety must come first.

There are a number of established and newly emerging perpetrator programmes, including:

- Dad's on Board (Bunston, 2013)
- Respect
- The Bradford Reducing Anger and Violent Emotions (BRAVE) project
- Strength to Change
- Caring Dad's – run in conjunction with the NSPCC⁶³

BRAVE is a third sector organisation that has been running for about 10 years and takes a 'strengths and resilience' approach to helping men who are violent to manage their emotions. They offer group counselling sessions, one-to-one support and telephone support services. The service has been recently been re-commissioned by the Big Lottery and is currently being evaluated by the Centre for Men's Health at Leeds Beckett University.

The Strength to Change programme in Hull has been found to be successful in recruiting men and reducing risk to women (Stanley *et al.*, 2011). The evaluation notes that having specialised provision is important, but these should also be seen as a 'repository of skills' that can be used to guide the whole of the sector as the demand is greater than these initiatives can manage (Stanley *et al.*, 2012). This worry over capacity was also a concern within in the consultation exercise (Featherstone & Fraser, 2012); with such a small number of dedicated interventions they could not cope with the potential demand they

⁶³ <http://www.nspcc.org.uk/fighting-for-childhood/our-services/services-for-children-and-families/caring-dads-safer-children/>

would be under and that it is preferable (and less stigmatising) to have locally-based interventions run by local services.

Those men who are victims of abuse need to feel that they will be believed and that support is available. A Dutch study of male victims of domestic violence found the majority of men in their study were unlikely to report the abuse to the police due to fear of not being taken seriously, shame, or the belief the police cannot do anything. Those that did report the abuse were those that had experienced actual physical harm in a hope that they could stop the violence. This group also included those cases where children were involved (Drijber *et al.*, 2013). One group of respondents reported that they themselves were then accused of abuse or the police refused to cooperate when the victim wanted to report the crime. The recommendations from the report included the need for screening tools to be designed that would help support male victims.

There is also a need for additional training for health professionals in working with men who are abused. A study of GPs who underwent a 'Health professionals responding to men for safety' training programme on how to work with men who presented in their surgery either suffering from abuse or who recognise themselves as a perpetrator of abuse (Williamson *et al.*, 2015), found increased confidence in the GPs in responding to requests for help and greater numbers of men identified. The respondents to the study noted that often the men they would see in relation to abuse were gay men, but they also saw men who were concerned about the impact of their behaviour on their wider family.

9.1 Working with male perpetrators and supporting victims

Domestic violence and abuse comes in many different forms and can affect both men and women and have a very negative effect on their children. Working with men as victims and as perpetrators can help save the cycle of misery caused for all concerned.

9.1.1 Recommendations for working with perpetrators

- Greater support for men who have anger problems, with anger management classes being freely and confidentially available
- Perpetrator programmes should be established and advertised to enable easy access
- Support for children of perpetrators to help them manage the experience and to break the possible link with their own future abusive behaviour should be considered
- Greater effort should be taken to keep fathers within the family home as this can be seen to be overall a better option for all concerned

9.1.2 Recommendations for supporting boys and men who are victims or at risk

- Police and social services should be helped to identify and support men who are the victim of abusive relationships
- Men in relationships with abusive mothers should be given support to help maintain the family unit
- Safe houses and support for men suffering domestic abuse should be established
- Older men at risk of abuse should be identified, with training for housing staff and other front line service deliverers
- Confidential helplines should be marketed at boys who feel they are at risk of abuse or exploitation

10 Men accessing General Practice and screening services

Across all the Commissioners there is a general awareness that men may not be accessing services in the same numbers as women. This goes across all provision, from weight management to health checks to mental health services. When men do attend services, there is an impression that they do so later than women, such that they are in greater need, and that they have engaged due to necessity. The effect of this is that they are thought to be in unnecessarily poor health once they present, with a reduced number of treatment options available and they are more likely to require expensive secondary care. However much of these suppositions are based on personal experience and received wisdom as there is a general lack of data for the Commissioners to base their planning on with regard to men, as often the gender split of those using services is not collected, or not collated and analysed if it is.

There have been recent attempts to understand men's relationship with their health and health behaviour, including the work of Robertson (2007). His 'don't care, should care' model has offered an insight into the conflict many men feel with regard to their desire to look after themselves and what is required to do that body maintenance. This is strongly related to the ability of the individual to take control over their own life and this may be restricted due to the social determinants of health and structural issues in the way services are designed and offered.

10.1 Accessing General Practice

An analysis of GP use by men was not completed in the current study due to a lack of accessible data; therefore it is not possible to state that there is a difference between men and women in Leeds. There was, however, specific mention of this as an issue by some of the Commissioners, who reported that men tended to be later in their presentation and as a consequence had more advanced problems at diagnosis. Presentation with a cough was mentioned specifically as a condition where men would present later and also delay in presenting with mental health concerns.

There have been studies conducted elsewhere that have explored whether men differ in their usage of GP services as compared to women, which show that for preventative health consultations, mental health problems and issues such as weight, men are less likely to attend than women. However when there are signs and symptoms of disease, they were mostly similar to women; for instance cough or backache, with little difference in the time taken between men and women to seek help (Wyke *et al.*, 1998; Wyke *et al.*, 2013). A larger analysis undertaken on routinely collected primary care consultation data (Wang *et al.*, 2013) suggested that although women did consult more often than men, once being in receipt of medication for depression or cardiovascular disease and once reproductive disorders were taken into account, the gap almost disappeared. However, it is important to note that differences between the genders were most evident in those living in more deprived areas and between the ages of 16-60 years, where men attended less often than women.

A study on sex-differences in consultation for bowel cancer, lung cancer and melanoma found that there was little difference in consultation patterns between men and women and survival rates were also similar between men and women (Wang *et al.*, 2014).

Preventive health care, including blood pressure monitoring, cholesterol checks and dental checks were found to be much lower in men in an American study (Vaidya *et al.*, 2012), however a Swiss study observed the opposite (Krähenmann-Müller *et al.*, 2014). A Polish study found more men than women received preventive services for tobacco use or alcohol screening and BMI measurements (Gowin *et al.*, 2009).

It is important to note this mismatch in perception, as it has implications for what changes in service provision are actually required. What is known is that men do not access health services as often as

women, but that there may be no direct effect on their health as a consequence. However it is also possible to note that as men tend to have a much higher rate of avoidable premature morbidity and mortality (often as a result of heavy impact diseases), there should be a more efficient way of working with younger men in the more deprived areas to reduce their risk.

10.1.1 Improving access to GP services

There have been moves within the City to make access to GP services easier for the working population. This includes some practices introducing a 'walk-in' system whereby there is no need to book for an appointment. An observation on this service from one of the Commissioners was that this had changed the demographics of those attending, with more working-aged men attending for an early morning appointment, as they know they will be seen.

There has been an assumption that men may prefer to use more electronic means of accessing health services. However there is evidence that women are more likely to use the internet for accessing health information than men. A German study found that women were more likely to use the internet to search for information, used a broader range of websites and were more discerning in the information they sought compared to men (Bidmon & Terlutter, 2015). However the same study also suggested that men might be more interested in virtual patient-physician relationships, such as the fixing of personal appointments on-line, referral to other doctors, writing prescriptions, and discussions of normal test results and doctor's notes/certificates of health via email or through on-line meetings such as Skype.

The use of emails has seen some success in Denmark, with practical issues such as home measure of blood sugar and blood test results giving both GP and patient more flexibility and reducing demand on both face-to-face and phone consultations (Bienkowska-Gibbs *et al.*, 2015), though there was no gender breakdown of their results. Although UK GPs have reported that there might be a benefit to greater use of email and other IT based communication strategies, their anxieties have tended to focus on the difficulties of lack of guidance on the right 'rules of engagement' and GP workload (Atherton *et al.*, 2013; Hanna *et al.*, 2012).

The Men's Health Forum have a 24 hours a day Man MOT text chat and email service with NHS professionals and hold a live text chat with a GP on-line on two evenings a month⁶⁴. The Haringey Men's Health Scrutiny report highlighted the need to focus on men's health and as a result they established a service with the Men's Health Forum to deliver health advice and services for men in that borough of London⁶⁵.

10.1.2 Recommendations

- Continue to address the problem that men in full-time employment, whether self-employed or as an employee, have difficulty accessing daytime services – open access and out-of-hours services options should be trialled and audited
- All GP contact with men of working age should be seen as an opportunity to undertake a health check
- Letters and /or phone calls should be sent to those in vulnerable groups giving a time and place for their health check, with follow up of problematic health checks monitored
- GP surgeries should consider how 'male friendly' the clinic appears

⁶⁴ <https://www.menshealthforum.org.uk/manmot>.

⁶⁵ <https://www.menshealthforum.org.uk/haringey>

10.2 Improving men's engagement with health checks and early detection of cancer

10.2.1 NHS Health Check⁶⁶

The national cardiovascular disease (CVD) risk assessment program (NHS Health Check) commenced in 2009 and offers measurement of CVD risk factors, assessment of global cardiovascular risk, risk communication and lifestyle advice in all individuals aged 40 to 74 years without existing CVD (DH, 2008). This programme has experienced variable uptake across the country and has struggled to meet the 75% up-take that was envisioned. In Leeds over the past six audit periods, men have been heavily targeted for health checks, with 9% more males invited to complete an NHS Health Check compared to women, however less men are completing health checks (20% more women completed health checks). Despite the lower engagement, men were more likely to receive a diagnosis of disease [8.4% of males screened vs. 5.8% of females screened (Figure 21), with hypertension and diabetes most commonly diagnosed (77% and 13.8% of men screened respectively).

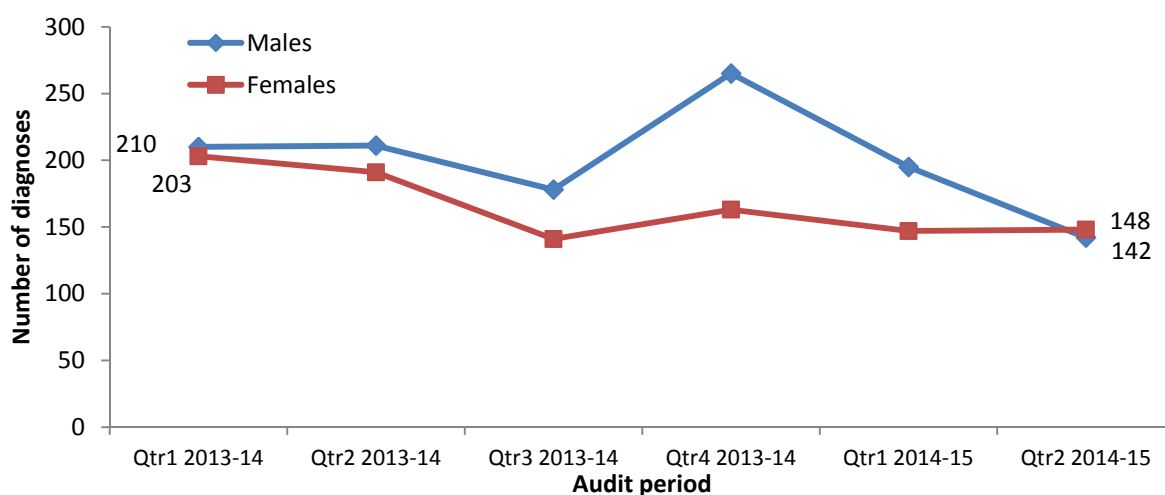


Figure 21. Number of males and females aged 40-74 receiving a diagnosis as a result of a NHS Health Check across the previous six quarters (Seims & White, 2015)

An early nationwide assessment of the uptake of NHS Health Checks noted that younger men and smokers were less likely to take up the opportunity (Dalton *et al.*, 2011). This was supported by a narrative scoping review of papers relating to uptake of health screening, which found that the group least likely to take up health checks were the less well-educated, single men on low incomes or unemployed with low socio-economic status (Dryden *et al.*, 2012). They also noted that those who did not attend were those in most need of early detection of problems as they tended to have a greater proportion of cardiovascular risk factors and be smokers. They argue that this group of men should be specifically targeted through service redesign and interventions to increase uptake. They suggest a number of different approaches, such as social marketing that focuses on getting the right message to the right group and also the use of financial incentives. They do warn however, of the challenges on clinicians working within the areas of high socio-economic deprivation in setting up complex interventions that may be difficult to sustain in the long run.

A study of GP's views of men self-referring showed an anxiety of the increased workload that may ensue if more working-age men used the service regularly (Hale *et al.*, 2010). They noted that men may be put off from further consultations if they have a negative experience:

“While male GPs may not overtly signal their disapproval during the consultation of patients they feel over attend, it is likely that this may be conveyed non-verbally to patients who perceive the GP as being unsympathetic to their anxieties.” (p709).

⁶⁶ Please refer to ‘The State of Men’s Health in Leeds: Data’ section 7.2 ‘NHS Health Checks’ for further detail and analysis of data

One of the Commissioners commented that GPs and other health professionals may need to reflect on how they manage working-age male patients, as they may have limited opportunities to attend.

A German self-reported study of participation in health checks found that overall socio-economic factors had a greater influence on up-take than gender. However, they also noted that the frequency of health checks rose faster in men, with similar numbers of men and women below the age of 54 years having a health check, and more men than women over the age of 54 years having a health check (Hoebel *et al.*, 2013). They suggest that physicians should raise the issue of health checks specifically with their patients from lower socio-economic backgrounds and that letters should be sent to more vulnerable groups inviting them in for a check-up with special scheduling of the sessions and reminders.

The findings from a large-scale study in Stoke-on-Trent on NHS Health Check uptake (Cochrane *et al.*, 2013) demonstrated that more men than women took up the offer of a check. Practice nurses or project support workers in each practice were required to contact all eligible patients, with up to three reminder letters sent before a non-response was recorded. This saw 8,521 men and 1,962 women in the targeted groups for health checks invited, with 5,332 (62.6%) men and 1,302 (66.4%) women responding and 3,829 (44.9%) of all men invited and 751 (38.3%) of all women invited attending. Many of those who did not attend had legitimate reasons, including administrative error, co-morbidity, and debilitating life circumstances, leaving 28.8% as genuine non-responders (gender breakdown was not given). They did note however, that older patients from more affluent areas were more likely to respond to the invitation.

A study based in inner-city Birmingham focused on offering NHS Health Checks to men aged over 40 years to increase diagnosis of diabetes, cardiovascular and kidney disease. Only 24% of the eligible men were screened (5,871 out of 24,166), with a higher uptake in South Asians, Black ethnic groups and those with a recorded phone number. It is important to note that 72% of those screened had raised levels of risk. Uptake was also low in men that smoked. There were some important lessons from the study - GPs who were in single-handed practices and were paid to provide screening had better uptake compared to multi-partner practices. The pharmacy recorded more risk factor data, was of a higher quality, and the men screened were more likely to be added to disease registers. Those practices that had better administrative arrangements in place had improved uptake as they had contact details and information relating to ethnicity and smoking status.

In Leeds, the NHS Health Check is delivered through all 107 GP practices in addition to an 18 month pilot whereby people can access an NHS Health Check within one of the 4 Asda pharmacies. This is due to finish at the end of March 2016 with a full evaluation report and it will be interesting to see what effect this has had on the gender balance of those attending these services and any possible change in rates of diagnosis.

10.2.2 Lung cancer awareness

Lung cancer is the second most common cancer in men, but results in the most cancer deaths. There have been major advances in managing the disease, but survival is very dependent on early detection and the targeting of the most at-risk groups (Marcus *et al.*, 2015). A review undertaken on men's uptake of lung cancer reporting found that men had lower levels of awareness of lung cancer symptoms than women, with non-specific symptoms causing further misinterpretation or non-recognition. This was compounded by a reluctance to seek help due to not wanting to make a doctor's appointment with a 'minor' or 'trivial' condition (Braybrook *et al.*, 2011).

An evaluation of the effectiveness of the recent Department of Health public awareness campaign to promote those with a cough for more than three weeks to seek a GP appointment, has shown that there has been a statistically significant increase in public awareness of persistent cough as a lung cancer

symptom, in urgent GP referrals for suspected lung cancer and in lung cancers diagnosed as compared to the control time period in the year preceding the intervention (Ironmonger *et al.*, 2014). Whilst data are collected nationally to monitor uptake of lung cancer diagnosis (including data for Leeds Teaching Hospitals NHS Trust), this is presented as a total of all persons and is not gender disaggregated (HSCIC, 2013).

Within Leeds, GPs had educational sessions on early detection to ensure those with a three-week cough were sent for a chest X-ray, with an additional option for those aged over 50 of self-referral to the X-Ray department. This is supported by the campaign 'Got a Cough, Get a Check', which was built on the national campaign but with different marketing. This was developed through local Focus Groups to test designs and messages, with the suggestion that it was better building on strengths rather than negative messages i.e. deaths. They also used local intelligence and ACORN data, to identify and target the at-risk groups. It has been noted by the Commissioners that there are big differences between areas in terms of uptake. There have been local evaluations to determine the acceptability of the campaign's communication strategies. There are three drop-in Chest Centres (Middleton, Seacroft, LGI), and since the start of this initiative there has been an increase in those X-rayed from 20,000 a year screened to 32,400 in 2014 (Price, 2015). Unfortunately it is not known if men attended as a result of a campaign due to lack of monitoring data - uptake should be evaluated by gender, age and MSOA to ensure that those men in areas with the greatest mortality rates are being targeted effectively and are engaging in the campaign.

10.2.3 Bowel cancer screening⁶⁷

Bowel cancer is the only cancer that has a national screening programme open to men at the moment. The NHS Bowel Cancer Screening Programme invites all men and women aged 60-74 to engage in the screening process every two years. In Leeds, a testing kit is sent in the post to men and women aged 60-69. Men in Leeds were less likely to complete a bowel cancer screening test when invited compared to women (45.2% of males invited vs. 54.5% of females invited), but were more likely to receive a positive diagnosis (2.4% of males tested vs. 1.2% of females tested).

Current on-going work nationally supports this higher rate of diagnosis in men and also notes men and women being at a similar stage of cancer at diagnosis, with similar routes to diagnosis and having comparable survivorship following treatment. This suggests that the principal way in which bowel cancer levels will be reduced is in greater prevention activity and a bigger push for earlier diagnosis – in this instance there is a case for screening to start at an earlier age for men (Brenner *et al.*, 2007).

Early detection is a key factor in successful cancer outcome, but the uptake differs greatly between different populations and is far less than hoped. Fish *et al.*, (2015) conducted a systematic review of research to identify the key psychological barriers to men accessing cancer screening opportunities. Identified barriers included low cancer knowledge, inaccurate interpretation of symptoms, feelings of embarrassment and fear, and conformity to masculine gender role norms. Being encouraged and supported by family members was the strongest facilitator of help-seeking behaviour.

It has been suggested that both men and women may be reluctant to take up screening due to unhappiness over the nature of the FOBT (Faecal Occult Blood Test) and colonoscopy (Sach & Whynes 2012; Sach & Whynes 2009; Chapple *et al.*, 2008; Wilkins 2011). The practical aspects of collecting the FOBT sample has been a barrier for some men, with a lack of confidence and ability stopping men in Vart's interview study (Vart, 2010). Being in full-time employment appears to also reduce the opportunity to collect faecal samples (von Wagner *et al.*, 2011).

⁶⁷ Please refer to 'The State of Men's Health in Leeds: Data' section 7.1 'Cancer screening' for further detail and analysis of data

Variation in the uptake of screening has also been attributed to ethnicity and the individuals socio-economic circumstances (von Wagner *et al.*, 2011). Increased delay in reporting in those from lower socio-economic groups has been linked to a fear of having cancer, fatalism, embarrassment, lack of confidence when talking to the doctor and also a lack of recognition of cancer warning signs (Beeken *et al.*, 2011; Robb *et al.*, 2009). However there were no significant sex differences in any responses.

10.2.4 Other examples of work with men on increasing health checks and screening

An initiative that based health checks in community settings (including pubs, clubs, workplaces and leisure centres) was positively evaluated by older men who had used the service (Kirkcaldy *et al.*, 2011). Interestingly, almost half of the men who used the service were already in the building and opted to use the service 'on the spur of the moment'. The opportunity to take the health check whilst in the work place was popular as it allowed the men a break from their work, whilst having venues that the men felt comfortable in was also an important factor. This idea of men being more likely to participate when they are in their 'comfort zone' has been noted by others (Carroll *et al.*, 2014; White *et al.*, 2008).

One interesting initiative has been conducted in Millwall where they have based a GP in the grounds on match days to meet the health and safety legislation requirement of having medical cover, whilst at the same time providing general practice support for the supporters (Leary *et al.*, 2008; Hart & Leary, 2015).

Stigma attached to lung cancer may also hinder help-seeking behaviour (Braybrook *et al.*, 2011). They explored current initiatives to increase awareness and screening, noticing that there is still dearth of good quality evaluations undertaken on this work. They advocate 'push' and 'pull' approaches that push people towards services through the use of community events, co-production, social marketing, and campaigns. There needs to be a concurrent emphasis on pulling people into the system more effectively through awareness raising and training for those working in primary care and more efficient x-ray services. The Doncaster Early Lung Cancer Intervention initiative was seen as a good example of this approach.

Braybrook *et al.*, (2011) also noted that initiatives need to better understand how men view their health and health behaviour. They suggest that men respond better to health messaging when they are going through life transitions that will place additional onus on them being in better health i.e. becoming a father, retirement, marriage. There is a concern that this could cause anxiety in some men as they realise their increased vulnerability at these important times, however, sensitive and appropriately focused initiatives could result in more men stopping smoking and coming forward for screening. They also note that men are very conscious of how other men may act in any given situation, such that they will compare themselves to what they think others might do in a similar situation. Normalising the screening process, such that it is acceptable for all men to attend the check-up with early symptoms, may also increase self-referral.

A Men's Health Forum study (Wilkins, 2011) exploring how to get more men engaged in bowel cancer screening found that men were more likely to take up the screening opportunity if they had either asked their doctor or their partner before making a decision to take part. Based on this they recommended that the pack sent out to male patients should include a leaflet suggesting that they should discuss the screening opportunity with their partner or GP before making their decision to take part.

There has been a recent national push to raise public awareness of bowel cancer symptoms through the 'Be Clear on Cancer', run by Public Health England, the NHS and the Department of Health. Evaluation of its effectiveness showed that there was a greater effect on men than on women. The evaluation found that there was a significantly greater increase in endorsement of 'looser poo' as a definite warning sign of bowel cancer for men than women and there was a significant increase in attendances by men for symptoms; greater for the most deprived areas (Moffat *et al.*, 2015). The NHS in Leeds, along with Leeds

City Council launched the 'Your Poo Can Save You' campaign, which aimed to raise awareness of bowel cancer and promote engagement with the screening process.

Three voluntary sector organisations have been commissioned to increase uptake within Leeds: Women's Health Matters; Feel Good Factor; and Healthy Living Leeds, BARCA. These use community engagement approaches to reach out and work with the public, but it has been noted that 80-90% of the contact they've had so far was with women. They were struggling to reach out to men and have made efforts to change this by requesting the organisations target locations where more men are to be found, such as men's groups, leisure facilities (pubs, working men's clubs), and businesses (taxi drivers). Engaging men was easier for services, such as Healthy Living Leeds, that already had good working contact with men, or have projects with men i.e. links with Armley Prison.

From the available evidence and the views of the Commissioners, greater effort should be placed on getting health checks to those most in need. With regard to men's health, men of working-age who are living in areas of high social deprivation are those who are least likely to take up the opportunity.

10.2.5 Recommendations

- Better use of social marketing to ensure campaigns effectively reach out to the right group in the right way
- Lung cancer
 - Campaigns that reinforce the increasing success of early intervention
 - Longer opening times and more locations for the drop-in chest X-rays
- Bowel cancer screening campaigns and leaflets should include recommendations to discuss the decision to participate with their partner
- Health checks should be undertaken in a variety of different settings, at different times, including pharmacies, work and social settings. Full evaluation of the trial with ASDA Health Checks, exploring the most preferred time of day as well as the gender of the contacts

11 Examples of good practice in men's health – local and national

11.1 Provision of male-focused services in Leeds

Over the years there has been a range of activity addressing the health of Leeds' male population. Founded in 1998, the Leeds Men's Health & Wellbeing Network has been one of the country's longest running men's health organisations and has provided an opportunity for those working in men's health to meet and discuss their work. The Network has supported the national Men's Health week with a broad spectrum of awareness-raising events.

A successful men's health campaign 'Tackling Men's Health' was run between Leeds Rhino's, the then Leeds Metropolitan University⁶⁸ and the regional Department of Health (Witty & White, 2011). Men's Health nurses attended the Headingley Carnegie Stadium delivering male health checks, health information and a weight loss group to male supporters. This two-season long initiative was followed by a weight loss group for men run by the Leeds weight management team at the Kirkstall training grounds of the Rhino's.

Another past initiative included 'The Healthy Living Network Leeds' which offered a range of male health promotion services in the Leeds area including work with Leeds Brewery, pubs, local work places and community groups.

Leeds Housing Concern's Men's Sector scheme⁶⁹ offers housing and support services for men with an offending background, drug and alcohol problems or a background of rough sleeping. Also, the Health for All 'Menspace' project⁷⁰ is a community engagement initiative operating in South Leeds, which has facilitated Dad's groups, walking groups, football groups and community development. The project is currently focusing on men aged 40 to 60 years, from inner south Leeds and aims to provide positive activities to improve health, reduce isolation and increase sense of belonging and self-worth. An additional aim is to establish groups of men which will eventually be able to become independent.

The Black Health Initiative⁷¹ have had a series of meetings to promote the needs of marginalised and disadvantaged men (BHI, 2013) and have secured funding to run a Men's MOT Clinic, which includes prostate cancer information and blood pressure checks to African Caribbean men.

The BLAST project⁷² (part of the MESMAC group of services⁷³), offers tailored one-to-one, online and outreach services for men and boys across Leeds and Bradford who are being, or are at risk of being, sexually exploited. The Leeds 'Surviving Trauma after Rape' (STAR) project supports men (and women) across West Yorkshire who have been raped or sexually assaulted and 'Support After Rape' and 'Sexual Violence Leeds', which together offer counselling, emotional and practical support for victims. There was a further support service – Start Treating Others Positively (STOP) – which was based in the Leeds city centre, but this lost its funding last year and is no longer running.

The Men's Room is run by the Space 2 team at Seacroft, this is supported by the Orion Men's Insight and Development Worker and offers a range of activities supporting the local male community on a weekly basis. The Leeds Irish Health and Homes charity run a weekly men's group at its Centre⁷⁴, which was specifically noted by one of those interviewed for this study:

⁶⁸ Now Leeds Beckett University

⁶⁹ <http://www.leedshc.org.uk/en/scheme/men.aspx>

⁷⁰ <http://www.healthforall.org.uk/?pid=55>

⁷¹ <http://www.blackhealthinitiative.org/>

⁷² <http://mesmac.co.uk/blast>

⁷³ <http://mesmac.co.uk/>

⁷⁴ <http://www.lihh.org/mens-group>

“I’ve been out to meet with Leeds Irish Health and Homes; they have a men’s health group in Harehills, which was great to go and visit. They’ve got an allotment project as well, so there are various things you know, thinking about how, where men are happy to go and meet together and have those conversations, and going to the places that they would be, rather than waiting for them to come to the health service or care service.”

Other key initiatives for men in Leeds include The Men’s Shed in Holbeck, run by Groundworks⁷⁵, which is a very popular initiative with the men who are able to attend. This was recently the subject of a BBC Look North news item which reported on the benefits of participation by the men. A further positive initiative in Leeds is the Walking Group that has been set up by former MP John Battle. Men are being referred to both of these initiatives by GPs who see them as a useful resource for socially isolated older men, who may have required medication for depression.

The Leeds United Football Foundation run a Social Inclusion group for disadvantaged children and young people, which although not aimed at boys specifically, it does offer a setting that appeals to them⁷⁶.

Much of the provision for men and boys in the Leeds area is based around more informal and less structured support groups. There are a number of men’s groups across Leeds, for men from a range of populations and with a range of needs. These include Menzone, in the Moor Allerton area of Leeds; a user led Asian men’s self-help group (Majlis); a male carers’ support group; and there are also a number of groups for elderly men including Morley Elderly Action.

There is another level of support that is mostly accessed by men within the city, this includes the St George’s Crypt⁷⁷ and Simon on the Streets⁷⁸, which are both aimed at the homeless. The York Street Health Practice⁷⁹ offers primary care to asylum seekers and those who are homeless or living in vulnerable housing and has a mainly male clientele. The Jigsaw Centre at Armley is another key organisation for men as it supports prisoners and offenders and their families. There are others that are focused on the provision for those with multiple vulnerabilities such as the West Yorkshire – Finding Independence (WY-FI)⁸⁰ initiative and Touchstone⁸¹.

There are a number of Voluntary and 3rd Sector organisations that are doing work on mental health in the city, with some of this focused on men:

- The Conservation Volunteers (TCV) working with men on initiatives such as Green Gym
- Health for All – Young Dad’s work, who are working on issues of resilience and crisis points
- BARCA⁸² in West Leeds provides a number of different services, including counselling (Reaching Out Counselling & Psychotherapy Service) and Targeted Mental Health in Schools (TaMHS). They also provide a Harm Reduction service for those who are affected by drugs and a drug and alcohol service. They also offer peer support through their Healthy Living Network
- ZEST – Health for Life - working with men in Meanwood
- Caring Dads offers support for young fathers who may be struggling with parenthood and relationships.

Another key 3rd Sector provider of support for those suffering an acute mental health crisis is the Leeds Survivor Led Crisis Service (LSLCS)⁸³. Their main provision is Dial House, which is open from 6am till 2am

⁷⁵ <http://www.groundwork.org.uk/Sites/leeds/pages/men-in-sheds-leeds>

⁷⁶ <http://www.leedsunitedfoundation.com/social-inclusion/>

⁷⁷ <http://www.stgeorgescrypt.org.uk/charity/>

⁷⁸ <http://simononthestreets.co.uk/>

⁷⁹ http://www.leedscommunityhealthcare.nhs.uk/our_services_az/york_street_health_practice/

⁸⁰ <http://wy-fi.org.uk/>

⁸¹ <http://www.touchstonesupport.org.uk/>

⁸² <http://barca-leeds.org/>

⁸³ www.lslcs.org.uk/

on three evenings a week and an additional BME support service through Touchstone. They also run a variety of different support services, including:

- LGBT Group
- My Time Thursday group
- Coping with Crisis Group
- Hearing Voices Group
- MANage Men's Group – this was a peer support group for men that seemed popular, but due to falling numbers has been discontinued.
- Self-Harm Support Group

Many of these initiatives have been funded by the Commissioners of the Public Health and Council services, which reflects their growing awareness of the need to be more effective at reaching out and targeting men specifically. The majority of these services are however, heavily reliant on short-term funding or highly motivated individuals, championing men's health in their locality. Whilst many of these groups and organisations undoubtedly provide valuable services to men, the instability of significant longer-term core funding for these organisations makes it extremely difficult to establish and develop sustained provision.

In addition to this third sector support, there are many city initiatives that are being established that can have a major impact on the health of men and boys. These include better management of the high rise flats, with more planning on the mix of people housed, better facilities, and a concierge who can help monitor and support the more vulnerable tenants (which are often young men).

The Patient Empowerment Project is an initiative run within Leeds where there is a central coordinating centre for all third sector referrals. This gives GPs and the public much easier access to the most appropriate service. The on-going evaluation is showing that men are as likely as women to use the service.

In Leeds, Armley now has an integrated service approach, where people can drop in a 'see-all' service provision, which is a good model to adopt more widely, due to the clustering of lifestyle factors and a high degree of co-dependence linked to mental health problems.

Leeds City has commissioned a Public Health 'Breakthrough Project' creating a whole-system approach to healthy lifestyles with a focus on inequalities. This project is working across the Council, with the CCGs, the voluntary and 3rd sector, harnessing the power of the Council's customer access and customer hub approach. It's about linking with digital technology, debt management, as well as smoking cessation and it is hoped that this joining together of services will enable a more comprehensive tackling of complex health problems.

11.2 Evaluation of local and national men's health projects

11.2.1 Lambeth and Southwark

A detailed analysis was undertaken of men's health in the London Boroughs of Lambeth and Southwark (Robertson, Zwolinsky & Raine, 2013). This work was instigated by the Guy's & St Thomas's Charitable Trust and carried out by the Centre for Men's Health at Leeds Beckett University. The study comprised analysis of the demographics of the men in the area, the mortality and morbidity data, lifestyle data, stakeholder interviews and a street survey of the men who lived in those Boroughs.

They identified the most worrying groups of men were those who were unemployed, divorced and those not registered with a GP. The key conditions that should be focused on were CVD, cancer, diabetes and mental health. The most appropriate approach to delivering services should be person-

centred programmes, health checks/screening/awareness programmes and multi behaviour change programmes. This should be supported by a training programme for local men to become volunteers and peer mentors, and training of staff in gender sensitive work with men.

As part of the study on Men's Health in Lambeth & Southwark, a collation of prior learning from previous programmes and projects aimed specifically at men was undertaken. This involved interviews with those who had developed or delivered male-focused interventions and a rapid review of the grey literature relating to men's health projects. There were six key messages that emerged from that analysis:

- The setting of the intervention - ease of access, familiarity and being in a safe and supportive environment are all important
- The style of approach has to be male-specific and sensitive to male identity
- The staff need to be aware of how to work with men, with training to ensure the necessary understanding, skills and confidence to work with men
- Engaging men in the development of services by asking and listening to their views is essential to get a sustainable project
- Good partnership working with all those associated with the intervention
- Mainstreaming the initiative as soon as practicable to ensure continuity

The Bradford Health of Men project had five years of funding to set up and run a broad range of male-focused activities. These were followed through participant observation and interviews with the boys and men and a series of interviews with the team and key stakeholders. The key messages that came from the interviews with the men included:

- All the men were aware that their health is important
- Getting to the health centre is a great difficulty due to work constraints
- The doctor is a person you visit only when you are physically ill
- Anonymity and confidentiality are very important, especially for the young
- When the team went out to the men it was appreciated and welcomed
- Once the men were with the team they were very willing to talk about their physical and emotional health
- Men from different cultures and socio-economic groups were keen to engage with the team and their work

11.2.2 Health Development Agency

An early analysis of projects working with young men was carried out for the Health Development Agency (Lloyd *et al.*, 2001). They conducted a literature review and survey of those initiatives working with men and found that:

- Young men responded when:
 - they were desperate
 - access was easy or easier
 - identity was involved - identity, culture, community base & common experience of racism were often significant factors
 - the services were advocates for young men
 - they had to be there i.e. young offenders / school based project
- Projects worked when:
 - they had a positive approach towards the young men they worked with
 - project workers looked past disruptive behaviour
 - projects were based on young men's needs
 - both male and female staff were positive and enthusiastic
 - an awareness of masculinity and gender permeated the project

- project workers understood the motivation young men had to get involved, and responded to what they had to offer
- they had been there long enough
- they were part of a broader strategy
- they accepted there were no quick fixes

11.2.3 The Young Foundation

A recent Young Foundation report (Johal *et al.*, 2012) on why men don't engage with social projects offers some important insights into what motivates men to engage or to disengage from interventions. The study surveyed over 500 organisations that received funding from the Big Lottery, with follow up to a sub-sample where more detail was obtained from key stakeholders.

They found that there were a number of very successful organisations in the voluntary sector that are effective at engaging men, with the key lessons being the need to: incentivise engagement, value the beneficiaries' input, target outreach, acknowledge differences, build up relationships of trust, provide effective support and encourage long-term engagement from beneficiary to volunteer.

From their findings they developed a useful set of guidelines for organisations to consider:

- The reluctance of men to engage with services, as beneficiaries to address their needs, is due to the presence of identifiable barriers, which included: help-seeking behaviours; fear of stigmatisation; a lack of visibility of men in services; hard to reach men; and a lack of discourse
- A full understanding of the barriers identified is necessary to find effective methods to overcome them and identify engagement facilitators. The facilitators that this research explores include: activities; time and venues; social connections and networks; partners/ wives/ families; peer support and male friendships; practitioners; and organisational partnerships
- Recommendations for projects that are trying to engage men more effectively: specifically target men; go where men are; have 'hooks' to appeal to motivations and interests; build up partnerships with gatekeepers and networks; tailor the service to provide for a range of needs; be flexible; build relationships on an individual basis; provide effective support; and encourage beneficiaries to become advocates and volunteers
- Recommendations for funders to support the engagement of men: supporting organisations that are targeting men; guidance notes for programmes should emphasise the inclusive nature of funding and reflect an interest in seeing more programmes that address men's needs. Encourage organisations to develop effective engagement strategies; measuring engagement; and sharing effective learning and practice

11.2.4 Movember - Men's Mental Health in the UK

A recent detailed analysis of initiatives and a systematic review of men and mental health (Robertson *et al.*, 2015) found the following to be key considerations when working with men with regard to their mental health (and their health generally):

- The setting of an intervention is crucial to creating a safe *male* space for engagement with boys and men. Safe settings are often those considered familiar and 'male friendly' – though what this means varies and needs to be understood as culturally and group specific
- Some settings stand out as appealing to certain groups: Schools for younger boys; Physical activity settings for young and middle-aged men; Workplace settings for working age men; Shoulder-to-shoulder settings for all (including older men); 'virtual' settings for boys and young men
- The right setting can act to reduce mental health stigma and also the stigma and discrimination experienced by marginalised boys and men

- Approaches that are embedded within communities and utilise a range of peer engagement and mentoring are particularly effective in generating ownership, facilitating trusting relationships and creating the space for disputing and re-thinking gender/masculinity
- Those involved in interventions need an array of characteristics to be most effective but having a positive and enthusiastic view about boys and men was a main core value required. The sex of those involved was not as important as having this male-positive, 'strength-based' view
- Activity approaches, based in areas of male interest (sport, DIY, music), were identified as an effective way to engage and sustain the involvement of boys and men. Such approaches helped overcome stigma, improved positive social engagement and acted to facilitate 'talk' over time
- Men often work well with direct, tangible and practical approaches that are solution-focused
- The language used within interventions is crucial and can act to facilitate or restrict engagement. 'Male friendly' language (appropriate for the specific group being engaged) and avoiding the language of 'health' and 'mental health' was important
- Like settings, partnerships were often crucial to intervention success. The benefits of partnerships were: assisting early engagement by improving the credibility of a programme; extending the reach and available activities; effective use of scarce resources; increasing sustainability and growth
- Partnership working was not always straight-forward and may require work to secure 'buy-in' from partners and to advocate with them for a specific emphasis on boys and men.

11.2.5 Leeds Insight

An important study was conducted by Insight (2014) in Leeds following the Suicide Audit. They found that within the LS12 area of the City there were problems associated with the availability, accessibility and quality of support in the area, a lack of social cohesion, problems re-adjusting following prison, a downward spiral of deprivation and a lack of local identity in the men they interviewed. They made a series of recommendations to be considered by the City Council:

- Community work targeted at single, workless men aged 30-60 years
- Establish a volunteer befriending network for men affected by social isolation and/or depression
- A greater promotion of relevant support services – especially crisis support
- Awareness raising
- A city-wide approach

12 Policy Context – Local and National

12.1 Local Strategy in Leeds

The policy environment for men's health and wellbeing is complex and multi-faceted, with a number of different factors and organisations having influence on the communities in which men live and the services they can access. As a broad definition, we take Buse, *et al.*'s (2007) summary that 'Health Policy' covers:

“Courses of action (or inaction) that affect the set of institutions, organisations, services and funding arrangements of the health and health care system.”

Understanding how to evaluate the influence of policy on men's health in the context of this complex environment is therefore crucial in order to identify how to implement meaningful improvements.

Figure 22 shows the policy environment for men's health based upon the Buse definition, from national legislation to local delivery. It shows that 'policy' is expressed through various outputs and that there are many different areas in which men's health priorities can be addressed. It also shows that the policy context for men's health is complex and conclusive judgements on effectiveness cannot be made by examining policy areas in isolation.

For this study we undertook a quantitative content analysis of city-wide strategies in Leeds (Walt *et al.*, 2008; Buse *et al.*, 2007). This involved a keyword search for gender-relevant words across published documents identified as relevant to the scope of this study.

In summary, it can be suggested from this analysis that inequalities are an important priority for the city and are evident throughout strategy documents. This is particularly the case with the Joint Health and Wellbeing Strategy having a principle in all outcomes that 'People who are the poorest will improve their health the fastest' and an emphasis on addressing inequalities is clearly evident in other strategies. The main strategic focus is on inequalities based upon economic deprivation, although this is not the sole focus. It can, however, be concluded that gender is not a well-represented theme in city-wide strategies generally, and the only mention of men specifically across all city-wide strategies which were within the scope of this study was in relation to them being perpetrators of domestic abuse. However, there is a strong theme of the family evident in the Children and Young People's Plan, Dementia Strategy, Domestic Violence Strategy and the Time of Our Lives Framework. This is apparent in some of the family-based approaches which are evident in the city, including family-group conferencing in Children's Services and neighbourhood, asset-based approaches in social care. These do provide opportunity to emphasise men as 'Fathers' and 'Sons', being positive assets in family structures.

However, this quantitative content analysis must be understood in the context of the policy environment shown in Figure 22. Quantitative content analysis solely serves to track the number of mentions, so it cannot be used for conclusions on quality or implementation on the ground. In addition, this analysis has only surveyed the top tiers of strategy because of the availability of documentation, and the wide scope of this research project has required a top-level city-wide view. Although these city-wide strategies are the highest profile, it is perhaps the lower tiers of the policy environment including local programmes and local delivery which have the biggest influence on men's health in Leeds. For example, it is how these are designed which will affect how services are targeted to men and the types of services that are commissioned.

Health Public Policy Environment			
Health Policy covers "Courses of action (or inaction) that affect the set of institutions, organisations, services and funding arrangements of the health and health care system" (Buse, 2007)			
Domain	Product	Example	Definition
National	Legislation		Any national legislation which imposes a duty on a body (eg. Leeds City Council)
National	Directives		Any policy statement or national initiative from a central government department or executive agency which places a requirement on a body (eg. Leeds City Council)
Local Partnerships	City-wide Strategy		Any strategy which covers people across a whole locality, be it covering health and wellbeing in general, a disease group or demographic.
Local Partnerships	City-wide Planning		Any plans which set out how services will be commissioned and/or provided across a whole locality.
Local Programmes	Contracting		Any individual contract for a commissioned service.
Local Delivery	Delivery		Any policy or action which is the local organisation's interpretation of existing policy statements and implementation in practice. This can encompass local discretion and flexibilities, and influences how services are delivered and who they are delivered to.

Figure 22. Leeds health policy environment

12.2 National Legislation and Strategy

Much of the research in this study has identified the importance of wider determinants on health outcomes for men. There has been a direction in national policy over recent years to have an increased focus on the links between healthcare and wider determinants. The Health and Social Care Act 2012 moved Public Health functions into the local authority and established Health and Wellbeing Boards, with a view to creating stronger partnerships across the health and wellbeing agenda and putting public health as a major priority of work across local authorities. In addition, the NHS England 'Five Year Forward' view has an emphasis on the NHS doing more to promote population health, with programmes around diabetes prevention, community capacity and town planning. The Care Act 2014 is built around a guiding principle of wellbeing, which requests local authorities to promote wellbeing when carrying any functions of care and support. How much this focus on integration and wider determinants have been undermined by significant cuts to local authorities and parallel policies of competition and choice, is a matter for another study.

There is a strong policy drive to explore the health and wellbeing of men through the introduction of the Equality Legislation (Equality Act, 2010). This Act has replaced the Sex Discrimination Act(, which relied on challenges to existing policies, whereas this new Equality Act makes ensuring the needs of men are considered across all public services a legal requirement. This moves the point of scrutiny back into the policy making stages as well as encouraging an examination of existing service provision. The Social Value Act has, at its core, the requirement that people who commission public services must think about how they can also secure wider social, economic and environmental benefits.

Although limited, there are some good examples of where gender has been included as an important factor in policy development. These include Bromley's (Lemic, 2013) and Portsmouth's (Mortimore, 2013) Directors of Public Health who have dedicated their annual report to men's health, and Greenwich who included a section on men's health in their 2010 JSNA. Greenwich held a time-limited review of men's health for their scrutiny panel in 2011 (Gillman *et al.*, 2011). This panel identified that men's health was under-supported and made six recommendations:

- Adopt an asset based approach when updating the Joint Health and Wellbeing Strategy
- Allocate a small dedicated budget, from within existing resources, to the Greenwich Men's Health Forum to facilitate greater publicity and communication regarding men's health issues
- Continue to prioritise men's health and allocate adequate resources to the men's health programme
- Introduce measures within the Joint Health and Wellbeing Strategy to utilise the Council's role as a major employer to improve the health of their male employees
- Consult the Greenwich Clinical Commissioning Committee when updating the Joint Health and Wellbeing Strategy with particular reference to the committee's commissioning intentions regarding men's health
- Ask the Greenwich Men's Health Forum to develop a men's health communication strategy with the aim raising the profile of men's health and publicising the men's health programme

In Greenwich's 2011-2013 Health and Wellbeing Strategy, men's health was included as one of the key 10 objectives.

Stockport was one of the first local authorities to examine the problems faced by men in their area through Scrutiny in 2003 (Stockport Metropolitan Borough Council, 2003). Newham had a Scrutiny review of men's health in 2009 (Vaughan, 2009), but this was restricted to prostate and testicular cancer. The London Borough of Lewisham had a wider ranging Scrutiny review of men's health in 2007

(Lewisham, 2007), as did Haringey in 2012 (Winskill *et al.*, 2012). Following the Haringey Scrutiny they have developed a dedicated service for men's health (Man MOT), run in collaboration with the Men's Health Forum, which includes an on-line support service for men. York has also recently had a scrutiny task force focused onto the health of men⁸⁴.

Wandsworth currently have a year of activity focused on men's health, which is supported by strong links with the Men's Health Forum. They are linking into the Man MOT through a 'Wandsworth Man' initiative⁸⁵ and the Wandsworth CCG has also supported the development of the Men's Health Forum (Wandsworth, 2013)⁸⁶.

Halton and St Helen's PCT had a 'GO Men's Health' Campaign that was evaluated by a team from University of Liverpool. This initiative was focused on getting men over the age of 40 years in deprived areas health checked. A qualitative analysis (Coles *et al.*, 2010) of the views of men using the service found that they were very keen to manage their health well, but that there were barriers in place that made it difficult. Some of these related to masculine expectations that limited their freedom to be seen to be associated with some health activities that were deemed too feminine and others to either a lack of male-focused services or structural issues in accessing services whilst at work.

A recent Freedom of Information request to local authorities undertaken by the Men's Health Forum⁸⁷ identified few local authorities that had taken gender into consideration in their JSNA's. The London Borough of Hillingdon was the most engaged with regard to gender-disaggregated data and men's health, with 71% of its JSNA measures gendered. Within the top four authorities were also Bolton (65% of its measures), Hampshire (54%) and the Wirral Metropolitan Borough (52%). The average number of gendered measures was 12, with Leeds City in 41st place with 16 (39%)⁸⁸. Again, these figures must be understood in the context of them being obtained from quantitative content analyses.

⁸⁴ <http://democracy.york.gov.uk/mgCommitteeMailingList.aspx?ID=835>

⁸⁵ http://www.wandsworth.gov.uk/info/200523/mens_health/2002/about_wandsworth_man

⁸⁶ <http://www.wandsworthccg.nhs.uk/getinvolved/Men's%20Health%20Forum/Pages/default.aspx>

⁸⁷ <https://www.menshealthforum.org.uk/gender-data-deficit-0>

⁸⁸ <https://www.menshealthforum.org.uk/jsna-gendered-league-table>

13 Recommended action for supporting specific groups of boys and men

13.1 Boys and Looked-after-children

Leeds has a goal of becoming a child-friendly city, and there are a raft of initiatives in place to support this. There are some areas that by focusing in on the gender of the child the potential for further improvements could be made.

Educating teachers into the issues relating to young masculinity and ways of managing boys, can help change the view of boys within the school environment and may give alternative ways of working with problematic behaviour (Mac an Ghaill & Haywood, 2012). Engaging more male teachers to provide role models for the young can also help in this process. It is good to see that PHSE education is helping ensure development of emotional intelligence in boys and skills in accessing primary care and other forms of support for emotional and physical health and wellbeing. Boys who leave school should have the capacity to recognise within themselves and others when external help is required (Hamblin & Kane, 2015a). This can further be developed by the availability of counselling services within schools.

Boys who are classified as 'Looked After' should be offered greater educational support to ensure they don't fall too far behind their peers. If they can be enabled to keep in contact with fathers (when appropriate) and other relatives may help boys cope better. A programme to manage the transition between child and adult services should be in place to reflect the needs of boys and young men (Everson-Hock et al., 2011).

Developing services for young men should consider their broader public health needs, including overweight and other forms of risky lifestyle. With greater linkage between the initiatives to allow clustering of health issues to be addressed (Zwolinsky et al., 2015). Getting the lads engagement in the development of services for them will create better buy-in and be more likely to have initiatives they are more likely to use (Head, 2011).

Keeping adolescent boys active is important in helping to keep down the prevalence of overweight. For those who are resistant to engaging with sports based delivery the development of alternative activities that get boys active, with provision that can build self-esteem and self-confidence can also be of great benefit. This will require planning processes to consider safe spaces for young men to grow and develop. It would also be helpful if there could be more youth support work in the community to engage with the young men to create alternative opportunities as they move from school if work is not available.

With the City's push for greater use of technology, imaginative use of social media, mHealth and eHealth technology in reaching out to young men should be encouraged.

Contraceptive advice and access to contraception should be made easily available, which links with sexual health services being made more accessible for boys and young men to ensure they have advice and guidance when it is needed.

13.2 Fathers and improving family relationships

Working with men prior to the birth of their child can have a positive effect – for example getting better preparation for parenthood at school and also in the antenatal period. There are issues, however with fatherhood still being under-recognised in planning services, with fathers seen as 'non-traditional clients

of family welfare services' (Scourfield *et al.*, 2014, p47), and the numbers being invited or attending structured parenting programmes remain small.

The recently introduced Leeds 'Preparation for Birth and Beyond' has a stronger father focus, which is encouraging. It will be good to evaluate this programme to observe how it is received by new fathers and the impact it has on mothers and on their children's development. The Leeds Central Families Need Fathers⁸⁹ have a series of recordings to help fathers understand the antenatal period and immediate aftermath of the birth. This might be extended to include more guidance on problems further down the line.

There is a growing level of support for fathers within Leeds. Leeds Dads⁹⁰ offers a monthly opportunity for fathers to meet. The SaturDads club is a regular meeting opportunities for dads, stepdads, granddads, uncles and brothers who have child care responsibilities for children under five. The Young Father's group offers an important support to young dads. Where there are abuse problems within families, the Caring Dads⁹¹ is an intervention programme for men to help them tackle their behaviour.

There has been a recent change in legislation that permits greater sharing of leave following birth. This increase in paternity leave has been shown in the Nordic countries to have a very positive effect on overall child welfare and results in a stronger bond between the mother and the father and reduces tension within the home (Scambor *et al.*, 2013). This should be encouraged with all employers in Leeds.

A systematic review showed that father's involvement in programmes for the primary prevention of child maltreatment was limited. Only three of the studies included in the review had made specific mention of fathers, however those that did reported statistically significant reductions in dysfunctional parental discipline (Smith *et al.*, 2012). One study where parents were informed of the risks of shaking a baby and guidance on how to manage with issues such as persistent crying, saw a big reduction in abusive head injuries (Dias *et al.*, 2005).

The Fatherhood Institute has Six Signposts for Fatherhood (Fatherhood Institute, 2010) that should be considered by service providers and employers of men:

- Fathers should get more leave when their baby is born
- Paternity leave should be paid at 90% of salary
- New fathers should get more information
- More fathers should be able to work flexibly
- Services should include fathers
- Fathers who do not live with their children should be supported to stay connected.

13.2.1 Recommendations

In addition to these six factors the council and partners could also consider:

- Fathers with young children should have more toddler group opportunities, with Commissioners supporting male only and female only toddler groups as well as open access parent groups
- All men should have better preparation for fatherhood. Young fathers should be given additional targeted support, with midwives and health visitors given training in how to work effectively with vulnerable young men.

⁸⁹ <http://leeds.fnf.org.uk/>

⁹⁰ <https://www.facebook.com/leedsdads>

⁹¹ <http://caringdads.org/m-about/m-about-caring-dads>

- Effort should be made to keep separated fathers engaged with their family
- Lone fathers should be identified and offered support

13.3 Older men

Older men can offer significant benefits to society with many volunteering in different guises to support community initiatives and other worthy causes; this has the added benefit of widening the men's social network and helping to avoid social isolation. There are also a large number of men engaged in unpaid care, and nationally there are now more male carers than female carers over the age of 65 years (ONS, 2013b), which is not always recognised in the support systems. Care takes many forms, from the increasing role grandfathers play in the supporting their offspring (Bates & Taylor, 2012) to caring for infirm partners and others. It is worth noting however that a significant factor in older men's lives is the effect of separation or divorce and losing a role for themselves within society, as noted by King & Calasanti (2013):

“But once parted from spouses and jobs, and especially as infirmities intrude, old men succumb more quickly than women to a host of physical and social threats, in an unintended consequence of having according responsibility for care work and social networking to the women in their lives.” (p706)

The Leeds Commissioners reported that older men in Leeds have similar difficulties to those seen nationally, with fewer using community-based health and social services and with many un-reached by current provision and remaining mostly housebound.

A scoping review on day centre provision for older people in the UK found that most older people's services were focused more onto the needs of women than men (Manthorpe & Moriarty, 2014). They identified that it was important for men to feel the services were reflective of their needs, including those provided for early dementia care. They did comment, however, that the men needed choice and some men wanted the company of women and not other men. This need for more focused provision has been noted elsewhere:

“In order to attract older men, attention should be paid by local authority and voluntary organisations to offering appropriate facilities and activities for older men so that they may be supported in leading socially integrated and independent lives within the community”(Davidson *et al.*, 2003, p88).

The masculine response to difficulties that accompany the ageing process have been noted to include control, feelings of invulnerability, efforts to maintain physical prowess, self-reliance and toughness, which can act as a positive response to ageing and allow many men to keep engaged within society for longer (Clarke & Bennett, 2012). An important aspect of successful ageing for men is the opportunity to be sociable, having contact with other men (Shaw *et al.*, 2014). However, this older male population is providing new challenges and is linked to a growing problem of social isolation and depression (Arber & Cooper, 1999; Steptoe *et al.*, 2013).

There is an increasing issue of survivorship in old men where we are now seeing cancer as a chronic disease and many of the problems are a result of treatment rather than the disease themselves. Incontinence is becoming a bigger problem in older men as a result of surgery on the prostate. This is a difficult area for men as there is a much larger product range for women's incontinence aids and men are not prepared for the likelihood of incontinence in the same way as women (Teunissen *et al.*, 2006).

A further side effect of prostate cancer treatment is osteoporosis as a result of hormone ablation therapy (Szulc *et al.*, 2012). This is not a well-recognised problem in men, despite a third of all fractures

in men over 50 being osteoporotic in nature and the possibility of death being double that of women in the first year following the fracture.

Whereas women tend to prefer face to face conversation, many men find this too personal and have been found to benefit from more 'covert' intimacy (Thompson & Whearty, 2004). This tends to take the form of shoulder-to-shoulder conversations as seen whilst engaging in activities, such as in gardening activities and the emerging trend in Men's Sheds (Wilkins & Kemple, 2011; Milligan et al., 2013; Johal et al., 2012). Keeping men active as they go through their older years is an also important aid to healthy ageing (Gulsvik et al., 2012).

A further key factor in engaging older men in activities is the sense that they are doing something worthwhile and practical, with men preferring to feel usefully engaged in activities that reflect their identities (Davidson et al., 2003); for this reason, men who attend older people's services are more likely to do so as a volunteer (although this tends to be men who are more affluent and middle class rather than men from more deprived backgrounds (Milligan et al., 2013)).

13.3.1 Recommendations

- The increasing older male population suggests that early intervention to reduce the risk of developing long-term conditions is key to minimising increased strain on local health services
- Targeted campaigns should aim to engage older men in healthy lifestyle services, including weight loss, stopping smoking, alcohol reduction services etc.
- Services for older men need to be developed, with the Horsforth Men's Shed being replicated in other parts of the city. Walking groups, volunteering and the continued development of green ideas should be encouraged. Winter-time initiatives need to be developed to ensure men's support is continued throughout the year
- Men with long-term conditions should be supported with gender sensitive services that enable them to retain a sense of masculine identity
- Greater opportunities should be made available for older men to engage in volunteering

14 General guidelines for working with men

There are a number of practical suggestions on working with men that have emerged from the study and from the literature. These should be seen in conjunction with the overall study recommendations as guidelines on how initiatives should be set up and run.

14.1 Hearing the voices of the men

Planning successful initiatives requires listening to the men and involving them in the planning process (Carroll *et al.*, 2014). Gaining access to the right target group can best be achieved through the local third sector and voluntary organisations already working with the men. The Joint Health and Wellbeing Strategy for Leeds has as one of its five outcomes that ‘People will be involved in decisions about them’; this has to extend to men.

Similarly, the 2015 URBACT project report (Newton *et al.*, 2015) promotes the use of community involvement, where service users are active participants as opposed to passive consumers of health. The URBACT report suggests that individuals and professionals should work together to design public services and that engaging communities can directly address social exclusion and health inequalities. In order to improve the health and wellbeing of boys and men, they must be engaged in this process to ensure services are meeting their needs which may be different from women’s.

14.2 Social focused events with a purpose

The suggestion from much of the work on men’s health is that getting men of all ages engaged in organised events delivered in local settings such as the Sheds, Walking Football, Walking Groups, FFIT and Premier League Health can give far more benefit than single focused groups. One of the most important facilitators for change is that the men can enjoy the initiative and start to form new friends. A key factor in getting men into new settings is that it creates a new social network with men who are also trying to change their lifestyles. This breaks the cycle of poor health behaviour and allows the individual time to adjust to new health behaviours (Robertson *et al.*, 2013). With increases in social networks and greater social capital men see improvement in their self-esteem, self-worth, and a general improvement in physical and emotional health alongside a general reduction in smoking, alcohol intake, and improvements in weight, and levels of physical activity.

14.3 Non-clinical, without a heavy ‘health’ focus

A further feature of the mass appeal interventions such as Premier League Health, The Sheds movement etc., were that they were non-clinical and most of the important health messaging was done in an informal brief therapy manner. It is also important that the men don’t feel they are being ‘told-off’ or stigmatised by the health profession. As in the Harland study, many young men already feel that they are seen as the problem and are reluctant to engage with initiatives where they feel they will be blamed or ridiculed (Harland, 2009b). The current focus on BMI as the measure of ideal weight is another area of contention for men, with the metric discredited by stories of sportsmen having high BMI levels and yet clearly not being fat (Monaghan 2007; Johnson *et al.*, 2014). The use of the tape measure around the abdomen is an acceptable tool for identifying overweight and for men who have a higher propensity for abdominal visceral fat, success can be more clearly seen (NICE, 2015). One of the key findings from the Robertson, *et al* (2015) review was that avoidance of the word ‘health’ is a great asset in getting men involved in [health] initiatives.

14.4 Running a campaign

Campaigns can be global, but are more effective when focused onto the target group and designed using social marketing techniques. Robinson & Robertson (2010) warn that marketing has to be thought through carefully so that it doesn't reinforce negative stereotypes of men. It is possible to get men's attention without resorting to imagery or text that panders to the male hegemonic stereotype. A study conducted at the Centre for Men's Health at Leeds Beckett for the Men's Health Forum (Robinson & Robertson, 2013) explored the appropriate approach for reaching out to young men (aged 16–21), new fathers (25–45), middle-aged men (40–55), and older men (60+). Each group were seen to want a different style of messaging.

Getting the message right is important, with the men appreciating an approach focused on informing them of the problem and the solution, rather than words indicating failure. Using terms such as 'help-lines' and 'support' are less likely to engage the male audience, and giving advice is also not likely to be successful. Giving men enough information from a trusted source with an engaging content to enable to them to make their own decision is what they would prefer, with each group having a different perspective on what they needed:

- Young men - More likely to enquire than seek solutions. More embarrassed talking about health/less likely to seek support
- New dads - Own health often loses out to other more immediate family pressures. Asking about health and seeking solutions
- Middle-aged men - Health more of a priority – starting to impact on day-to-day life. Enquiring and also more solution-focused than younger males
- Older men - More often dealing with health in an ongoing way. Seeking solutions/advice, for example concerning self-care. More likely to seek information alongside personal support (Robinson & Robertson, 2013)

At the height of the AIDS epidemic the government funded The Terrence Higgins Trust to help get the message across to the gay community as they launched their hard hitting 'tombstone' campaign. Working in collaboration with the charity they got the right message, to the right people, in the right way⁹².

14.5 Taking an asset based approach

There are many excellent examples of outreach work with men within the city that can be built on (see section 11 '*Examples of good practice in men's health – local and national*'), with the opportunity for existing best practice to be developed and their success shared with others. Greater use of peer mentorship and engaging Community Champions can offer access into local communities others would find hard to achieve to offer localised personal guidance (South, 2015).

The 'power of the badge' was a major attraction in the Premier League Health initiative and a similar effect of having The Rhinos, Leeds United etc., working to support the local community is huge.

14.6 Working in partnership

Credibility is an important factor for men's engagement in campaigns, with trust in the provider of high importance. Charitable and voluntary sector organisations working in collaboration with statutory services can bring the benefits of local knowledge and willing support alongside more mainstream

⁹² <http://www.tht.org.uk/our-charity/Our-work/Our-history/1980s>

provision. Such relationships can also facilitate referral onto the appropriate services. The Leeds Patient Empowerment Project is a good example of where individuals can be directed onto community provision with the benefit of having a GP referral to give the service credence and credibility.

14.7 Settings based approaches

An emerging feature of the initiatives that have tried to target hard to reach men are the use of alternative settings. These settings have included workplace, sporting stadia, community facilities, places of worship and educational establishments. Qualitative interviewing of men (Carroll *et al.*, 2014; Robertson, Zwolinsky, Pringle *et al.*, 2013; White *et al.*, 2008; Pringle *et al.*, 2013) who have used these settings have tended to identify the following factors:

- Convenience
- Ease of access
- Creating a 'Comfort Zone'
- Safe and supportive
- Involve a shared experience
- Involve their peers and include a degree of homogeneity and group safety
- Usually are organised at times when working men can attend

Street clinics can also be an effective way of reaching men who are not likely to want to attend health centres.

The use of sporting settings in conducting public health initiatives has been the focus of a book due to be published in December 2015 (Conrad & White, 2015).

14.8 Use of eHealth and mHealth

The use of smartphone apps and internet health initiatives are gaining in popularity, with a myriad of services and applications now available that are targeting men's health. The Man MOT, being run by the Men's Health Forum has been adopted (and tailored) by Haringey council⁹³ for their male population. 'Man Therapy'⁹⁴ is a successful Australian website for men's health, where two fictional characters (a doctor and a straight-talking tradesman) use humour and honest discussion to guide men through the interactive toolkit designed to provide men with strategies to improve wellbeing and mental health. The Irish Men's Health Forum have developed the 'Work Out' online app⁹⁵, designed to promote mental health and encourage help seeking in men. In Leeds there is a big push to have a robust mHealth⁹⁶ People Driven Digital Health and Wellbeing⁹⁷ agenda across the city (Newton *et al.*, 2015) and efforts should be made to ensure that local at-risk men are considered within the design and implementation of this strategy.

14.9 Continuity of the service

It is often the case that men are enrolled onto a short term programme and they do not want to leave once it has completed. For the Fit Fans weight loss group in Hull this necessitated introducing a follow-on activity-based intervention for the men to continue to meet (nsmc, 2010). The Premier League

⁹³ <https://www.menshealthforum.org.uk/haringey>

⁹⁴ www.mantherapy.org.au

⁹⁵ <http://www.workoutapp.ie/>

⁹⁶ <http://mhealthhabitat.co.uk/>

⁹⁷ http://mhealthhabitat.co.uk/wp-content/uploads/2015/06/M-Habit-P_AW.pdf

Health initiative evaluation found that many of the groups that were formed on a short-term basis were ineffectual until they were made open-ended; this allowed lads who lead more chaotic lives to join in and still feel welcome (White *et al.*, 2012). Considering the longer term needs of the men at the start of the initiative will help ensure a smoother transition and also better recruitment.

Word of mouth support has been identified in a number of studies as the main way of getting men engaged due to anxieties over what other people may think of participation (White *et al.*, 2008; Pringle & Hickey 2010; Kierans *et al.*, 2007). This can result in men's services taking a long time to get established. To help with this process, it is important to mainstream services as soon as possible to promote stability and longevity in a service.

14.10 Use of humour

Joking, ribald comments, and laughter are a common feature of most men's health initiatives (Williams 2009; Morgan *et al.*, 2011). It is an area that is getting more attention but is still under-researched. In interviews and through participant observation studies, having fun and being able to laugh about their situation emerges as a way of bringing men into initiatives and allows them the enjoyment to stay and become part of the group (Robertson, Zwolinsky, Pringle *et al.*, 2013; Oliffe *et al.*, 2009). It is also a way for men to manage the process of forming new relationships with other men; for some men there is a need to be competitive and to find a place for themselves within the new environment, and humour is a way of displaying who they are and that they want to become a member. There is also a therapeutic angle to humour, with men in difficult situations using humour as a way of displacing their anxieties (Branney *et al.*, 2014; Smith *et al.*, 2008; Oliffe *et al.*, 2009).

Interventions that are male-only tend to have more joking than in mixed-sex groups, and interviews with leaders of groups have found that they need to be able to manage the humour and to see past the behaviour of the lads to enable successful engagement. Men can use joking as a way of testing out those running the sessions to see if they can be trusted and a way of managing power differentials. It is also important to note that humour can be both positive and negative, with a dark side that can be homophobic, sexist and unpleasant (McCann *et al.*, 2010; Kehily & Nayak 1997; Williams 2009). Oliffe *et al.*, (2009) notes that humour has to be monitored as it can be damaging to some group members and a way of excluding some from the initiative.

14.11 Gender of the facilitator

The gender of the facilitator when working with men has been explored as a factor, with the consensus of opinion being that gender is rarely an issue as long as the individual is engaged and can create a safe and supportive space for the men, though this is not fully researched. Although Ashton *et al.*, (2014) found most interventions aimed at young men's sexual health were delivered by men, there are many examples of where women have initiated and successfully delivered what could be classed as very sensitive interventions, such as work with perpetrators (Dominey, 2005) and community outreach (Davis, 2007; Deville-Almond, 2009).

14.12 Getting the new initiatives evaluated

So many good ideas are lost by the lack of evidence base of their acceptability and effectiveness. To address this waste it is important that robust audit and evaluation are factored into the planning process and funding set aside to ensure studies generate valid and reliable results.

14.13 Developing training programmes for staff

Few practitioners (including teachers, medical students, nursing students, social workers etc.) have had any consideration of male socialisation or discussions as to how to work effectively with men as part of their pre-registration education. Many service workers are similarly not aware of how best to engage with male participants, an example could include Housing Associations enhancing the training of their staff to recognise men at risk. Training programmes can assist in raising awareness of men's needs and how to manage initiatives to good effect (Giorgianni *et al.*, 2013).

15 Recommendations for the Council and partners

In order for this report to impact upon service delivery and ultimately the health of men in Leeds, direction is needed at the top management level to influence policy and the remit and operation of each service.

15.1 Creating policy and strategy

- The Health and Wellbeing strategy for Leeds should consider how services should be developed to better meet the needs of men
- Investment in those MSOAs with the biggest clustering of men's health issues, to improve the social determinants of health, should be considered a high priority
- Move to talking about 'men' and 'women' and not 'the population'; 'boys' and 'girls', not 'children'; and 'mothers' and 'fathers' and not 'parents' to ensure the male perspective is not lost
- All health and social care policy should make specific reference to gender
- Develop a men's health campaign for Leeds to raise the overall awareness of the population of Leeds of the issues men face with regard to their health

15.2 Collection and analysis of data

- Data should be collected and published on the ethnicity, age and gender of those who are using services
- Those on benefits with mental health problems need to have the nature of the problem recorded so appropriate support can be provided
- A register should be kept of all ex-servicemen to ensure they are offered the right specialist support if required
- Deeper analysis should be considered of the available data to explore how services are reaching out and targeting men and outcomes

15.3 Commissioning of services

- Community groups that have had success in reaching out and targeting men should be supported, with those who are struggling to recruit given options to learn from their experiences
- Services commissioned by the council should be given specific guidelines on how to target men
- The council should allocate enough time for new services for men to be established, with early mainstreaming to ensure funding is secure
- Partnership working with religious leaders to promote men's health and to establish men's health initiatives within religious settings
- Greater partnership working with key men's health organisations within the city, including the Leeds Men's Health & Wellbeing Network and the Black Health Initiative

15.4 Next steps

The current study has been limited to a desk-based analysis of data and policy and interviews with commissioners. What is needed now is to hear from men themselves and also the providers, both

statutory and the 3rd/Voluntary sector. There is also benefit in having a deeper analysis of some of the data to resolve some unanswered questions regarding men's use of primary care services.

- Men's voices: A qualitative study should be undertaken to explore the experiences of specific groups of men within the city.
- Providers' voices: The identification of what services actually are available for men and how men use them is an important next step of the work in Leeds. Creating a map of activity and uptake by men will help to determine gaps in provision.
- Data mining: More detailed analysis of primary care data to explore access of men to GP services should be undertaken to resolve the confusion over whether men do delay in accessing services.

16 Conclusion

Leeds has great aspirations, as befitting the third largest city in the UK. It is putting in place the building blocks to become the healthiest city in the UK and has rightly recognised that an important part of this endeavour is tackling the health of its male population, a challenge few other cities have contemplated.

The completion of the study has not been straightforward, with problems in both access to data and the quality of the data that were available. The rush to transfer public health into the council has meant the legal framework allowed for the transfer of NHS data was not in place. As a result, key information needed to allow for data-driven decisions was not available for the Public Health team.

The data we were able to collect showed that men in Leeds reflect trends elsewhere, with higher levels of premature death than women across a wide range of health conditions and marked variation between those inner city areas with high poverty and the wealthier suburbs. Boys and men had poorer educational attainment, were more likely to be unemployed and on the majority of benefits. They had higher levels of smoking, alcohol and were more likely to be overweight, but they were least likely to have their data collected at the GP with many services failing to reach out and target men effectively.

It is important to note that the areas where men's health is poorest are in the very areas that can least afford to manage this additional burden - any improvement will have a positive effect.

Building on community assets and mobilising the men and women in an area can help to re-build a stronger, healthier population. Investing in those organisations that are already showing that they can work effectively with men provides opportunities for them to share their knowledge and expertise with others who are struggling to reach men. Educational support and training is needed for all who have to support men in their line of work or to make decisions that will affect the male population.

It is also important that any initiative also engages with religious leaders, the police, and social services, including housing to get the right support for vulnerable men. Initiatives should also get key organisations involved such as The Leeds Rhinos, Leeds United, Leeds Carnegie and other major sporting clubs, which may draw men in and encourage them to adapt more healthy ways of living.

For initiatives to be effective with men, it is important that they are developed to the man's perspective. As such they need to be planned with local men's involvement and, importantly, then given time and resources to succeed.

All the work that has previously been conducted with men shows that men do care about their health. Once men engage with health services they are more likely to quit smoking, lose weight, stop drinking, get fitter, and get screened than women - the challenge is to get men to the right services. This requires more effective campaigning and ensuring it is easier for working men and men leading chaotic lives to engage with the support they need.

A higher level of activity is needed, however, any initiative aimed at men will fail unless the root causes of their difficulties are recognised and acted upon. These men have not chosen to be feckless, they have not as a collective decided to have poor educational attainment and poor health. Men's health is worst in areas of high poverty, and it is imperative that services related to education, housing, employment, and other social determinants consider how they are responding to men's needs.

Engaging earlier and more proactively with fathers, working with local industry to improve the health of their male workforce and having teachers reflect on how they work with boys can all benefit male health in the long run.

Good quality educational provision is needed to ensure boys leaving school have the qualifications needed to enable them to seek work and also the social skills required to handle life's difficulties; this is an essential part of addressing the needs of future generations of men. Ensuring boys have a better level of health literacy and an understanding that emotional problems can be handled without loss of face or resorting to alcohol, self-harm, suicide or violence is also imperative to many problematic health behaviours in men.

Recognition of men's needs within policy and within planning decisions across all council services, including health, social care, housing, benefits etc., is required. This requires a new look at the Equality Act and to consider a gender audit of more services. Having Men's Health as an objective within the Leeds' JSNA and a dedicated report on Men's Health by the Director of Public Health would be a good start to this process.

It is also important to recognise that many of the issues facing men are relational, in so much that they are directly affected by, and affect, their male and female partners, family and friends. We are looking at a significant degree of social re-engineering to address men's health effectively, with a societal change needed to allow boys and men to grow up in a different world that gives them the opportunity to live healthier lives. Only a city the size of Leeds has the capacity to engage in the debate on how this could be achieved.

A simple fact that is worth remembering is that improving the physical and emotional wellbeing of men and boys will have benefits that spread out across the city and will make it happier, healthier and wealthier.

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