**Women and Equalities Committee: Mental health of men and boys**

**Written evidence submitted by Business Disability Forum, February 2019**

**1. About Business Disability Forum and our submission**

1.1 Business Disability Forum is a not-for-profit membership organisation which exists to transform the life chances of disabled people. We do this by bringing business leaders, disabled people, and Government together to understand what needs to change to improve the life opportunities and experiences of disabled people in employment, economic growth, and society more widely.

1.2 We conducted interviews and a TwitterChat with men from employee mental health networks and individuals with a mental health condition to ask men about their perceptions of and experiences of mental ill health. We have used insight from these research activities to inform this submission. The perspectives given in this submission are therefore from this cohort only.[[1]](#footnote-1) The insights in sections 3-6 below are therefore **not a *comparison* between women and men’s experiences**; they are the voices of men only.

1.3 Although we have kept within the remit of the Committee’s requirements in this submission, Business Disability Forum recognises that gender identity is not always as dichotomized into a distinguishable category of “men and boys”, and this was reinforced by experience of some of our research respondents who rarely thought of their mental health as a ‘one gendered’ experience. As an example, people who are considering or undergoing gender reassignment, or who identify as non-binary or intersex are a near-silent group (or, at least, their experiences are given much less visibility) in current business mental health debates and policy making.

1.4 We see much evidence that people who are managing a disability or long-term condition also have a ‘secondary’ mental health condition or are experiencing mental ill-health, most commonly generalised anxiety and/or depression. Some of our research participants said the most ‘urgent’ intersection with mental health is for them not their gender, but their disability. As this issue reaches beyond the scope of the Women and Equalities Committee inquiry’s Terms of Reference at this time, we have not expanded on this within this submission.

**2. Understanding the terminology of “mental health and wellbeing”**

Findings from our research on young people’s experiences of mental health and wellbeing[[2]](#footnote-2) showed a huge gender disparity when research participants were asked what the phrase “mental health and wellbeing” means: 62 per cent of young women between 16-24 years old strongly felt they understood what the phrase encompassed in comparison to 49 per cent of men. We also found a huge gender divide between the percentage of young women who strongly felt “we should all be talking more about mental health and wellbeing”: 73 per cent of young women compared to just 48 per cent of young men. These findings indicate the level knowledge about mental health as a topic is not as high for young men as young women. It also shows that young men do not feel they should be talking more about their mental health.

**3. Stigma and gender stereotyping in society**

3.1 In our research for this inquiry, male respondents all separately referred to common phrases that they said are still active in society and which continue to reinforce the idea that men need to remain ‘strong’. Some of the phrases cited by respondents include: “man up”, “grow a pair”, or being “manly”. One respondent said there is “*constant ridicule of men in public life who may cry or show emotions”.* Another respondent told us: *“It has been almost impossible in the past for people, especially men, to admit that they are suffering from any type of mental illness. While this has improved over the past few years, there is still an enormous stigma attached to men being mentally unwell, with this being viewed as weakness and the sufferer being viewed as ‘less of a man’. There is greater stigma attached to a man being mentally unwell than a female, with men until this point being expected to be strong and able to cope with everything”.* There was general agreement that men continue to be, in another respondent’s words, *“almost universally portrayed as strong, in control, and physically perfect”.*

3.2 The impact of ‘traditional’ gender stereotyping on the mental health of men should not be under-stated. Each respondent, interviewed separately, referred to the notion of a man or father in a heterosexual relationship as ‘breadwinner’. One respondent commented that this often means they can be “*stuck in situations where they are unhappy*” (such as a job) which can also cause a “*constant fear of not being able to provide*”. Although there was recognition that such gender-divisive ideas were more ‘traditional’ than *current*, it was widely felt by respondents that men today continue to experience the ‘hangover effect’ of gender roles that were so prevalent and entrenched in how (western) society used to function. Some respondents told us they became mentally unwell following redundancy or loss of a job, and another directly linked the experience of becoming employed again with increased self-worth and improved mental health.

3.3 Respondents also told us that there needed to be more knowledge at various levels in communities, by employers, and by health services of the diversity of *how* and the context in which men can become mentally unwell. A few respondents referred to the lack of recognition that fathers too can experience post-natal depression, but that this is still widely seen as a ‘woman only’ issue by health professionals. Similar was also said of eating disorders; that diagnosis of an eating disorder was somehow less ‘thought of’ or, in one respondent’s words, “slow to be recognised” when the patient is a man.

3.4 The recently coined construct and terminology of “toxic masculinity”, generally referring to when men do not fit into the previously-traditional stereotypical role of, in one respondent’s words, “alpha male” was felt by respondents to have had an adverse effect on men: *“There is a large amount of negative stereotyping of men currently in society. This is having a detrimental effect on many men whose behaviour is not reflective of this stereotyping. In addition, there are phrases being used, such as ‘toxic masculinity’ which leave men with a negative view of who they are, without an ability to express”.*

**4. The impact of changing gender-specific roles in society**

As society has developed its narrative on previously defined gender stereotypical roles, respondents told us men generally feel a sense of ‘identity loss’. Although respondents agreed the increased attention given to advancing women’s opportunities in society and employment is very much needed, it was felt that equalities issues had not ‘kept up’ with how changes in society have affected and equalised (or not) the experience of men’s progression and self-worth. Respondents felt that, at the same time as their female partners and new mothers are going out to work and having conditions such as eating disorders and postnatal depression diagnosed, the ‘traditional’ idea of men as “provider and protector” has not yet entirely left the consciousness of our society. One respondent commented: *“This has led to many men being unsure of their position as the changes take place and there is much uncertainty, with divided opinion on what role men should play. This can lead to a sense of loss of identity, which can in turn have a negative effect on mental health.”*

**5. Gender roles and stigma in the workplace**

5.1 Respondents felt gender stereotyping in society (particularly that of ‘breadwinner’) continues to be transferred into the workplace. One respondent commented that they felt, *“men have a societal expectation to be a ‘breadwinner’ and as such they should dedicate their lives to their career. The progress for work-life balance seems to have been mostly directed towards women, with men taken as an after-thought. This then becomes a ‘stay late’ culture where if you are seen to be leaving early, you are seen as a less willing employee.”* Some said that this leads to workplace “ridicule and bullying”of men who actively seek to find a healthy work-life balance or who talk about managing their mental health and wellbeing. One respondent even referred to being “hounded out” of the workplace and being seen as “weak and unworthy” by his colleagues.

5.2 The ‘always on’ culture of modern workplaces is also seen as a ‘constant pressure’ which men felt was applied more to them than their female co-workers (even though it was recognised that this affects everyone): *“Employees are always on demand, not having an opportunity to switch off. Part of this is down to emails and calls at any time outside of work hours, with the expectation that these will be answered and responded to”.[[3]](#footnote-3)*

5.3 We encourage employers to ensure employee support services such as Employee Assistance Programmes (EAP), which often include counselling and debt advice services, are regularly well communicated across their workforces. However, we hear from employees in some sectors that accessing such services can often be quite ‘visible’ in the workplace; for example, blocking out an hour’s call to speak to a counsellor, or requesting time away from duties to access support. Our Advice Service also receives calls from managers saying they have suggested to an employee that they use Access to Work’s Mental Health Support Service, but the employee refuses because the support is delivered in the workplace environment and employees did not want colleagues and managers to ‘see’ that they are seeking support for mental health.

**6. Suggestions for moving forward**

6.1 *Develop more local mental health screening opportunities*. Many respondents told us that NHS mental health support needs to “meet us we are”, irrespective of gender identity. Many public places, such as supermarket or hospital car parks, have screening for health conditions (such as for cancer and diabetes); there was a discussion during our TwitterChat over whether there could be such a screening programme for mental health related conditions and situations. From the employers we work with, we often hear about very lengthy waiting times for mental health related NHS appointments and which are offered in locations not close to work or home causing increased absences, with employees often having to take a whole day off to travel to the appointments, or being signed of sick for a number of months while they are on a NHS waiting list to access talking therapies or more specialist psychotherapeutic treatments.

6.2 *Implement a targeted public and public services education programme.* Given our findings which show a significant percentage of men were unclear on what “mental health and wellbeing” means (see section 2, above), consideration should be given to if a public education programme ‘by men and for men’ should be rolled out. It was felt by respondents that such programmes do not always target men in the right places; one respondent commented, “*Reaching men where they are comfortable and engaged is vital*”. Men’s fitness spaces and men’s groups were examples given by respondents of targeting men in “men’s spaces” rather than having information stands or posters in more public places where men are unlikely to stop and digest information if they are with, for example, their families (because, as above in section 3.1 and 3.2, they feel they need to maintain a perception of “strength” to those close to them). It was felt by respondents that these such programmes should be mobilised by local authorities. This would also allow local authorities to use their stakeholder groups and knowledge of community networks to disseminate and communicate such programmes, particularly where local cultural nuances may necessarily mean alterations to some messaging or language might mean a more effective uptake of engagement within a specific community (for example, an area in a higher prevalence of multi-cultural or diverse religious groups).

6.3 *Employers need to do more to address and prevent work-related stress more specifically*. “Work-related stress” often gets absorbed into business narratives about “mental health and wellbeing”. We see a huge difference in experiences between employees managing a diagnosed or ‘clinical’ mental health condition compared with employees are who are experiencing work-related stress. How teams work, good communication, workload and skills gap analyses, and creating an environment where people are not bullied, harassed or discriminated against are all key to preventing and reducing work-related stress; yet these interventions are unlikely to eliminate a significant amount of difficulties experienced by employee who is, for example, managing a mental health condition with medication or therapeutic treatment, for example. Mental health conditions and work-related stress need to be addressed differently by employers. Someone who needs support may not necessarily use the terms “mental health” or “stress”. Workplace cultures need to be developed whereby people managers as well as peers can ‘spot the signs’ of someone struggling and have an appropriate line of reporting this which ‘kick-starts’ a supportive process for the person who needs it.

6.4 *Talking about mental health as a ‘topic’ itself is not enough*. Many public campaigns and initiatives about mental health are focussed on ‘talking more’ or seeking support. There, however, remains a huge stigma or *shame*, about being prescribed and taking medication for managing mental health. We see workplace conversations about disability and health improving, but the topic of ‘taking medication’ is still relatively silent. Our Advice Service receive calls from employers where callers reveal many misconceptions about employees who take medication such as anti-depressants, anti-psychotics, and mood stabilisers. The concerns we are told about are particularly related to whether such medications compromises: the health and safety of other colleagues; whether the employee will no longer be able to do their job while on medication; or if the employee’s behaviour will change if the medicine ‘wears off’ during working hours. Narratives and communications about mental health should therefore include education to banish the stigma of taking mental health related medicines.

**7. Contact for further information**

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1. We did not collect data about diversity, and we therefore cannot report nuances within the experiences respondents by, for example, age, race, sexual orientation, or socio-economic background – all of which may impact of the experiences spoken about during data collection. [↑](#footnote-ref-1)
2. Business Disability Forum, October 2018. Further information [here](https://businessdisabilityforum.org.uk/media-centre/news/press-release-generation-z-let-down-by-employers-and-universities-over-mental-health-support-new-study-shows/). [↑](#footnote-ref-2)
3. As per section 1.3, Business Disability Forum is not saying taking the view that an ‘always on’ culture does apply to men more than women. We are reporting the experiences and opinions given to us by men during our research. [↑](#footnote-ref-3)