Promoting mental health in men

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Abstract

Health promotion is essential to improve the health status and quality of life of individuals. Promoting mental health at an individual, community and policy level is central to reducing the incidence of mental health problems, including self-harm and suicide. Men may be particularly vulnerable to mental health problems, in part because they are less likely to seek help from healthcare professionals. Although this article discusses mental health promotion and related strategies in general, the focus is on men's mental health.

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MEN'S HEALTH

Aims and intended learning outcomes

This article aims to assist readers in their understanding of mental health promotion in general, and specifically in relation to men's mental health, and the risk of suicide. After reading this article and completing the time out activities you should be able to:

- Examine the effects of mental health problems on mortality.
- Discuss mental health promotion in general and specifically for men.
- Explore the incidence of suicide between nations and within society, and discuss risk factors and preventive approaches.
- Explain universal, selective and indicated approaches to promoting health and preventing illness.
- Consider the value of the above approaches in meeting the mental health needs of individuals and communities.

Introduction

According to the World Health Organization (WHO) (2009), 'health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health. It is a core function of public health and contributes to the work of tackling communicable and non-communicable diseases and other threats to health.'

Health is a positive concept incorporating social, personal and physical factors. Good health may be seen as contributing to achievement in physical, mental and social domains. Factors that may influence health include inequalities, dietary patterns, urbanisation and its effects on the environment and social organisation. As well as these structural, environmental and economic factors, individual lifestyle and personal health behaviours are essential in developing and maintaining health. Health promotion aims to address these factors by:

- Tackling determinants of poor health, such as housing, income, education, employment and access to health care.
- Developing supportive environments for health so that healthy choices can be accessed readily and easily.

- Providing information about healthy lifestyles, and support for individuals and communities, to increase control over health behaviours and lifestyle.
- Preventing the development of ill-health through early intervention, including screening and risk assessment.

Health promotion at the individual level seeks to develop protective factors such as feeling valued and supported, together with a sense of hopefulness about the future. Awareness of risk factors for mental health problems, such as neglect or abuse in early life, bereavement and loss, carer burdens and family history of mental disorders, may provide opportunities for specific preventive and supportive interventions (Taylor *et al* 2007).

Health is often considered in terms of physical, mental and social dimensions. However, mental health and physical health are intrinsically linked. A person's ability to maintain good physical health is to a large extent determined by their mental health and, vice versa, poor physical health may contribute to increased risk of mental health problems. Medical illnesses, particularly long-term conditions such as diabetes, coronary heart disease, renal disease, asthma and arthritis, have been associated with increased prevalence of mental health problems, including depression and anxiety disorders (Haddad 2009). Evidence from the WHO World Health Survey, involving nearly 250,000 participants from 60 countries in all world regions, indicated that having one or more long-term physical conditions was associated with a more than threefold increase in the prevalence of depression (Moussavi *et al* 2007). Furthermore, research indicates that depression combined with medical problems increases disability to a greater extent than either depression or medical conditions alone (Egede 2007, Moussavi *et al* 2007).

Complete time out activity 1

Disability

Mental health problems, in particular depression and anxiety disorders, are the greatest cause of disability in developed societies: depression alone is ranked the third leading cause of global disease burden, and is ranked first place in middle and high income countries such as Australia, United States (US), Japan, UK and EU countries (WHO 2008). Mental illness accounts for approximately one third of all life years lost as a result of disability (WHO 2008).

The disabling effects of depression and other mental illnesses relate to their high prevalence, typically long duration and tendency to reoccur, as well as their association and negative interaction with other health problems (Prince *et al* 2007).

The effect of mental health problems also relates to when they first began. Although mental health problems may occur at any age, onset is typically in childhood or adolescence, although treatment often does not begin until many years later (Wang *et al* 2007). Evidence from large-scale international population studies indicates that the median age of onset is earliest for phobias, attention deficit hyperactivity disorder (ADHD) and conduct disorder, which usually arise in childhood or the early teenage years. Anxiety disorders other than phobias – which include generalised anxiety disorder and panic disorder, depression, alcohol and substance misuse disorders, and schizophrenia – begin most commonly between the late teens and early adulthood (Kessler *et al* 2007). Because of the typically early age of onset of mental health problems, there is increased likelihood for disruption of educational performance, personal relationships and social participation, with consequent effects on employment and income.

Complete time out activity 2

Gender

Mental health problems are widespread, however there are differences in the distribution of certain conditions among men and women, and their effects. The effects of health problems may be compounded by different approaches to seeking help between men and women, with men seeking help less frequently than women (Galdas *et al* 2005), particularly for psychological problems (Smith *et al* 2006). Women are nearly twice as likely to develop depression and some anxiety disorders than men, and around three times more likely to develop an eating disorder (WHO 2012a). The misuse of alcohol and drugs is three to four times more common in men, as is antisocial personality disorder (WHO 2012a).

The most common mental disorder in childhood is conduct disorder, characterised by persistent defiant and antisocial behaviour. The disorder is twice as common in boys as girls, affecting 8% of boys and 4% of girls in Great Britain (Green *et al* 2005). Hyperkinetic disorder and ADHD are more common in

1 Are mental health problems an important cause of disability? Consider the effect of mental health problems and other conditions on individuals.

2 Consider the distribution of mental health problems among men and women. Which, if any, conditions are more common in men, and which are more common in women? Are there any explanations for different rates of mental illness among men and women?

boys and men: in Great Britain, eight times as many boys as girls have hyperkinetic disorder (Green *et al* 2005). Findings from the most recent national adult household study of mental disorders in England for key conditions exhibiting marked gender differences in prevalence are shown in Table 1 (McManus *et al* 2009).

There are particular groups in society at increased risk of mental ill health, such as 'looked-after children' (children looked after by the state or in the care system), refugees, homeless rough sleepers and those in prison. Some of these groups, such as offenders in prison and homeless people, are mainly comprised of men. The US federal inmate population is 93.5% male (US Department of Justice 2012) and in England and Wales, males make up 95.2% of this population (Berman 2012). Nine out of ten rough sleepers in the UK are estimated to be male (Crisis 2012). These groups are particularly vulnerable to mental health problems, most commonly alcohol and substance misuse, and personality disorders. They are also vulnerable to mortality from accidents, violence and suicide.

Responses to stressors and help-seeking behaviour

It appears that in response to stressors, there may be a tendency for women to internalise emotions, possibly leading to withdrawal, anxiety and depression, while men may be more likely to externalise emotions, leading to aggressive, impulsive or antisocial behaviour (Eaton *et al* 2012). Gender differences in the prevalence of these conditions appear to relate to a complex array of influences rather than simple biological factors, and these differences interact with social markers such as education, income, housing tenure, employment, marital status and ethnicity (WHO 2012a). For example, although lower socio-economic status is associated with increased prevalence of common mental disorders, its influence may be more pronounced among men: those with the lowest household income in England were found to be three times more likely to have depression or an anxiety condition as those in the highest income households (23.5% and 8.8% respectively), while for women, household income appeared to have less of an influence on mental health (McManus *et al* 2009).

Job insecurity and high levels of job strain have been identified as risk factors for depression (Wang *et al* 2012). Links have also been made between the economic recession and its effects on work and traditional roles, particularly in terms of increased likelihood of depression among men (Dunlop and Mletzko 2011). Analysis of suicide rates in England reveals that regions with the greatest rise in unemployment related to the economic recession have had the greatest rise in suicide rates, particularly among men (Barr *et al* 2012).

The differences in risk of mental health problems in men and women may reinforce stereotypes and social stigma. Women are more susceptible to depression and anxiety than men, and are also more likely to acknowledge and seek help for these problems (Smith *et al* 2006). In general, men use all parts of the healthcare system to a lesser extent than women (Smith *et al* 2006), and delay seeking help when they become ill (Galdas *et al* 2005). When men do seek help, they appear to spend less time in consultations than women, and are more likely to focus on physical than emotional problems (Smith *et al* 2006). Men's disinclination to report psychosocial problems and distress is particularly apparent among younger individuals (Mackenzie *et al* 2006), and appears to be a product of the social construction of masculinity, involving characteristics such as self-reliance, stoicism and suppression of emotion (Möller-Leimkühler 2002, Smith *et al* 2006).

Gender and other patient characteristics, in addition to affecting help-seeking behaviour, may influence healthcare professionals' responses. GPs' detection of mental health problems, including depression, may be affected by patients' gender, with some studies identifying that detection is less likely in men (Borowsky *et al* 2000). However, a range of other factors, such as comorbid medical illness,

TABLE 1

Findings from the 2007 adult psychiatric morbidity household survey in England for the incidence of mental disorders in men and women

Mental disorders	Men (%)	Women (%)
Mixed anxiety and depressive disorder	6.9	11.0
Generalised anxiety disorder	3.4	5.3
Depressive episode	1.9	2.8
All phobias	0.8	2.0
Eating disorder (screen positive and significant impact)	0.6	2.5
Alcohol dependence (all severities)	9.3	3.6
Drug dependence (any illicit drug)	4.5	2.3
Antisocial personality disorder	0.6	0.1

(McManus *et al* 2009)

age and ethnicity, play a part in the recognition of mental disorders (Maginn *et al* 2004).

Cost of mental health problems

The cost of mental health problems should be viewed in relation to the individual, society and the economy. Mental health problems often arise and cause disability at a time when the person affected would be at his or her most productive. For example, the teenage years are associated increasingly with incidence of mental health problems, with half of all lifetime cases of mental illness commencing by the age of 14 (Kessler *et al* 2005), exacerbated by increased incidence of relapse and persistence.

In England in 2007, the direct costs of mental illness, incorporating NHS, social care and other agency costs, were £22.5 billion. Indirect costs of lost employment were estimated to be an additional £26.1 billion (McCrone *et al* 2008). Including the wider costs to the economy in England, such as that related to informal care, has resulted in cost estimates of £77 billion per year (Sainsbury Centre for Mental Health 2003). Evidence about the extent of social and economic costs of mental health problems has contributed to increased recognition of the need to promote positive mental health and wellbeing, and invest in approaches to prevent the onset of such problems (National Mental Health Development Unit 2010a, 2010b).
Complete time out activity 3

Mental health and mortality

Evidence of increased mortality associated with mental illness has been derived from linked database studies, reviews of autopsy records and population-based cohort studies. Although suicide is an important cause of death linked to mental illness, increased mortality among people with mental illness mainly results from 'natural' causes, such as cardiovascular disease, cancers and respiratory disease (De Hert *et al* 2009). Increased mortality is particularly associated with people who have substance misuse disorders and severe mental illness (psychosis) (Chang *et al* 2010). Studies of the life expectancy of people with mental health disorders have estimated 17 life years lost for substance misuse and 10-15 years for schizophrenia, compared with the general population (Chang *et al* 2011).

An increased risk of death from all causes is not restricted to the most severe mental illnesses, but is also associated with conditions such as depression and anxiety disorders (Osborn 2001). Depression is associated with a near doubling of all-cause mortality rates (Saz and Dewey 2001, Cuijpers and Smit 2002). This is important because the high prevalence of these common mental health problems means that there is a significant overall effect on mortality.

Effects of psychological distress

Several prospective studies (Stansfeld *et al* 2002, Robinson *et al* 2004), and a pooled analysis of population survey findings linked to death certification (Russ *et al* 2012), provided evidence that reduced life expectancy is not limited to specific diagnosed mental illnesses. It appears that there is a significant relationship between psychological distress and premature mortality. Findings based on nearly 70,000 adults from ten household population-based studies in England, showed that after controlling for confounding factors, all-cause mortality was increased by between 20% and 70% according to the level of psychological distress experienced (Russ *et al* 2012). Effects were examined in relation to death from three major causes: cancer, cardiovascular disease and external causes such as unintentional accidents, assault, homicide and intentional self-harm. An increase in all categories was associated with all levels of emotional distress, although effects on mortality were pronounced for higher levels of distress, and greatest for cardiovascular disease (an increase of between 25% and 70%) and external causes (up to threefold increase among those with high distress levels) (Russ *et al* 2012).
Complete time out activity 4

Risk of suicide

Suicide is the tenth leading cause of death in the world, accounting for nearly one million deaths each year (WHO 2002). In the past 45 years, suicide rates have increased by up to 60% worldwide, and account for 1.5% of all deaths worldwide (Hawton and van Heeringen 2009). The reasons for suicide are complex and best understood in the context of each person's life circumstances. However, there appear to be variations in risk of suicide associated with age, sex, culture, employment and ethnicity, as well as mental and physical health status.

There are variations in the suicide rates for different parts of the world, with the highest rates in the Russian Federation, Baltic States, Sri Lanka and Japan, and the lowest rates in Latin America (Haddad and Gunn 2011).

3 Does mental illness shorten life? To what extent, and for which mental disorders, is this effect most apparent? Do you think psychological distress has an effect on mortality? Discuss your thoughts with a colleague.

4 Does the rate of suicide vary between countries and are there any particular nations where the rate is especially high? Do you think there is a difference between the risk of suicide among men and women? If so, please explain.

Although suicide rates are highest in older people in most countries, it is one of the three leading causes of death among those aged 15-44 (WHO 2012b). Suicide rates have risen in young people, especially men. In 21 of the 30 countries in the WHO European region, suicide rates in young men aged 15-19 increased between 1979 and 1996, and similar changes in suicide rates were evident in Australia and the US (Wasserman *et al* 2005). However, suicide rates in young men have generally decreased in the UK over the past decade (Samaritans 2012), although this trend has altered since 2008, with an increase in suicide among men and women that appears to be linked to the economic recession and in particular, rising unemployment (Barr *et al* 2012).

Gender and suicide

In most regions of the world, suicide rates are significantly higher in men than women. In the UK there is a threefold difference between men and women, and this ratio is similar in many industrialised Western nations (Hawton and van Heeringen 2009). However, this gender difference is markedly reduced in Asian countries such as India, while in rural China, the rate of suicide among women, particularly those aged 20-34, is higher than that for men. In several other countries, including Sri Lanka, El Salvador, Cuba and Ecuador, suicide rates among young women exceed those of young men (Wasserman *et al* 2005).

Suicide and mental illness

Ideas of suicide, acts of self-harm and completed suicide are associated with mental health problems, with approximately 90% of people who complete suicide having a diagnosable mental disorder, although only half of these individuals will have had a history of involvement with mental health services (Luoma *et al* 2002). Several health problems are associated with increased risk of suicide, and depression appears to be the most important mental disorder for suicidal ideation and behaviour among all age groups (Mann *et al* 2005). Other mental disorders that may be associated with suicide include bipolar affective disorder, schizophrenia, and alcohol dependence and addiction to other substances (Hawton and van Heeringen 2009).

Suicide and social and economic factors

There is an increased risk of suicide and deliberate self-harm in men and women who are unemployed (Kposowa 2001), although findings suggest that risks may be increased for unemployed men (Ying and Chang 2009). Risks of self-harm and suicide are increased among particular groups who are marginalised within society. As previously noted, offenders in prison and homeless people are particularly vulnerable, with male prisoners five times more likely to die by suicide than men in the general population (Rivlin *et al* 2010), and a sevenfold increased risk of suicide in homeless men (Nielsen *et al* 2011).

Certain occupations are associated with increased risk of suicide. Men and women working as healthcare professionals have significantly higher mortality rates associated with suicide than the general population (Hawton and van Heeringen 2009). Nurses of both genders also have increased suicide mortality rates compared to the general population (Hawton and van Heeringen 2009). There is also increased risk of suicide among men working in construction and agricultural occupations (Meltzer *et al* 2008). This is likely to be related to the access that these individuals may have to means of committing suicide, such as drugs, firearms and dangerous equipment.

Access to means of causing harm is an important factor in enabling acts of self-injury and completed suicide. Observational studies in the UK and other countries provide evidence that restricting access to potential means of harm reduces suicide rates. For example, changing domestic gas supplies in the UK from toxic town gas to North Sea gas, restricting access to firearms and pesticides, mandatory use of catalytic converters in motor vehicles, providing barriers at jumping sites, and changing analgesic packaging and quantities have all been associated with reductions in suicide rates (Sarchiapone *et al* 2011).

Previous suicide attempts

A history of previous self-harm or suicide attempts is one of the most significant predictors of subsequent suicide (Hawton and van Heeringen 2009). Risk appears highest for those acts that involve high suicidal intent (apparent wish to die), and where other risk factors – such as presence of a mental disorder, or alcohol or substance misuse – are evident (Hawton and van Heeringen 2009). Identifying whether there is a history of suicide attempts, associated intentions and nature of the self-harm act is an important part of assessing risk. In addition, identifying the extent and type of support necessary for people with suicidal ideation or following self-harm is important.

Suicide prevention

Knowledge of the association between risk factors and suicide is important to provide opportunities to identify individuals at increased risk. Suicidal ideation is a common feature of depression, and evaluating the risk of suicide is an essential aspect of assessment in all people who present with depression (National Institute for Health and Clinical Excellence (NICE) 2009). The skills to engage, assess and monitor risk involve exploring patient history, mental state, and interpersonal and social status, and the type and extent of stressors and supports. The potential exists for increased suicide risk in the early stages of the treatment of depression (NICE 2009), and this should inform the scheduling of reviews and the incorporation of risk assessment within follow-up consultations.

Complete time out activity 5

Knowledge of possible means of suicide for vulnerable individuals, such as access to medications that are toxic in overdose, is an essential part of risk assessment and management. Approaches to suicide prevention that incorporate and combine different levels of action may be more likely to reduce suicide rates, with elements including improving public awareness, restricting access to potential means of suicide, and training for healthcare professionals to recognise and refer those at risk, if necessary (van der Feltz-Cornelis *et al* 2011).

Complete time out activity 6

Mental health promotion

Health promotion is a broad-based approach concerning more than direct health issues and including areas such as housing, education, justice and community participation. Prevention is a key part of broader health promotion activity, in which initiatives are introduced to modify circumstances known to contribute to health problems. These initiatives are categorised as universal, selective and indicated prevention strategies. Universal mental health problem prevention consists of initiatives that target the public as a whole or particular groups within the population that have not been identified as having a high risk of mental ill health, for example employees, school pupils and university students. Selective prevention targets people or groups identified as being at increased risk of these disorders. Indicated prevention targets those who show some signs of a mental disorder, but with insufficient criteria to merit diagnosis (World Federation for Mental Health 2012).

Universal prevention

Because mental and behavioural problems are relatively common and begin early in life, there is an opportunity for prevention among young people. Universal prevention of mental health problems may incorporate mental health promotion for young people using a whole-school approach. Preventive interventions for reducing bullying, antisocial behaviour and substance misuse, assisting young people in coping with bereavement, loss and separation, and developing positive relationships and self-esteem are key aspects of the Personal, Social and Health Education and Citizenship Education curriculum in UK schools, and are central in promoting the emotional health and wellbeing of school-aged children (Health Development Agency 2004).

The Social and Emotional Aspects of Learning Programme (Department for Children, Schools and Families 2007) for primary and secondary schools, which provides a framework for promoting social and emotional literacy, was implemented in 2003 and is used in most primary schools in England, as well as three quarters of secondary schools. However, evaluations of its effectiveness have provided mixed findings (Department for Education 2010).

Other programmes designed to promote wellbeing among pupils have been subjected to more rigorous evaluations. Perhaps the most widely evaluated school initiative is the Penn Resiliency Project (University of Pennsylvania 2007), which has been the subject of more than 13 randomised trials. This programme involves a workshop-delivered intervention based on cognitive behavioural therapy principles to extend life skills and emotional awareness. A large-scale UK evaluation for year 7 children (aged 11-12) in 22 secondary schools identified significant, albeit generally short-term effects on pupils' depression and anxiety scores, with results suggesting the intervention was most effective for more disadvantaged pupils and those with worse reported psychological health (Challen *et al* 2011).

The suicide prevention strategy for England (Department of Health (DH) 2012) suggests that improving the mental health of the population as a whole is one way of reducing suicide rates. This involves broad policies incorporating elements such as promoting workplace mental health, ensuring accessible primary and specialist health and social care, advocating more sensitive and responsible media reporting of mental health problems and suicide, and actions to tackle

5 Think about people that you encounter in your clinical area who may be at risk of suicide. Do you assess these individuals for suicidal ideas and intentions routinely? Are there particular health and social problems, and aspects of lifestyle that are important in understanding and helping you to manage risk?

6 Outline examples of whole population and specific targeted health promotion approaches to reduce the incidence of mental health problems.

stigma associated with mental health problems. The restriction of access to potential means of harm is an important universal measure to prevent suicide.

Selective prevention

Several selective prevention approaches are available to enhance protective factors or provide specific support for individuals and groups at risk of health problems. It has been noted that children and young people in public care have an increased risk of emotional or behavioural problems than the general population: 45% of children aged five to 17 in public care in England have a diagnosable mental disorder (Meltzer *et al* 2008). A selective intervention for this vulnerable group might be the provision of independent living programmes designed to provide young people leaving the care setting with social skills to limit any disadvantage and assist successful transition into adulthood. A review of such programmes indicated that they may improve education, employment and housing-related outcomes (Donkoh *et al* 2006).

Selective approaches are used to prevent the onset of postpartum depression by identifying mothers who are at risk of developing the condition and providing individual support for postnatal women through intensive home visits by nurses and health visitors (Dennis and Creedy 2004). In addition, there is evidence that eating disorder prevention programmes delivered to at-risk females are effective in reducing risk factors involved in the development of eating disorders such as body dissatisfaction (Stice *et al* 2007).

Hazardous alcohol use and binge drinking are especially prevalent among young adults, and are associated with cigarette smoking and other substance use, road traffic accidents, violence, unwanted sexual experiences, depression and suicide (NICE 2011). Screening and brief targeted interventions in primary care settings and emergency departments have been found to reduce hazardous and harmful alcohol use. Around 10-15% of people respond to these interventions, with men appearing more likely than women to reduce alcohol use following advice about behaviour change (Kaner *et al* 2007).

To reduce the incidence of suicide in England, identification of particular at-risk groups likely to benefit from targeted interventions is recommended (DH 2012). At-risk groups include looked-after children; young and middle-aged men; asylum seekers; people from minority groups; survivors of abuse; people in the care of mental health services; those with untreated depression; individuals who misuse drugs or alcohol; people living with long-term physical illness; those in contact with the criminal justice system; and those whose occupation places them at increased risk. Selective approaches to reduce risk include national and local initiatives, training to assist risk recognition, such as mental health first aid (www.mhfaengland.org), suicide intervention skills training, support and advice services for specific groups such as lesbian, gay, bisexual and trans people, and health visitor-led services for vulnerable families.

Indicated prevention

There is some evidence that initiation of early treatment improves the degree of recovery. Indicated prevention approaches target individuals at high risk of a particular health problem and who have some features suggestive of that problem. For example, schizophrenia typically begins in young adulthood and its onset is usually preceded by a period of non-specific emotional and cognitive symptoms, known as prodromal symptoms. Early intervention approaches targeted at young people (typically between 14 and 29 years) with features suggestive of this prodromal phase – and termed high risk or ultra high risk – have been developed in Australia, the US, the UK and other European countries. These involve targeted monitoring and support from specialist teams and, where indicated, psychological and antipsychotic medication interventions. Systematic reviews of evaluations indicate possible benefits (in terms of preventing schizophrenia onset and improving clinical outcomes in people who develop psychosis), although findings to date are not conclusive (de Koning *et al* 2009, Marshall and Rathbone 2011).

For suicide prevention, indicated approaches focus on people with suicidal intentions and those with a history of self-harm. Interventions centre on monitoring risk factors, such as suicidal ideation and plans, appropriate psychological and social assessments, crisis management, and follow-up care programmes and close monitoring. Ensuring that associated conditions are appropriately treated is vital, particularly in the case of depression.

Mental health promotion for men

Many mental health promotion activities that are not specifically devised for men may still be particularly relevant to their wellbeing.

Typically, prevention involves a multifaceted approach, including increased awareness about suicidal behaviour and risk factors. Primary care is a key setting because many people seek medical care in the month before attempting suicide, which provides a crucial window of opportunity for intervention (Mann *et al* 2005). Depression is one of the most important risk factors for suicide, therefore it is important to improve recognition and management of depression in primary care by providing healthcare professionals with training in clinical detection, and appropriate assessment, intervention and referral of patients.

Skills training for healthcare staff who are likely to come into contact with people with mental health problems is designed to increase identification of those at risk of suicide. The Skills and Training On Risk Management (STORM) initiative, designed to develop skills required to assess and manage those at risk of suicide, has been implemented and evaluated among healthcare professionals in primary care, emergency departments, and mental health and prison services in England and Scotland. Evaluations indicate that STORM training can improve identification of patients at risk of suicide (Appleby *et al* 2000, Gask *et al* 2006).

A variety of training programmes are used in the UK and other countries, and several are endorsed by health boards and mental health charities. The Mental Health First Aid training programme developed in Australia, and used in 20 other countries, appears the most widely used and best evaluated (Morawska *et al* 2013). Training focuses on the help provided to the person at risk of developing a mental health problem or the person in a mental health crisis.

Initiatives focused on young men's mental health in Northern Ireland have sought to educate clinicians and young men through a programme of seminars and associated projects about mental health, and provide guidance in engaging and supporting emotional health and self-esteem. Several evaluations of pilot projects designed specifically for men's mental health and suicide risk have been conducted (Oliver and Storey 2006). These involved delivering

References

Appleby L, Morriss R, Gask L *et al* (2000) An educational intervention for front-line health professionals in the assessment and management of suicidal patients (The STORM Project). *Psychological Medicine*. 30, 4, 805-812.

Barr B, Taylor-Robinson D, Scott-Samuel A, McKee M, Stuckler D (2012) Suicides associated with the 2008-10 economic recession in England: time trend analysis. *British Medical Journal*. 345, e5142.

Berman G (2012) *Prison Population Statistics – Commons Library Standard Note*. www.parliament.uk/briefing-papers/sn04334 (Last accessed: February 20 2013.)

Borowsky SJ, Rubenstein LV, Meredith LS, Camp P, Jackson-Triche M, Wells KB (2000) Who is at risk of nondetection of mental health problems in primary care? *Journal of General Internal Medicine*. 15, 6, 381-388.

Challen A, Noden P, West A, Machin S (2011) *UK Resilience Programme Evaluation: Final Report*. Department for Education, London.

Chang CK, Hayes RD, Broadbent M *et al* (2010) All-cause mortality among people with serious mental illness (SMI), substance use disorders, and depressive disorders in southeast London: a cohort study. *BMC Psychiatry*. 10, 77.

Chang CK, Hayes RD, Perera G *et al* (2011) Life expectancy at birth for people with serious mental illness and other major disorders from a secondary mental health care case register in London. *PLoS One*. 6, 5, e19590.

Crisis (2012) *Rough Sleeping*. www.crisis.org.uk/pages/rough-sleeping.html (Last accessed: February 20 2013.)

Cuijpers P, Smit F (2002) Excess mortality in depression: a meta-analysis of community studies. *Journal of Affective Disorders*. 72, 3, 227-236.

De Hert M, Dekker JM, Wood D, Kahl KG, Holt RI, Möller HJ (2009) Cardiovascular disease and diabetes in people with severe mental illness position statement from the European Psychiatric Association (EPA), supported by the European Association for the Study of Diabetes (EASD) and the European Society of Cardiology (ESC). *European Psychiatry*. 24, 6, 412-424.

de Koning MB, Bloemen OJ, van Amelsvoort TA *et al* (2009) Early intervention in patients at ultra high risk of psychosis: benefits and risks. *Acta Psychiatrica Scandinavica*. 119, 6, 426-442.

Dennis CL, Creedy D (2004) Psychosocial and psychological interventions for preventing postpartum depression. *Cochrane Database of Systematic Reviews*. Issue 4, CD001134.

Department for Children, Schools and Families (2007) *Social and Emotional Aspects of Learning (SEAL) for Secondary Schools*. Department for Children, Schools and Families, Nottingham.

Department for Education (2010) *Social and Emotional Aspects of Learning (SEAL) Programme in Secondary Schools: National Evaluation*. tiny.cc/SEAL_programme (Last accessed: February 20 2013.)

Department of Health (2012) *Preventing Suicide in England: A Cross-Government Outcomes Strategy to Save Lives*. tiny.cc/outcomes_strategy (Last accessed: February 20 2013.)

Donkoh C, Underhill K, Montgomery P (2006) Independent living programmes for improving outcomes for young people leaving the care system. *Cochrane Database of Systematic Reviews*. Issue 3, CD005558.

Dunlop BW, Mletzko T (2011) Will current socioeconomic trends produce a depressing future for men? *British Journal of Psychiatry*. 198, 3, 167-168.

Eaton NR, Keyes KM, Krueger RF *et al* (2012) An invariant dimensional liability model of gender differences in mental disorder prevalence: evidence from a national sample. *Journal of Abnormal Psychology*. 121, 1, 282-288.

Egede LE (2007) Major depression in individuals with chronic medical disorders: prevalence, correlates and association with health resource utilization, lost productivity and functional disability. *General Hospital Psychiatry*. 29, 5, 409-416.

Galdas PM, Cheater F, Marshall P (2005) Men and health help-seeking behaviour: literature review. *Journal of Advanced Nursing*. 49, 6, 616-623.

Gask L, Dixon C, Morriss R, Appleby L, Green G (2006) Evaluating STORM skills training for managing people at risk of suicide. *Journal of Advanced Nursing*. 54, 6, 739-750.

staff training in education settings, social and youth services, employment services, homeless organisations, and drug and alcohol agencies, as well as working directly with young men perceived to be at high risk of mental health problems. These projects provided interesting, but inconclusive findings, identifying challenges associated with engaging young men, and enabling mental health issues to be raised and shared (Oliver and Storey 2006).

Mental health and football

Football has been used to promote health in general, and mental health in particular. In 2004, a programme called 'It's a Goal!' (www.itsagoal.org.uk) was launched at Macclesfield Town football club in England to tackle depression and suicide risk among young men. Subsequently, this programme was adopted by 15 other professional clubs. Group support is offered within club facilities to develop problem-solving, relaxation and assertiveness skills.

The programme can be implemented by primary care trusts and local authorities to promote mental health among young men. Although 'It's a Goal!' has not yet been evaluated formally, organisers note success in engaging with young men experiencing depression and achieving high programme completion rates. 'Premier League Health' has been established to provide men's health promotion through 16 English Premier League football clubs. This intervention aims to improve men's health through weekly classes and exercise sessions, addressing physical activity, diet, smoking and alcohol consumption. An evaluation of this programme indicated significant improvements in relation to these healthy behaviours. Although the

Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005) *Mental Health of Children and Young People in Great Britain, 2004*. The Stationery Office, London.

Haddad M (2009) Depression in adults with a chronic physical health problem: treatment and management. *International Journal of Nursing Studies*. 46, 1411-1414.

Haddad M, Gunn J (2011) *Fast Facts: Depression*. Third edition. Health Press, Oxford.

Hawton K, van Heeringen K (2009) Suicide. *The Lancet*. 373, 9672, 1372-1381.

Health Development Agency (2004) *Promoting Emotional Health and Wellbeing through the National Healthy School Standard*. tiny.cc/promoting_wellbeing (Last accessed: February 20 2013.)

Kaner EF, Beyer F, Dickinson HO *et al* (2007) Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database of Systematic Reviews*. Issue 2, CD004148.

Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustün TB (2007) Age of onset of mental disorders: a review of recent literature. *Current Opinion in Psychiatry*. 20, 4, 359-364.

Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE (2005) Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*. 62, 6, 617-627.

Kposowa AJ (2001) Unemployment and suicide: a cohort analysis of social factors predicting suicide in the US National Longitudinal Mortality Study. *Psychological Medicine*. 31, 1, 127-138.

Luoma JB, Martin CE, Pearson JL (2002) Contact with mental health and primary care providers before suicide: a review of the evidence. *American Journal of Psychiatry*. 159, 6, 909-916.

Mackenzie CS, Gekoski WL, Knox VJ (2006) Age, gender, and the underutilization of mental health services: the influence of help-seeking attitudes. *Aging & Mental Health*. 10, 6, 574-582.

Maginn S, Boardman AP, Craig TK, Haddad M, Heath G, Stott J (2004) The detection of psychological problems by General Practitioners: influence of ethnicity and other demographic variables. *Social Psychiatry and Psychiatric Epidemiology*. 39, 6, 464-471.

Mann JJ, Apter A, Bertolote J *et al* (2005) Suicide prevention strategies: a systematic review. *Journal of the American Medical Association*. 294, 16, 2064-2074.

Marshall M, Rathbone J (2011) Early intervention for psychosis. *Cochrane Database of Systematic Reviews*. Issue 6, CD004718.

McCrone P, Dhanasiri S, Patel A, Lawton-Smith S (2008) *Paying The Price: The Cost of Mental Health Care in England to 2026*. King's Fund, London.

McManus S, Meltzer H, Brugha T, Bebbington P, Jenkins R (Eds) (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a Household Survey*. The NHS Information Centre for Health and Social Care, Leeds.

Meltzer H, Griffiths C, Brock A, Rooney C, Jenkins R (2008) Patterns of suicide by occupation in England and Wales: 2001-2005. *British Journal of Psychiatry*. 193, 1, 73-76.

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

Morawska A, Fletcher R, Pope S, Heathwood E, Anderson E, McAuliffe C (2013) Evaluation of mental health first aid training in a diverse community setting. *International Journal of Mental Health Nursing*. 22, 1, 85-92.

Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, Ustun B (2007) Depression, chronic diseases, and decrements in health: results from the World Health Surveys. *The Lancet*. 370, 9590, 851-858.

National Institute for Health and Clinical Excellence (2009) *Depression in Adults (Update). Depression: The Treatment and Management of Depression in Adults*. tiny.cc/depression_update (Last accessed: February 20 2013.)

National Institute for Health and Clinical Excellence (2011) *Alcohol-use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence*. Clinical guideline 115. NICE, London.

National Mental Health Development Unit (2010a) *Factfile 4: Public Mental Health and Well-Being*. www.nmhdu.org.uk/silo/files/nmhdu-factfile-4.pdf (Last accessed: February 20 2013.)

National Mental Health Development Unit (2010b) *Factfile 3: The Costs of Mental Ill Health*. www.nmhdu.org.uk/silo/files/nmhdu-factfile-3.pdf (Last accessed: February 20 2013.)

Nielsen SF, Hjorthøj CR, Erlangsen A, Nordentoft M (2011) Psychiatric disorders and mortality among people in homeless shelters in Denmark: a nationwide register-based cohort study. *The Lancet*. 377, 9784, 2205-2214.

Oliver C, Storey P (2006) *Evaluation of Mental Health Promotion Pilots to Reduce Suicide Amongst Young*

programme did not specifically address mental health, Pringle *et al* (2013) acknowledge its benefits in mental as well as physical health.

The use of football to tackle mental health discrimination, increase social inclusion and promote mental health has been adopted by the Time to Change campaign (www.time-to-change.org.uk), an England-wide programme that commenced in 2007 and is run by mental health charities Mind and Rethink. The aim is to change attitudes and behaviour towards people with mental health problems, and prevent stigma and discrimination. Part of this programme involves football clubs that, in partnership with community trusts, run 'Imagine Your Goals' programmes – a range of mental health projects designed to improve social inclusion and wellbeing for people with mental health problems, with a focus on social contact, physical activity and campaigning.

Conclusion

Mental health is key to individuals' wellbeing and many of the approaches central to its promotion address broad social and environmental factors. However, it is essential that interventions also focus on the risks that are specific to mental health. Evidence indicates the value of approaches that address the mental wellbeing of children and young people, and of groups at high risk of mental health problems, such as those in contact with the criminal and youth justice systems, homeless people, those who misuse substances and individuals at risk of developing psychosis. Men, because of their vulnerability to particular mental health problems and their reluctance to seek help for health problems, require particular attention **NS**

Complete time out activity 7

7 Now that you have completed the article, you might like to write a practice profile. Guidelines to help you are on page 60.

Men. Thomas Coram Research Unit, University of London, London.

Osborn DPJ (2001) The poor physical health of people with mental illness. *Western Journal of Medicine*. 175, 5, 329-332.

Prince M, Patel V, Saxena S *et al* (2007) No health without mental health. *The Lancet*. 370, 9590, 859-877.

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

Rivlin A, Hawton K, Marzano L, Fazel S (2010) Psychiatric disorders in male prisoners who made near-lethal suicide attempts: case-control study. *British Journal of Psychiatry*. 197, 4, 313-319.

Robinson KL, McBeth J, MacFarlane GJ (2004) Psychological distress and premature mortality in the general population: a prospective study. *Annals of Epidemiology*. 14, 7, 467-472.

Russ TC, Stamatakis E, Hamer M, Starr JM, Kivimäki M, Batty DG (2012) Association between psychological distress and mortality: individual participant pooled analysis of 10 prospective cohort studies. *British Medical Journal*. 345, e4933.

Sainsbury Centre for Mental Health (2003) *The Economic and Social Costs of Mental Illness*. Policy Paper 3. Sainsbury Centre for Mental Health, London.

Samaritans (2012) *Suicide Statistics Report 2012: Data for 2008-2010*. tiny.cc/suicide_statistics (Last accessed: February 21 2013.)

Sarchiapone M, Mandelli L, Iosue M, Andrisano C, Roy A (2011) Controlling access to suicide means. *International Journal of Environmental Research and Public Health*. 8, 12, 4550-4562.

Saz P, Dewey ME (2001) Depression, depressive symptoms and mortality in persons aged 65 and over living in the community: a systematic review of the literature. *International Journal of Geriatric Psychiatry*. 16, 6, 622-630.

Smith JA, Braunack-Mayer A, Wittert G (2006) What do we know about men's help-seeking and health service use? *Medical Journal of Australia*. 184, 2, 81-83.

Stansfeld SA, Fuhrer R, Shipley MJ, Marmot MG (2002) Psychological distress as a risk factor for coronary heart disease in the Whitehall II Study. *International Journal of Epidemiology*. 31, 1, 248-255.

Stice E, Shaw H, Marti CN (2007) A meta-analytic review of eating disorder prevention programs: encouraging findings. *Annual Review of Clinical Psychology*. 3, 207-231.

Taylor L, Taske N, Swann C, Waller S (2007) *Public Health Interventions to Promote Positive Mental Health and Prevent Mental Health Disorders Among Adults: Evidence Briefing*. tiny.cc/evidence_briefing (Last accessed: February 20 2013.)

University of Pennsylvania (2007) *Resilience Research in Children: The Penn Resiliency Project*. www.ppc.sas.upenn.edu/prpsum.htm (Last accessed: February 20 2013.)

US Department of Justice (2012) *Federal Bureau of Prisons: Inmate Population*. www.bop.gov/news/quick.jsp (Last accessed: February 20 2013.)

van der Feltz-Cornelis CM, Sarchiapone M, Postuvan V *et al* (2011) Best practice elements of multilevel suicide prevention strategies: a review of systematic reviews. *Crisis*. 32, 6, 319-333.

Wang PS, Angermeyer M, Borges G *et al* (2007) Delay and failure in treatment seeking after first onset of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry*. 6, 3, 177-185.

Wang J, Patten SB, Currie S, Sareen J, Schmitz N (2012) A population-based longitudinal study on work environmental factors and the risk of major depressive disorder. *American Journal of Epidemiology*. 176, 1, 52-59.

Wasserman D, Cheng QI, Jiang G-X (2005) Global suicide rates among young people aged 15-19. *World Psychiatry*. 4, 2, 114-120.

World Federation for Mental Health (2012) *Promotion and Prevention*. www.wfmh.org/00PromPrevention.htm (Last accessed: February 20 2013.)

World Health Organization (2002) *World Report on Violence and Health*. WHO, Geneva.

World Health Organization (2008) *The Global Burden of Disease: 2004 Update*. WHO, Geneva .

World Health Organization (2009) *Milestones in Health Promotion, Statements from Global Conferences*. WHO, Geneva.

World Health Organization (2012a) *Gender Disparities in Mental Health*. www.who.int/entity/mental_health/media/en/242.pdf (Last accessed: February 20 2013.)

World Health Organization (2012b) *Suicide Prevention (SUPRE)*. www.who.int/mental_health/prevention/suicide/suicideprevent/en (Last accessed: February 20 2013.)

Ying YH, Chang K (2009) A study of suicide and socioeconomic factors. *Suicide and Life-threatening Behaviour*. 39, 2, 214-226.