Community-based mental health and suicide prevention interventions for men

Rapid Evidence Review November 2019
(with Updated Postscript October 2021)

This rapid evidence review forms part of the Men's Mental Health and Suicide Prevention project funded by the Champs Public Health Collaborative for the NO MORE Suicide Partnership. The required target audience is men aged 40-60. The required outputs are:

1   Develop a set of evidence-based criteria and guidelines for implementing a men's mental health project, utilising a rapid review of the existing evaluated men's mental health programmes.

2   In collaboration with local suicide prevention leads conduct a needs assessment for each local area, identifying gaps in provision of men's mental health programmes.

This brief report is based on a rapid evidence review of publicly available peer-reviewed evidence of community mental health and suicide prevention programmes for middle aged men. The reviewed programmes included activities such as sport, other cultural activities, gardening and wellbeing initiatives, and evaluations of specific projects including Men's Sheds and MATES. One of the major limitations of the current evidence base is the lack of cost effectiveness analyses and variability in approaches to monitoring and evaluation (where they exist).

The report is also informed by evidence provided by partners to the authors relating to projects which have not been formally evaluated, but which include important local insight of practical relevance.

Data from Public Health England on various indicators of mental health and illness (including suicide prevalence) and latest Joint Strategic Needs Assessments (JSNA) information from each of the boroughs in Cheshire and Merseyside are also included.

> **This report should be read in conjunction with the following report which is also available on the No More Suicide website (https://no-more.co.uk/mens-mental-health/):**
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> **Everton in the Community, Edge Hill University and State of Mind Sport (2021).** *Community Suicide Prevention for Middle-Aged Men in Cheshire and Merseyside: Learning from NHSEI-Funded Programmes and Implications for Future Practice.* **Liverpool: Everton Football Club.**

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Prevalence of mental illness and suicide
The most recent suicide data for the United Kingdom indicate that, in 2018, there were 6,507 registered suicides, an 11.8% increase from 2017 (5,821 deaths) (Office for National Statistics [ONS], 2019). Males continued to represent three-quarters of the registered suicides in 2018 (4,903; 17.2 deaths per 100,000), an increase of 14% from 2017 (15.5 deaths per 100,000). Males had the highest age-specific suicide rate, with 21.7 deaths per 100,000 among males aged 45-49. Depression and anxiety are the most reported mental illnesses globally, with other mood disorders, substance-use disorders (including alcohol and recreational drug misuse), eating disorders and related body-image-oriented conditions becoming more prevalent (Wilkinson and Pickett, 2010; 2018; WHO, 2017).

The prevalence of mental disorders across Cheshire and Merseyside between 2017 and 2018 was high, with Liverpool, Knowsley, Halton, and St Helens above the England average (16.9% per 100) and above the North-West average (18.0% per 100). Wirral, Sefton, Warrington, Cheshire West and Cheshire East are similar to the England average and just below the North-West average (PHE, 2019b). The prevalence of recorded depression for each of the Cheshire and Merseyside boroughs, except Cheshire West, is above the England average (9.9%).

Data on suicide rates (per 100,000 of the population) from Public Health England's Finger Tips database for Cheshire and Merseyside identified St Helens, Sefton, Knowsley, Halton and Wirral as being above the England average, with those in Liverpool, Cheshire East, Cheshire West and Chester and Warrington just below the national average (PHE, 2019c) (see Appendix 1). Male suicide rates across the nine boroughs were highest in St Helens (which was double the national rate), with those in Knowsley, Sefton, Halton and Wirral also above the England average. Male suicide rates in Liverpool, Cheshire East, Cheshire West and Chester and Warrington were just below the national average (PHE, 2019c) (see Appendix 2).

The Mental Health Foundation (2019) listed four broader areas that include possible risk factors for suicide. These are: (1) societal factors (e.g. difficulty accessing care); (2) community factors (e.g. poverty and employment opportunities); (3) relationships (e.g. social isolation and loneliness); and (4) individual factors (e.g. previous suicide attempt and poor physical health) (for the full list, see Appendix 3). In a systematic review of risk factors for suicidal behaviour in men (62 prospective and 43 retrospective studies), Richardson et al (2021) identified 68 different risk factors which reflect the complexity of suicidal behaviour, and which can interact and change over the life course. Particularly notable risk factors included alcohol and other drug use or dependence, marital status, experiencing depression, having a low level of education,

and previous suicide attempts. Other risks included experiencing negative lie events/trauma (e.g. financial difficulties, unemployment, bereavement), physical health problems and impulsivity (Richardson et al., 2021).

In Cheshire and Merseyside, Knuckey (2017) identified the most common factors related to suicides by men aged 45-64 were physical health problems (70%), mental health diagnosis (55%), alcohol misuse (40%) and a previous attempt (37%).

Social determinants of (mental) health
Marmot (2015) and Wilkinson and Pickett (2010, 2018) demonstrate how in highly unequal countries such as those in the UK, health problems affect all groups but become progressively more common lower down the social ladder. Those living in areas of higher social deprivation tend to have limited access to professional health care, precarious employment, low educational attainment, poorer diet and low levels of physical activity (Wilkinson & Pickett, 2010, 2018). The social determinants of health (including housing, education, access to health services, employment, income, social support, communities and childhood experiences) contribute to an individual's chance of leading a flourishing life (WHO, 2008). Where access to each determinant is limited, the more negative impact it is likely to have on an individual's health (Marmot, 2015).

According to the 2019 English Indices of Deprivation, many areas within Cheshire and Merseyside are among the top 50% most deprived areas in England (IMD, 2019). Liverpool, Knowsley and Halton local authorities also have some of the highest proportions of neighbourhoods in the most deprived 10 per cent in England (Ministry of Housing, Communities & Local Government, 2019). Joint Strategic Needs Assessment (JSNA) data and Public Health England Local Authority data (PHE, 2019a) (see Appendix 5 and 6) indicate that in Cheshire and Merseyside there are significant concerns about excessive alcohol consumption, substance misuse, high rates of years spent in 'not good' health, low educational attainment, and a significant number of households in fuel poverty. Furthermore, the most common employment industries include wholesale and retail trade, construction, and manufacturing, all of which are associated with precarious forms of employment and increased risk of poor mental health and suicidal ideation.

Since the most common form of employment in Cheshire and Merseyside includes construction and manufacturing, it is important to acknowledge concerns about poor mental health and suicidal behaviour among this population. While suicides within low-skilled industries are increasing (Windsor-Shellard & Gunnell, 2019), Milner et al. (2017) and Ross et al. (2019) found that barriers to help-seeking and risks of suicide among the construction worker population are like the risks for non-construction workers. It was concluded that there are a variety of work and non-work factors that contribute to suicides by those in the construction industry. Suicide prevention for this population should be approached in similar ways to suicide prevention more generally and consider the individual's wider social contexts and circumstances (Milner et al., 2017). An example of a programme situated within the construction industry is the Mates in Construction (MATES) workplace suicide prevention programme. MATES consisted of general awareness training about suicide as an issue prevalent in the industry, training for staff to become 'connectors' to identify at risk colleagues and help them access professional services, and the Applied Suicide Intervention Skills Training (ASIST) (Gullestrup et al., 2011; Ross et al., 2019). Activities and training of a similar nature have been integrated within other men's

community-based mental health programmes, for example *Offload* (Wilcock & Smith, 2019; Wilcock et al., 2021).

What works for community-based men's mental health interventions?
Less than half of those living with a diagnosable mental illness seek help (Sickel, Seacat & Nabors, 2019) and it is well established that fewer males engage in help-seeking behaviours (Addis & Makalik, 2003). Compared with men who do not, men with mental illness are at an increased likelihood to engage in behaviours that are harmful to both themselves and others. These behaviours include substance abuse, excessive alcohol intake, recreational drugs, anger, violence, or other risky behaviours, and generally conduct themselves negatively (Wendt & Shafer, 2016). Men's reluctance to seek help often relates to (Ellis, 2018, p.131):

- Gender ideology (seeking assistance is a sign of weakness, is effeminate, a demonstration of failure; men need to be tough, invincible, to provide for/protect others)
- Avoidance/self-reliance
- Perception of health care professionals and services
- Not recognising or acknowledging symptoms
- Meeting societal expectations
- Denial
- Embarrassment
- Adoption of coping strategies prior to seeking assistance (alcohol or substance misuse or suppression of emotions)
- Poor health literacy
- Distrust of the healthcare system
- The stigma of drug and psychological treatment

Retaining men with mental illness who do engage with traditional services and treatment plans can be difficult and rates of dropout are high (Dixon, Holoshitz & Nossel, 2016). Reasons for discontinued engagement include a low perceived need for the treatment, belief the treatment is not working, participants wanting to manage with their mental health/illness alone, perceived ineffectiveness, practical reasons (e.g. services operating at inconvenient times for the individual, transportation barriers) and financial barriers (Andrade et al., 2014; Dixon et al., 2016).

Types of men recruited to programmes
Evaluations have generated insights into males' experiences prior to their engagement with a programme or group. Programmes reached and attracted men aged 40-60 who (Dixon et al., 2018; Friedrich & Mason, 2017; Spandler et al., 2012; Wilcock & Smith, 2019; Wilcock et al., 2021):

- Are employed, unemployed or retired
- Previously accessed professional medical help (e.g. through a statutory mental health service, their GP, primary care)
- Been diagnosed with a mental illness
- Have not had contact with a health professional about their mental health
- Have had experiences with excessive alcohol consumption and recreational drug abuse
- Socially isolated or experiencing loneliness

- Experienced breakdowns of meaningful social or domestic relationships
- Experienced mental health related stigma and discrimination

Outcomes achieved
Increasingly, community-based programmes or groups have been developed to address the concerns associated with male mental health and suicide. These use various activities (e.g. physical activity, talking groups, construction) to engage men. Where programme evaluations do exist, programme outcomes included increased confidence and self-esteem (Bingham et al., 2014; Dixon & Flynn, 2016; Henderson et al., 2014; Spandler et al., 2013), developed positive coping mechanisms (Spandler et al., 2013) increased social and emotional connections (Dixon et al., 2018; Henderson et al., 2014; Pringle et al., 2013; Spandler et al., 2013) and increased positive lifestyle choices including increased physical activity, better diet choices, reduced substance abuse and beginning to engage with community activities (Bingham et al., 2014; Dixon and Flynn, 2016; Henderson et al., 2014; Pringle et al., 2013; Spandler et al., 2013).

Limitations of the data
A significant limitation of existing evaluations of community-based mental health programmes for middle-aged men is the general lack of cost effectiveness analyses in approaches to programme monitoring and evaluation. An exception to this was the *It's a Goal!* evaluation which suggested that those who used IAG! would be less likely to require further treatment or use of health care services. The comparative costs of the programme are presented in Appendix 6 (Spandler et al., 2012). Other cost-effective analyses which have been conducted for suicide prevention programmes, including those in the workplace, have been undertaken by Public Health England (2017) and are presented in Appendix 7. These data indicate that the cumulative return per pound invested was £1.93 in Year 2, £12.96 in Year 5 and £39.11 in Year 10 (PHE, 2017).

Other limitations include: variability and inconsistency in the age of male participants; programme length, locations and settings; a general lack of pre- and post-evaluations and control groups; and variability in outcomes. To this end, the following presents a summary of the key design features or programmes which have been shown to be effective in engaging and retaining men in community mental health programmes using a range of activities. Significantly, the evidence suggests that it is   not so much the nature of the activities which are important, but the mechanisms of engagement and it is this which are the focus here.

Key elements of programmes
Drawing on the latest reviews of the literature surrounding community-based men's health promotion and suicide prevention, it is concluded that programmes should tackle social determinants of health and men's health inequalities in male-friendly spaces (Oliffe et al., 2019). A review of 22 studies involved interventions that were complex/multimodal, meaning they had a variety of modes of activity (Struszczyk et al., 2019). The authors explained that specific activities were not the single reason for programme success; rather programme success is often a result of an amalgamation of the key elements presented below. Men also preferred programmes where they were offered elements of choice (Robinson et al., 2015). Hence, going forward, it is important to work with men within the local communities to identify their specific needs and include those needs into the relevant key elements of men's health programmes that are recognised internationally (Anstiss

et al., 2018; Oliffe et al., 2019; Robertson et al., 2016; Robinson et al., 2015; Struszczyk et al., 2019).

Recommendations for programme design features
The following are recommendations which compile features of programmes or groups that have been most successful in engaging men in community mental health and suicide prevention programmes and have generated the most favourable outcomes.

1. The intervention should be delivered in a safe setting where men routinely reside.
Programmes engaged men in settings that juxtaposed statutory service provision (Robertson et al., 2016) and were often locations of 'male appeal', so where men typically present themselves, were familiar, accessible via public transport and non-medical (Cooper et al., 2017; Cooper at al., 2015; Movember Foundation, 2014; Robertson et al., 2013). Settings included sports facilities, workplaces and other community settings (e.g. Men's Shed) (Anstiss et al., 2018; Dixon et al., 2018; Malcolm et al., 2013; Parnell et al., 2015; Pringle & Sayers, 2004, 2006; Spandler et al., 2013; Wilcock & Smith, 2019; Wilcock et al., 2021).

2. Use language familiar to men
The language used in male mental health interventions or programmes is particularly important and contributes to successfully engaging men. Using language that avoids stigmatising attitudes, is male-oriented and not seen to be feminised (e.g. 'building mental fitness' rather than 'mental health'), associated with sports (e.g. calling the participants 'players', the sessions as 'fixtures'), and uses humour is more likely to increase familiarity and maintain engagement (Cooper et al., 2017; Robertson et al., 2016; Dixon et al., 2018; Movember Foundation, 2014; Pringle & Sayers, 2004; Spandler et al., 2013; Wilcock & Smith, 2019; Wilcock et al., 2021).

3. Deliver male-only sessions in male communities
Interventions should be taken into, and embedded within, the communities in which the target population is to help develop trusting relationships between the participants and the programme facilitators (Movember Foundation, 2014). This is particularly important for those working with marginalised groups within the community (e.g. LGBTQ+ and ethnic minority groups) (Robertson et al., 2016). Providing a male familiar environment offers promise and promotes engagement and inclusion by normalising mental health and reducing stigma and discrimination (Cooper et al., 2015).

4. The programme facilitators characteristics
Those responsible for delivering and facilitating the programme are often identified as key contributors to the success by being approachable and responsive to the needs presented by the group (Crone, 2007; Mason & Holt, 2012). Moreover, facilitators who had a willingness to work with men, characteristics including being non-judgemental and supportive, respectful, empathetic, genuine, passionate and adaptable (Dixon et al., 2018; Robertson et al., 2016; Movember Foundation, 2014; Wilcock & Smith, 2019) and dressed in appropriate clothing (e.g. sports/club kit, construction work gear) (Curran et al., 2014; Dixon et al., 2018; Malcolm et al., 2013; Pringle et al., 2014).

5. Use programme delivery staff who have lived experience.

Delivery staff who had experiences of mental illness were appreciated by programme participants who were able to relate well to the experiences being presented, so delivery staff with lived experience should be actively included in programme design and delivery (Cooper et al., 2017; Cooper at al., 2015; Movember Foundation, 2014; Robertson et al., 2013; Wilcock & Smith, 2019; Wilcock et al., 2021).

6. Using a group-based environment

Group or team-based environments facilitated the delivery of mental health programmes and a place to talk about mental health related topics where personal experiences or illness diagnosis were not judged (Mason & Holt, 2012; Seaton et al., 2017). Using a group-based setting develops a sense of togetherness and a sense of belonging while increasing social capital, which contrasted men's experiences of social isolation and loneliness (Benkwitz & Healy, 2019; Dixon et al., 2018; Henderson et al., 2014; Mason & Holt, 2012; McKeown et al., 2015; Parnell et al., 2015; Robertson et al., 2013; Wilcock & Smith, 2019; Wilcock et al., 2021).

7. Use an activity and include goal setting

Activities that appeal to men (e.g. sports, physical activity, construction, gardening) are often reported as a crucial 'hook' to engaging men who are typically under-reached (Friedrich & Mason, 2017). Using an activity reduces stigma and creates a positive outlet for emotions, encourages social interactions among the men that will assist in improvements to their mental health and offers opportunities for feelings of achievement, meaning and worth (Robertson et al., 2016; Robertson et al., 2018; Robinson et al., 2015; Seaton et al., 2017).

8. Deliver the intervention at an accessible time

Men in Cheshire and Merseyside often work shift patterns or unsocial hours. Interventions or programmes should consider this and offer sessions during early and late evenings and weekends (Benkwitz & Healy, 2019; Dixon et al., 2018; Henderson et al., 2014; Mason & Holt, 2012; Parnell et al., 2015; Pringle et al., 2013; Robertson et al., 2013).

9. Be aware/understand the social environments and personal experiences of those in the area/region

When developing and implementing an intervention, the social environments and the personal experiences of the men in those areas should be considered to ensure that the personal needs of the men are addressed and the intervention is meaningful (Cooper et al., 2017; Cooper at al., 2015; Movember Foundation, 2014; Robertson et al., 2013; Robinson et al., 2015; Wilcock & Smith, 2019; Wilcock et al., 2021).

10. Embed partnership working and co-production across all phases of programme development and implementation

Partnership working and participant co-production enables organisations with different skills and knowledge to come together and design and implement programmes, with benefits including credibility, increased resources, and extended reach (Movember Foundation 2014; Robertson et al., 2018; Spandler et al., 2012; Wilcock & Smith, 2019; Wilcock et al., 2021). All partners should be sensitive to designing interventions and include attitudes which are positive to working with men to help with their mental health (Movember Foundation, 2014). Co-production also ensures that the programme continually meets the needs of its target group

population (Wilcock & Smith, 2019; Wilcock et al., 2021).

11. Have an established exit route

All interventions or programmes (particularly those that have a set period of time for delivery, e.g. 10 weeks) should have an established exit route to reduce dependency. Suitable exit routes include assisting the men into other programmes or projects within your organisation or the community or assisting the men into opportunities for further training that enable the development of skills necessary for future employment (Henderson et al., 2014; Mason & Holt, 2012).

Postscript: Suicide and COVID-19

This evidence review accompanies a report which outlines key learning from NHSEI-funded suicide prevention projects delivered between February 2020 and June 2021 for middle-aged men (40-60-years-old) living in Cheshire and Merseyside (Everton in the Community, Edge Hill University & State of Mind Sport, 2021). The preceding sections of this review were completed and published in late 2019, before COVID-19. Given many of the funded projects had either not started or were paused because of the various COVID-19 restrictions implemented by government, the potential impact on suicide rates and mental health of COVID-19 (including among men) became of increased concern and quickly became an important part of the context within which the projects would ultimately be delivered.

It is now clear that the COVID-19 crisis and associated lockdowns have unambiguously accelerated, widened, and deepened pre-existing inequalities between and within countries in ways that have negatively impacted mental health (Bambra et al., 2021; Marmot et al., 2020). In the UK, the mental health impacts of COVID-19 have been experienced unequally (Campion et al., 2020) and it is now clear that inequalities in mental health and other socially patterned health inequalities 'have emerged through the syndemic nature of COVID-19—as it interacts with and exacerbates existing social inequalities in chronic disease and the social determinants of health' (Bambra et al., 2020, p. 4). More specifically, for the most disadvantaged communities, COVID-19 has been 'experienced as a syndemic: a co-occurring, synergistic pandemic which interacts with and exacerbates their chronic health and social conditions' (Bambra et al. 2021, p. 28), including their mental health and risk of suicide. Numerous risk factors for suicide, including 'isolation, loss of social support, disruption to mental health care economic adversity, trauma, bereavement, domestic violence and alcohol misuse' (Appleby et al., 2021, p. 1), are likely to have been exacerbated and much concern has been expressed about potential rises in suicide because of COVID-19 restrictions. Although the evidence base is limited, Appleby et al. (2021) have noted that there does not appear to have been an increase in suicides in England in the months after the first national lockdown in March 2020. They also noted that the suicide figures reported in their study (based on data from established systems of real time surveillance) were preliminary and may change, and that the overall figures 'may mask increases in suicide in population groups or geographical areas, just as the impact of the acute pandemic has not been uniform across communities' (Appleby et al., 2021, p. 5).

Data from the ONS on suicide deaths in England and Wales also indicated that there had been no rise in suicide during the early period of COVID-19 restrictions (ONS, 2021). It was reported that 1,603 suicides occurred between April and July 2020 (based on official death registrations), equivalent to an age-standardised mortality rate of 9.2 deaths per 100,000 people which was statistically significantly lower than

rates for the same period in the previous three years (ONS, 2021). The lower suicide rates were largely accounted for by statistically significant declines in male suicide rates (between 2017 and 2019), while statistically significant declines were also recorded for 10-24-year-olds and 25-44-year-olds when compared with the same period in 2019 (ONS, 2021).

But how can we explain these findings given the increased levels of distress and negative mental health impacts of COVID-19, and what are the implications for future suicide prevention efforts? As Appleby et al. (2021, p. 6) have noted, 'suicide is complex and rates do not simply follow levels of mental disorder'. They add that:

> It may be that lockdown, as well as presenting greater risks to some, brought greater protections to others in the form of vigilance and support from families, friends and neighbours, and reduced access to certain suicide methods. More broadly, the national crisis may have led to an increase in social coherence - as is believed to have occurred in past conflicts. In the first lockdown there may have been a sense that the crisis would soon pass, preventing the despair that is an important cognitive step towards suicide. If these explanations are correct, there is reason to be concerned in 2021 as social divisions appear entrenched ... Vigilance over suicide prevention remains a vital part of how we respond to COVID19 in the long term.

Future suicide prevention efforts will also need to consider changing patterns of mental health risk as the long-term impacts of COVID-19 and associated inequalities become clearer. Among these risks will likely be economic stressors, uncertainty in the labour market, the impacts of long COVID, and prolonged isolation and loneliness. Since previous natural disasters, wars, and economic downturns (especially recessions) have been followed by momentary declines in suicide before rates increase again (often within a couple of years, and particularly among men of working age and the unemployed), it is important that future suicide prevention strategies are developed to help mitigate the long-term impacts of COVID-19 on suicide risk (Wasserman et al., 2020).

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Appendices

Appendix 1

Table 1. Cheshire and Merseyside Boroughs suicide rates 2016-2018 (Public Health England, 2019b)

Rank	Borough	Suicide rate England (per 100,000)	Suicide rate (persons) (per 100,000)
1	St Helens	9.6	16.1
2	Sefton	9.6	11.5
3	Knowsley	9.6	11.5
4	Halton	9.6	11.4
5	Wirral	9.6	9.7
6	Liverpool	9.6	9.5
7	Cheshire East	9.6	8.8
8	Cheshire West	9.6	8.7
9	Warrington	9.6	7.2

Appendix 2

Table 2. Cheshire and Merseyside Boroughs male suicide rates 2016-2018 (Public Health England, 2019b)

Rank	Borough	Suicide rate England (per 100,000)	Suicide rate (persons) (per 100,000)
1	St Helens	14.9	29.0
2	Knowsley	14.9	20.9
3	Sefton	14.9	18.0
4	Halton	14.9	17.8
5	Wirral	14.9	15.9
6	Liverpool	14.9	14.6
7	Cheshire East	14.9	14.2
8	Cheshire West	14.9	13.2
9	Warrington	14.9	10.8

Given the complexity of suicidal behaviour, there are multiple explanations or factors that can contribute to an act of suicide. Table 3 covers several of these risk factors.

Appendix 3

Table 3. Suicide risk factors (Mental Health Foundation, 2019)

Societal	Community	Relationships	Individual
Difficulty accessing/receiving care	Poverty	Isolation and lack of social support	Previous suicide attempts or self-harm
Access to means of suicide	Experiences of trauma or abuse	Loneliness	Mental illness
Inappropriate media reporting	Experiences of disaster, war or conflict	Relationship breakdown	Drug and alcohol misuse
Mental health stigma	Discrimination	Loss or conflict	Financial difficulties
Substance abuse	Employment opportunities		Chronic pain/physical health
			Family history of suicide.

Based on information from the Cheshire and Merseyside suicide audit in 2017, listed in Table 4 are contributing factors for suicides in the region.

Appendix 4

Table 4. Reasons for suicide in Cheshire and Merseyside and access to services (Knuckey, 2017)

Risks of suicide	Access to health services
• Physical health problem (60%) • Single (50%) • Unemployed (42%) • Previous suicide attempt (38%) • Relationship problems (35%) • Financial problems (21%) • Bereaved by suicide (6%)	• 52% of men had a mental health diagnosis • 35% of people accessed their GP or primary care and 26% had been in contact with mental health services in the month prior to their death

Appendix 5

Table 5. JSNA Data for Cheshire and Merseyside Boroughs

Borough	Key JSNA themes
Cheshire East (Cheshire East Council, 2019)	204.6 per 100,000 emergency admissions for self-harm - Less than 1 in 5 adults do less than 30 minutes of physical activity per week 64.8% of people are overweight. - Increased rate of alcohol admissions since 2012/13 (now 610.1 per 100,000) - Of those aged 40-74, 50.9% accepted the NHS health check they were offered. - Working age population in employment is 77.5%, 68.0% are in full-time employment, and the average (median) gross weekly earnings of full-time employees is £556 - Dominant employment industry is wholesale and retail trade repair of motor vehicles and motorcycles jobs, followed by professional, scientific and technical activities, human health and social work activities and manufacturing. 13.8% of households are workless. 10.8% of households experience fuel poverty 79.9 per 1000 population total crime rate
Cheshire West & Chester (Cheshire West & Chester Council, 2019)	11.3% of households experience fuel poverty 183rd out of 317 local authorities (deprivation) 16 neighbourhoods – 10% most deprived in England 7.3% of working age people have no qualifications 75.6% of working age population are in employment - Main employment industries: retail, health, professional, scientific and technical, and manufacturing. - Full-time employment weekly (median) earning - £562.20 - Years spent in 'not good' health for men is 13 years 1 in 5 adults are physically inactive. 63.5% of adults are overweight or obese. - Harmful alcohol consumption by 29% of population 1 in 6 adults experience a common mental health disorder. 30% of households are single person.

	• April 2018 – 6,204 registered on housing waiting list.
Halton (Halton Borough Council, 2017)	• Of those aged 40-74, 45.1% accepted the NHS health check they were offered. • 341.5 per 100,000 emergency admissions for self-harm • 9.7% of households experience fuel poverty • 77% of males aged 16-64 are economically active and 74% are in employment • 48% of residents lived in the 20% most deprived areas in England • 58% of men achieve their weekly recommended physical activity level • 17% of men are smokers • 659 male admissions for alcohol related conditions (in 2015/16) • Main employment industries: professional, scientific and technical, construction, production, transport & storage and business administration and support services.
Knowsley (Knowsley Council, 2011)	• 67.6% employability rate (October 2008-September 2009) • 24% worklessness rate, 1 in 5 working age residents not in employment • Average weekly wage £413.30 • 5.8% of working age residents receiving Jobseekers allowance. • Public sector employment accounted for 32% • High hospital admissions for alcohol related harm • 19.8% live in fuel poverty • Combined overweight and obesity rated approximately 60%
Liverpool (Liverpool City Council, 2018)	• 33.7% have at least one morbidity, 15% have multimorbidity, 7.6% have physical and mental health comorbidity. • 4 out of 10 people living in the 10% most deprived neighbourhoods. • 1,215 first time offender in 2017. • Crime rate 249.2 per 100,000. • Ranked 5th out of 8 core cities for long term unemployment. • 4 out of 10 deaths are premature (under age 75) • A third of children live in poverty.
Sefton (Sefton Metropolitan Borough Council, 2018)	• April 2017-March 2018: 2,361 foodbank vouchers redeemed and 5,547 received help from foodbanks.

	• 15% of households claiming Housing Benefits • 70.2% of economically active people are employed • 4.8% of economically active people are unemployed • Gross weekly pay for full-time workers £524 • 9.6% of those aged 16-64 have no qualifications • Healthy life expectancy – 60.7 years • Low life satisfactions score – significantly higher than the national rate. • 5.9% of eligible population received the NHS health check (2016/17)
St Helens 2017 (St Helens Borough Council, 2018)	• In-work poverty: 31% of St. Helens residents earn below the Living Wage Foundation living wage (23% nationally) • Main employment industries include wholesale and retail trade, construction and manufacturing, administration and support services, education and human health and social work activities. • 16% of homes do not meet the minimum statutory standard. Estimated 15,449 serious health and safety hazard within private sector homes.
Warrington, 2019 assessment (Warrington Borough Council, 2019)	• Alcohol-related mortality – significantly higher for men than women. • Alcohol and drug treatment services: 827 people in structured treatment (as at March 2018). • 10.1% of homes were fuel poor • 66.9% of adults were overweight or obese. • In 2015-2017 there were 30 deaths from substance misuse. • 41.6% of those in alcohol and drug treatment services stated they were a parent. • 50.7% meet the recommended '5-a-day'. • 66.9% are classified as overweight or obese. • 24.6% are physically inactive.
Wirral (Wirral Intelligence Service, 2018)	• 1.9% of adult population estimated to be dependent drinkers • 22% of crime costs in 2015/16 related to alcohol. • Men are an at-risk group of alcohol related harm. • Alcohol related harm 889.2 per 100,000. • 2 in 3 adults are of an unhealthy weight. • 63.3% excessive weight

	• 70.8% of those aged 16-64 are employed.
	• 17.0 per 1000 violent crime rate
	• Worse fuel poverty to England average

Appendix 6

Table 6. Local Authority Health Profiles for each Cheshire and Merseyside borough (PHE, 2019a)
This table considers the indicators that are identified as having a potential impact on male mental health.

Indicator	England average	Cheshire East	Cheshire West & Chester	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
Life expectancy at birth – male (years)	79.6	80.3	79.9	77.4	76.7	76.1	78.7	77.5	78.9	78.3
Inequality in life expectancy at birth (male)	9.4	9.2	10.4	11.0	9.9	11.1	11.0	11.3	11.1	12.6
Suicide rate	9.6	8.8	8.7	11.4	11.5	9.5	11.5	16.1	7.2	9.7
Emergency hospital rate for intentional self-harm	185.5	204.6	206.5	340.0	327.7	266.3	268.4	397.9	311.4	271.5
Hospital admission rate for alcohol-specific conditions	32.9	38.4	34.5	57.6	49.9	45.1	40.6	97.9	46.4	54.2
Hospital admission rate for alcohol-related conditions	632.3	610.1	616.5	830.2	879.9	883.8	757.4	825.3	699.9	858.8
Percentage of physically active adults (19+ years)	66.3	73.7	67.0	62.8	63.3	66.4	63.7	61.7	59.6	62.1
Percentage of adults classified as overweight or obese (18+ years)	62.0	64.8	63.5	74.4	71.2	62.4	71.2	71.6	66.9	62.5
Smoking prevalence in adults in routine and manual occupations	25.4	21.6	26.1	32.3	22.9	18.0	18.8	25.3	19.3	23.0
Percentage of children in low income families	17.0	10.2	12.7	19.6	25.0	26.3	17.1	19.5	11.5	19.2
Percentage of people in employment	75.2	75.4	74.7	73.9	71.5	67.6	70.6	69.8	76.3	73.8
Violent crime hospital admissions for violence	43.4	45.2	35.2	89.2	96.3	121.9	79.5	91.6	68.6	85.0

Appendix 6

Estimated cost of programme	
Cost per person per week	£78
Cost per week per player completing programme.	£155
Cost of each season per area	£8600
Cost per PCT / area	34,400 per annum
Total cost for 7 areas	£240,000 per annum

Figure 1. Estimated cost of It's a Goal! 2012-13. (Spandler et al., 2012, p.51)

It's a Goal!	Per service user	Per contact hour
Per player (If 10 on course)	£16	£78
Per completer (If only 5 complete)	£31	£78
Comparable Service Costs [20]		
Counselling in Primary Care (1:1)	£66	£66
Cognitive Behavioural therapy (1:1 CBT with a psychologist)	£115	£115
Assertive outreach team for adults with mental health problems	£55	£55
Mindfulness based cognitive therapy - group based intervention (12 on course)	£14	£84

Figure 2. Comparable costs of It's a Goal! (Spandler et al., 2012, p.52)

Appendix 7

Table 7. Total net costs and qualify adjusted life years saved for suicide prevention intervention (per 100,000 population) (PHE, 2019a)

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total Cost / Saving
Cost of Additional Psychosocial Assessments	£24,230	£1,732	£1,665	£1,601	£1,540	£1,480	£1,423	£1,368	£1,316	£1,265	£37,621
Ambulance Costs	£0	-£419	-£432	-£443	-£451	-£459	-£464	-£468	-£471	-£473	-£4,080
Immediate Treatment for Self Harm/Suicide	£0	-£3,514	-£3,425	-£3,337	-£3,249	-£3,163	-£3,078	-£2,995	-£2,912	-£2,831	-£28,504
Ongoing Psychological Treatment	£0	-£6,784	-£6,402	-£6,041	-£5,699	-£5,376	-£5,071	-£4,782	-£4,508	-£4,250	-£48,913
Productivity Losses	£0	-£12,794	-£24,434	-£35,000	-£44,565	-£53,196	-£60,959	-£67,915	-£74,120	-£79,629	-£452,612
Police Investigations	£0	-£432	-£826	-£1,183	-£1,506	-£1,797	-£2,060	-£2,295	-£2,504	-£2,690	-£15,292
Coroner Inquests	£0	-£377	-£719	-£1,030	-£1,312	-£1,566	-£1,795	-£1,999	-£2,182	-£2,344	-£13,325
Intangible Costs	£0	-£25,682	-£49,050	-£70,260	-£89,459	-£106,786	-£122,369	-£136,332	-£148,789	-£159,846	-£908,573
Total cost consequences (saving if negative value)	£0	-£50,002	-£85,288	-£117,293	-£146,241	-£172,343	-£195,796	-£216,786	-£235,487	-£252,063	-£1,471,300
Total costs (saving if negative value)	£24,230	-£48,270	-£83,622	-£115,692	-£144,701	-£170,863	-£194,373	-£215,417	-£234,172	-£250,799	-£1,433,679
Cumulative Return per Pound Invested	£0.00	£1.93	£4.90	£8.64	£12.96	£17.71	£22.78	£28.07	£33.54	£39.11	£39.11
Quality Adjusted Life Years Saved	0.03	2.77	3.24	3.69	4.11	4.50	4.88	5.23	5.55	5.86	39.86