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HOW TO ENGAGE MEN IN SELF-MANAGEMENT SUPPORT





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MEN'S HEALTH FORUM

Founded in 1994, the MHF is the independent voice for the health and wellbeing of men and boys in England and Wales. Our goal is the best possible physical and mental health and wellbeing for all men and boys.

How To Engage Men In Self-Management Support
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Men's Health Forum,
32-36 Loman Street, London SE1 0EH
Registered charity No. 1087375
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England

020 7922 7908

www.menshealthforum.org.uk



HOW TO... ENGAGE MEN IN SELF-MANAGEMENT SUPPORT

Introduction	4
THE SCALE OF THE PROBLEM	7
WHAT TYPE OF SELF-MANAGEMENT SUPPORT APPEALS TO MEN?	12
TOP TEN TIPS	28
EVALUATION AND DATA COLLECTION	32
Suggested Further Reading	33
About The Author	34
Acknowledgements	34
Case Studies throughout	

HOW TO... GUIDES

Men are often considered 'hard to reach' when it comes to health. The Men's Health Forum's 'How To...' Guides give you the blueprint to change that.

INTRODUCTION

- OUR AIM IN PUBLISHING THIS GUIDE IS TO ENCOURAGE THE DEVELOPMENT OF SELF-MANAGEMENT SUPPORT PROGRAMMES THAT MEN WILL WANT TO JOIN.

Improving the treatment and management of long-term conditions (LTCs) is currently one of the most significant challenges facing the NHS.

Self-management support interventions are those designed to help develop the abilities of patients to undertake management of LTCs through education, training or support to:

- > develop patient knowledge,
- > enhance skills and/or
- > improve psychological and social resources.

Such interventions have the potential to improve health outcomes, help patients make better use of available health care support, and avoid interventions that are burdensome for patients and their families or carers, and inefficient for the NHS. Unfortunately, men appear to be much less likely than women to access or make continuing use of self-management support services, despite having an increased risk of developing some of the most serious and disabling long term conditions.

During 2013 and 2014, a research group at York, Manchester, Glasgow and Glasgow Caledonian Universities conducted a systematic review of the qualitative research relating to men's experiences of self-management support. The review was funded by the National Institute for Health Research, Health Services and Delivery Research programme (NIHR is the research arm of the NHS) and led by Dr. Paul Galdas of the Department of Health Sciences at the University of York.

The York review is the first time ever that all the available evidence on men's experiences of, and perceptions towards, a variety of different self-management support interventions and activities have been gathered together in a systematic



fashion. The goal of the review was to identify the key elements that make self-management support appealing and accessible to men with LTCs.

The review involved the screening of over 6,000 potentially eligible research studies and, as such, offers a comprehensive picture of the available qualitative research.

Six researchers from multi-disciplinary backgrounds and expertise in the areas of men's health, self-management, health psychology, and LTCs were involved in analysing and synthesising the evidence. Men living with long term conditions were also involved in key stages of the analytical process to allow for the consideration of service-user perspectives and enhance the applicability and impact of the findings.

This How To guide takes the findings from the York review and condenses them into a practical guide for those people designing, delivering, or commissioning self-management support services. Readers of this guide are also encouraged to refer to the review itself where more detailed information or supportive evidence is provided. The full report is available here:

<http://www.nets.nihr.ac.uk/projects/hsdr/12500114>

Our aim in publishing this guide is to encourage the development of self-management support programmes that men will want to join. As you will see from the content of the guide, this does not necessarily mean delivering “men only” programmes. The guidance provided should be equally useful to those who are currently delivering mixed-sex programmes but who want to make sure they are as accessible and acceptable as possible for male participants.

- THIS GUIDE SHOULD HELP MAXIMISE THE LIKELIHOOD OF MEN JOINING PROGRAMMES.

The NIHR-funded review was able to pick out key themes in the evidence that have been shown to be important to men when engaging in self-management support activities. For these reasons, this guide should help maximise the likelihood of men joining programmes. At the same time, because one of the things shown by the review is that the research base is still relatively limited, there is still plenty of scope to try out new ideas in programme development. We are hopeful that this guide will improve the chances of those new ideas being good ones.

Finally, as in previous MHF “How to...” guides, we have included a short section on data collection and evaluation. It is, of course, important to measure outcomes at the local level and we hope that the advice in this handbook will help people to do that well. However, it is arguably even more important to collect (and report) standardised data so that one programme can be compared with another. Unless we do this, we will be seriously hampered in our attempts to develop model ways of working that we know are effective and that can be replicated around the country.

THE SCALE OF THE CHALLENGE

In England, more than 15 million people have a long term condition (LTC). This figure is set to increase over the next 10 years, particularly those people with three or more conditions at once. Examples of LTCs include high blood pressure, depression, dementia and arthritis.

LTCs can affect a person's ability to work, to have relationships and to access housing and education opportunities. Care of people with long term conditions accounts for 70% of the money spent on health and social care in England including half of all GP consultations.

- CARE OF PEOPLE WITH LONG TERM CONDITIONS ACCOUNTS FOR 70% OF THE MONEY SPENT ON HEALTH AND SOCIAL CARE IN ENGLAND INCLUDING HALF OF ALL GP CONSULTATIONS.

The table on page 9 shows the figures for LTCs recorded on QOF disease registers. However, some conditions do not have QOF disease registers - for example, over 5 million people report they have musculoskeletal conditions and 10-20% of the population are estimated to have irritable bowel syndrome.

The scale of the challenge is expected to grow. Although the number of people with one long term condition is projected to be relatively stable over the next ten years, the number of those with multiple LTCs is expected to increase to 2.9 million by 2018 (from 1.9 million in 2008).

LTCs AND GENDER

Some LTCs affect men more than women. In the GP Patient Survey 2014, which is based on self-reporting, 54% of men reported having at least one LTC. The survey suggests that men are more likely than women to have diabetes (9% of men compared to 6% of women), angina or long-term heart problems (6% to 4%) and hypertension (19% to 18%). Women are more likely to have asthma or long-term chest problems (10% to 12%) and



arthritis or long-term joint problems (10% to 16%).

LTCs AND AGE

LTCs do not just affect older people. In the General Lifestyle Survey of 2009, 14% of those aged under forty reported having an LTC. In the GP Patient Survey 2104, 41% of men under 45 reported an LTC (and 28% of men under 25). Two in five men with LTCs (40%) are in full-time paid work (30 hours or more each week).

LTCs AND CLASS

The impact of LTCs is heavily influenced by social class. Compared to social class I, people in social class V have 60% higher prevalence of long term conditions and 30% higher severity of conditions.

LTCs AND DISABILITY

Disability and LTC are clearly linked but not the same. Disability is defined in different ways for different purposes. The Equality Act 2010 says a person is disabled if they have a physical or mental impairment which has a substantial and long-term adverse affect on their ability to carry out normal day-to-day activities.

Some people with LTCs may be disabled, others not. The government's own disability facts and figures say there are over 11 million people in Great Britain with a limiting long term illness, impairment or disability. The self-reported GP Patient Survey includes some common impairments and suggests that 1% of men are blind or have a severe sight impediment, 2% have a learning disability, 4% are deaf or have a severe hearing impediment and 10% have arthritis or a long-term joint problem.

Condition	Number (2011)	Increase	% of men	% of women	Name of condition where different in 2014 survey
Hypertension	7,460,000	+11%	19%	18%	
Depression	4,878,000	N/A	5%	5%	(long term mental health problem)
Asthma	3,273,000	+6%	10%	12%	(asthma or long-term chest problem)
Diabetes	2,456,000	+25%	9%	6%	
Coronary Heart Disease	1,878,000	-1%	6%	4%	(angina or long-term heart problem)
Chronic Kidney Disease	1,855,000	+45%	2%	1%	(kidney or liver disease)
Hypo-thyroidism	1,667,000	+22%			
Stroke or TIA	944,000	+9%			
Chronic Obstructive Pulmonary Disease (COPD)	899,000	+17%	See asthma above		
Cancer	876,000	+79%	3%	3%	
Atrial Fibrillation	791,000	+14%			
Mental Health	438,000	+15%	See depression above		
Heart failure	393,000	-6%			
Epilepsy	337,000	+5%	1%	1%	
Dementia	267,000	+25%	<1%	1%	

The most common long-term conditions (numbers from 2010-11 and increases compared to 2006-07 are from the Department of Health Long Term Conditions Compendium of Information Third Edition, 2012 while self-reported gender percentages are from the GP Patient Survey 2014)

CASE STUDY:

‘MY FIRST HEART ATTACK

DEREK, 82

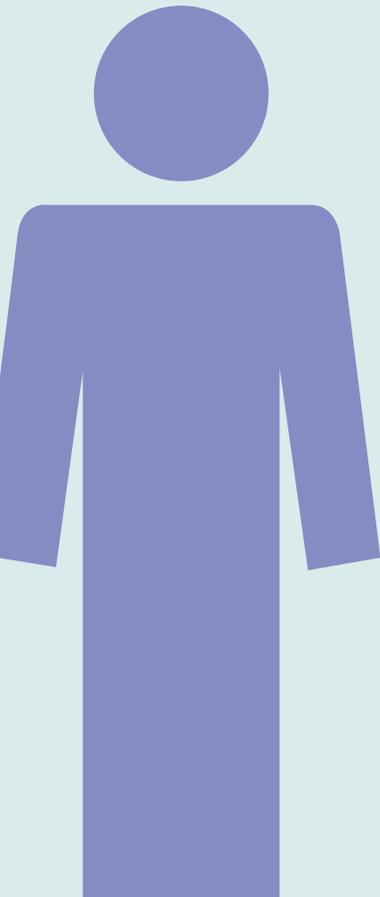
My ‘heart attack’ story begins with my family. My father died very suddenly on a bowling green at the age of 65. This was repeated by two of his brothers.

I was aware that heart problems would affect me, but I took no precautions. I did exercise a full life with four sons, plenty of hill and mountain walking (twice a year up Snowdon), and the use of a cycle regularly in York.

My first heart attack took place at age 49, a brief spell in the coronary care unit, and four months of “rest” which was followed by similar activities, but a little more gentle. Diet was the pattern, with beta blockers plus dispersible aspirin. Mountain walking was a little less energetic.

At age 55 I had a major heart attack with three consultants expressing their surprise that I survived! A long period was spent in the Coronary Care unit with a discharge after 16 days. This was followed by an angiogram six months later by a consultant whose verdict was: ‘your heart is 95% blocked, but I reckon is best left alone due to its location.’ Exercise continued on much the same level as before.

My next consultant eventually changed the diet by substituting beta blockers with warfarin, simvastatin, etc. which added breathlessness and difficulty in coping with inclines. This was the end of hills and mountains!



TOOK PLACE AT AGE 49'



Until this time I had suffered from angina, but the new medication took away all traces of angina.

I made sure I kept up reasonable exercises. I went for a walk of approx. a mile every morning, continued to use my electrical bike for short distances, and helped my busy son with his allotment.

I was introduced to Caroline, the heart function (or rather failure) nurse, who gave me a lot of advice, and linked me to the by-monthly self-management support group. I had been unaware of this group for some considerable time. Since then I have tried to be a regular attender with my supportive wife.

Sometimes the support group is very helpful, at others less-so! Often this is due to good visiting speakers who are quite knowledgeable, but not very gifted at holding peoples' attention. On other occasions the meetings are entertaining and most helpful.

My GP (who has helped me cope with gout), encouraged me to make good use of Caroline, and to expect her to be far more knowledgeable than he is! She has given me a lot of good advice and helped me to do my exercises with several sessions under the guidance of a very good physio.

WHAT TYPE OF SELF-MANAGEMENT SUPPORT APPEALS TO MEN

The current evidence does not point toward one specific type of support intervention or activity that is most appealing to men living with long term conditions. However, a systematic review of the research highlights some key elements in relation to the content and process of self-management support that should help interventions to be more accessible and acceptable to men. These are summarised under five themes in the ensuing pages of this guide.

It is important to recognize that there is unlikely to be a 'one-size-fits-all' approach to making self-management support acceptable for men. Clearly, men are not a homogeneous group, and some factors discussed are more likely to help to improve the acceptability and accessibility of interventions for certain sub-groups of male service users, but not others.

Similarly, some of the guidance offered here is likely to be equally relevant to female service users.

In addition to following the advice offered in this guide, health professionals and service

MORE THAN HALF
OF MEN HAVE AN
LTC (54%) >



NEARLY ONE IN FIVE
HAS HYPERTENSION >



commissioners might usefully consult with their own male service users about how to make existing support interventions more appealing to, and congruent with, men's needs.

We have categorised the findings from the York review under five key headings. These key headings arise naturally from the evidence and have allowed us to group together some of the most important considerations. We have tried to describe these considerations in a way that is practical but which acknowledges that it is not always possible to be definitive. Taking account of these considerations should maximise the chances of local initiatives appealing to men and working effectively for men. The key headings are as follows:

- > Taking account of men's identities
- > Identifying and offering a clear benefit with a tangible result
- > Building and maintaining a trusted environment
- > Getting value from peer support
- > Education, information, and becoming an expert

- MANY MEN WILL HAVE EXPERIENCED TENSIONS BETWEEN A DESIRE TO CONTINUE TO 'LIVE UP' TO SOCIO-CULTURAL EXPECTATIONS LINKED TO THEIR IDENTITY AS A MAN AND ACCEPTANCE OF THEIR LTC.

TAKING ACCOUNT OF MEN'S IDENTITIES

Many men living with a long term condition will have experienced tensions between a desire to continue to 'live up' to socio-cultural expectations linked to their identity as a man, and acceptance of living with and needing support to manage a condition that has disrupted and potentially threatened their male identity. The research evidence suggests that self-management support is likely to be more accessible and acceptable to men when it takes account of valued aspects of

CASE STUDY:

‘MY STATE OF MIND IS AS

BARRY

Having been diagnosed with Type 2 Diabetes in 1998, I found that support for the condition from the medical community was sketchy. The educational programme provided by the local hospital was ill-considered and, in some areas, downright misleading.

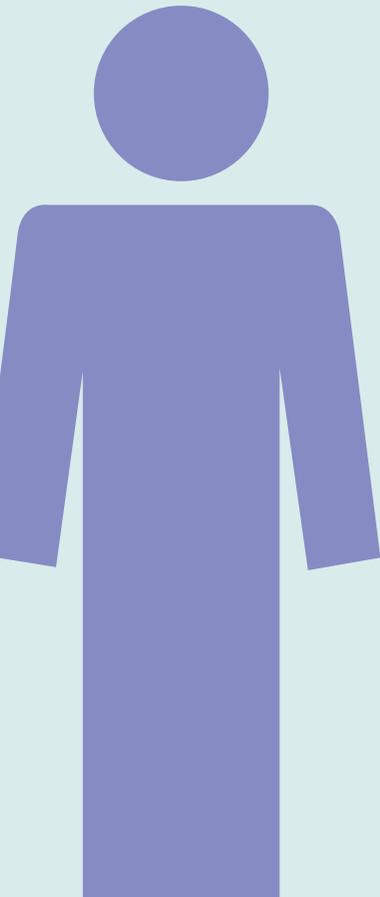
I looked around for other support and found it difficult to come across a group that matched my needs. Too many seemed to be focussed on raising funds rather than raising awareness of the condition or providing practical help and advice.

So, rather than join a support group, I researched the condition more thoroughly and became chairman of a newly-formed diabetes group to learn more and provide that support. Additionally, my involvement with the group allowed me regular access to a wide range of healthcare professionals.

And, I soon learned that healthcare isn't just about people in white coats and it doesn't just involve physical symptoms.

It also involves professionals in exercise and nutrition and is most frequently provided effectively in buildings unrelated to doctors' surgeries, clinics and hospitals: environments that can be uninviting, intimidating and impersonal – not the sort of places to foster learning.

And, my state of mind is just as important (if not more so) than my state of body. They are linked inexorably - something that most healthcare professionals seem to have forgotten (always assuming that they considered it in the first place).



IMPORTANT AS MY BODY'

In our town, I've found out that support provided by the NHS for people with diabetes has been severely constrained by finances, and my early efforts to help get round this were met with a smokescreen of 'clinical governance' and 'lack of medical qualifications'. But my qualifications are far superior to most of the people treating me – I have diabetes. It's not a 9-5, Monday to Friday, superannuated affair with lots of perks and holidays. It's 24/7, 365 and utterly devoid of perks.

From my experience, lots of men find it difficult to even go to the doctors, especially with a problem most often manifested by an over-active bladder. Us lads don't like admitting to problems in that area, let alone going to the doctors to discuss it.

Women are more used to dealing with problems in their sensitive areas and I believe that they are far more likely to approach their doctors with any relevant concerns.

Similarly, women are more likely than men to discuss their problems with other people around.

Like most long-term health problems, people like to mix with others, and that's where groups like ours come in, and we're pretty much 50/50 men and women. Everybody takes part in our meetings and discussion forums with equal enthusiasm.

Members and visitors like our group because we recognise that, first and foremost, they are people - and not defined by their condition. It's something they have, not something they are. They live with it, not as it!

their masculine identity. Key factors to consider in addressing this issue are:

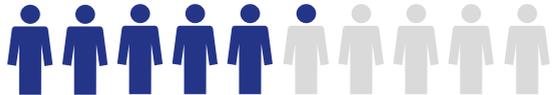
- > Seeking and accepting support can pose greater threats to identity for men who place value on the masculine 'ideals' of stoicism, independence and self-sufficiency. Some activities, such as sharing problems in a group, can make men feel weak and out of control.
- > Some men may feel the need to justify or legitimize their involvement in self-management support in order to protect or maintain their masculine identity. For example, support that focuses on improving strength, skill or knowledge is more in line with many men's identities than activities that focus on addressing vulnerabilities.
- > Whilst many men value emotional support, they may feel less comfortable than women with reporting this as a motivation for using support interventions.

LONG TERM CONDITIONS: A MAJOR MALE WORKFORCE ISSUE

40% OF FULL TIME
MALE WORKERS
HAVE AN LTC >



SO DO 53% OF
PART-TIME MALE
WORKERS >



SO DO 60% OF
UNEMPLOYED MEN >



SO DO 30% OF
MALES IN FULL-TIME
EDUCATION >



- MEN MAY PREFER SELF-MANAGEMENT ACTIVITIES THAT DO NOT HAVE EMOTIONAL SUPPORT AS AN EXPLICIT, ADVERTISED COMPONENT.

- > Men may view self-management activities more appealing and accessible when they do not have emotional support as an explicit, advertised component. Emotional support that occurs as a 'by-product' of other shared activities may be more acceptable. For example, men may develop a sense of camaraderie and mutual support when engaging in physical activities, but not when sat in a group discussion.
- > Using the word 'support' in the marketing and advertising of interventions may discourage some men from attending.

IDENTIFYING AND OFFERING A CLEAR BENEFIT WITH A TANGIBLE RESULT

For men to seek, access, and continue to use self-management support, many may feel that an intervention has to provide a clear, tangible benefit that addresses an unmet need. The following factors may help inform interventions to address this:

- > Family and friends can be pivotal in helping men to identify an unmet need and encouraging their involvement in support interventions.
- > Structured, action-orientated interventions that offer tangible benefits (such as improved physical fitness, symptom management, or mental wellbeing) may be particularly attractive to male service users.
- > Taking part in an activity-based support intervention (such as exercise, interactive discussion with a health professional) may be more preferable to 'just talking' and can allow men to maintain a sense of independence, strength, and control.

- BEING ACTIVELY INVOLVED IN A SUPPORT INTERVENTION, AS OPPOSED TO BEING A PASSIVE RECIPIENT, CAN HELP SOME MEN REGAIN CONTROL

- > Physical activity can offer a purpose and focus to support interventions that is particularly appealing to many men.
- > Affording men opportunities to help others in self-management support groups – being able to ‘give back’ – can be a motivator to access and continue to engage in interventions; for example, by being involved in the management, administration or delivery of support activities.
- > ‘Giving back’ can also make it less problematic for some men to admit to benefiting from the group themselves.
- > Being actively involved in a support intervention, as opposed to being a passive recipient, can help some men regain control and reclaim a sense of identity which can be disrupted through chronic illness.
- > For some men, giving and receiving advice and information about ways to better manage a condition can also offer reassurance, and serve to provide emotional support by reducing uncertainty and increasing feelings of control.
- > Emotional support and informational support are interrelated for some men, possibly more so than in women.

A pencil is positioned vertically on the left side of the page, pointing downwards towards a blue architectural drawing. The drawing shows a staircase with various measurements and labels, including 'TREPPEHAUS' and '0.4 9.550'. The drawing is a technical plan of a staircase, showing the steps, landings, and structural elements.

BUILDING AND MAINTAINING A TRUSTED ENVIRONMENT

Delivering interventions in a safe, trusted environment can be crucial to ensure support is appealing and accessible to men. This is likely to be especially important when taking part can make participants feel vulnerable or lacking in confidence; for example, in group-based activities that involve emotional sharing that might be seen to threaten masculine ideals and behavioural norms. Some important considerations associated with building a trusted environment are:

- > Men may prefer an environment in which emotional support is framed in a way that focuses on strength, perseverance, and camaraderie.
- > Emotional support conveyed covertly through humour or supportive silence may also be valued by some men.
- > In interventions involving physical activity, matching the pace or intensity of exercise to individuals' current physical health and limitations can improve the appeal to male service users by allowing men to participate without feeling inadequate about their bodies or their physical capabilities.
- > For interventions involving group-based talk, allowing men the ability to listen without feeling an expectation to speak or the pressure to share their specific experience can improve acceptability.
- > The anonymity offered by online communities can allow men to 'open up' to emotional expression and intimacy that may otherwise be considered difficult in face-to-face interactions

- > Environments can be made more accessible for some men by allowing female ‘significant others’ to attend.
- > For others, the exclusion of female family and friends from self-management support groups can promote greater trust by allowing men to speak without worrying about any negative consequences in their existing social networks.
- > Group dynamics in face-to-face support groups can work to either support or stifle men’s emotional expression. Facilitators of support groups are key to fostering group dynamics.

GETTING VALUE FROM PEER SUPPORT

Interacting with peers – those who have a shared illness experience – can offer men a much-needed sense of belonging and community which can help them adjust and come to terms with their health problems. Offering opportunities for peer support may be particularly important for men when experiencing a chronic problem which makes them feel that they ‘stand out from the herd’: distinct from other men and perhaps unable to engage in work and leisure activities that they have been accustomed to at other times in their adult life. When designing and delivering peer support interventions, the following should be taken into account:

- > Peers and group identity can encourage and motivate positive behaviour change through a sense of camaraderie and social commitment.
- > Constructive and purposeful discussion (e.g. providing and sharing information and being solution-oriented), particularly in the context of other group-based activities, may generally be seen as more appealing and acceptable to men.

- INTERACTING WITH PEERS – THOSE WHO HAVE A SHARED ILLNESS EXPERIENCE – CAN OFFER MEN A MUCH-NEEDED SENSE OF BELONGING AND COMMUNITY

- 
- The background of the page is a light blue architectural drawing or blueprint. It features various lines, shapes, and text, including labels like '6.7', '133', '6.5', 'INST.-SCHACHT', 'HAUS', and '9.55'. The drawing appears to be a floor plan or a technical drawing of a building structure.
- > Men may particularly find purposeful discussion preferable to peer support that offers ‘just talking’ or which focuses on the expression of emotions. This is especially likely where peer support lacks an effective facilitator.
 - > Some men may wish to attend male-only groups. However, being able to identify with the illness experience of others is likely to be of greatest importance.
 - > In some cases, especially among men living with long term conditions perceived to be ‘stigmatised’, identifying others as peers might require having multiple things in common, such as age, culture, sexuality, and gender.
 - > Men can view peers as ‘credible sources’ from which to learn about self-management through interaction, information exchange, and social comparison.
 - > Attendance of women and significant others at self-management support can have both a positive and negative impact on men’s perception of acceptability and accessibility; this may vary with condition and with activity / intervention type.

CASE STUDY:

'MEN LIKE BEING IN BUT WOMEN FIND IT

LES, 66

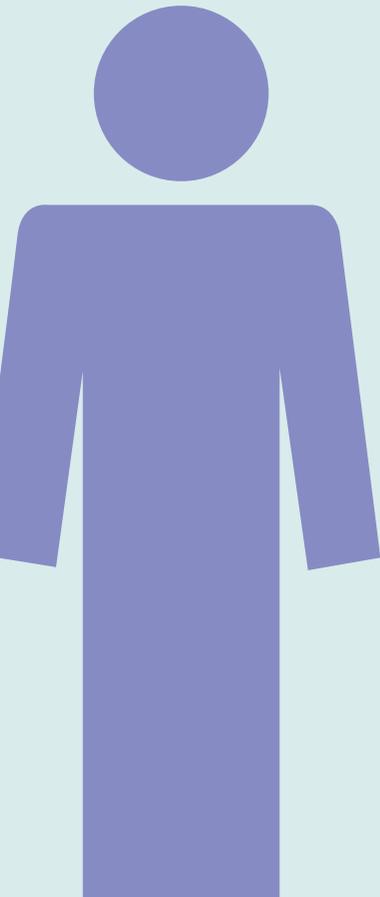
Back in January 1992, when first diagnosed with type 1 diabetes, the thought of injecting myself several times a day for the rest of my life was a little frightening. After all, I was in my early 40's and rarely had a day's illness.

A nurse came around to show me the correct procedures for testing blood glucose and injecting insulin. With a fear of needles by the rest of the family, I had to take control of the situation myself.

It was the nurse that suggested I attend group meeting of carers, parents and others who had diabetes. This was excellent advice. I quickly learned that this did not have to change my life dramatically, if I could avoid complications associated with diabetes. Group members and speakers at the group were a great source of information that helped me achieve this.

I experienced some loss of vision when first diagnosed, which was quickly corrected by a few sessions of laser treatment. This made me realise that my actions were the main input into my well being. I think men in general find it easier than women to manage their long term conditions, because they like to be in control of situations. But women find it easier to attend group meetings and easier to talk about their illnesses. By talking and sharing a problem it is easier to deal with.

After 20 years of injecting and experiencing poor blood glucose control, an insulin pump was offered to me. Being aware that poor control could



CONTROL OF SITUATIONS EASIER TO TALK?



result in complications, I accepted the offer. The pump requires an input from me every time I eat. The information required was blood glucose levels, which I was familiar with, and carbohydrate levels in food I was about to consume.

Counting carbohydrates was completely new to me, and training was given by the Diabetic team at the Friarage Hospital. This knowledge was essential for the correct use of the pump, and of tremendous value to me. I wish I had been given this knowledge when I was first diagnosed.

However, through attending lectures and training, listening to speakers at the group meetings, being able to talk to people with similar conditions, I have managed to lead an almost normal life. I am now 66 and have a full time job in the construction industry.

My active lifestyle and hobby of long distance walking and hill climbing, did have to be curtailed a little, but I was able to continue at a more acceptable pace, and when possible, with a companion.

EDUCATION, INFORMATION, AND BECOMING AN EXPERT

Men may value opportunities to learn from peers and health professionals in order to develop their capacity to be informed consumers of healthcare; a role that can complement the need to identify a purpose and tangible benefit to an intervention. Education and information provision can be made more accessible and acceptable for men by considering some of the following:

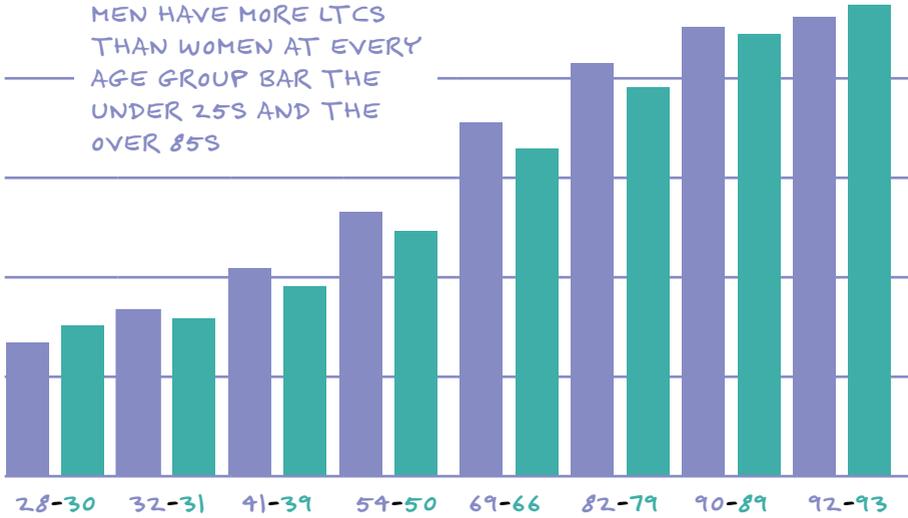
- OVERLY COMPLEX INFORMATION CAN ACT AS A BARRIER TO LEARNING AND MAY ALSO PROVOKE ANXIETY OR FEELINGS OF BEING OVERWHELMED.

- > Contextualising and individualising information in the form of strategies or “usable information” that can be incorporated into daily life.
- > Although some men may place a high value on technical information and knowledge, overly complex information can also act as a barrier to learning and may also provoke anxiety or feelings of being overwhelmed.
- > Men may value learning to better navigate health services, facilitate patient-health professional interactions, and attain partnership in decision-making. However, some may wish to retain a passive rather than proactive role in health care decision-making at certain points in their illness trajectory.
- > Acceptability of health information may be improved through the use of medical information/evidence and terminology, which may also help to foster group identity in face-to-face support groups.

PERCENTAGE OF PEOPLE WITH LTCS IN EACH AGE GROUP

16-24 25-34 35-44 45-54 55-64 65-74 75-84 85+

MEN HAVE MORE LTCS THAN WOMEN AT EVERY AGE GROUP BAR THE UNDER 25S AND THE OVER 85S



% OF MEN - % OF WOMEN

CASE STUDY:

‘I STAY ON MY MEDICATIONS

RICHARD, 40

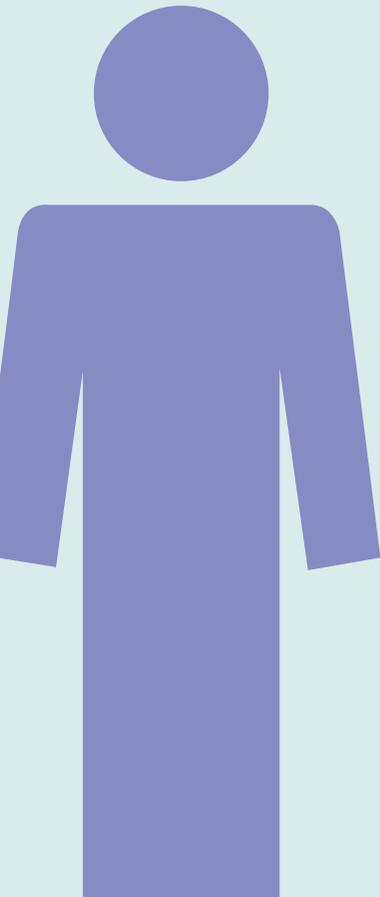
I was diagnosed with paranoid schizophrenia in 1999. If I hadn't I'd have topped myself within weeks – indeed I had just stopped myself from jumping off the Clifton Suspension Bridge in Bristol a few days before.

Dealing with schizophrenia you have multiple symptoms. Depression, which they say affects 25% of the population and leaves you feeling flat and unable to cope. You suffer mania at times where you are over energised, and don't sleep for days. Finally, I had weird ideas that I believed - this is known as psychosis.

After my initial five years of treatment I did an MA in broadcast journalism at University College Falmouth. That was when I discovered how disabling the stigma of mental illness can be.

My Community Psychiatric Nurse had been off sick for six months when one of his team phoned me to check if I was OK? I told them that I was fine, and was deciding whether to take a job offer at a major international news organisation or to do a PhD in the cultural theory of terrorism. The CPN's response on the phone was priceless: 'Richard, we'd better send someone round to see you!'

Two weeks later I dropped the minor detail about my schizophrenia to the news organisation, which led to a heated grilling by two HR officers and a lawyer, before they dropped the job offer.



DESPITE SIDE-EFFECTS'



Like many people who have disabilities I am freelance so I can operate under my own steam. This isn't to say I cruise through life – I work jolly hard and have had some great successes as a journalist. I see my psychiatrist every three months and as necessary call for support. I stay on my medication, even though the long term health effects are life shortening – I prefer to live life to the full than risk being in and out of institutions all my life.

Cuts to services are a real issue. Psychiatric inpatient units used to be places of rest, where now they are only for the very disturbed due to cuts to services. Community support from professionals, where once for anyone who had a decent diagnosis like mine, just isn't there unless you're about to jump off a bridge.

Where more people are getting stressed out due to the economic climate to the point they can't cope anymore, fewer are able to get the help they need.

TOP TEN TIPS

- MEN APPEAR TO PREFER PROGRAMMES THAT ARE STRUCTURED AND INVOLVE ACTIVE PARTICIPATION.

✓ **What's in it for me?** Making the purpose and potential benefits of attending a support intervention clear can help to make self-management support more appealing to men. Men often want to feel that an unmet need will be addressed.

✓ **Man-handle with care:** Seeking and accepting self-management support can be uncomfortable for some men who pride themselves on being independent and self-reliant. Support is more likely to be accessible and acceptable for men when it builds on these aspects of men's identities, rather than threatens them.

✓ **Family Ties:** Men's family or friends can be pivotal in encouraging and legitimising their involvement in self-management support activities, and should be considered in the advertising and/or referral to interventions.

✓ **Talk the talk:** allowing men opportunities to provide, share and discuss information as part of group-based activities is likely to be more attractive to men and a more acceptable way to gain and offer emotional support, compared to activities with an explicit focus on emotional aspects of self-management.

✓ **Walk the walk:** men appear to prefer programmes that are structured and involve active participation, rather than those that involve them being a passive recipient. Creating opportunities for men to contribute to the organisation and/or delivery of programmes can be valued by all attendees.



✓ **Log on:** online communities can be attractive spaces for men to share and discuss self-management strategies and information, and ‘open up’ to emotional expression that some may find difficult in face-to-face situations.

✓ **Don’t push too hard:** allowing the choice to opt-in or opt-out of an activity without it leading to feelings of embarrassment or inadequacy can be appealing and allow men to maintain a valued sense of self-control and autonomy.

✓ **I know how you feel, mate:** being among others who are going through a similar experience can lead to a sense of camaraderie and mutual support that can keep men engaged in programmes. Consider whether this might be best achieved by making a group male-only.

✓ **Knowledge is power:** making practical information and useable evidence a core element of an intervention can allow men the opportunity to be informed consumers of healthcare. It may also fulfil the commonly encountered male need to identify a clear purpose and tangible benefit to an intervention.

✓ **Just like home:** support interventions can be made more accessible and acceptable to men if they are offered in a safe, private, trusted space. Consider non-healthcare environments such as sports venues, gyms or business premises.

CASE STUDY:

PERSONAL DEVELOPMENT

BARRY, 52

I developed rheumatoid arthritis when I was a teenager. The biggest challenge at first was the psychological impact as I loved sport and was very active. I also saw arthritis as something affecting the old, and I can remember being extremely embarrassed to say the word arthritis.

I would hope things are different nowadays (I'm in my fifties now) but back then no one asked me how I felt about it. All the focus was on the physical symptoms. I didn't mind being in pain so much, it was not being able to do things and worrying about what sort of job would I be able to do that affected me the most.

Later in life I overcame my embarrassment and joined Arthritis Care. The fact they had a youth section then really helped. I met people much more impaired than I was and the positive outlook they had worked better on me than any counselling ever could. I realised I felt sorry for myself and was comparing myself with an idea of a more physically able self. The people I met in Arthritis Care made me realise that it is the person's character and personality that matters, not any physical abilities. I also realised there were people much more limited physically than me, but they were much more positive than I was.

Over my life I learned some things that have helped me absorb my impairments into my life without feeling lesser as a person. This has taken



AS VALUABLE AS MEDICINE?



some time and any programmes or support that help people diagnosed with illnesses or physical impairments to learn such things should be encouraged. In my view this has as much or even more value than medication and treatment.

The sort of thing I am referring to is being able to ask people to help me without being apologetic or feeling in their debt. I routinely ask colleagues at work to carry things for me, or open bottles and they do it without question. I used to find that difficult and it is such minor but every day things that can affect a person's mental health.

I've also put my focus into the things I can do rather than the things I can't. Doctors don't give advice about such practical matters and perhaps it isn't their job to, but it should be someone's, especially for young people with arthritis.

In more recent years I have sought NHS help with deterioration of joints and I also get regular podiatry. This has been very helpful. The only difficult aspect is fitting in appointments around work. It would be really useful to be able to email my GP and podiatrist to make appointments and ask straightforward questions. If I could do this I would probably reduce my visits.

EVALUATION AND DATA COLLECTION

It is widely recognised that locally-based public health interventions can be difficult to evaluate. This is sometimes because the intervention does not easily lend itself to evaluation, sometimes because there are insufficient resources to evaluate the intervention properly and sometimes because not enough importance is attached to the need to evaluate.

Evaluation and good data collection are particularly important in the field of male health. This is because interventions are often more successful at engaging women than men. Unless all data are collected and reported in gender disaggregated form, men's under-use of services may pass unnoticed.

In relation to self-management support specifically, collection of the right data reveals whether there are gender differences in engagement with the project or in health outcome. Ultimately it is not possible to differentiate between what works well for women and what works well for men, unless the right data are collected and good evaluation processes are in place.

Poor or inadequate evaluation disadvantages both sexes but is, in general, more likely to disadvantage men. If women are more likely to use a service in the first place, then evaluation that does not take gender into account will inevitably tend to identify as more successful, those elements that work well for women. These elements will then be emphasised in future interventions thus – albeit inadvertently - creating a cycle in which male need is consistently underacknowledged.

SUGGESTED FURTHER READING

- > European Commission: The state of men's health in Europe report. 2011. http://ec.europa.eu/health/population_groups/docs/men_health_report_en.pdf.
- > Galdas PM Darwin Z Kidd L Blickem C McPherson K Hunt K Bower P Gilbody S Richardson G (2014) The accessibility and acceptability of self-management support interventions for men with long term conditions: a systematic review and meta-synthesis of qualitative studies BMC Public Health 14; 1230
- > Galdas PM (2013) Man Up: Engaging men in primary care Practice Nursing 23(12); 10-13
- > Hunt K McCann C Gray CM Mutrie N Wyke S (2013) "You've got to walk before you run": Positive evaluations of a walking program as part of a gender-sensitized, weight-management program delivered to men through professional football clubs. Health Psychology 32(1):57.
- > Men's Health Forum; Men's Health Manifesto https://www.menshealthforum.org.uk/sites/default/files/pdf/mens_health_manifesto_lr.pdf
- > White A McKee M Richardson N Visser R Madsen SA Sousa BC Hogston R Zatoński W Makara P (2011) Europe's men need their own health strategy BMJ 343:d7397.

For men with long-term conditions, useful resources include:

- > menshealthforum.org.uk/lrc
- > Jim Pollard: The User's Guide to the Male Body (Sheldon, 2009) - a general men's health guide which also has a chapter on 'how to be ill with skill' including long-term conditions.

ABOUT THE AUTHOR: PAUL GALDAS

Paul Galdas, senior lecturer at the Department of Health Sciences, University of York, is a leading researcher in the field of men's health.

He has a clinical background as a registered nurse, working in medical cardiology at City Hospital, Birmingham, and St James' Hospital, Leeds, prior to embarking on an academic career as a nurse lecturer and health services researcher.

His PhD on the influence of masculinity on men's help-seeking behaviour for cardiac chest pain was awarded in 2006 from the University of Leeds.

Since this time he has developed a programme of research investigating men's help-seeking behaviour and engagement with health services in a variety of issues including coronary heart disease, depression, and chronic illness, and has published widely on these topics.

He held academic positions at the University of British Columbia, University of Sheffield, and Sheffield Hallam University before joining the University of York in 2011.

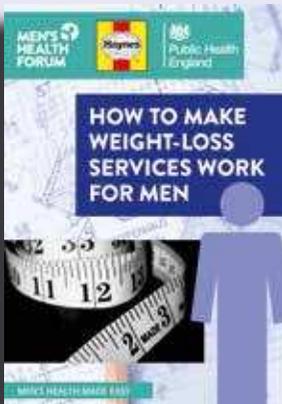
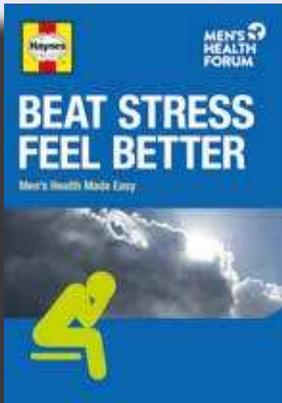
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'IT WAS CHALLENGING BUT DIDN'T MAKE YOU FEEL BAD ABOUT YOURSELF. I REALLY LIKED THE STYLE.'



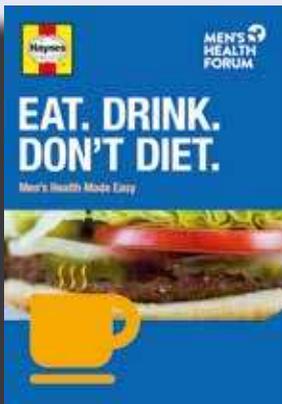
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