



This is a repository copy of *Successful mental health promotion with men: The evidence from 'tacit knowledge'*.

White Rose Research Online URL for this paper:
<http://eprints.whiterose.ac.uk/132203/>

Version: Accepted Version

Article:

Robertson, S. orcid.org/0000-0002-5683-363X, Gough, B., Hanna, E. et al. (4 more authors) (2018) Successful mental health promotion with men: The evidence from 'tacit knowledge'. *Health Promotion International*, 33 (2). pp. 334-344. ISSN 0957-4824

<https://doi.org/10.1093/heapro/daw067>

Reuse

Items deposited in White Rose Research Online are protected by copyright, with all rights reserved unless indicated otherwise. They may be downloaded and/or printed for private study, or other acts as permitted by national copyright laws. The publisher or other rights holders may allow further reproduction and re-use of the full text version. This is indicated by the licence information on the White Rose Research Online record for the item.

Takedown

If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing eprints@whiterose.ac.uk including the URL of the record and the reason for the withdrawal request.



eprints@whiterose.ac.uk
<https://eprints.whiterose.ac.uk/>

Successful mental health promotion with men: evidence from 'tacit knowledge'

ABSTRACT:

There remains significant concern about men's mental health, particularly in terms of personal and societal barriers to help-seeking, negative coping mechanisms and high suicide rates. This paper presents findings from a multi-phase study looking at 'what works' in mental health promotion for men. Work here reports the collection and analysis of the tacit knowledge of those working within mental health promotion interventions for men.

A 'multiple hub and spoke' approach was used to assist data collection. Thirteen key players, active in the men's mental health field, half from the UK and half beyond, formed an Investigative Network collecting data, mainly through interviews, from wider geographical and professional community contexts where they had networks. The focus of data collection was on 'what works' in mental health promotion for men. Data was analysed using thematic analysis techniques.

Findings suggest that settings which created safe male spaces acted to promote trust, reduce stigma and normalise men's engagement in interventions. Embedding interventions within the communities of men being engaged, fully involving these men, and holding 'male-positive' values engendered familiarity and consolidated trust. Using 'male-sensitive' language and activity-based approaches allowed for positive expressions of emotions, facilitated social engagement, and provided a base for open communication. Appropriate partnerships were also seen as a necessary requirement for success and as crucial for maximising intervention impact.

The importance of gender and 'masculinity' was apparent throughout these findings and taking time to understand gender could facilitate positive ways of working alongside men, increasing levels of engagement and successful outcomes.

Key words: Men's health; mental health; health promotion programmes; gender; masculinity

INTRODUCTION:

Men's life expectancy continues to improve in many countries (European Commission, 2011) and is improving at a greater rate than women's in the United Kingdom (UK)(Bennett et al., 2015), the United States of America (USA)(National Center for Health Statistics, 2015) and Australia (ABS, 2014). However, significant issues remain in men's health particularly in relation to understanding the wider factors that impact on men's health practices and their engagement in health promotion. Work on sex-differences in help-seeking has shown far less difference than has previously been thought. The majority of differences that do exist are accounted for by access to reproductive care (contraceptive and maternity services), preventative health practices (such as screening services), and in engaging for mental health concerns rather than to differences in seeking help for physical ill-health symptoms (e.g. Hunt et al 1999; Wang et al 2013). Sex-difference in help-seeking for psychological issues are a consistent finding and a particular concern. It is well established that fewer men than women are treated for what are referred to as 'common mental disorders' (Deverill & King, 2009) in the UK (e.g. Richards & Borglin, 2011) and elsewhere (Addis, 2008). Some have

suggested that this is due to sex-differences in diagnosis and engagement with mental health services rather than a sex-difference in actual prevalence (Addis, 2008). To add to this, what is expected in terms of appropriate gender behaviour for men, particularly about being rational, stoical and not showing weakness, is also said to play a part in men's reluctance to engage with mental health and wellbeing interventions (Kingerlee et al., 2014). However, elements of masculine norms, particularly those around control and responsibility, have also been shown to be a resource for men in coping with mental distress (Emslie et al, 2006; Valkonen & Hänninen, 2012). To make sense of such apparent contradictions, within this paper we draw on a gender relations framework that recognises masculinities not as character types or traits but as 'configurations of practice'; as arrangements of social practices that men engage in that vary depending on social context (Robertson, Williams & Oliffe, 2016). In this way, masculinities are not to be found in, or possessed by, individual men but are demonstrated in social encounters; they are part of the 'doing' of gender. This becomes important in the discussion when exploring and situating the findings.

When men do come forward with mental health issues there may be a lack of appropriate services and support (see Morrison, Trigeorgis and John, 2014). This can mean that difficulties in engaging in mental health interventions are intensified for men, poor coping strategies exacerbated (e.g. alcohol and substance misuse), and suicide risk increased: men now account for 78% of suicides in the UK, the highest rate since 2001 (Office for National Statistics, 2015).

Whilst some work has been completed reviewing physically oriented health promotion interventions for men (Robertson et al 2008), and in generating robust evidence around the physical and lifestyle changes of sports-based health promotion interventions for men (e.g. Hunt et al 2013; Zwolinsky et al 2013), much less work has been completed looking at the engagement and impact of mental health promotion interventions for men (though many physical health interventions also demonstrate improved mental wellbeing). In the relative absence of a well-developed evidence base, Brechin and Siddell (2000) highlight the importance of drawing on 'experiential knowing' - the craft or tacit knowledge built up over years of practical experience - as an important form of evidence when developing health care work. This paper builds on earlier work by Robertson et al. (2013a) looking at the tacit knowledge of men's health promotion interventions. It expands previous work through having a greater geographical reach, garnering data from larger communities of practice rather than a small number of key individuals, and by having a specific focus on tacit knowledge relating to men's mental health promotion interventions rather than both physical and mental health promotion interventions. Conceptually, this paper links to work that holds a 'relational' view of health promotion and recognises the utility of Bourdieu's work to understanding health practices (Veenstra & Burnett, 2014), particularly in the context of health promotion interventions for men (Robinson & Robertson, 2014), and we return to this in the discussion. The article focuses on what those working in the men's mental health promotion field have to say about what works, for which men and why in relation to successful mental health promotion interventions, and integrates these data, drawing out key messages for public health practice and contributing to health promotion theory.

METHOD:

The work reported here is from a multi-phase project looking at 'what works' in men's mental health promotion. The project was primarily centred on the UK but also sought to capture existing

knowledge across a wider, developed world context (particularly from Australia, Canada, New Zealand, and the USA – all countries which have invested in dedicated mental health initiatives for men). The methodological challenge for this part of the work was how best to capture tacit knowledge (within manageable time and budgetary constraints) when, by its very nature, it is widely dispersed and not immediately accessible.

The approach taken involved creating a ‘multiple hub and spoke’ mechanism for collecting evidence facilitated through the establishment of an ‘Investigative Network’. After gaining approval through [blinded for review] University ethics committee, key players, active in the men’s mental health field across the five countries were identified. These ‘Investigative Network’ members were identified through iterative conversations between [blinded for peer review], the [blinded for peer review] and the Men’s Health Forum (England & Wales): collectively these organisations have extensive networks within the UK and international men’s health field. The international Investigative Network subsequently established is distinct from the research team that conducted this multi-phase project and that prepared this paper. The rationale was that these key Investigative Network members have prior knowledge and established links to those working in men’s mental health within different geographical and professional community contexts and could therefore feasibly act as information seeking hubs and conduits. Thirteen of the fifteen identified hub members approached (a mix of individuals and organisations) agreed to participate (Table 1.). These network members, and those they reached out to, were tasked with gathering information on what intervention approaches seem productive for which men, within which contexts and why. Network members are identified here, but any details of those members engaged with to gather information from are kept anonymised. A topic area template for completion of information was provided but there were no prescriptive instructions on how this information should be gathered as this would vary depending on the particular networks the members were involved with. The specific approaches taken by the members are summarised in Table 1. Most network members identified individuals and organisations within their networks who were engaging men around mental health concerns and the network members then completed interviews with these individuals and/or organisations: in total, over 100 interviews were completed (the majority of which were semi-structured around the aforementioned topic area template). Several network members also interrogated grey literature (particularly service evaluations) from organisations known to be active in men’s mental health using the topic areas as a framework to collate relevant information. One member conducted a survey with 50 responses which were then collated under the topic headings. Topic areas covered included: which settings work best; what ‘styles’ and approaches are important; what is the best role for men themselves in such work; how do networks and partnerships assist or hinder; are staff characteristics important. Each of these areas had sub-prompts that could be used to elicit greater detail if needed.

[INSERT TABLE 1. AROUND HERE]

The reports received from Investigative Network members totalled 138 pages and over 55,000 words. Although approaches to data collection varied, these final reports were similar in style, mainly providing text accounts with information collated under the topic theme headings. This data was then subject to thematic analysis by the research team examining at both the semantic level (looking for common areas in what was explicitly stated) and the latent level (looking for underlying areas that inform what is explicitly stated) (Braun & Clarke, 2006). This dual level approach was employed in order to ascertain not only participants’ descriptive accounts about what they think

works, but to also explore why particular views were held; that is, what concepts and values underpinned those stated accounts. All documents provided by the Investigative Network members were closely read separately by two research team members. Data was then independently coded by these two research team members, line by line, before codes were clustered into linked categories using constant comparative approaches (Silverman, 2001). Both research team members then worked together to jointly consider, further cluster, and finally integrate these codes and categories under main theme headings. This analysis was then passed by the Investigative Network members for further comment and refining: during this process only issues of factual accuracy were commented on by the members. This paper was then jointly produced by the research team (not the Investigative Network members) with each team member contributing either to writing sections and/or suggesting amendments to early drafts.

FINDINGS:

Following analysis, findings from the Investigative Network evidence were organised under three theme headings: 'safe settings', 'gender-sensitive approaches' and 'benefits of partnerships'.

Safe settings:

The settings that interventions were delivered through consistently came across as being important. Paying attention to this was seen to "widen the door" [IN 10], facilitating greater participation in interventions by making access easier and more acceptable to men. This was often linked to creating a 'safe space' where men could feel relaxed and comfortable. Such safe settings were generally juxtaposed to mainstream, statutory service provision, or even certain community settings, which were frequently presented as feminised or unfamiliar environments and therefore off-putting for many men:

"Community facilities are predominantly used by women and therefore have become unattractive to men, particularly older men." [IN 9]

The issue was compounded for particular groups of men who had poor experiences with formal service settings and a general distrust of formalised structures. Groups specifically identified in this way were gay men, those from deprived localities and minority ethnic groups:

"A trusted setting and trusted people are particularly important for Aboriginal men as they can have a profound mistrust of white run services, and of welfare services in general." [IN 7]

A big part of creating safe space was making it a specifically safe male space; that is to say, interventions need to be aware that locations and settings themselves are not gender-neutral. It is important to work in settings that are already recognised as male-familiar or 'male friendly' to make engagement and access easier. Fundamentally, this familiarity and safety of settings acted to promote trust; something noted across a range of men's health work and evaluations as being slower to develop amongst men (Robertson et al 2013b):

“Trust is very important to men and this can begin to be built from the selection of the correct location for a project.” [IN 9]

Rather than selecting a setting, many interventions used what one member termed “in-situ programme delivery” [IN7]; that is, developing interventions in locations, social spaces, where men already gather. Given that different groups of men are familiar and comfortable in different settings, there is not a ‘one-size-fits-all’ solution, and settings need to be considered based on what is group-sensitive:

“Settings that work best were those selected on the social and cultural identities of the men they intended to serve. For example, barbershops have a historical and cultural position in the lives of many African American men.” [IN5]

From the data some statements can be made about specific settings that seem to be particularly effective for engaging certain groups:

- Physical activity settings e.g. sport [IN4] [IN5] [IN8] [IN10] [IN13] particularly for younger men [IN4] [IN10]

“Many men and boys respond to services that have a physical element in which they can ‘let off steam’ in order to bond with others including those providing the service or support”. [IN4]

- Workplace settings [IN5] [IN7] [IN12]

“For older men, workplaces and community employment schemes appear to be an appropriate setting.” [IN12]

- ‘Shoulder to shoulder’ settings which facilitate social support as well as offering the opportunity for mental health support e.g. sheds [IN4] [IN7] [IN8] [IN9] [IN12]

“The Shed is run by the men themselves with the support of Aboriginal staff. It is run very informally and men can drop in anytime for company, a chat or a cup of tea and something to eat. The Shed is a place men trust and like to go - it is ‘their place’.” [IN7]

Working in the right setting helped reduce stigma by shifting culture and ‘normalising’ participation in an initiative across a whole group and not just those with a mental health ‘issue’. For example, in an initiative run for men with post-traumatic stress in a sports setting:

“The support service works because it is not on a mental health site and there is no stigma attached to attending the group.” [IN8]

The stigma that settings helped overcome could be directly mental health related but could also be related to being part of a marginalised group; such as the stigma and discrimination associated with being from a minority ethnic group or being gay. Here, interventions directly embedded within these communities were often essential to foster and facilitate engagement.

The potential that remote or 'virtual settings' (or 'virtual communities') might offer as intervention platforms for men, particularly for younger generations, was mentioned. This was suggested to be related to men's greater desire for confidentiality, anonymity and sense of 'control'.

Such approaches removed the need for men from marginalised groups to engage directly with services perceived as discriminatory or untrustworthy:

"Online settings can serve as "communities" for boys and men, particularly those who are dealing with more stigmatized challenges regarding their mental health (e.g., depression, PTSD, etc.) and social identities (e.g., men of color, sexually marginalized men, etc.) [...] who are less likely to disclose their mental health status face-to-face." [IN5]

However, consideration of the acceptability and effectiveness of web-based services was also said to be lacking a firm evidence base and it has previously been suggested that the use of new information technologies in health promotion for men, especially young men, may not be as straight-forward as many think (Robinson & Robertson, 2010a).

The right settings were important in making access easier and more acceptable than it is within statutory services for many men. This was especially so for particular groups of men, (gay men, those from deprived localities and minority ethnic groups) who often have mistrust of formalised services. In this regard settings do not stand apart from the wider issue of effective approaches taken to engage men.

Gender-sensitive approaches:

Linked to settings was recognition that approaches taken to interventions should be embedded within the communities of men being engaged and showing genuine insight into the needs of that community. This was true across all groups of men, but was particularly important for marginalised communities. As with settings, embedding interventions in this way provided a fertile environment for developing trusting relationships:

"Community interventions allow organisations to develop knowledge, relationships and trust" [IN1]

As a significant part of the process of 'embedding', community development approaches were required that centralised the role of the men being served:

"For real ownership to be established it is vital that men are involved from the earliest stage in project development. They must set the agenda and control the project rather than being passive participants in something that will be seen as organisation led." [IN9]

Peer involvement was firmly linked to ideas about familiarity and trust but also to the issue of having a shared sense of identity. Importantly, peer involvement also played a part in drawing out and promoting positive expressions of masculinity:

“Involving men in the design of interventions can be an empowering experience creating a sense of ownership which is conducive for ‘buy in’ and engagement. This is consistent with a strengths-based masculinities approach that reinforces participants’ sense of autonomy, control and independence.” [IN12]

Whilst it may seem obvious, having a desire, willingness and aptitude to work with men was not always felt to be the starting point for many in existing services and this created negative experiences for some men and a concomitant lack of engagement:

“Too often, service providers start from a position that men are to blame for their predicament and enter into the work with an agenda to fix the problem that is ‘men’. Not surprisingly, men will intuitively uncover this value base and misguided motivation, and either not engage or promptly disengage.” [IN12]

In contrast, ‘good’ intervention facilitators were said to be: sensitive (including gender-sensitive) [IN2][IN3][IN5][IN11]; respectful, non-judgemental and supportive [IN3]; charismatic (especially in work with young men)[IN3][IN5]; skilful and empathic [IN4][IN8,]; authentic and genuine [IN6]; welcoming [IN8]; good communicators [IN8]; persistent and adaptable [IN10]; reflexive [IN12]; enthusiastic and passionate [IN12].

There was general consensus that the sex of those working within interventions (with the exception of certain work such as sexual violence prevention work) was not as important as holding the required values and skills listed above. Many of these values could be captured under the rubric of being ‘male-positive’ and of recognising the assets men bring; for example, recognising that men can demonstrate care, do wish to help and mentor others and can and do show respect for self and others. Having this positive view was seen as an important core value. Linked to this, approaches should also be non-judgemental and implicitly challenge stereotypical male practices:

“The style or tone prevailing in community-based strategies is best described as non-hierarchical and non-shaming. This is important as it overtly avoids one-upmanship and the competitiveness that often emerges within groups of men in other arenas” [IN6]

Understanding men in this way was something that training could help facilitate, particularly training around what gender-sensitive work with men would entail:

“Gender-sensitive training is imperative for successful mental health programmes geared toward men. Passion does not always result in gender- and situational- sensitivity.” [IN5]

Activity, or ‘action-oriented’ approaches, were identified by many as a particularly good way to engage and sustain men’s involvement. Such approaches were often described as a ‘hook’ that could help “overcome the initial stigma of mental health” [IN9] helping create the safe spaces mentioned previously by removing any need to be too quickly engaged in ‘opening up’ emotionally. Yet this emphasis on activity was not an alternative to talking approaches but rather was a key to helping facilitate these:

“Whilst the mental health angle in projects may not be explicit, the rationale is that through an activity, having a base, and having supportive (and sometimes challenging) relationships, there will be opportunity to talk about issues affecting the young men.” [IN10]

The focus on activity then was important in creating a positive outlet for emotions and in facilitating social engagement (increasing male sociality) in ways conducive to improving mental wellbeing.

Much was said about the requirement for approaches with men to be direct and solution-focused. Participants described the importance of setting goals that related to tangible aspects of life and of men liking ‘action plans’ and ‘rule-based’ approaches.

An area mentioned frequently was the significance and importance of the language used in interventions. This was partly about making language ‘male friendly’, using humour, but also avoiding stigmatising language or language seen as feminised by its association with feeling and emotions. This formed part of the wider discussion about creating safe and trusted environments and relationships:

“If we’ve got a door which says ‘For Mental Health Users’, then they’re probably not going to walk through that door, if we’ve got a door which says ‘Feeling Shit? Come Here’, it’s an easier door to walk through.” [IN10]

Both settings and approaches then make a clear difference to the success of interventions, but are often not enough in isolation - the right partnerships are also required to maximise intervention success.

The benefits of partnerships:

The earlier discussion about ‘embedding’ approaches within communities implies and requires partnerships. All Investigative Network members provided examples of partnership working, spelling out the range of benefits such partnerships can bring. Primarily, the embedded, ‘in-situ’ nature of many interventions meant partnerships provided “a non-stigmatising route into the project” [IN8] and the opportunity to avoid the appearance of mental health help-seeking. As another member put it, partnerships “improve the credibility of the programme” [IN7] particularly through partnership working with existing agencies that are already trusted by the particular group of men being targeted.

Partnerships helped extend the reach of programmes across a range of activities or sites, and enabled funding and resources to go further by provision of ‘in kind’ support. For some, it seemed that forging partnerships was the only way to ensure the longevity or growth of interventions in challenging economic times:

“Increasingly, to sustain let alone scale-up health programmes, evidence and a variety of partnerships are needed.” [IN6]

Yet, partnerships were recognised as sometimes being difficult to establish and much thought was needed about how they might be best developed to benefit interventions in terms of supporting growth:

“How partnerships work on the ground depends on the intervention and its purpose. It also depends on the skills within the group/organisation undertaking the intervention. At times a small group may feel the need to grow by an “add on” model e.g. a sporting group partnering with a health provider, or an employer partnering with a mental health support team.” [IN4]

Some therefore saw part of the role of a ‘men’s health’ specific intervention as advocating for an increased focus on men and greater recognition of men’s needs amongst potential partners. Partnership agencies often had to be able to see that benefits could accrue from such engagement in order to be persuaded to be involved and before giving time and resource. However, for other interventions, externally visible success could lead to organisations asking to form productive partnerships that might expand the work:

“Empire Fighting Chance describes how initially it was peer referral that brought boys to their gym. However, in time, schools started contacting them to refer pupils, asking “how are you doing this? We’ve seen a massive improvement; can we send more kids to you?” [IN10]

These positive elements of partnerships were well recognised and appreciated, but there was also an identified downside in terms of the energy required to make and keep such successful partnerships:

“Partnerships also mean more work, more meetings, more reporting – all of which needs to be borne in mind when deciding whether to partner and how many partners to get involved.” [IN7]

Despite this, it seems that partnerships represent a necessary requirement for success, are also a reflection of such success, and are crucial for maximising impact within and beyond the communities of men that the projects work alongside.

DISCUSSION:

The difficulties for men in negotiating mainstream health services have been well documented (e.g. Coles et al 2010) and the concomitant need for health promotion work to therefore be developed and delivered in male-friendly environments and in male-sensitive ways also well recognised. The data here support this position and develop it further by highlighting some of the specifics in relation to different groups of men and to mental health promotion more directly. Within mental health promotion, the conflict between traditional (hegemonic) notions of masculinity (particularly the importance of emotional control and rationality) and engagement with initiatives is significant; more so than in relation to physical health concerns. Careful attention to language and genuinely male-positive approaches are needed to ensure that men feel valued and engaged rather than alienated, marginalised or stigmatised as men: that is, approaches need to be sensitive to men’s requirement to safeguard their identity as men rather than feeling that engagement requires surrendering this. However, the risks of reinforcing aspects of masculinity which have been implicated in health-

defeating practices by utilising 'male-friendly' approaches in public health have also been previously highlighted (Robinson & Robertson, 2010a; Fleming et al, 2014; Gough, 2009). It is clear then that mental health promotion interventions face a challenge in engaging men in ways that utilise aspects of masculinity to develop trust whilst not simultaneously reinforcing negative health practices. Linking to the gender relations framework outlined in the introduction, and recognising that varied contexts facilitate and constrain particular masculinity practices (certain ways of 'doing masculinity'), is key here. The nature of most interventions discussed was such that, once initial trust was developed and maintained, the work itself often generated useful challenges to traditional masculinity practices and created safe spaces for men to reflect on the values they ascribe to 'being male' and to begin to reframe aspects of these. An example is useful here. The utilisation of sport settings mentioned by many in this study could act to reinforce issues of violence and homophobia that have been associated with hegemonic masculinity practices surrounding sport (Robertson, 2003). However, as Robertson et al (2013b) have shown, even in interventions that utilise the masculine 'hook' of sport to engage men, it is possible to take approaches that then draw on other positive masculinity assets (for example those mentioned earlier of care, mentoring and respect) to create a salutogenic, health enhancing, context that stimulates good mental wellbeing. There is an interesting balance then between using empathetic male approaches to ensure trust in initial engagement and the sustained work which often challenges certain aspects of masculinity.

This balance can be helped by the fullest possible embedding of initiatives within the community of men being engaged. The importance of involving communities in participation in public health programmes, not least in terms of understanding the role that social relationships play in such work, has been highlighted previously (South et al. 2012b). Involving community members as voluntary health leaders, such as in the 'health champions' programme, has been shown to increase the self-confidence and esteem that opens the door to other opportunities such as employment and education (Woodall et al, 2013). Furthermore, the utilisation of community embedding and peer involvement for community work with men has also been shown to be successful – though not without considerable effort being expended in providing appropriate training and support for peers and others involved (e.g. Robinson et al, 2010). Data here suggest that such community embedding of mental health promotion work for men is important in creating trust but also in facilitating the modelling of alternative forms of masculinity. It is particularly generative of environments where men can feel safe to talk about issues of concern whilst engaging in social activities – the importance of the 'shoulder-to-shoulder' environment (as opposed to a direct route into talking therapy) that combines enjoyable social activity with the opportunity to 'chat' should not be underestimated in men's mental health promotion work. It is important to recognise that, within these safe settings, men are seen to be keen to engage in social interaction with other men in a more open way and often eager to "talk in a critical way about masculine culture" within such environments (Coles et al, 2010: 934). What we see then is the opportunity to facilitate and engender more positive configurations of gender practice amongst the men engaged by such community-embedding.

Once this type of environment has been established, and when engagement in more formal therapeutic work with men was required, then approaches often needed to be quite direct and 'solution focused'. This has been recognised in previous work with men (Mental Health Foundation, 2010). It is possible that using direct, solution-focussed approaches allows many men to give up one form of masculine capital (de Visser et al, 2009), that of being stoical and not seeking help, whilst

demonstrating a high degree of other forms of masculine capital - particularly rationality, and being 'strong enough' ('man enough') to seek help. Drawing on these aspects of masculinity has also been shown to be useful for men in re-establishing a valued male identity when dealing with depression (Emslie et al, 2006; Oliffe et al, 2012). Recognising men's practices as somewhat contradictory, fluid and contextual (in line with the gender relations framework discussed) means that those involved with interventions can learn to identify the best approaches to take to maximise men's opportunities and likelihood of engaging in positive practices of care, mentoring, and being respectful (amongst others).

The crucial role of partnerships is well established in community health promotion work (Ponton & John, 2012). The interesting aspect here though is the cyclical relationship of gender to these partnerships. Network members demonstrated how, for many interventions, work with men could only commence when trusted, established, community organisations provided legitimacy to the work. As shown in previous work (e.g. Pringle & Sayers, 2004; Robertson et al 2013b), and reiterated here, examples were provided where external organisational branding (usually linked to that which is traditionally 'masculine') enabled men to legitimately engage in the intervention being established. However, network members also identified how many interventions had significant work to do in helping partners, or potential partners, develop a more positive view of working with men (recognising what assets they bring) and explaining what gender-sensitive work with men looks like in practice. The importance of partnerships has been previously well-recognised in men's health promotion work (e.g. Kierans et al, 2007; Robertson et al, 2013a; Robinson et al, 2010), but what is specifically apparent here is the role that men's mental health promotion interventions often implicitly play in both 'selling' the idea of positive approaches with men to partners and in providing informal (often unrecognised) training or role-modelling on how to engage with men in gender-sensitive ways. The importance of drawing on community-based assets to promote health has been previously identified (e.g. Foot & Hopkins, 2010) but the additional skills, values and training that may be required to achieve this approach with men has had limited prior recognition.

Whilst insufficient space is available to discuss it in detail, this work also adds to the evidence base for considering behaviour change in health promotion. In particular, it affirms work which suggests a 'relational' model is needed within health promotion, that recognises the interdependency of individual action (agency) and social structures (Veenstra & Burnett, 2016). The tacit knowledge of those engaged in the delivery of mental health promotion for men presented here highlights how interventions need to move beyond approaches focused on 'individual choice' to ones that recognise the importance of the social contexts within which these men reside. The data provides examples of how shifting the places and spaces (settings) for the men being engaged can act to (re)establish different, more positive, sets of relationships and associated health (and social) practices. To link this to Bourdieu's work and its application to health promotion (Williams, 1995), within these safe (male-friendly) settings different forms of 'masculine capital' can be explored and different dispositions for action ('habitus') engendered. Specific approaches taken can also assist the development of these different forms of masculine capital. For example, the recognition here of the importance of peer involvement at all stages of intervention helps build networks of social support and concomitant obligation and provides men (particularly in areas of multiple deprivation) with valued ways of relating, helping them (re)identify in positive ways as men within their communities (Robinson & Robertson, 2014) and thereby improving mental wellbeing. 'Agency' then (including an

ability to action health 'choices') is not seen as 'held' by or within the individual "but instead inheres in relations between individuals within spatial contexts" (Veenestra and Burnett's 2014: 190) and this is inherent to understanding successful health promotion interventions.

CONCLUSION:

Reported here are particular findings from a large scale project which considered what works for men in relation to mental health promotion interventions. Specifically, we report on the work that gathered the tacit knowledge of those involved in developing, delivering and sustaining such interventions. Although this work can stand alone in terms of the importance of the findings, it is better understood in relation to existing peer-reviewed evidence about such interventions and, most importantly, in relation to what men themselves have to say about what best supports their mental health and wellbeing.

Findings here reflect previous research around what is important in community health promotion interventions but also offer additional insights relating to the integration and consideration of gender in mental health promotion work with men. Developing trust and 'safe' settings for men in the context of mental wellbeing requires working positively alongside them, recognising the assets men bring, rather than assuming they are problematic and unwilling to engage. This is significantly helped by firmly embedding work within the communities of men being engaged, having them involved at every stage, and avoiding approaches and language that may be culturally insensitive and/or 'feminised'.

For most men, an initial focus on activity rather than 'talking' is a safer way to facilitate engagement. The social and fun elements of such activity focus should not be underestimated in terms of their impact on wellbeing. It helps secure engagement in a non-stigmatising way and acts to facilitate 'talk' in a non-threatening manner. This allows men to maintain aspects of traditional male identity whilst surrendering the socially expected requirement not to be seen as requiring help. Partnerships are key to broadening the scope and reach of projects and working with existing, trusted partners can provide legitimacy to new projects focused on men's mental wellbeing. However, the people involved in such projects, including men themselves, often also have a crucial role to play in helping partner agencies understand what successful, asset-based and gender-sensitive work with men entails.

Aspects of gender are then crucial within mental health promotion work with men. Failure to consider gender fully can lead to unfounded, negative views about the likelihood of successful engagement with men or to approaches that become self-fulfilling failures through lack of sensitivity. However, taking time to understand gender in a nuanced way, as a range of configurations of possible practices, can facilitate positive ways of working alongside men, increasing the level of engagement and potentially leading to successful outcomes that benefit not only the men themselves but also the lives and communities around them.

REFERENCES:

ABS (Australian Bureau of Statistics) (2014). Deaths, Australia, 2013. ABS cat. no. 3302.0. Canberra: ABS

Addis, M. E. (2008). Gender and Depression in Men. *Clinical Psychology: Science and Practice* 15: 153-168.

Bennett, J.E. Li, G. Foreman, K. Best, N. Kontis, V. Pearson, C. Hambly, P. Ezzati, M. (2015) The future of life expectancy and life expectancy inequalities in England and Wales: Bayesian spatiotemporal forecasting. *The Lancet* [http://dx.doi.org/10.1016/S0140-6736\(15\)60296-3](http://dx.doi.org/10.1016/S0140-6736(15)60296-3)

Braun V, Clarke V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* 3(2): 77–101.

Brechin A, Siddell M. (2000) Ways of knowing. In: Gomm R, Davies C (eds). *Using Evidence in Health Care*. Buckingham: Open University Press

Coles, R. Watkins, F. Swami V. Jones, S. Woolf, S. Stanistreet, D. (2010) What men really want: a qualitative investigation of men's health needs from the Halton and St.Helens Primary Care Trust men's health promotion project. *British Journal of Health Psychology* 15(4): 921-939

Deverill, C. King, M. (2009) Common mental disorders. IN: McManus S., Meltzer H., Brugha T., Bebbington P. & Jenkins R. (Eds) *Adult psychiatric morbidity in England, 2007. Results of a household survey*. Leeds: NHS Information Centre for health and social care.

De Visser, R. Smith, J.A. McDonnell, E.J. (2009) 'That's not masculine': masculine capital and health-related behaviour. *Journal of Health Psychology* 14(7): 1047-1058

Emslie, C. Ridge, D. Ziebland, S. Hunt, K. (2006) Men's accounts of depression: reconstructing or resisting hegemonic masculinity? *Social Science & Medicine* 62(9): 2246-2257

European Commission (2011) *The First State of Men's Health in Europe Report*. Luxembourg: European Commission.

Fleming, P.J. Lee, J.G.L. Dworkin, S.L. (2014) "Real Men Don't": Constructions of Masculinity and Inadvertent Harm in Public Health Interventions. *American Journal of Public Health* 104(6): 1029-1035

Foot, J. Hopkins, T. (2010) *A Glass Half-Full: How an Asset Approach Can Improve Community Health and Wellbeing*. London: Improvement and Development Agency, Healthy Communities Team.

Gough, B. (2009) Promoting 'Masculinity' Over Health: A Critical Analysis of Men's Health Promotion With Particular Reference to an Obesity Reduction 'Manual', in B. Gough & S. Robertson (Eds) *Men, Masculinities and Health: Critical perspectives*. Basingstoke: Palgrave

Hunt K, Ford G, Harkins L, Wyke S. (1999) Are women more ready to consult than men? Gender differences in family practitioner consultation for common chronic conditions. *Journal of Health Services Research & Policy* 4(2): 96-100.

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, 57-65.

Kierans, C. Robertson, S. Mair, M.D. (2007) Formal health services in informal settings: findings from the Preston Men's Health Project. *Journal of Men's Health & Gender* 4(4): 440-447

Kingerlee, R. Precious, D. Sullivan, L. Barry, J. (2014) Engaging with the emotional lives of men. *Psychology* 27(6): 418-421

Mental Health Foundation (2010) *Grouchy Old Men? A brief guide to help develop services that engage isolated older men and promote good mental health and wellbeing*. London: Mental Health Foundation

National Center for Health Statistics (2015) Health, United States, 2014: With Special Feature on Adults Aged 55–64. Hyattsville, MD.

Office for National Statistics (2015) *Suicides in the United Kingdom, 2013 Registrations*. London: ONS

Oliffe, J. Ogrodniczuk, J.S. Bottorff, J.L. Johnson, J.L. Hoyak, K. (2012) "You feel like you can't live anymore": Suicide from the perspectives of Canadian men who experience depression. *Social Science & Medicine* 74(4): 506-514

Ponton, M. John, M. (2012) Partnership working: the lynchpin of wellbeing. In: Walker, P. John, M. (Eds) *From Public Health to Wellbeing*. Basingstoke: Palgrave Macmillan

Pringle, A. and Sayers, P. (2004) It's a goal!: basing a community psychiatric nursing service in a local football stadium. *Journal of the Royal Society for the Promotion of Health* 124 (5): 234–238.

Richards, D. A. & Borglin, G. (2011). Implementation of psychological therapies for anxiety and depression in routine practice: Two year prospective cohort study. *Journal of Affective Disorders*, 133, 51-60.

Robertson LM, Douglas F, LudBrook A, Reid G, Teijlingen E. (2008) What works with men? A systematic review of health promoting interventions targeting men. *BMC Health Services Research* 8: 141.

Robertson, S. (2003) "If I let a goal in, I'll get beat up": contradictions in masculinity, sport and health. *Health Education Research* 18(6): 706-716

Robertson, S. Williams, B. Oliffe, J. (2016) The Case for Retaining a Focus on "Masculinities" in Men's Health Research. *International Journal of Men's Health* 15(1): 52-67

Robertson, S. Witty, K. Zwolinsky, S. Day, R. (2013a) Men's health promotion interventions: what have we learned from previous programmes? *Community Practitioner* 86(11): 38-41

Robertson, S. Zwolinsky, S. Pringle, A. McKenna, J. Daly-Smith, A. White, A. (2013b) "It's fun, fitness and football really": a process evaluation of a football based health intervention for men. *Qualitative Research in Sport, Exercise and Health* 5(3): 419-439

- Robinson, M. Robertson, S. (2010a) Young men's health promotion and new ICTs: illuminating the issues and research agendas. *Health Promotion International* 25(3): 363-370
- Robinson, M. Robertson, S. (2010b) The application of social marketing to promoting men's health: a brief critique. *International Journal of Men's Health* 9(1): 50-61
- Robinson, M. and Robertson, S. (2014) Challenging the field: Bourdieu and men's health. *Social Theory & Health*. 12(4): 339–360.
- Robinson, M. Robertson, S. McCullagh, J. Hacking, S. (2010) Working towards men's health: findings from the Sefton Men's Health Project. *Health Education Journal* 69(2): 139-149
- Silverman, D. (2001). *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction* (2nd Ed). London: Sage
- Smith, J.A. Robertson, S. (2008) Men's health promotion: A new frontier in Australia and the UK? *Health Promotion International* 23(3): 283-289
- South, J. Kinsella, K. Meah, A. (2012b) Lay perspectives on lay health worker roles, boundaries and participation within three UK community-based health promotion projects. *Health Education Research* 27(4): 656-670
- Valkonen, J. Hänninen, V. (2012) Narratives of masculinity and depression. *Men and Masculinities* 16(2): 160-180
- Veenestra, G, Burnett, P.J. (2014) A relational approach to health promotion practices: towards transcending the agency-structure divide. *Sociology of Health & Illness* 36: 187-198
- Veenstra, G, Burnett, P.J. (2016) Towards a relational health promotion. *Health Promotion International* 31(1): 209-213
- Wang Y, Hunt K, Nazareth I, et al. (2013) Do men consult less than women? An analysis of routinely collected UK general practice data. *BMJ Open* 3: e003320. doi:10.1136/bmjopen-2013-003320
- Williams, S.J. (1995) Theorising class, health and lifestyles: can Bourdieu help us? *Sociology of Health & Illness* 17(5): 577-604
- Woodall, J. White, J. South, J. (2013) Improving health and wellbeing through community health champions: a thematic evaluation of a programme in Yorkshire and Humber. *Perspectives in Public Health* 133(2): 96-103
- Zwolinsky, S. McKenna, J. Pringle, A. Daly-Smith, A. Robertson, S. White, A. (2013) Optimizing lifestyles for men regarded as 'hard-to-reach' through top-flight football/soccer clubs. *Health Education Research* 28(3): 405-413

Table 1. Investigative Network areas and approaches

Name	Investigative Network member code	Area of focus	Methodology
Prof. Raghu Raghavan & Dr. Ed Griffin (De Montfort University, UK)	IN1	UK, Ethnicity	Identified relevant organisations and emailed them in the first instance, then followed up with a telephone interview. Conducted a literature search of academic articles, grey literature and also examined websites
Dr Damien Ridge (University of Westminster, UK) Dr John Barry	IN2	UK, Psychology	36 interviews with key informants, including psychotherapist counsellors and others from communities of practice
Dr Andrew Smiler (Independent Therapist, USA)	IN3	USA	A survey was conducted online which was advertised via social media, with a \$25 random prize incentive. Overall 50 people responded via the survey or through interviews. Qualitative analysis of programme content was also carried out
Hugh Norriss (Mental Health Foundation of New Zealand)	IN4	New Zealand	Identified and summarised the activities of Five New Zealand organisations that met the criteria. Five telephone interviews were conducted
Dr Daphne Watkins (University of Michigan, USA) Dr Derek Griffith(Vanderbilt University, USA)	IN5	USA (ethnicity)	Reviewed 20 programmes, which were identified by internet searches and then ranked in relation to the network brief. The director of each selected programme was then interviewed
Prof. John Oliffe (UBC)	IN6	English Speaking Canada	Web searches, grey literature searches and academic literature searches were conducted
Prof. John MacDonald (MHIRC)	IN7	Australia	Outcome findings from previous project studies and evaluations were summarised and the experience of MHIRC staff was captured
Toby Williamson (Mental Health Foundation)	IN8	UK, Ageing men	Semi-structured interviews with experts were conducted, and interviewees made further suggestions of people for interview and then interviews were conducted with these persons. 15 interviews were completed in total. Interviews were transcribed and member checked with participants
Chris O'Sullivan (Mental Health Foundation)	IN9	Scotland	A brief grey literature review was conducted, nine telephone interviews were conducted and six other people provided information via email
Toby Williamson	IN10	UK, Young men	Semi-structured interviews with experts were conducted, and interviewees made further

(Mental Health Foundation)			suggestions of people for interview and then interviews were conducted with these persons. 13 interviews were completed in total. Interviews were transcribed and member checked with participants
Prof. Gilles Tremblay (Laval University) & Philippe Roy (Université de Montréal)	IN11	French Speaking Canada	Three key informants were interviewed and a review of grey literature conducted - predominantly literature that was available only in French including expert reports and evaluation reports
Dr Paula Carroll, Billy Grace & Dr Noel Richardson (Men's Health Forum in Ireland)	IN12	Ireland (all)	Eight key front line personnel were interviewed and documentary evidence of programmes (n=6) was reviewed. Reanalysis of a literature review, eight focus groups and seven interviews from the perspective of effective engagement from the "Engaging Young Men Project: Report on Mapping Exercise in Ireland" [available at http://www.mhfi.org/EYMPmappingreport.pdf]
Peter Baker (Independent Consultant)	IN13	Europe (including the UK)	Six Interviews were conducted, Google searches of projects and appraisal of relevant academic literature was completed