**Identifying the Key Health Inequalities for Men and Boys in Wales**

A report for NHS Centre for Equality and Human Rights by families need fathers both parents matter cymru in conjunction with public health wales



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# Executive Summary

In February 2018, Public Health Wales, Centre for Equality and Human Rights, commissioned Families Need Fathers Both Parents Matter, Cymru (FNF-BPM Cymru) to lead the production of this review. Its purpose is to support national and local level change in Wales by identifying the evidence of discrimination that impacts negatively on the well-being of men and boys in respect of key health inequalities.

Health and well-being inequalities for men and boys are substantial and to be found across all aspects of life: education, accidents, disease, domestic abuse, suicide, imprisonment, substance abuse and the impact of family break-down. To some this may seem quixotic. “Inequality” is so often linked with women and girls, or with minorities, that it has become an unchallenged axiom that males *qua males* have no claim on our concern. Yet the truth is quite the opposite. The observation that senior positions are still occupied more by men than women – professors, consultants, high court judges – is not apposite. It is not these men that bring down the average male longevity or populate the prisons or swell the ranks of the under-educated. The intersection of men-plus-deprivation is a more virulent combination even than women-plus-deprivation, as the data presented herein demonstrate. And there are far greater numbers of the unprivileged than there are professors or Old Etonian politicians.

This brief review has identified some of the evidence of discrimination that impacts negatively on the well-being of men and boys in respect of key health inequalities. In Wales [the Public Health Outcomes Framework](http://gov.wales/topics/health/publications/health/reports/health-framework/?lang=en) emphasises the broad factors that can impact on health and well-being. They include an individual’s social environment, employment and education (amongst other things). The evidence of disadvantages to men and boys in these areas is considerable. The impact on health is starkly clear across a range of metrics. Some of the key issues are summarized below. Suggestions for action or further research are listed in Section 5.

The Tables and Figures may be found in the separately presented Appendices.

The terms “male” and “female” are used throughout to refer to biological sex. Gender, as distinct from sex, is not discussed. Grammatical purists will be upset by my usage of “males” and “females” as nouns. Unfortunately there is no word in English to denote both adults and juveniles of any age of the same sex. The use of “males” is to avoid the cumbersome “men and boys” – or, the worse, but more accurate, “men, boys and male infants”.

**Physical Health and Premature Death**

More males die young.

In the UK, one man in five dies before he reaches 60. Two in five by 70.

Defining premature death as death before age 75, there is a premature death gender gap of 45% in England and Wales, and 49% in Wales. There is an even more adverse gender gap in premature death *rate* in Wales of 52%.

Defining early death as death before age 45, there is an early death gender gap of 74% in England and Wales (2016) and 84% in Wales (2011). [Stats Wales data on mortality in Wales by age group extends only as far as 2011. Updating to the present would be useful].

The top causes of premature death (before age 75) in England and Wales were cancers, cardiovascular diseases, respiratory diseases and digestive system diseases, in that order for both sexes, accounting in total for 77% of premature deaths of men, and 80% of premature deaths of women.

In both England and Wales, and Wales alone, more than twice as many men die prematurely from cardiovascular diseases as women.

The number of premature male deaths from cancers exceeds the number of premature female deaths from cancers by 16% in England and Wales combined (2016), and by 21% in Wales (2016).

All types of cancer result in more premature deaths of men than of women, excluding only the female-specific cancers of breast, cervix, ovary and uterus (noting that some men do die of breast cancer).

By far the largest cancer killer, for both sexes, is lung cancer and there is a strong socioeconomic dependence in the incidence of lung cancer. In both England and Wales the most disadvantaged quintile is about 2.6 times more likely to die from lung cancer than the least disadvantaged quintile. This is explicable in terms of the prevalence of smoking by demographic.

Prostate cancer, as a killer of men, has now overtaken breast cancer as a cause of mortality in women. However, a greater proportion of breast cancer deaths are premature (before 75). Prostate cancer is responsible for about half as many *premature* deaths as breast cancer. Nevertheless, prostate cancer is the 4th most important *premature* cancer killer in men.

Overall premature death rates, as well as premature death rates from the individual leading causes (cardiovascular diseases, lung cancer, colorectal cancer and oesophageal cancer), are all significantly greater in Wales than in England. This is true for both sexes. For cardiovascular diseases this is illustrated graphically by Figure A.3.1.

Claims in some quarters that violence is one of the top killers is simply false. Out of 19 causes of premature death listed in Table A.3.1, homicide lies in 17th place for men and 18th place for women. The number of premature deaths by homicide is only 0.8% of the number of premature deaths due to cancers. As regards early death (before age 45), Table A.3.2 shows that homicide is in 14th place out of 17 for both sexes.

Figure A.2.1 displays graphically why the early death gender gap is even more adverse for males than the premature death gender gap. Young men in their early twenties are subject to a death rate three times that of young women the same age. This Figure is an emphatic, and salutary, indication of the extent of male inequality in longevity.

Obesity is implicated in many health issues, and obesity starts early in life. Diet is only one part of the problem; the reduction in children’s physical activity is another key factor. This can be asserted of both sexes, though obesity – and the resulting health problems – are more common in males.

The value of PSA testing as a diagnostic tool for prostate cancer continues to be controversial amongst the experts. Unfortunately, when combined with the generally asymptomatic nature of the disease until it reaches an advanced stage, this leaves men with inadequate protection against this major killer. The health authorities in Wales may wish to review the value of repeat PSA testing following a “fingerprinting” methodology, as a means of offsetting the uncertainty of the test as an absolute indicator.

Should the improved diagnostic protocol for prostate cancer centred around the mpMRI technique, currently being trialed in England, prove as successful as anticipated, the method should be considered for adoption in Wales. This subsumes acquisition of sufficient numbers of the MRI machines throughout Wales.

Cancers caused by human papilloma viruses (HPV) are responsible for similar numbers of premature deaths in men and women. An NHS programme to vaccinate girls against HPV at age 12 onwards was started ten years ago. Women also have a screening programme for the major HPV related cancer in females, i.e., cervical cancer. There has been controversy that the HPV vaccination was not also offered to boys, especially as the major HPV related cancer in males, i.e., oropharyngeal cancer, has been increasing steeply. A number of authoritative medical bodies expressed their view that the HPV vaccine should be extended to boys, and the EHRC became involved in questioning the compliance of a girls-only vaccination programme with the Equalities Act 2010. Earlier this year the decision was taken to roll out the HPV vaccination to boys at age 12/13 (but without back-fitting to older boys). This extension of the programme is to be welcomed.

For male healthcare generally, initiatives such as [Men’s Health Week](https://shop.menshealthforum.org.uk/collections/mens-health-week-2017) require more promotion. The excellent material available from the [Men’s Health Forum](https://shop.menshealthforum.org.uk/collections/man-manuals) could be used as a starting point.

**Are Lifestyle and Obesity the Cause of Male Health Disadvantage?**

The National Survey for Wales, 2016-17, has provided valuable information on lifestyle against five beneficial criteria: not smoking, not drinking alcohol above weekly guidelines, eating five or more portions of fruit or vegetables daily, being physically active for at least 150 minutes per week, and maintaining a healthy body mass index (BMI). The gender difference in smoking prevalence is slight. In contrast, smoking is about 3 times more prevalent in the most deprived quintile as compared with the least deprived. The gender difference in diet, as regards the five-a-day criterion, is also slight. Men do rather better than women as regards the extent of exercise taken. However, men drink significantly more than women, and more men are overweight than women. There is a deprivation disadvantage in diet, in exercise and in BMI which is generally greater than the gender disadvantage.

Overall, there are more men than women with unhealthy lifestyles, defined as achieving none, or only one, of the lifestyle indicators (13% of men and 8% of women). This may account for part of the observed male disadvantage in health outcomes. However, it may not be gender *per se* but the intersection of gender and relative deprivation which is the cause of this disadvantage. This is suggested by the generally greater demographic than gender differences in the lifestyle ‘scores’. It is beyond the scope of this review to determine whether the extent of the gender/deprivation lifestyle differences are commensurate with the health outcome differences, though this would be worth further study.

**Men’s Fertility**

The advent of the oral contraceptive pill for women was of such overwhelming significance that a large part of the social changes of the last half century can be attributed to its consequential effects. For men, there is no equivalent contraceptive. And yet, with their external gonads, men present a far easier opportunity for contraceptive intervention, without chemical interference with the endocrine system – in contrast to the female pill. The barriers to an effective, persistent and reversible male contraceptive are not primarily technological but commercial. Big Pharma needs to be convinced there is a market. That there probably ***is*** a market arises partly because there is an increasingly clear desire *by women* that men should bear some of the burden of contraception. This could only reduce the need for abortions, currently some [185,00 per year](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/433437/2014_Commentary__5_.pdf) in England and Wales. The NHS could be pro-active in surveying for the likely uptake of a convenient persistent, reversible male contraceptive.

More worryingly, contraception may soon be unnecessary in Western countries if the [reports of falling sperm concentrations](https://www.nhs.uk/news/pregnancy-and-child/western-sperm-counts-halved-in-last-40-years/) are valid and continue. If the reported rate of decline is correct and does not reduce, the average man in Western countries could be infertile in 20 to 30 years’ time. One might have expected this issue to be receiving more attention.

**Men’s Access to Healthcare**

A long section (3.8) reviews the literature on men’s access to healthcare services. It is often claimed that men’s poorer health outcomes are due to their reluctance, or tardiness, in seeking medical assistance (and to attribute this in turn to men’s self-destructive masculine characteristics). However, the literature suggests that there is a smaller gender gap in accessing healthcare than is popularly believed, especially when the apparent gap is adjusted to allow for women’s greater access for contraceptive, pregnancy, childcare and national screening purposes. The latter is a disadvantage imposed on men, not an aspect of male behaviour.

The residual gender gap in access to primary healthcare appears to be due in the main to men’s working patterns, and the resulting difficulties of access to healthcare and community health programmes during the working day. This contention is supported by several studies. Whilst it might be argued that men’s working patterns are an individual choice, it would be disingenuous not to concede societal, financial and practical obligations which act in this respect. . It may be worth considering trials of well-advertised out-of-hours services to promote the health of this disadvantaged sector.

**Social Well-Being**

**Employment**

Young people who leave education at age 16 have very high rates of unemployment. Currently the UK unemployment rate for 16 to 17 year olds is about 30%, and was recently about 40% (in 2011). This is the demographic within which much future disadvantage will be focused.

Unemployment rates for those over 18 are currently low, 4.4% for both sexes (UK and Wales). However, the formally unemployed are less than half of all those people without jobs who wish to work – the remainder are the economically inactive who nevertheless wish to work.

One of the most significant features of the huge social changes over the last half-century is the increased participation by women in the labour force. The percentage of women who are economically inactive has reduced from 45% in 1971 to an all-time low of 26% by 2017 (UK). What is less widely appreciated is the huge increase in men’s economic inactivity over the same period (from 5% in 1971 to 17% now). In 1971 there were 0.8 million economically inactive men in the UK, but by 2017 this had increased to 3.4 million. [NB: the economically inactive are those aged between 16 and 64 who are neither employed nor registered as unemployed].

The dominant reasons for men being economically inactive are being in full time education, closely followed by long term sickness. The dominant reasons for women being economically inactive are being a full time home-maker, followed by being in full time education, closely followed by long term sickness.

More than twice as many men are full time home-keepers now than in 1993. In contrast, a million fewer women are now full time home-keepers than in 1993, though women are still 88% of full time home-keepers (UK). 80% of the gender gap in economic inactivity is due to the sex difference in the full-time home-keeper role.

There are roughly half a million people of each sex in the UK whose economic inactivity is classed in national statistics simply as “other”. This catch-all category may hide significant disadvantage. An outstanding issue is to clarify the nature of people in this category.

**Education**

It is well known that boys underperform in education compared with girls. At Key Stage 2 (age 11) girls now achieve better results in SATS across all subjects: reading, writing, the spoken word, maths and science. The gender difference in maths and science is small, but girls’ dominance in all three English and Welsh subjects is emphatic. By age 16, at GCSE, girls’ dominance in English and Welsh has increased further, by up to 18% in 2017.

The number of girls in Wales attaining A Levels with grades C to A\* exceeded the number of boys in Wales attaining grades C to A\* by 44% in 2017 (9,940 cf 6,902).

Women have been the majority of undergraduates at UK universities for quarter of a century. In the UK as a whole, 100,000 more women than men applied to university in 2017, and 71,100 more were accepted onto courses, an excess of women over men of 36%. In respect of UK students at Welsh universities, 29% to 37% more women than men are awarded first degrees, and 40% more women attain postgraduate degrees.

Contrary to popular belief, there are more women on STEMM courses in the UK than men (by 6%). (STEMM is science, technology, engineering, maths, medicine and subjects allied to medicine). There are also more women taking the pure sciences.

70% of university subjects are dominated by women undergraduates in the UK.

Poor white males have the least chance of going to university (~10%) out of 20 combinations of sex, race and an indicator of deprivation. Poor black women are three times more likely to go to university than a poor white male.

Despite the percentage dominance of women at university, one should not lose sight of the fact that more men are starting university now than, say, 10 years ago. However, the increase may now have stalled, the number of men starting university in 2017 being less than that in 2015 and 2016. The number of women starting university continues to increase.

The usual reaction to boys’ underperformance in education is to wag the finger and instruct the slackers to try harder. I suggest this approach is unlikely to work. The issue is motivation. “*a 14 year-old’s answer to “do you want to continue in Full Time Education after age 16?” is strongly associated with socio-economic status. This does not necessarily mean that working class children have low aspirations, but they are significantly less likely to see schooling as instrumental to achieving them*” (House of Commons Education Committee, Underachievement in Education by White Working Class Children, June 2014).

**Family Breakdown and Fatherlessness**

There is evidence that fatherlessness is causal in children’s social-emotional development, increasing adolescent externalising and risky behaviours, including smoking, drug taking and early pregnancy, and having adverse effects on educational attainment. These psychological harms of father absence experienced during childhood persist into adulthood and throughout life, including mental health issues. Consequently, fatherlessness is a driver of disadvantage for the affected children.

As regards specifically Welsh evidence, it is known that [Adverse Childhood Experiences (ACEs)](http://www.wales.nhs.uk/sitesplus/888/page/88517) have serious implications for promoting adverse outcomes for children which persist into adulthood and are in danger of propagating to the next generation. The recently issued 2018 “[Report 1: Mental Illness - Welsh Adverse Childhood Experience (ACE) and Resilience Study](http://www.wales.nhs.uk/sitesplus/documents/888/ACE%20%26%20Resilience%20Report%20%28Eng_final2%29.pdf)” shows a very strong (negative) correlation between the availability of constant personal support from ***both*** parents and the prevalence of ACEs (see Figure 17 of the report, reproduced in section 3.5.3.1).

The drivers of fatherlessness are therefore important factors affecting the outcomes for children. The drivers are both divorce and the decline of marriage. Cohabiting couples are far more likely to split than married couples. Only 5% of children living with both parents at 15 will have unmarried parents. A child now has only a 51% chance of living with both parents until aged 15.

Marriage has declined steeply since 1980, but this is strongly demographic dependent. In the top quintile of income about 88% of new mothers are married, in the bottom quintile only 24% of new mothers are married. Consequently, socioeconomic disadvantage to children operates, not only directly, but also indirectly through the strong correlation with fatherlessness. Lone parents with dependent children represent 24% of all families with dependent children (UK, 2015). The number of dependent children living with a lone parent is over 3 million. In Cardiff 013D and 039E, 59% of homes with dependent children involve single mothers (and 3% single fathers).

**The Experience of Being a Welsh Father**

The “deadbeat dad” mantra is appallingly lacking in compassion in refusing to recognise the significant role played by the Family Courts in promoting fatherlessness. Every year in the UK, tens of thousands of fathers are denied meaningful access to their children after partnership break-up. These men struggle with all the might they can muster, in the teeth of a hostile system, to retain an involvement in their children’s lives. Many will fail completely, many others will be granted a few hours contact every other weekend, grossly insufficient for the desired benefits to the child to accrue.

Most fathers and male carers don’t have major difficulties, particularly if they are living with the mother of their children. However, Welsh fathers’ experience, as recorded from surveys, points to a fundamental underlying problem: fathers experience a state funded system that sees mothers as important while fathers are often an irrelevance or a problem. Around 2/3rds of fathers believe that their role isn’t recognised or valued equally with that of mothers. Almost 80% of fathers surveyed identified that Government and Local Authorities needed to do more to engage them as parents, irrespective of separation issues.

Society sends fathers a mixed message: demanding their greater involvement in child rearing, whilst denying them the means to achieve it.

Where separation issues arise, fathers reported feeling excluded, marginalised and socially isolated. Moreover, many services will refuse to engage with a separated, non-resident father, even if he has Parental Responsibility.

**Alienation and ACEs**

The recognised Adverse Childhood Experiences (ACEs) are sexual abuse, physical abuse, verbal abuse, physical neglect, emotional neglect, domestic violence, parental separation, and living with someone abusing alcohol or drugs, suffering mental illness, or with a record of incarceration. [The most common of these ACEs is parental separation](http://www.wales.nhs.uk/sitesplus/documents/888/PHW%20ACEs%20Resilience%20infographic%20%28Eng%29.pdf) (25% of those surveyed in Wales). Adults with a childhood history of being exposed to four or more ACEs are correlated with severe adverse outcomes across a wide range of metrics. The [Welsh Adverse Childhood Experience (ACE) study](http://www2.nphs.wales.nhs.uk:8080/PRIDDocs.nsf/7c21215d6d0c613e80256f490030c05a/d488a3852491bc1d80257f370038919e/%24FILE/ACE%20Report%20FINAL%20%28E%29.pdf) and its [2018 update](http://www.wales.nhs.uk/sitesplus/documents/888/PHW%20ACEs%20Resilience%20infographic%20%28Eng%29.pdf) indicate a prevalence of 14% of such people in Wales. A child having the constant support of both parents is far less likely to acquire multiple ACEs than a child who does not have the constant support of both parents (see the Figure reproduced in section 3.5.3.1).

Alienation is the phenomenon in which one parent turns a child against the other parent by negative portrayal. The result is an unjustified rejection of a parent where there was previously a normal loving, “good enough”, relationship. The child becomes hostile, vitriolic and abusive, before usually rejecting the parent and refusing contact. It is important to appreciate how unnatural this is. Children are wired to attach to their parents and caregivers, even if they are neglectful or abusive. The alienated child’s mind is an induced pathology. Alienation is a form of child abuse.

Alienation almost always occurs within the context of parental separation, and hence there is immediately one ACE inflicted on the associated children. However, other ACEs will generally also occur. Verbal abuse is highly likely, as are allegations of domestic violence and sexual abuse, and the issue of mental health arises. Consequently, alienation may impose a constellation of ACEs upon the affected children, raising them in one ‘fell swoop’ from zero ACEs to the dangerous 4+ ACEs category.

It has been estimated that parental alienation is responsible for around 80% of the most intractable cases before the family courts. In these cases, based on a sample of 54, false allegations of domestic violence against the partner were made in 67% and false allegations of sexual abuse of the child in 81% of cases ([Whitcombe, 2017](http://www.malepsychology.org.uk/wp-content/uploads/2017/08/Male-Psych-slides-edited.pdf)).

More research is needed to ascertain the incidence of alienation. More research is needed to determine the incidence of false allegations within private family law cases. Most importantly of all, the family courts and their ancillary functions need to recognise the nature of alienation and be trained to recognise it in practice. In February 2017 CAFCASS CEO, Sir Anthony Douglas, acknowledged that parental alienation is “*undoubtedly a form of neglect or child abuse*”. That being the case, the family courts need to identify cases of alienation, and act accordingly in conformity with the paramountcy principle.

**Domestic Abuse**

Domestic abuse has strong demographic dependencies. Teenagers are two or three times more likely to be involved in domestic abuse as people over 55. For the lowest income groups, women are three times more likely to suffer domestic abuse than when household income exceeds £40,000 pa (with a somewhat less marked socioeconomic dependence for male victims).

But the most significant demographic effect is marital status. Women who were cohabiting, or single, or separated, or divorced, or widowed, at the time of the crime survey were 18 times more likely to report domestic abuse than married women. Men were 12 times more likely. Men or women who were separated or divorced at the time of the survey reported by far the greatest prevalence of domestic abuse (see Figure A.9.1). This is a very important observation, but one which goes generally unremarked. It suggests that ***either*** domestic abuse is causal in separation/divorce ***or*** that separation/divorce is causal in domestic abuse ***or*** that both are caused by some unidentified third variable. It is clearly of importance to ascertain which of these is the case, but existing data does not do so.

Whatever statistics tell us, there continues to be a stubborn resistance to perceiving domestic abuse of men as being as serious an issue as domestic abuse of women. Ancient gendered perceptions act to turn a huge prevalence of domestic abuse against men into a miniscule level of service provision. The big picture is marked by the gradual replacement of high levels of prevalence with very little support for male victims, as follows,

* The crime surveys in England and Wales indicate about 34% of domestic abuse victims are men. (International research suggests at least half of victims are men, if not more);
* Of reports of domestic violence to the police in England and Wales, 24% are from men;
* Successful prosecutions of women for domestic abuse are 7.5% of the total convictions for domestic abuse;
* Service provision for male victims is around 1% of that for women.

The lack of proportion between the demand and the provision of support for male victims of domestic abuse may be in violation of the public sector duty in relation to the protected characteristic “male”.

The high levels of demand for services for women victims of domestic abuse are such that no diminution of support to abused women is acceptable, and existing women’s services should rightly concentrate on that task. Support for male victims should be provided via separate services tailored to men’s specific needs, without re-allocation of resources from the women’s sector.

It may seem that issues relating to the courts are not within the scope of health and well-being. But the inequitable operation of justice, in both the criminal courts and the family courts, is a major driver (and symptom) of men’s societal disadvantage. As usual, this affects particularly those men who are already disadvantaged in other ways. The significance of domestic abuse in undermining men’s well-being, including driving suicide, cannot be fully understood until its key role in the operation of the family courts is appreciated. Both domestic abuse *of* men, and false allegations of abuse *by* men, are significant. Around half of child arrangement disputes in the family courts involve *allegations* of domestic abuse. This often guides court decisions. And yet CAFCASS research suggests that, in the most serious cases, the person culpable for harming a child is just as likely to be someone other than the man accused of domestic violence. These are highly contentious issues, but to ignore them would be to ignore one of the most significant causes of men’s mental health issues – including depression, substance abuse and suicide – affecting tens of thousands of men in England and Wales annually.

**Suicide**

To some extent the designation of suicide as a mental health issue is a matter of semantics. But there is a paradox in regard to women’s greater incidence of mental health issues in contrast with men’s far greater rate of suicide. This points to a more significant role of exogenous factors in male suicide, and there is some evidence that this is the case. We need to “[look beyond male suicide as a mental health issue](https://stopmalesuicide.com/2017/01/24/the-one-thing-that-can-stop-male-suicide/)”. Divorce/separation hugely elevates suicide risk in men, but not in women, especially when child contact is an issue. Suicide risk is also elevated significantly by domestic abuse. Consequently, the dearth of domestic violence services for male victims is relevant in the context of suicide.

Imprisonment hugely elevates suicide risk, and this affects 21 times more men than women.

Wales has a suicide and self-harm prevention strategy. Although men in middle age are now acknowledged as being a high-risk group, we are still ignorant about what factors underlie the higher statistics for males – especially as regards quantifying the importance of various different risk factors. Quantitative research into the causes of male suicide is long overdue.

**Men in Prison and ex-Offenders**

The trend in the UK for 72 years has been increasing numbers of men in prison. The number of prisoners held in Wales will increase when Berwyn is competed and fully occupied, and there are plans to build another prison in South Wales. There is no doubt that men are more readily incarcerated, and for longer, than women. There is a strong lobby to imprison fewer women, exemplified by the 2007 Corston Report, whose dictum was “equality does not mean treating everyone the same”. One wonders why not. Like so many issues, this is a remnant of the old gendered mindset: men are agentic, powerful and responsible; women are weak, vulnerable and in need of protection. In truth, it is not a person’s sex which determines these things, but other factors. Most men are not powerful, and some men are vulnerable, as the present report serves to demonstrate.

There is clear statistical evidence that men are treated far more harshly than women in respect of imprisonment, despite the popular belief to the contrary. Men commit 6 times more serious offences than women, but there are 21 times more men in prison, a disparity which can be explained by the greater likelihood of a man being imprisoned, and for longer, than a woman convicted of the same offence.

Prisoners are not a representative cross-section of society. Overwhelmingly, prisoners are disadvantaged, often in multiple ways. Suicide rates are horribly high in prisons, and rising. There is also a far larger number of older prisoners, over 60, than there used to be. As a result, the non-self-inflicted death rate is also rising alarmingly. Moreover, these older prisoners are particularly disadvantaged, often by limited mobility, or even dementia.

**Homelessness**

In Wales in 2016/17 and in 2017/18, similar numbers of men and women were assessed for housing needs, more men than women were deemed “eligible, homeless, and subject to a duty to help to secure housing”, but substantially fewer men than women were housed. Three or four times more men than women were deemed “not in priority need” despite being homeless.

The number of people sleeping rough on a given night differs markedly from the number of people who have slept rough at some time during a given year. The latter is perhaps 7 or 8 times the former (based on London data). Single night snap-shots in 2017 identified 188 people sleeping rough in Wales and 4,751 in England. These data suggest there may be around 35,000 people who have slept rough in England or Wales at some time during 2017. Based on English data, at least 84% of rough sleepers are men. Rough sleepers who die on the streets of England are 90% men. Welsh rough sleeper data is not currently disaggregated by sex. No part of the UK government records homeless death statistics at a national level, and local authorities are not required to count rough sleeper deaths. This should be considered.

**Mental Health**

It is recognised that mental health is one of the top priorities of the Welsh Government and that this is reflected in Welsh Government budgetary allocations. However, there could be more focus on research and data collection. This has been acknowledged by the Welsh Government, for example in respect of data to understand the real consequences of mental ill health in Wales. For instance, while the Welsh Health Survey 2015 provides details on the number of people who experience mental health problems in Wales, there is scant information on mental health diagnosis, treatment and support. And, although the *Mental Health (Wales) Measure (2010)* places legal duties on health boards and local authorities to improve support for people with mental ill-health, there is a scarcity of available information in terms of what is captured at the Local (Community) Mental Health Board level.

Unlike England, where four studies on the trend of psychiatric disorders have been conducted since 1993, no Wales nationwide mental health survey of the adult population was carried out during the 15-year period 2000-2015 to ascertain the trends in mental health, availability of support services, or the number of adults receiving mental health treatment.

Drugs and alcohol are both a marker for, and a cause of, disadvantage – and they are more prevalent in men. Tackling substance abuse remains a key part of addressing deprivation. It is noted that there is an absence of suitable individual level socio-economic data that could help to explain key alcohol indicators and their relationship to areas of deprivation.

# 1. Purpose and Context

In February 2018, Public Health Wales, Centre for Equality and Human Rights, commissioned Families Need Fathers – Both Parents Matter, Cymru (FNF-BPM Cymru) to lead the production of this review. Its purpose is to support national and local level change in Wales by identifying the evidence of discrimination that impacts negatively on the well-being of men and boys in respect of key health inequalities.

The [Equality Act 2010](https://www.gov.uk/guidance/equality-act-2010-guidance) recognises nine protected characteristics and requires public bodies to ensure that people with protected characteristics are not unfairly discriminated against in the context of public service provision and employment. Public bodies are also subject to a general duty to promote equality, eliminate unlawful discrimination and promote good relations across all protected characteristics. Sex is a protected characteristic that applies to both men and women.

In social issues generally, and for health matters in particular, there has been a considerable focus on gender equality in relation to women and girls. There has been less focus in the past on equality issues for men and boys. There has been less available research evidence to understand how the wider determinants of health impact on men and boys, or to appreciate the health inequalities that men and boys may experience on grounds of their gender. For example, in England, the Chief Medical Officer for England has produced a report on “[The Health of the 51%: Women](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/595439/CMO_annual_report_2014.pdf)” and yet there is no equivalent for men and boys. This is curious in view of the shorter life expectancy of men being well known. When it comes to disadvantage, being dead is indisputably a case in point.

It will be emphasised in this report that the greater male death rate is not just a feature of the old but is the aggregated result of the greater death rate of males at all ages to 80. The excess of male over female deaths is several tens of percent for babies, boys, young men and middle aged men, as well as older men. Health and longevity are not determined solely by physical disease but also by a range of psychosocial factors. These non-physical factors will also be considered here, necessarily so for it will be found that disadvantages of psychosocial origin are often the chief cause of gender disparities in death rates to the disadvantage of males.

Wales now has an opportunity to address, or at least to recognise, these neglected areas of inequality.

One of the key issues, explored here, is that social disadvantage affects outcomes for males even more than it indubitably affects females. This is hardly surprising. In the social sciences it is generally found that, whatever attribute or characteristic is being discussed, the distribution for males will most often have a greater variance than that for females. From this statistical vantage, it is to be expected that the extreme end of the distribution of deprivation will feature males disproportionately. It will be shown that the effects of this are evident in mortality data and other measures. It can be seen by all of us on the streets in the form of rough sleepers, who are predominantly men. This observation is sometimes obscured by a concentration on the other end of the same distribution: the relatively privileged. But the man who is under-educated, or unemployed, or mentally or physically afflicted, hardly gains much succour from the thought that other men are quite the opposite: in high status employment and in rude good health. Unfortunately, the former are far more numerous.

Psychosocial disadvantages are therefore of central importance in understanding gendered aspects of health. However, one must not lose sight of the fact that there are also biological differences. In sex-specific ailments this hardly needs defending. However, even in diseases from which both sexes might be expected to suffer equally, there are sex differences in both incidence and mortality – generally to the disadvantage of males. In many cases it appears that males have impaired immune response compared with females. [Testosterone has been implicated](https://med.stanford.edu/news/all-news/2013/12/in-men-high-testosterone-can-mean-weakened-immune-response-study-finds.html) in this weakened immune response in males. The higher male than female death rate in babies and very young children is evidence of this. Contrary to cultural assumptions, [the male is more fragile](http://www.bmj.com/content/321/7276/1609) than the female as regards health. Biology also matters.

## 1.1 The International Environment

The focus of this review is Wales, within the context of the UK. However, it is apposite also to consider briefly the international context. The newly published [Global Health 50/50 Report 2018](https://globalhealth5050.org/wp-content/uploads/2018/03/GH5050-Report-2018_Final.pdf) notes that, worldwide,

“*Over the past 25 years, men have consistently suffered higher rates of ill-health (measured as Disability Adjusted Life Years, DALYs) than women. Much of this difference can be accounted for by men’s exposure to tobacco, alcohol, and poor diets as well as higher rates of violence and traffic-related deaths and injuries*.”

Despite the wide diversity of cultures contributing to the Global Health 50/50 report, we will see that these observations apply also in the context of the UK and Wales.

The Global Health 50/50 report makes a salutary observation regarding the mismatch between the focus of the aid organisations (NGOs) and the known health inequalities. Referring to the Figure reproduced below, they write,

*“(The Figure) maps the key areas of health focus of the NGOs included in our sample. Each dot represents a stated area of attention for an NGO. We find that the majority of NGOs are focusing their work on health issues that were prioritised during the era of the Millennium Development Goals, namely: maternal health, child health and infectious diseases (particularly HIV, TB and malaria).*

*The more comprehensive health agenda of the Sustainable Development Goals, which addresses all key areas of health and illness, remains relatively free of NGO attention in our sample.*

*Furthermore, in our sample of 40 NGOs, 14 stated that they focus exclusively on the health needs of women and girls. Many of these organisations address women’s maternal and reproductive health as well as the health of newborns and young children. Very few NGOs address the changing epidemiology and shifting burden of disease in women, e.g. by addressing non-communicable diseases including heart disease, cancer or diabetes (i.e., the Sustainable Development Goals agenda).*

*Finally, no organisation in our NGO sample focuses exclusively on the health of men and boys, despite longstanding evidence of higher disease burden and lower life expectancy among men. This analysis of the focus of NGOs speaks to the need for organisations to truly adopt a gendered approach to programmes and strategies in realising the right to health for everyone.”*

**Figure from the Global Health 50/50 Report 2018**



This recognition of the dangers of conflating gender equality with women, and the importance of being driven by evidential data, is welcome. It is fully consistent with the World Health Organisations ‘Gender Fact Sheet’: “*Gender equality in health means that women and men, across the life-course and in all their diversity, have the same conditions and opportunities to realize their full rights and potential to be healthy, contribute to health development and benefit from the results*”.

The Global Health 50/50 report earlier notes that the health organisations from which they obtained their data are still dominated, in terms of senior staff, by men. “*Global health is led by men: Sixty-nine percent (69%) of organisations are headed by men; Eighty percent (80%) of board chairs are men*”. This further reinforces the danger, alluded to above, of conflating the fortunes of the top end of the male distribution with the misfortune at the bottom end of that distribution. There is a danger of holding a misguided belief that the preponderance of men in senior positions will advantage the common run of men. It does not.

## 1.2 The Legislative Framework in Wales

In Wales, the relevant legislative background is provided by the [Well-being of Future Generations (Wales) Act 2015](http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en). Section 10(1) requires that progress towards the achievement of its goals shall be measured against [46 National Indicators for Wales](http://gov.wales/docs/desh/publications/160316-national-indicators-to-be-laid-before-nafw-en.pdf). Those of most relevance to mental or physical health, or social well-being, are,

(2) Healthy life expectancy at birth including the gap between the least and most deprived.

(3) Percentage of adults who have fewer than two healthy lifestyle behaviours (not smoking, healthy weight, eat five fruit or vegetables a day, not drinking above guidelines and meet the physical activity guidelines).

(5) Percentage of children who have fewer than two healthy lifestyle behaviours (not smoking, eat fruit/vegetables daily, never/rarely drink and meet the physical activity guidelines).

(24) Percentage of people satisfied with their ability to get to/ access the facilities and services they need.

(29) Mean mental well-being score for people.

(30) Percentage of people who are lonely.

(34) Number of households successfully prevented from becoming homeless per 10,000 households.

As a minimum, the health inequalities of men and boys in Wales must be addressed with reference to the gendered aspects of the above issues. This does not exclude other areas of health or social disadvantage to men and boys.

In Wales, [the Public Health Outcomes Framework](http://www.publichealthwalesobservatory.wales.nhs.uk/phof) (“the Framework”) is the vehicle recommended to measure and monitor the health of the Welsh population. It supports the above National Indicators. This Framework recognises that the achievement of good health, and the wider economic, environmental and social determinants of health, can only be tackled by concerted and collective action. The present report examines these in the specific context of men and boys in Wales.

The Public Health Outcomes Framework makes reference to a Bibliography for the relevant Indicators. A few salient features from the Bibliography are,

* Findings from a range of studies show that poor mental health is consistently associated with unemployment, less education, low income or material standard of living, poor physical health and adverse life events. They concluded that poor mental health is both a cause and a consequence of social, economic and environmental inequalities.
* In the context of the gap in healthy life expectancy between the most and the least deprived, it is noted that common mechanisms behind this socioeconomic variation included differences in: access to resources; unemployment rates; social isolation; access to care; and, uptake of preventive services (amongst other factors). The author of the study concluded that a sizeable proportion of the burden of disease and premature death is a result of social inequalities.
* The Warwick-Edinburgh Mental Well-being scale (WEMWBS) is mentioned as an appropriate tool to measure mental health;
* The Bibliography refers to specific measures of “sense of community” and the benefits of social cohesion in avoiding depression.

The Framework is further developed in the document [Measuring the health and well-being of a nation](http://gov.wales/docs/phhs/publications/160329frameworken.pdf). This identifies essential themes, of which one is “wider social determinants”. This notes the broad factors that can impact on health and well-being. They include an individual’s social environment, employment and education (amongst other things). It also observes that people living in ways that improve health and well-being will be supported by, and work with, services that help them act to improve their own and their family’s health and well-being.

All this guidance emphasises the need to include social inequalities as a health issue in this review. Thus, educational failure, unemployment and social isolation are identified as the root causes of much disadvantage which has health impacts. These issues will be seen to affect men and boys especially. They become particularly significant for men separated from their children by partnership break-up, for whom social isolation is an endemic problem, enhancing suicidality.

Indicator 10 in [Measuring the health and well-being of a nation](http://gov.wales/docs/phhs/publications/160329frameworken.pdf) is: “School leavers with essential literacy and numeracy skills”. It notes, “*Low levels of literacy and numeracy are strongly linked to socioeconomic status and employability, while low levels of health literacy impact on the ability to access appropriate services, including preventative health programmes, all of which result in poorer health outcomes*.” Consequently, it is important to include education in the discussion on inequalities. Indicator 43 is “Suicide”, and it is noted that “*suicide is one of the three leading causes of death in the most economically productive age group (15-44 years)*”. Consequently, it is also important to include suicide in this review of inequalities.

As recognized by the ‘Framework’, there is a need to reverse the growth of an underclass of the socially and economically disenfranchised. It will be clear from this review that family break-up, separated fathers and fatherlessness cannot be divorced from health outcomes for men and their children.

## 1.3 Report Structure and Limitations

The report is structured around three major themes: physical health, social wellbeing, and mental health. These are addressed in Sections 2, 3 and 4 respectively.

Tables and Figures have mostly been presented in a series of Appendices (A.1, A.2, etc), reported separately. The companion file should be read in conjunction with this text.

Where sources are not explicitly stated in the main text they are given in the Appendices. All sources are gathered together in the References section.

No literature review is ever really complete. That is particularly the case here, where the scope to be covered is extremely broad and the material has been compiled quickly. Nevertheless, a picture of the health and well-being inequalities faced by men and boys in the UK, and Wales in particular, emerges which is believed to be representative, although additional evidence could certainly be adduced with further effort. Desirable further research is identified in Section 5.

# 2. Physical Health

## 2.1 Gender Dependent Longevity in Wales

Over the whole of Wales, the average life expectancies at birth of men and women are 78.2 years and 82.2 years respectively, a gender disparity in expected longevity of 4.0 years (2012 data, see Appendix A.1). In the same year, the average life expectancy at birth for men and women in England were 79.2 and 83.0 years respectively, so both men and women fare worse in Wales, on average ([ONS data](https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/datasets/lifeexpectancyatbirthandatage65bylocalareasinenglandandwalesreferencetable1)).

Life expectancy is poorer in lower socioeconomic areas. For example, in Rhondda Cynon Taff the life expectancies for men and women are 76.4 and 81.0 respectively, compared with 80.1 and 83.9 in Monmouthshire.

However, men’s life expectancy is impacted more than women’s by economic disadvantage. The gender disparity in life expectancy is greater in the lower socioeconomic groups and this is due to the disparity being significantly correlated with men's life expectancy but not with women’s (see Figures A.1.1 and A.1.2). In plain words, where the gender gap in life expectancy is larger it is more due to men's poorer life expectancy than women's better life expectancy.

[Public Health Wales](http://www.publichealthwalesobservatory.wales.nhs.uk/inequalities-and-inequities/) recommend a measure of inequality in life expectation due to differing levels of deprivation within a given population (see Appendix A.1 for details). Stats Wales have provided this [life expectancy inequality data](https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Life-Expectancy/inequalitygapinlifeexpectancyandhealthylifeexpectancyatbirthslopeindexofinequalityinyears-by-localhealthboard-localauthority) for the 22 unitary authorities, see Table A.1.2 and Figure A.1.3 (data up to 2014).

Figure A.1.3 illustrates that where deprivation inequality is relatively small (around 3 years) there is little difference between the deprivation inequality for males and females. However, where the deprivation inequality is larger (greater than 6 years) there is a clear tendency for male deprivation inequality to be larger than that for females.

Thus, for men, there is an intersectional effect of gender with socioeconomic disadvantage which enhances the gender disparity in life expectancy.

Life expectancy rather than “healthy life expectancy” has been used exclusively here. This is because the former is regarded as a more reliable statistic. Datasets for “healthy life expectancy” are smaller and suffer from a significant subjective element. Survey respondents must judge for themselves when ill health first compromised their quality of life. In particular, this subjective element of perception may differ in a systematic fashion between the sexes, rendering comparison of “healthy life expectancy” between the sexes unreliable.

## 2.2 Gender Disparity In Premature and Early Death

What lies behind the gender gap in longevity is a huge percentage gender gap in premature death rates. For England and Wales jointly in year 2016 this is shown in Figure A.2.1 (see Appendix A.2 for sources).

Young men between the ages of 18 and 30 have more than double the death rate of women of the same age (triple in their early twenties). Suicide is a major contribution to this disparity.

However, even mature men, between, say, 40 and 60 years old, still have death rates 40% to 70% greater than women of the same age. The number of male deaths exceeds the number of female deaths up to age 83. Even male babies have a significantly higher mortality than female babies.

Defining premature death as death before age 75, the number of premature deaths of males in England and Wales in 2016 was 101,759 compared to 69,962 females – an excess of male over female premature deaths of 45%. This is, arguably, the most emphatic indicator of male disadvantage, though it generally goes unremarked.

The premature death rate for males exceeds that for females in Wales alone by 52%, an even larger disparity than for England and Wales combined – see Appendix A.2 and Figure A.2.2. Thus, the gender disparity in premature death, whilst large in both nations, is even more adverse for males in Wales.

## 2.3 Major Causes of Premature and early Death

Key data on premature and early death, with sources, is presented in detail in Appendix A.3: the data is given in Tables A.3.1 through A.3.4 and gender disparities in Tables A.3.5a through A.3.7b.

### 2.3.1 Premature Death

Premature death is defined as death before age 75 (i.e., up to age 74).

Table A.3.1 shows that in 2016 the top causes of premature death in England and Wales were cancers, cardiovascular diseases, respiratory diseases and digestive system diseases, in that order for both sexes, accounting in total for 77% of premature deaths of men, and 80% of premature deaths of women.

Tables A.3.3-4 show that the top causes of premature death in Wales follow essentially the same pattern.

Table A.3.5a shows the excess of male over female premature deaths in England and Wales in 2016 (derived from Table A.3.1).

Cardiovascular diseases are far and away the most significant cause of excess male over female premature deaths, with cancers in an easy second place, in both England and Wales (Tables A.3.5a and A.3.6a).

Across all causes there is a 45% excess of premature deaths of men over that of women in England and Wales (49% in Wales alone).

A rather different picture emerges if the excess of male over female premature deaths is calculated as a percentage of the latter (Tables A.3.5b and A.3.6b). In England and Wales this statistic indicates that the top nine premature death gender disparities occur in this order: transport accidents, suicide, drug misuse, homicide, poisoning by noxious substances other than drugs or alcohol, cardiovascular diseases, alcohol, undetermined causes and ‘falls, drowning or fire’. All of these top nine causes of gender disparity in premature death cause nearly double, or more than double, the number of male deaths compared with female deaths. Noting that accidents and homicide are not listed in the dataset of Table A.3.6b, the picture for Wales is very similar to that for England and Wales.

One of the most noteworthy features of the excess male premature deaths, when expressed as a percentage of female premature deaths, is the prominence of the psychosocial causes - suicide, accidents, homicide, drugs and alcohol – over the physical diseases.

However, one should not lose sight of the fact that, in terms of absolute numbers of excess premature male deaths, cardiovascular diseases are way out in front, with cancers an easy second.

In particular note that, in terms of absolute numbers of premature deaths, homicide of men is in 17th place out of the 19 causes in Table A.3.1, and in 18th place for women. Violence is not the big killer that is sometimes claimed.

### 2.3.2 Early Death

Early death is defined here as death before age 45 (i.e., up to age 44).

Across all causes, there are 74% more early male deaths than early female deaths (England and Wales, 2016). In Wales alone there were 84% more early male deaths than early female deaths (2011).

The top cause of ***early*** death of younger men in both England and in Wales was suicide (Tables A.3.2.1 and A.3.2.2). This confirms the oft-repeated claim that suicide is the biggest killer of men under 45 in England and Wales (15.3% of all early deaths, and 18.5% in Wales in 2011). The next three causes of early death in order of importance were cancers, cardiovascular diseases and drug misuse.

There is an emphatic gender difference in the pattern of early deaths. For women, the top cause of early death is cancer, which accounts for nearly four times the number of early deaths as suicide in women.

Even the *absolute* excess of early male over early female deaths shows dominance by psychosocial factors: the top causes being suicide and drugs, with traffic accidents and alcohol in 4th and 5th places (Table A.3.7a).

When based on the *percentage* disparity, the excess of male over female early deaths presents a picture which is even more dominated by the psychosocial pathologies and accidents (Table A.3.7b for England and Wales). The top five causes in order are then: transport accidents, ‘falls, drowning or fire’, accidental poisoning by exposure to noxious substances other than drugs or alcohol, suicide and drug misuse.

Indicator 43 in [Measuring the health and well-being of a nation](http://gov.wales/docs/phhs/publications/160329frameworken.pdf) is “suicide”. It is stated there that “*Suicide is one of the three leading causes of death in the most economically productive age group (15-44 years); the other two being road traffic injuries and inter-personal violence*.” Suicide is indeed the No.1 killer of men under 45, but it ranks as 4th for women in Table A.3.2. However, the claim that traffic accidents and violence are within the top three killers of people under 45 is simply incorrect. For men, traffic accidents are in 6th place whilst for women traffic accidents are in 11th place (Table A.3.2). The significance of interpersonal violence is far less than the quote indicates, homicide lying at 14th place out of 17 for both men and women in Table A.3.2, accounting for only 2% of early deaths.

### 2.3.3 Cardiovascular Diseases

Cardiovascular diseases are easily the most significant cause of excess male over female premature deaths.

Cardiovascular disease (CVD) is the collective term for all diseases affecting the heart and blood vessels. This subsumes a large range of diseases including: coronary heart disease, myocardial infarction (heart attack), heart failure, and cerebrovascular diseases (including strokes), and many others. Coronary heart disease (CHD) is the collective term for diseases that occur when the walls of the coronary arteries become narrowed, usually due to a gradual build‑up of fatty material called atheroma. Within the CVD categories, the biggest killers are CHD and stroke.

There is a strong regional dependence of the incidence of CVD. Figure A.3.1 shows that the rate of premature death due to CVD is higher in Wales, Scotland and parts of northern England than it is in southern and south-eastern England. This is confirmed by a simple pro-rata estimate, based on population size, of the number of CVD deaths expected in Wales obtained by scaling the figure for England and Wales. The actual number of deaths in Wales exceeds expectation on this simplistic basis.

There is a huge gender difference in premature death by CVD. In both England and Wales and Wales alone more than twice as many men die prematurely from CVD as women.

Nevertheless, there is little difference between England and Wales as regards the premature deaths by CVD as a proportion of all premature deaths, CVD accounting for about 25% of premature deaths of men and 17% - 19% of premature deaths of women in both nations.

Despite the justified ongoing concern about CVD related deaths, it is worth pointing out that premature deaths by CVD have reduced dramatically over the decades, making a major contribution to increasing longevity in all the UK nations (see, for example, Figure A.3.2 for Wales). Nevertheless, the ratio of male to female premature deaths by CVD has remained stubbornly persistent. Figure A.3.3 illustrates how that ratio varies with age and with specific disease within the CVD group. For most CVD diseases the ratio of male to female deaths reaches a maximum in excess of 2 at about age 50. For CHD the peak male:female death rate ratio is in excess of four.

### 2.3.4 Cancers

Table A.3.8 gives the number of premature deaths from cancers in 2016 for England and Wales. Table A.3.9 gives the number of deaths due to cancers in Wales alone (average of the three years 2013 to 2015). The number of premature male deaths from cancers exceeds the number of premature female deaths from cancers by 16% in England and Wales combined, and by 24% in Wales (in 2013-15, or by 21% in 2016, Table A.3.4).

The leading cancer causes of premature male mortality are lung cancer, colorectal cancer, oesophageal cancer and prostate cancer in that order. This is true in both England and in Wales, with lung cancer being easily the top killer. (In women the top four causes of premature death by cancers are lung cancer, breast cancer, colorectal cancer and ovarian cancer, in that order, in both England and in Wales).

Tables A.3.8-9 show that all types of cancer result in more premature deaths of men than of women, excluding only the female-specific cancers of breast, cervix, ovary and uterus. Again this is true in both Wales and in England. (Endocrine cancers in Wales appear to be an exception, but this may be an artefact of very small statistics). Figure A.3.3 illustrates just how much more affected are men by non-sex-specific cancers.

By far the largest premature killer of both men and women by cancer is lung cancer, followed by colorectal cancer. These cause 21% (18%) and 42% (58%) more premature male than premature female deaths respectively in England and Wales (Wales alone). Colorectal cancer has a national screening programme starting at age 60 for both sexes. It is the only national cancer screening programme applicable to men.

Oesophageal cancer is the third most important premature killer of men by cancer, and results in roughly three times as many premature deaths of men as women.

#### 2.3.4.1 Lung Cancer

Lung cancer is by far the biggest cancer killer, for both sexes. It is also the cancer responsible for the largest number of premature deaths, in both sexes. Lung cancer causes more premature deaths of men than women (by about 20%). A thorough review of lung cancer is beyond the scope of this report, but a few remarks regarding the influence of gender are pertinent.

By far the most important cause of lung cancer is smoking. Estimates are that between 80% and 90% of lung cancers are caused by smoking. However, people who have never smoked can also get lung cancer.

Two other significant causes are exposure to carcinogenic substances, and natural radon. Implicated carcinogenic substances include diesel fumes, certain solvents, arsenic, some metals, asbestos, wood dust, ‘second-hand’ smoke, and a range of other chemicals. Exposure to these substances is often work related, with people such as painters, builders, plumbers, garage mechanics, truck drivers, and a whole range of manufacturing industries being potentially at risk. The gendered nature of employment in these areas leads to men being more at risk from these sources.

Naturally occurring radon is another cause of lung cancer. Though radon is thought to account for only ~4% of lung cancer deaths, in the UK this is over a thousand deaths. Radon concentrations in dwellings vary with local geology. Some granite geologies can be prone to raised radon levels.

The incidence of lung cancer in men exceeds that in women, as does the mortality. Survival rates in diagnosed men are poorer than those in women. It is beyond the scope of this review to examine the causes of this gendered effect. However, the male death rate by lung cancer has reduced markedly since the 1970s (Figure A.3.5) as a result of the reduced prevalence of smoking. In 1948 some 65% of men in the UK smoked compared. As of 2016, [this had reduced to 17.7%](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2016). The prevalence of smoking continues to fall for both sexes. The difference in the prevalence of smoking between men and women in the UK has been slight, about 3 or 4 percentage points, for around 30 years.

The death rate of women by lung cancer has increased since the 1970s, despite the prevalence of smoking amongst women having reduced from a peak of 44% in the mid-1960s to 14.1% by 2016. This is probably explained by the delayed effect of smoking, with women today paying the price for a habit indulged perhaps 40 years ago. What makes more obvious sense is that male and female mortality rates have tended towards convergence as smoking prevalence has also converged. An excess of male over female deaths due to lung cancer remains, perhaps due in part to poorer male survival rates and in part to a greater exposure of males to carcinogenic substances in the workplace.

The number of male deaths from lung cancer in Wales between 2001 and 2011 (Figure A.3.7) does not show a reduction - contrary to expectation based on the UK death rate (Figure A.3.5). This may be because the reduction in smoking prevalence in Wales has lagged behind that in England. The number of deaths of women from lung cancer, is, however, increasing in Wales, consistent with UK data.

There is a strong socioeconomic dependence in the incidence of lung cancer. This is illustrated by Figure A.3.8 for England and Figure A.3.9 for Wales. In both cases the most disadvantaged quintile is about 2.6 times more likely to die from lung cancer than the least disadvantaged. The latter Figure indicates that this can be explained primarily in terms of the higher prevalence of smoking in the most disadvantaged demographic.

#### 2.3.4.2 Prostate, Testicular and Breast Cancer

Prostate cancer is frequently paired with breast cancer for purposes of comparison, because they are the most significant sex-specific cancers for men and women respectively, and by a large margin. Prostate cancer has now exceeded breast cancer as the larger killer. In England and Wales, 10,456 men died of prostate cancer in 2016, compared with 10,178 women who died of breast cancer (plus 72 men). However, a larger proportion of these male deaths are post-75 than the female deaths. The number of *premature* male deaths from prostate cancer in 2016 was 2,588 compared with 5,340 *premature* deaths of women from breast cancer. Hence, prostate cancer accounts for roughly half as many premature male deaths as breast cancer does of women.

A similar ratio can be seen in the Welsh premature death data (Table A.3.9), within the limits of smaller statistics.

Nevertheless, even for deaths before age 75, prostate cancer is one of the leading cancer killers of men (4th in Table A.3.8). Prostate cancer causes more premature deaths than ovarian cancer, and far more premature deaths than cervical cancer and uterine cancer combined. Across all ages, prostate cancer kills 60% more men than cervical cancer, uterine cancer and ovarian cancer combined kill women.

Prostate cancer kills a comparable number of men under the age of 75 as colorectal cancer kills women under 75. If the latter deserves a national screening programme, so does the former. The issues are cost and diagnostic technology (see Section 2.3.7.1).

Men *can* get breast cancer. One of the most surprising facts in cancer death statistics is that more men in the UK die of breast cancer than die of testicular cancer, namely 72 and 50 respectively in 2016 in England and Wales. In terms of premature deaths these figures are 42 and 45 respectively. The incidence of testicular cancer in the UK is about 2,400 cases per year. But the survival rate is about 98%. The incidence of breast cancer in UK men is about 390 cases per year, but the survival rate is not good (no doubt because it takes a while to be diagnosed, because "men don't get breast cancer"). However, these mortality numbers are relatively small.

#### 2.3.4.3 HPV Related Cancers

Human papilloma viruses (HPVs) are a group of more than 200 related viruses. More than 40 HPV types can be spread through direct sexual contact, from the skin and mucous membranes of infected people to the skin and mucous membranes of their partners. They can be spread by vaginal, anal, and oral sex. There are also HPVs which are not sexually transmitted and which cause non-genital warts. Around [90% of sexually active people will be infected with HPV](https://www.cancer.gov/about-cancer/causes-prevention/risk/infectious-agents/hpv-fact-sheet) at some time, though only around half with a high risk variant.

A range of HPVs are causally connected to various cancers. The most significant cancers caused by HPV are cervical cancer and oropharyngeal cancers. One HPV variant or another is responsible for virtually all cervical cancers. Hence, HPV caused 499 premature deaths of women by cervical cancer in England and Wales in 2016 (Table A.3.8).

The proportion of oropharyngeal cancers which are caused by HPVs is uncertain, but substantial. Some sources put this at [less than 50%.](http://www.cancerresearchuk.org/about-cancer/causes-of-cancer/infections-hpv-and-cancer/hpv-and-cancer) However, it is likely that this is based on old statistics prior to the incidence of HPV-related oropharyngeal cancers increasing steeply from the mid-1980s. The best estimate at present is that about 70% of oropharyngeal cancers are HPV induced (see Chaturvedi, et al. [Human papillomavirus and rising oropharyngeal cancer incidence in the United States](https://www.ncbi.nlm.nih.gov/pubmed/21969503)).

Consequently, based on 70% of the data in Table A.3.8, HPVs probably caused about 870 premature deaths of men and 326 premature deaths of women from oropharyngeal cancers in 2016 (England and Wales).

HPVs also cause about [95% of anal cancer](https://www.cancer.gov/about-cancer/causes-prevention/risk/infectious-agents/hpv-fact-sheet). There were around [140 anal cancer deaths of males in 2014, and about 220 of women](http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/anal-cancer#heading-One) (England and Wales). About half of these deaths occur after age 75, so the number of premature deaths due to anal cancer is about 70 and 110 for men and women respectively.

There are other cancers associated with HPV, but they are relatively rare. In total, then, about 940 men and 935 women suffered premature deaths in 2016 due to HPV induced cancers in England and Wales. (In Wales alone the matter is not so clear due to small statistics, but it is noted that oropharyngeal cancers and cervical cancer cause the same number of premature deaths of men and women respectively, Table A.3.9).

That the number of premature deaths due to HPV cancers is virtually the same for the two sexes is noteworthy in view of there being an NHS vaccination programme against HPV for girls, but no such programme for boys. There is also a national screening programme for cervical cancer, but no screening programme for oropharyngeal cancers. These issues are taken up in Section 2.3.7.2.

### 2.3.5 Diabetes

The Men’s Health Forum has recently published a report “[One In Ten: The Male Diabetes Crisis](https://www.menshealthforum.org.uk/one-ten-male-diabetes-crisis)”. From their report,

“*Men are 26% more likely to develop Type 2 diabetes than women; Public Health England estimates that 9.6% of men have type 1 or type 2 diabetes – one man in ten has diabetes.*

*Men are more likely to suffer from diabetic retinopathy, foot ulcers and to have a foot amputation. 69.6% of those presenting with a foot ulcer are men. Men are more than twice as likely to have a major amputation as a result of diabetes.*”

Men are 57% more likely than women to suffer premature death due to diabetes in England and Wales (Table A.3.1), whilst in Wales men are more than twice as likely to die prematurely from diabetes (Tables A.3.3-4).

The major cause of Type 2 diabetes is being overweight. Men are more likely to be overweight (body mass index, BMI, greater than 25). Men also develop diabetes at a lower BMI than women. However, men are less likely to be aware that they are overweight or to participate in weight management programmes.

The Men’s Health Forum report notes that sex inequalities have not been highlighted by health policy makers and practitioners and calls for better engagement of men in NHS health checks, routine eye tests, weight management programmes and diabetes education programmes.

The tendency to be over-weight often starts young. [Peter Baker, men’s health consultant](http://pbmenshealth.co.uk/public-health-england-its-time-to-tackle-mens-health/), notes that,

“*Boys are significantly more likely than girls to be overweight or obese. At ages 4-5 in 2014/15, 22.6% of boys were overweight or obese compared with 21.2% of girls, a gap of 1.4 percentage points. More children are overweight or obese at ages 10-11 than 4-5, and there is also greater inequality between the sexes, with 34.9% of boys and 31.5% of girls with excess weight, a gap of 3.4 percentage points.”*

No doubt the fact that children tend to play energetic games less often than in the past, in favour of more sedentary pastimes indoors, is part of the problem. But these issues require further research to elucidate.

### 2.3.6 Workplace Injuries and Deaths

#### 2.3.6.1 Deaths of Workers

Deaths at work are massively dominated by men. [97% of fatal injuries](http://www.hse.gov.uk/statistics/pdf/fatalinjuries.pdf) to workers in Great Britain in 2016/17 were men (133 out of 137). In 2013 it was [98% (122 out of 124)](http://www.hse.gov.uk/foi/fatalities/2013-14.htm). However, the number of deaths at work has reduced substantially over the last 40 years. In the early 1980s there were typically around 500 deaths at work per year in Great Britain. So, whilst many of us may have been occasionally exasperated by ‘health and safety gone mad’, the far tighter focus on safety has been successful. When judged by deaths per 100,000 employees, waste and recycling was clearly the dominant area in terms of worker death rate in 2016/17. Transport and manufacturing are the remaining significant sectors. Construction and agriculture are the main causes of deaths at work, between them accounting for 73% of such deaths. However, this is slightly misleading because of the large number of people employed in these sectors.

#### 2.3.6.2 Non-Fatal Injuries at Work

Workers self-reported 609,000 non-fatal injuries in Great Britain in 2016/17, of which [62% were injuries to men](http://www.hse.gov.uk/statistics/causinj/index.htm) and 38% to women. The bulk of these will be minor injuries. A breakdown of the data by both injury severity and gender is not readily available (though the far greater male death rate at work suggests that severe injuries will also be skewed towards men).

### 2.3.7 Gender-specific health funding and provision

#### 2.3.7.1 Prostate Cancer

There is no national screening programme for prostate cancer. This is not justified in terms of its mortality. Prostate cancer causes 5 times as many premature deaths as cervical cancer (and 14 times as many over all ages), yet there is a national screening programme for cervical cancer. Prostate cancer kills about as many men under the age of 75 as colorectal cancer kills women under 75, yet there is a national screening programme for colorectal cancer (for both sexes).

The usual reason which is cited for this omission is the lack of a suitable, reliable diagnostic tool to form the basis of such a screening programme. The problem is exacerbated by the relative inaccessibility of the prostate (e.g., compared to a breast or testicle). A further exacerbation is that prostate cancer is often largely, or totally, asymptomatic until it reaches an advanced stage.

In the absence of a national screening programme, a man must be pro-active in seeking a diagnostic test. This is usually a blood test, the so-called PSA (Prostate Specific Antigen) test. Men over 50 are entitled to a PSA test on the NHS, although this entitlement is described in NHS guidance with the proviso “after discussing the pros and cons with your doctor”. The necessity to be pro-active, even in the absence of symptoms, is unfortunate.

In practice[, it is the experience of many men that GPs or practice nurses will be reticent about offering a PSA test](https://prostatecanceruk.org/prostate-information/prostate-tests/psa-test#what-if-my-gp-wont-give-me-a-psa-test). This reticence by GPs is largely due to the very high rate of both false positives and false negatives from the PSA test, though one suspects that practice costs also play a part. Nevertheless, the PSA test is the usual initial tool which may trigger further investigations. A digital-rectal examination can be a helpful additional check, a negative result of which can restore peace of mind. However, this, too, is unreliable.

It is usually a high PSA result (in excess of 4 ng/ml) which motivates further action. Only 25% of men with PSA above 4 ng/ml turn out to have prostate cancer – an indication of the limitations of the test (and lower readings are no guarantee of being clear of the disease). Up to now the ‘further action’ following high PSA would most likely be a biopsy, carried out by inserting a needle into the prostate through the wall of the colon. Usually a dozen or so samples are taken. But even a biopsy does not provide certainty. False positives are unlikely, but false negatives more so. A biopsy is literally ‘hit and miss’, so a false negative will result if, by bad luck, the needle fails to hit the tumour. About half of all such biopsies produce a negative result – rightly or wrongly.

Currently about 100,000 men in the UK are given prostate biopsies annually, and about 47,000 turn out to have prostate cancer.

Very recently it has been announced that the NHS in England is [trialling the use of an MRI technique](http://home.bt.com/news/uk-news/nhs-launches-one-stop-service-to-slash-diagnosis-times-for-prostate-cancer-11364255448347) as the follow-up to a suspicious PSA result or other GP referral, initially in three London hospitals. This particular type of MRI scan, known as a mpMRI (multi-parametric MRI scan) has been shown very recently to be twice as effective as biopsies at spotting prostate cancer. A series of tests on 576 men with raised PSA counts was reported in [The Lancet in February 2017](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2816%2932401-1/fulltext). The efficacy of mpMRI was compared with standard biopsy. 40% of the men had clinically significant cancer and mpMRI spotted 93% of these cases compared with only 48% spotted by standard biopsy.

As well as being more reliable, and less uncomfortable for the patient than biopsy, the use of mpMRI considerably speeds up diagnosis times. In the UK under present arrangements it takes an average of 56 days, from the time a man first reports symptoms to a GP, for him to be confirmed with prostate cancer. In 25% of cases it takes more than four months. In comparison, for breast cancer, diagnosis takes on average just 14 days. If the new procedure employing mpMRI were rolled out nationwide, the diagnosis time for prostate cancer would contract to something close to that for breast cancer.

The adoption of the mpMRI based arrangements in Wales, assuming the London tests prove as successful as anticipated, will hinge upon the availability of sufficient of the expensive MRI machines throughout Wales.

Angela Culhane, chief executive of the charity Prostate Cancer UK[, has said](http://www.bbc.co.uk/news/health-42890405) that prostate cancer currently receives only half the funding and half the research that is devoted to breast cancer, adding that developing better diagnostic tests that could be used as part of a nationwide screening programme should be a priority.

However, the immediate funding issue may be the acquisition of sufficient MRI machines, in a sufficient number of locations. And that presupposes that the improved diagnostic technique is approved [in the devolved administration in Wales](https://www.prostatecanceruk.org/about-us/news-and-views/2016/11/turning-guidelines-into-lifelines-nice-agrees-to-early-review-of-treatment-protocol-for-prostate-cancer).

#### 2.3.7.2 HPV Related Cancers

Section 2.3.4.2 has identified that a similar number of men suffer premature death due to HPV induced cancers as women. In men this is predominantly due to oropharyngeal cancers, which are increasing rapidly, probably due to the growth in popularity of oral sex. In women both cervical cancer and oropharyngeal cancers are significant.

Ten years ago an [NHS programme to vaccinate girls](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/310958/HPV_Joint_Letter_14_May.pdf) against the most high risk variants of HPV was rolled out to Year 8 girls, i.e., from age 12 (though it is available free up to age 18). Wales has the same vaccination programme for girls. By 2012 the uptake of the complete course by girls in Wales was reported to be [87%](http://www.publichealthwalesobservatory.wales.nhs.uk/child-profile-key-messages-5/).

There was no NHS vaccination programme against HPV for boys between 2008 and 2018. Over this ten year period there was agitation from many quarters, not least from authoritative medical bodies, that the vaccination programme should be rolled out also to boys. In July 2018 it was finally announced by the UK government that [boys are to get the vaccination](https://www.gov.uk/government/news/hpv-vaccine-to-be-given-to-boys-in-england) on the NHS. This is very welcome news, but the saga which was required to get to this point is worth recording.

[The reason cited](https://www.nhs.uk/conditions/vaccinations/hpv-human-papillomavirus-vaccine/) for omitting boys from the original programme was that vaccinating girls “*helps to indirectly protect boys from these types of HPV through what's known as herd immunity because vaccinated girls won't pass HPV on to them*”. The obvious flaw that this does not protect men who have sex with other men was the first counter-argument to be recognised. In England, the government confirmed in February 2018 that it will introduce a nationwide HPV vaccination programme for men aged 45 or younger [who have sex with other men](https://www.gov.uk/government/news/hpv-vaccination-programme-for-men-who-have-sex-with-men). This will be made available at specialist sexual health clinics (so there will be a need to be pro-active).

But resistance to an NHS vaccination programme for heterosexual boys was maintained for ten years. The then-Secretary of State for Health and Social Care, [Jeremy Hunt confirmed](http://www.newspaperstoday.co.uk/item/jeremy-hunt-advisers-say-hpv-vaccine-for-boys-not-cost-effective) in March 2018 that there was no intention to roll out HPV vaccination for boys, on grounds of cost. Whilst vaccination at a private clinic might cost £300, it is believed that the cost to the NHS, due to economies of scale, is more like £30. Meanwhile, Australia, Austria, Croatia, New Zealand, South Korea and some provinces of Canada have state funded vaccination programmes for boys, in some cases for the last ten years, with several more countries likely to follow suit.

One cannot help but observe that the same argument based on “herd immunity” would apply equally if only boys but not girls were vaccinated. But such an approach would hardly be regarded as acceptable (including to the present author) and would certainly meet with compelling opposition from women’s groups.

Quite apart from issues of equality and ethics, even a lay person can see that the “herd immunity” argument is seriously flawed. [Gross immigration into the UK](https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/bulletins/migrationstatisticsquarterlyreport/february2018), before allowance for emigration, is currently running at over a million every two years. Not only will most of these immigrants not be protected against HPV, but neither will any native male having sex with such an immigrant. Moreover, many UK men will have sex with women from abroad at some time (and once is enough). One need only think of the large proportion of non-UK students at universities (about 20% of undergraduates, and nearly half of postgraduates), together with the high incidence of casual sex at universities, to be concerned. In a letter to the Secretary of State in June 2016, [13 HPV experts observed](https://www.analcancerfoundation.org/press/the-times-hpv-vaccination-for-adolescent-boys/) that “*approximately 15% of 25-34 year old males have had at least one sexual partner from outside the UK in the past five years*”. They added, “*the total burden of these diseases affects men and women about equally and we therefore believe that there is a strong ethical argument for the equal protection of both sexes*”. They also noted that the costs of treating anogenital warts and oropharyngeal cancers was such that there was a cost-benefit case to be made for vaccinating boys. It would probably cost less than £20M per year to vaccinate all UK boys at the same age as girls.

Dentists are often the first to spot the signs of oropharyngeal cancer and so are particularly aware of its increasing incidence. The [British Dental Health Foundation](https://www.dentalhealth.org/News/open-letter-calls-for-hpv-vaccination-for-boys) has been campaigning for years to get boys vaccinated. As late as May 2018 the charity was lobbying government to change their policy.

Thirteen senior doctors published [their opinion on boys and the HPV vaccine in the British Medical Journal](http://www.bmj.com/content/353/bmj.i3372.full) in June 2016 (transcript [here](https://www.analcancerfoundation.org/press/the-times-hpv-vaccination-for-adolescent-boys/)), including Elizabeth Carlin, president of the British Association for Sexual Health and HIV, and Saman Warnakulasuriya, emeritus professor of oral medicine and experimental pathology at King’s College, London. They urged Jeremy Hunt to extend the English national HPV vaccination programme to boys.

The July 2018 decision to roll out the HPV vaccine to boys at 12/13 in Wales, England & Scotland follows near-unanimous support from [all Parties in Parliament](https://hansard.parliament.uk/commons/2018-05-02/debates/234E27F7-7D80-4B93-A72F-8F36A733A504/HPVVaccinationForBoys) and concern being expressed by the [Equalities and Human Rights Commission](https://www.equalityhumanrights.com/sites/default/files/briefing_wesminster_hall_debate_case_for_hpv_vaccination_for_boys_house_of_commons_2_may_2018.pdf). The outcome is most welcome, but one wonders why ten years of lobbying was required to implement what is merely an obvious issue of equality.

#### 2.3.7.3 Male Contraception

The advent of the oral contraceptive pill for women was of such overwhelming significance that a large part of the social changes of the last half century can be attributed to its consequential effects.

For men, there is no equivalent. Men have only the condom, which is not widely liked, though its use does confer significant benefit in terms of protection against infection. As well as being inconvenient, unpopularity arises from the fact that the condom decreases sensitivity. In circumcised men this can involve a double loss of sensitivity, and hence a further disincentive. Moreover, in long term relationships, the condom is generally forgone in favour of ‘the pill’, thus throwing all the burden for contraception upon the woman.

It is therefore a moot point whether the absence of a convenient “persistent” male contraceptive is more of a disadvantage for men or for women. What ***is*** clear is that the absence of a convenient, reversible, “persistent” male contraceptive is a gender inequality.

For women the inequality lies in the unfair placing of the burden of responsibility. The pill is by no means free of side effects or medical disadvantages. It is becoming increasingly clear that many women would welcome the burden of contraception being shared by men.

For men the inequality lies in having little or no control over their own fertility. Should their partner become pregnant, the woman has the option of the morning-after pill or an abortion. The man has no recourse to such after-the-event preventatives: it is a woman’s right to choose. That being the case, it is even more important that a man should be able to prevent an unwanted pregnancy in the first place.

It is important to recognise that an effective “persistent” male contraceptive need not mean a “male pill”. For men, unlike women, the gonads are conveniently placed outside the body. Access is easy. This means that “mechanical” interventions which prevent sperm being ejaculated are relatively easy to engineer. There are [many options](https://www.malecontraceptive.org/prospective/) which show promise. Such medical devices have a major advantage over a “male pill” in avoiding interference with the endocrine system with the unavoidable adverse implications.

[This US survey](https://news.blog.gustavus.edu/files/2017/09/Gustavus_Male_Contraception_Survey_7.17.pdf) indicates that two-thirds of men would use a male contraceptive if in a long-term relationship, and more than half of men would do so outside such a relationship. The same survey indicated that 80% of women in a long term relationship would trust a man to take the contraception. That far fewer women would trust a man with contraception in the case of casual relationships is not so relevant, because, in such cases, the man’s motivation would be more to protect himself.

Another major driver for effective and persistent male contraception is that its widespread uptake would markedly reduce the need for abortions, currently some [185,00 per year](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/433437/2014_Commentary__5_.pdf) in England and Wales.

### 2.3.8 Male Fertility

Male fertility is challenged by two factors: a global decline in average sperm counts, and age.

Unlike women, whose fertility comes to a final full-stop at men0pause, the saying goes that “men can have children at any age”. Whilst technically true, this perception disguises the substantial decrease in sperm count which occurs continuously from age 20 throughout a man’s life. Women are acutely aware of their biological clock. Men and women tend to be unaware that a man also has a biological fertility clock. The fact that the clock does not actually stop should not obscure the fact that it slows down a very great deal. [It has been estimated](https://yourfertility.org.au/for-men/age/) that the average time to pregnancy if a man is under 25 is just over 4.5 months but nearly two years if a man is over 40 – even if his partner is under 25.

The major indicator of male fertility is sperm count. Average sperm counts are falling across Western countries. Initially controversial, this declining sperm count now appears well founded. The 2017 meta-analysis “[Temporal trends in sperm count: a systematic review and meta-regression analysis](https://academic.oup.com/humupd/article-abstract/23/6/646/4035689?redirectedFrom=fulltext)” by Levine et al (Human Reproduction Update, **23** (6) 646–659) examined thousands of independent studies and conducted a meta-analysis of 185 of them. The international team of researchers ultimately looked at semen samples from 42,935 men from 50 countries between 1973 and 2011.

“*This comprehensive meta-regression analysis reports a significant decline in sperm counts (as measured by sperm concentration and total sperm count) between 1973 and 2011, driven by a 50–60% decline among men unselected by fertility from North America, Europe, Australia and New Zealand. Because of the significant public health implications of these results, research on the causes of this continuing decline is urgently needed*.”

This decline in sperm count in Western men was not matched by a significant decline in non-Western men. The cause is not currently known. The decline in sperm concentration appears to be worryingly large, a reduction by approximately 50 million/mL since 1973. The likelihood of conception begins to fall steeply below a sperm concentration of 40 million/mL, and sperm concentrations below 15 million/mL are regarded as nominally infertile.

The Levine et all meta-analysis also reported that unselected Western men had an overall drop in sperm concentration from 99 million/ml in 1973 to 47 million/ml in 2011. Taken at face value, these results are extraordinarily concerning. The study did not report any levelling off of the declining trend. Consequently, low male fertility might soon be the norm in “Western” countries, with nominal infertility becoming the norm within 25 years at the current rate of decline. The best of studies can, of course, be wrong.

# 3. Social Wellbeing

## 3.1 Education

Unless otherwise stated, see Appendix A.4 for sources.

### 3.1.1 Primary School Attainment

Primary school attainment can usefully be measured by the Key Stage 2 SATS assessments, taken in Year 6 (age 11). For consistency the teacher assessment results are used for both Wales and England. The two nations’ results in 2015 are compared in Table A.4.1 (boys) and Table A.4.2 (girls), and the extent to which girls’ scores exceed the boy’s scores is given in Table A.4.3.

* At the expected attainment level (4 or above) there is little difference between England and Wales;
* In reading, writing and maths, fewer pupils of either sex achieve the higher attainment (Level 5) in Wales than in England (red text in Tables A.4.1,2);
* More girls than boys achieve both levels 4+ and 5 in virtually every subject in both nations. The gender gap is broadly similar for the two nations;
* The gender gap is greatest in writing, with up to 15% more girls attaining Level 5.

The [Stats Wales teachers’ assessment SATS results](https://statswales.gov.wales/Catalogue/Education-and-Skills/Schools-and-Teachers/Examinations-and-Assessments/Key-Stage-2/nationallevelresults-by-subject-year-gender) confirm that girls have outperformed boys in reaching the expected level 4+ in all eight subjects (maths, science, reading, writing and spoken English, and reading, writing and spoken Welsh) and in every year recorded in that reference, from 2013 to 2018 inclusive. In 2018 the attainment gap in achieving the expected level 4+ (girls – boys) raged from 3.1% (maths) to 9.9% (written Welsh). Girls also outperform boys in all eight subjects as regards achieving the higher level 5. In 2018 the attainment gap (girls – boys) ranged from 0.7% (maths) and 5.5% (science) to 15.0% (written English).

### 3.1.2 Secondary Schools – Age 16

Attainment at age 16 can conveniently be gauged by GCSE performance at pass grades (i.e., grades C to A\* in the old system or grades 4 to 9 in the new English system). Table A.4.4 gives the percentage of the cohort achieving pass grades in mathematics, English language and English literature. Pupils of both sexes do rather less well in Wales than in England at maths, but markedly better at English literature.

Girls outperform boys at maths, but only marginally, in both nations. However, girls outperform boys emphatically in both English subjects and in both nations – by up to 18%.

A larger percentage of girls than boys in Wales attaining a grade C-A\* at GCSE in 39 of the listed 41 subjects, including maths and ICT (data taken from [Stats Wales GCSE Results 2017](https://statswales.gov.wales/Catalogue/Education-and-Skills/Schools-and-Teachers/Examinations-and-Assessments/Key-Stage-4/gcseentriesandresultspupilsaged15only-by-subjectgroup-gender)). Boys do better than girls only in physics (by 1%) and numeracy (by 2%). The attainment gap (girls – boys) in sample other subjects are: ICT 13%, English language 15% and Welsh 17%. At the top A\* grade, girls again outperform boys in 38 of the 41 subjects, the exceptions (physics, numeracy and Spanish) having attainment gaps of only -1% or -2%.

Girls dominance over boys in English and Welsh, already very clear at age 11, has increased further by age 16.

### 3.1.3 A Levels (Wales)

In 2017 in Wales the numbers of A Level entries (counting each subject separately) were 9,586 for boys and 12,744 for girls, an excess of entries by girls over boys of 33%. The number of boys gaining grades C to A\*, again counting each subject separately, was 6,902, compared with 9,940 girls, an excess of girls over boys of 44%.

Across all subjects, the same number of boys and girls gained a top A\* grade, but substantially more girls gained grades A, B and C, see Figure A.4.1(n).

Figures A.4.1(a-m) show the grade distributions by sex for all those individual subjects which involved over 1,000 total entries in Wales. Most of these popular subjects have a very clear gender-skew in one direction or the other. This gender-skew will be reflected later in the subjects taken up at university.

### 3.1.4 University Entry 2017 (UK)

In 2017 [the number of men applying to HE institutions](https://www.ucas.com/file/115911/download?token=EokhytEH) was less than the number of women by just short of 100,000. [Application rates](https://www.ucas.com/file/140396/download?token=ekh0PW6p) via UCAS for men and women were 32.5% and 44.0% respectively. Entry rates were 27.8% and 37.7% for men and women respectively. The number of women exceeded the number of men by 36% as regards both applications and entry.

The number of women starting at UK universities in 2017 exceeded the number of men by 71,100 – the largest ever gender disparity (see Figure A4.2).

If attention is confined to UK students (i.e., students resident in the UK prior to starting university) there is an even greater proportion of female students, especially at postgraduate level. For example, as regards UK students attending HE institutions in England in 2016, women undergraduates exceeded male undergraduates by 38.7% and women postgraduates exceeded male postgraduates by 50.0% respectively (see HESA dataset [Table 10a: HE qualifications obtained by location of HE provider, sex, level of qualification obtained, mode of study and domicile 2011/12 to 2015/16](https://www.hesa.ac.uk/files/sfr-files/student_sfr242_1516_table_10a.xlsx)).

The following data relate to university entry (undergraduates) and have been taken from [UCAS end of cycle report 2017](https://www.ucas.com/corporate/data-and-analysis/ucas-undergraduate-releases/ucas-undergraduate-end-cycle-data-resources/applications-and-acceptances-types-higher-education-course-2017).

* There is a great deal of focus on women’s participation in STEMM subjects (science, technology, engineering, maths and medicine and subjects allied to medicine). In fact, women now dominate in STEMM as undergraduates (by 6%).
* Women also dominate in the pure sciences, their dominance in biological sciences outweighing the larger number of men in the physical sciences.
* It is only in “TEM” (technology, engineering and maths), plus architecture, that men are dominant. In technology (IT) and engineering, men outnumber women about 5 to 1. In maths and architecture, the ratio of women to men is about 0.6.
* There are 50% more women medical students than men.
* There are twice as many women as men reading law.
* In “veterinary and agricultural sciences” there are nearly three times as many women as men. Women dominate in agriculture alone. In veterinary science there are four women to every man.
* In languages and literature there are three times as many women as men.
* In the social sciences there are 60% more women than men.
* In teaching studies there are six times as many women as men.
* In “subjects allied to medicine” there are 4.5 times more women than men, but if the nursing component of this subject area is considered separately there are more than 9 times as many women in nursing alone.

All told, women dominate in 70% of university subjects. (Alternatively expressed, 70% of people at university are studying subjects in which there are more women than men).

Dividing the UK population into 20 demographic classes by sex, race and an indicator of socioeconomics (FSM, or non-FSM, where FSM is ‘free school meals’), Figure A.4.3, taken from the [2o15 UCAS end of cycle report, Figure 96](https://www.ucas.com/sites/default/files/eoc-report-2015-v2.pdf) shows that eight of the top nine demographics are women. Males are concentrated in the bottom half of the distribution.

Poor white males have the least chance of going to university (~10%). For comparison, poor black women are three times more likely to go to university than a poor white male.

### 3.1.5 Degrees Awarded by Welsh Universities by Sex

Table A.4.4.1 gives the number of UK students achieving higher education qualifications from HE establishments in Wales in 2015. Note that these data exclude foreign students. The data were taken from the [Higher Education Statistics Agency](https://www.hesa.ac.uk/data-and-analysis) (HESA). At first degree level there are 37.2% more women than men obtaining degrees from Welsh universities. At postgraduate level there are 40.2% more women than men. In 2016 these figures were 29% and 41% respectively (from dataset [Table 10a: HE qualifications obtained by location of HE provider, sex, level of qualification obtained, mode of study and domicile 2011/12 to 2015/16](https://www.hesa.ac.uk/files/sfr-files/student_sfr242_1516_table_10a.xlsx)).

## 3.2 Employment and Unemployment

This Section starts with a summary of unemployment and economic inactivity in the UK as a whole (sections 3.2.1-3). This is followed by data specific to Wales in Section 3.2.4. Finally, Section 3.2.5 considers employment by sex across different sectors.

### 3.2.1 Definitions and UK Unemployment Data

The “unemployed” are defined as those without a job but who have been actively seeking work in the last 4 weeks and able to start work in the next 2 weeks (including those who have found a job but are waiting to start). The “labour force” consists of those people between the ages of 16 and 64 who are employed plus those who are unemployed, in the above sense. Those people who are of nominal ‘working age’ (taken to be 16 to 64) who are not within the labour force are said to be “economically inactive”. This includes full time students and all people who do not wish to be in paid work, e.g., full time home-makers and those who are retired prior to age 65.

The unemployment rate is the number of unemployed as a percentage of the labour force. The unemployment rate is ***not*** usually defined as a percentage of the whole population or even the whole population of working age.

The economic inactivity rate is the number of economically inactive people as a percentage of the working age population. The labour force participation rate is the number of people in the labour force as a percentage of the working age population. The economic inactivity rate and the labour force participation rate are thus complementary measures, they add to 100%.

Figure A.5.1 shows the unemployment rate in the UK from 1971 to the end of 2017 ([ONS data](https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/unemployment)). The unemployment rate for men has been persistently higher than that for women since 1981, though the difference is currently slight (being about 4.4% for both sexes). Men’s unemployment rate is lower than it has been for over 40 years. The peaks in the unemployment rate demonstrate how recessions affect men’s employment more than women’s (e.g., those in the early 1980s, early 1990s and post-2008).

At the end of 2017 there were 782,000 unemployed men and 689,000 unemployed women.

However, it is important to recall that the ‘unemployment rate’ only measures those actively seeking and able to work. It does not measure those who have dropped out of being recognised as economically active.

#### 3.2.1.1 Unemployment Amongst the Young

Those young people who leave education at age 16 have very high rates of unemployment. Currently the unemployment rate for 16 to 17 year olds in the UK is ~30%, and has recently been ~40% (see Figure A.5.7). This is the demographic within which much future disadvantage will be focused. (See also Section 3.2.4 for NEETs).

### 3.2.2 UK Economic Inactivity Data

Those in society between 16 and 64 who do not feature as either employed or unemployed are the economically inactive. One of the most significant features of the huge social changes over the last half-century is the increasing participation of women in the labour force. Figure A.5.2 shows how the percentage of women who are economically inactive has reduced from 45% in 1971 to an all-time low of 26% by 2017. What is less widely appreciated is the huge increase in men’s economic inactivity.

In 1971 only 5% of men were economically inactive, i.e., 95% of working age men were participating in the labour force. Now some 17% of working age men are economically inactive.

The obvious feature of Figure A.5.2 which tends to be elided in popular discourse is that the increasing economic participation of women has been largely mirrored by a decreasing economic participation of men. Overall, economic inactivity has reduced only marginally, from 25% (1971) to 21% (2017) – and the main reason for this is that fewer people under 65 are retired than used to be the case.

Over the period 1971 to 2017 the working age male population of the UK has increased from 16.5 million to 20.5 million. Hence, in 1971 there were 0.8 million economically inactive men in the UK, but by 2017 this had increased to 3.4 million. There are four times more economically inactive men of working age than there used to be in 1971.

### 3.2.3 Reasons for Economic Inactivity (UK)

It is important to appreciate that there is a distinction between economically inactive women and economically inactive men. Some of the reasons for economic inactivity are specified in [this ONS dataset](https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity/datasets/economicinactivitybyreasonseasonallyadjustedinac01sa).

At the end of 2017, 25% of men and 22% of women who were economically inactive did, in fact, want a job (850,000 men and 1.16 million women respectively). These figures are larger than the numbers classed as unemployed, illustrating how the unemployment figures under-state the number of people who want a job. The sum of the unemployed and the economically inactive who wished to work at December 2017 was 1.63 million men and 1.85 million women.

Nevertheless, about three-quarters of people who were economically inactive did ***not*** want a job. The number of economically inactive men who did not want a job is increasing (Figure A.5.3).

The dominant reason for men being economically inactive is being in full time education, closely followed by long term sickness. The dominant reason for women being economically inactive is being a full time home-maker followed by being in full time education. However, the absolute numbers of the economically inactive who are students or are long term sick are about the same for men and women (in very rough terms there are the order of a million in each category and each sex), see Figure A.5.4.

The greater number of women than men under 65 who are retired explains part of the excess of the female over the male economically inactive. However, the number of men under 65 who are retired has been increasing whilst the number of women under 65 who are retired has been falling steeply over the last 5 years, so the gap is closing (Figure A.5.5).

The overwhelming majority of the sex disparity in the numbers of economically inactive is due to the difference in full time home keeping / child care. In the last 25 years, the number of economically inactive men in a full time home-keeping role has increased substantially from about 100,000 to about a quarter of a million. Over the same period the number of economically inactive women in that role has reduced from just under 3 million to just under 2 million – see Figure A.5.6, noting the different y-scales. Despite these changes there is still a gap of about 1.6 million, which accounts for about 80% of the gender gap in the economically inactive (about 2 million in all).

For both sexes the number of economically inactive classified as “discouraged workers” is relatively small (21,870 men and 16,470 women). Although small in volume, we might expect to find particular disadvantage in this category.

Finally, there is a sizeable number of the economically inactive classed as “other” (418,000 men and 522,000 women). This may also be an interesting category as regards implicit disadvantage. This would require further research to elucidate.

Since 1993 about half the increase in the number of men who are economically inactive is due to the increasing number of students, with the remainder due in roughly equal parts to increases in men as home-keepers, male retirees under 65, and the “other” category. Together these account for the ~0.9 million increase in the male economically inactive since 1993. Since there has been a 2.6 million increase in the male economically inactive since 1971, it appears that in 1971 there must have been a far smaller number of long term sick.

By far the dominant reason for the reduced number of economically inactive women is the smaller number of women who are now full time home-keepers, a reduction by over a million since 1993. This swamps the increase in female student numbers (about 450,000 since 1993). There are now also fewer women retired before 65.

### 3.2.4 Unemployment and Economic Inactivity in Wales

Unemployment and economic inactivity data for Wales has been taken from the Welsh Government site on “[statistics and research, key economic statistics](https://gov.wales/statistics-and-research/key-economic-statistics/?lang=en)”. Welsh unemployment rates track UK rates closely, see Figure A.5.8. In particular the current unemployment rate (at March 2018) is 4.4%, as it is in the UK as a whole.

However, the economic inactivity rate in Wales is a couple of percentage points greater than in the UK as a whole, namely 23.0% (Wales) compared with 21.0% (UK), at March 2018, see Figure A5.9. Correspondingly, the employment rate in Wales is lower than in the UK as a whole (73.4% cf 75.6%).

Young people are of particular interest, especially those who are not in education, employment or training (the so-called “NEETs”). Data on NEETs in Wales may be obtained from the Welsh Government, “[Statistics and Research, Young people not in education, employment or training (NEET)](https://gov.wales/statistics-and-research/young-people-not-education-employment-training/?lang=en)”. For comparison, the corresponding data for England has been taken from the UK Government National Statistics site “[NEET statistics quarterly brief: October to December 2017](https://www.gov.uk/government/statistics/neet-statistics-quarterly-brief-october-to-december-2017)”. Figure A.5.10 shows the number of NEETs as a percentage of people of the same age, versus year, comparing Wales with England. Two age ranges are plotted: 16-18 and 19-24. The percentage of NEETs is substantially greater in the older age range. The percentage of NEETs is also substantially larger in Wales than in England, in both age ranges.

The Welsh NEET data are not disaggregated by sex. However the English NEET data is available by sex, as shown in Figure A.5.11. In England, a decade ago, there was a significantly larger number of female NEETs than male NEETs. As of the last couple of years this is no longer the case: the NEET rates for young men and young women have converged. Data is not available to confirm if this is also true in Wales.

Senedd Research, National Assembly for Wales, has compiled summary information on inequalities available as “[Gender equality in Wales: progression or regression?](https://seneddresearch.blog/2018/03/08/gender-equality-in-wales-progression-or-regression/)” (8 March 2018). Items relevant to employment by sex, and referring specifically to Wales, are,

* Twice as many men (18.6%) as women (9.2%) are self-employed;
* The economic activity rate is greater for men (79.3%) than for women (72.2%);
* More men (9.5%) than women (5.8%) have been engaged in ‘early stage entrepreneurial activity’;
* More women (15.7%) than men (13.8%) are benefit claimants;
* Nearly three times more women (42.5%) than men (14.6%) work part-time;
* While the NEET rate for women aged 16-18 and 18-24 reduced from 2015 to 2016, the NEET rate for men has increased for both age groups;
* More women (34,255) than men (25,985) were in apprenticeships;
* In Wales the median hourly part-time pay rates (excluding overtime) are £9.00/hr for women and £8.41/hr for men, a gap of £0.59/hr or 7.0% in favour of women. This is larger than the corresponding part-time pay gap for the UK as a whole (5.1% in 2017, from [here](https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/agegroupashetable6)).
* In Wales, the median hourly full-time pay rates (excluding overtime) are £12.08/hr for women and £12.98/hr for men, a gap £0.90/hr or 6.9% in favour of men. This is smaller than the corresponding part-time pay gap for the UK as a whole (9.1% in 2017, from [here](https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/agegroupashetable6)).

### 3.2.5 Employment by Sector and Gender

A thorough review of employment by gender across all occupations is beyond the scope of this report. However, since the subject at hand is male inequality, it is apposite to consider briefly some of the sectors and occupations in which men are underrepresented. Table A.5.2 lists 54 such areas, though the list is not exhaustive. The public sector is dominated by female employees, and is reviewed briefly in Section 3.2.5.1, whilst 3.2.5.2 looks in more detail at the education sector.

#### 3.2.5.1 The Public Sector

In 2016/17, total UK public spending was [£762 billion, which broke down as](http://economicsonline.co.uk/Global_economics/Fiscal_policy_government_spending.html),

|  |  |  |  |
| --- | --- | --- | --- |
| **Area** | **£billions** | **Area** | **£billions** |
| Pensions and benefits  | 240 | Housing & Environment | 34 |
| Health | 145 | Public Order | 34 |
| Education | 102 | Personal Social Services | 30 |
| Defence | 46 | Transport | 29 |
| Debt Interest | 39 | Others not itemised | 63 |
| **TOTAL** | **762** |  |  |

This £762 billion public spending compares with the UK’s total GDP which is about £2 trillion.

[In December 2017](https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/publicsectorpersonnel/bulletins/publicsectoremployment/latest), some 5.35 million people were employed in the public sector, and 26.9 million in the private sector, so the public sector currently accounts for 17% of employment.

Health and education together account for substantially more than half of public employees. Over one million people are employed in schools in England alone (see Section 3.2.5.2 below for details), roughly 1.25 million across the whole of the UK. 75% of these are women. Altogether education employs about [1.5 million people](https://www.ifs.org.uk/bns/bn145.pdf) in the public sector.

The NHS employs about 1.7 million people, UK wide (1.3 million in England and about 155,000, 85,000 and 65,000 in Scotland, Wales and N.Ireland respectively – see [here](http://www.nhsconfed.org/resources/key-statistics-on-the-nhs) and [here](http://www.answers.com/Q/How_many_employees_in_the_NHS)). Of these roughly half are clinically qualified (doctors, nurses, midwives, dental staff, health service staff, paramedics, etc). NHS employees are [roughly 75% women](https://www.kingsfund.org.uk/projects/time-think-differently/trends-workforce-overview).

Hence, education and health care account for about 3.2 million of the 5.35 million public sector workers (60%). Of this 3.2 million, about 2.4 million (75%) are women.

About two-thirds of public sector workers overall are women.

In contrast, women account for only about 40% of private sector employees.

Staff [in the voluntary sector](https://data.ncvo.org.uk/a/almanac17/workforce-4/), totalling about 853,000 people, are about 65% women.

#### 3.2.5.2 School Staff

**England**

Table A.5.1 breaks down all school staff in England (2016). Salient features are,

* Of all teaching staff, across all schools, 24.2% are men and 75.8% are women;
* About one-in-eight primary classroom teachers is a man;
* About one-in-three secondary classroom teachers is a man;
* About one-quarter of primary heads are men;
* 55% of secondary heads are men;
* Auxiliary staff across all schools are 20.4% men and 79.6% women;
* Across all schools and all staff, 22.1% are men and 77.9% are women.

**Wales**

At March 2018, the number of school teachers registered with the [Education Workforce Council in](https://www.ewc.wales/site/index.php/en/policy-hub/education-workforce-statistics.html) Wales was 26,856 women (75.5%) and 8,720 men (24.5%). These are almost identical to the figures for England. A more detailed break-down in terms of primary versus secondary schools, and head teachers versus classroom teachers, has not been obtained. Stats Wales does not disaggregate by sex.

#### 3.2.5.3 Occupations Dominated by Women

The ONS dataset [EMP04: Employment by occupation, April-June 2017](https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/employmentbyoccupationemp04) has been used to compile Table A.5.2 which lists 54 occupations in which men are underrepresented. The Table lists the percentage by which the number of women employed exceeds the number of men (i.e., 100\*(w-m)/m). The top ten occupations as regards the percentage by which women exceed men are,

* Dental nurses
* Childcare and Related Personal Services
* Nursing and Midwifery Professionals
* Senior Care Workers
* Social Workers
* Houseparents and Residential Wardens
* Therapy Professionals
* Care workers and Home Carers
* Child and Early Years Officers
* Special Needs Education Teaching Professionals

Some of these areas deserve special attention in view of male disadvantage as the ***clients*** of these services. This applies in particular to men’s health, and men’s experience of social work, and childcare and early years officers. The latter are of significance in the context of the fathers’ experience, especially after partner separation (see Sections 3.5 – 3.7).

## 3.3 Family Dissolution and Fatherlessness

The increased prevalence of family break-down over the last 50 years cannot be ignored as a [driver of adverse health outcomes](http://www.civitas.org.uk/content/files/Experiments.pdf) – for all concerned. Only about half of children in the UK will still be living with both their biological parents by their 15th birthday. The number of lone parents with dependent children in the UK has doubled from one million to two million since 1980. In 2015, lone parents with dependent children represented 24% of all families with dependent children. The number of dependent children living with a lone parent is over 3 million.

Lone mothers and children living without their biological fathers are far more likely to be in relative poverty. Lone mothers have poorer physical and mental health and raised death rates. Non-resident biological fathers indulge in more destructive behaviours and have death rates up to twice that of married men. The outcomes for children of broken families is serious across a wide range of metrics, see Section 3.4.

The decline of marriage cannot be ignored as a driver of adverse health because married couples are less likely to split than cohabiting couples, or couples who do not live together at the time of birth (and separation is a driver of adverse health outcomes). Unmarried couples with children are about three times more likely to break up than married couples (see Figure A.6.1). Consequently, the fact that half of children are now born to unmarried couples (Figure A.6.2) is of concern. The sequence of events is that the decline of marriage drives the rise in broken families (generally fatherlessness) which in turn drives adverse outcomes for all concerned.

The [Marriage Foundation](http://marriagefoundation.org.uk/wp-content/uploads/2017/07/Establishing-the-facts-about-family-breakdown-1.pdf) advises that,

* 93% of parents who remain together until their children are 15 are married;
* Only 5% of children living with both parents at 15 will have unmarried parents;
* Of the teenagers not living with both parents, only one-third involved divorce. Two-thirds were never married. Hence, fatherlessness is more due to the decline of marriage than it is to divorce;
* More than a quarter of a million children are affected by family breakdown in England and Wales per year (Figure A.6.3).

24% of families with dependent children are lone parent families. The great bulk of lone parent homes (~92%) involve a lone mother, i.e., they are fatherless. However, these lone parent families tend to be concentrated in relatively deprived geographical locations – the infamous ‘man deserts’. For example, in Cardiff 013D (Trowbridge) and Cardiff 039E (Ely), 59% of homes with dependent children involve single mothers (and 3% single fathers).

Extracts from the June 2013 report from the Centre for Social Justice “[Fractured Families](https://www.centreforsocialjustice.org.uk/core/wp-content/uploads/2016/08/CSJ_Fractured_Families_Report_WEB_13.06.13.pdf)”, inform us as follows,

* The [Millennium Cohort Study](http://www.cls.ioe.ac.uk/page.aspx?sitesectionid=851) suggests that as many as four in ten children being brought up by lone mothers have no contact with their fathers at all - this means that 1,162,880 children are estimated never to see their father.
* Somewhere between 15 % and 30% of non-resident parents never see their children, not even having indirect contact (via telephone, email, etc.), whilst 40% of non-resident parents see their child two times a year or less.
* A review by Wilson and Oswald lists 23 longitudinal studies that provide compelling evidence of a causal link between marriage and health, mental health and longevity. The authors conclude that “*the size of the health gain is remarkable. It may be as much as the benefit from giving up smoking*”.
* Teenage pregnancy can be closely associated with previous and future family breakdown. The rate of pregnancies in under 18 year old girls is higher in Wales than England.

### 3.3.1 Marriage Decline and Demographic

A particularly pernicious aspect of the decline in marriage is its strong socioeconomic dependence. In the top quintile of income about 88% of new mothers are married. This contrasts starkly with the bottom quintile of income for which only 24% of new mothers are married (Figure A.6.4). Until the mid-1990s the marriage rate for new mothers in the middle income bracket had stood up quite well. But this has now changed and only ~60% of middle income mothers of children under five are married. The impact of this on children from these typical families has yet to be felt.

## 3.4 The Impact of Fatherlessness

One of the most distressing aspects of the prevailing perception of parenting is that a case for fatherhood needs to be advocated at all, rather than being accepted by all. No one finds it necessary to argue that mothers are desirable. But fathers, it seems, have to prove their worth.

In some quarters it is regarded as being in bad taste to suggest that fathers have any essential role in child rearing, especially if it is claimed that fathers bring something qualitatively distinct to parenting compared to mothers. The mantra that “families come in all sorts of shapes and sizes” serves to elide the benefits to the children of being raised in a traditional two-parent family. Yet to ignore the impact of single parenthood on children – generally meaning fatherlessness – is not only to ignore the elephant in the room, but to ignore the entire Serengeti on your doorstep.

The fact that the President of the Family Division can opine that “[the collapse of the nuclear family should be welcomed and applauded](http://www.dailymail.co.uk/news/article-5797049/Collapse-nuclear-family-applauded-new-reality-single-sex-parents.html#ixzz5HM8Skz57)” illustrates how far the Family Courts are from recognising that their actions are diametrically opposed to their stated objective of making the children’s interests paramount.

Little justice can be done in a few short paragraphs to the complex issue of fatherlessness. Fatherlessness is both the cause and the consequence of the other socioeconomic disadvantages. Educational failure, poor mental health and destructive behaviours are all correlated with fatherlessness, and consequently their sequelae – economic deprivation and poor health – become correlates also. In the socio-dynamic cycle of disadvantage, fatherlessness is one of the complex of interacting factors. This would be a serious matter even if fatherlessness were relatively rare. In view of how common it now is (Section 3.3) it is catastrophic.

A measure of childhood experiences which correlates with adverse outcomes for the child later when adult, and which thus propagates to the next generation, are the ACEs, or Adverse Childhood Experiences, discussed further in section 3.5.3.1. A most dramatic finding of the recent Welsh survey of ACEs is the very clear (negative) correlation between a child receiving constant support from ***both*** parents and the number of ACEs to which the child is likely to be subject. This is shown by Figure 17 of the 2018 “[Report 1: Mental Illness - Welsh Adverse Childhood Experience (ACE) and Resilience Study](http://www.wales.nhs.uk/sitesplus/documents/888/ACE%20%26%20Resilience%20Report%20%28Eng_final2%29.pdf)” reproduced in section 3.5.3.1.

A few extracts from the 2013 “[Fractured Families](https://www.centreforsocialjustice.org.uk/core/wp-content/uploads/2016/08/CSJ_Fractured_Families_Report_WEB_13.06.13.pdf)” report are,

* *Young people from fractured families are twice as likely as those from ‘intact’ families to have behavioural problems. They are more liable to suffer depression, turn to drugs and alcohol, perform worse at school and have a far higher risk of living in relative income poverty.*
* *Family breakdown is associated with numerous poor outcomes, including mental and physical ill-health, addiction to drugs and alcohol, worklessness, educational failure, debt and poverty*.
* *There are also a number of crucial areas in which public services may inadvertently inhibit family formation and even encourage family breakdown. Fathers frequently feel excluded from services that are largely geared towards mothers and children and which – in some cases – automatically suspect men of domestic or child abuse. There is often a perception that a man’s role is one of providing but not nurturing and caring, or that positive father involvement can be an added bonus rather than something obligatory.*
* *This is also further reinforced by law, which does not require unmarried fathers to be named on the child’s birth certificate. This can be detrimental to children’s development, given the important role fathers have to play. Fathers are important to children’s emotional and physical health, educational attainment and behaviour, and their implicit exclusion is therefore cause for concern.*

The evidence for fathers’ difficulties in accessing children’s services in Wales is presented in Section 3.5.1, whilst the role that allegations of domestic violence or child abuse play in levering men out of their children’s lives is taken up in Section 3.7.

The importance of family stability to children’s educational outcomes is seen most strikingly amongst looked-after children. The Equalities and Human Rights Commission report “[*Is Wales Fairer? The state of equality and human rights 2015*](https://www.equalityhumanrights.com/sites/default/files/is-wales-fairer-2015.pdf)” indicates that just 17% of children in care achieved five GCSEs at Grades C-A\* including maths and English or Welsh in 2012/13 – exactly the same attainment as children formally registered as having Special Educational Needs (and contrasting with 63% of non-SEN pupils). A similar catastrophic attainment by children in care is seen in England.

Social scientists will rightly criticise simplistic observations of single variable correlations. To observe correlations is one thing, to identify causality is quite another. Sceptics will point out that economic disadvantage, for example, may explain the adverse outcomes apparently related to fatherlessness. They are correct to be cautious; disentangling causation is difficult in a social dynamic in which the fatherlessness of one generation is as significant to the economic fortunes of the next generation as *vice versa*. Despite that, well-founded studies are emerging which do claim to identify causality, for example “*The Causal Effects of Father Absence*” by Sara McLanahan *et al* ([Annu. Rev. Sociol. 2013. 39:399–427](https://static.squarespace.com/static/5154a075e4b08f050dc20996/t/533d5bf0e4b0907609ad2c66/1396530160194/MCLANAHAN2013.pdf)). The paper gives a careful account of the many different methodologies which can be, and have been, applied. Multivariate regression is an old favourite, but regression coefficients are only correlations and, however statistically significant, and however many other variables are used as controls, they suffer from the possible neglect of unidentified variables wherein the true causality lies. McLanahan *et al* discuss other analysis options, including several variants using data before and after the alleged life changing event (fatherlessness) as well as methods based on siblings with distinct family experiences. The authors are acutely aware of the problems in claiming causal connections, but their confidence shows in the paper’s title. They conclude,

"*We find strong evidence that father absence negatively affects children’s social-emotional development, particularly by increasing externalizing behavior. These effects may be more* *pronounced if father absence occurs during early childhood than during middle childhood, and they may be more pronounced for boys than for girls.*

*Effects on social-emotional development persist into adolescence, for which we find strong evidence that father absence increases adolescents’ risky behavior, such as smoking or early childbearing. The evidence of an effect on adolescent cognitive ability continues to be weaker, but we do find strong and consistent negative effects of father absence on high school graduation. The latter finding suggests that the effects on educational attainment operate by increasing problem behaviors rather than by impairing cognitive ability.*

*The research base examining the longer term effects of father absence on adult outcomes is considerably smaller, but here too we see the strongest evidence for a causal effect on adult mental health, suggesting that the* *psychological harms of father absence experienced during childhood persist throughout the life course*."

If even achieving consensus on the importance of fathers is problematic, how much more so is agreement on what should be done about fatherlessness. There is a strong tendency in society to react to mothers in trouble with offers of support, but to react to fathers in trouble with condemnation. Such a mindset is exemplified in phrases such as “deadbeat dads”. Even in individual cases where one might be tempted to think such expressions are applicable, there is a failure to recognise the cycle of disadvantage in operation. Senior politicians (of either sex), with a stable family background and with glowing educational credentials, may wag their finger at those they deem feckless fathers. But the unskilled, all-but-unemployable, educational failures who arise from the previous cycle of disadvantage may not have the capability to rise to the challenge which that wagging finger represents.

The “deadbeat dad” mantra is appallingly lacking in compassion in refusing to recognise the significant role played by the Family Courts in promoting fatherlessness. Every year in the UK, tens of thousands of fathers are denied meaningful access to their children after partnership break-up. These men struggle with all the might they can muster, in the teeth of a hostile system, to retain an involvement in their children’s lives. Many will fail completely, many others will be granted a few hours contact every other weekend, grossly insufficient for the desired benefits to the child to accrue.

## 3.5 Societal Constraints on Fathers’ Relationships with Their Children

### 3.5.1 Fathers’ Experience of Children’s Services in Wales

It is concerning that the only data on Welsh fathers’ access of, and experience with, children’s services and parenting services is that obtained by FNF-BPM Cymru’s own surveys. This is largely because the sex of the parent accessing such services is not recorded. FNF-BPM Cymru has requested that the gender be recorded in future, particularly in the context of Families First. Unfortunately, the Welsh Government has so far declined to do so, on grounds of cost.

FNF-BPM Cymru has carried out surveys to identify (a) Welsh dads’ experience with children’s services, and, (b) feedback from family support and parenting programme providers on their experience with men as fathers in Wales. This Section considers the first of these, whilst the latter is addressed in Section 3.5.2.

Society has changed massively in the last 50 years. There is a far greater expectation that fathers should contribute to child care issues, and there is a far greater willingness by fathers to do just that. However, the expectations of society – and fathers - are often frustrated rather than facilitated by support services.

The [2017 Welsh Dads Survey](https://www.fnf-bpm.org.uk/image/upload/branch/cymru/WELSH_DADS_SURVEY_2017_report_FINAL.pdf) carried out by FNF-BPM Cymru provides a valuable source of evidence for fathers and grandfathers experience of being dads – and in particular their experiences with support services for children. The survey was presented to the Welsh Assembly’s Cross Party Group on Fathers and Fatherhood in June 2017. Some key observations drawn from the survey report are given below, with a selection of the fathers’ comments being reproduced in Appendix A.9.

The survey had 419 responses, at least some from all 22 unitary authorities in Wales, though unevenly distributed (skewed towards Cardiff).

* 74% of respondents identified as ‘Father’, 5% as Grandfather, 13% as ‘Non Resident father’;
* 11% of respondents were sole or main carer, 46% shared caring duties roughly equally, 18% provided some care, and 18% said they were excluded from the care of their children;
* 64% were aged 30 – 49;
* 11% of respondents did not identify as White Welsh / British.

The survey indicates that most fathers and male carers don’t have major difficulties, particularly if they are living with the mother of their children. However even these dads often experience low level sexism in terms of the care of their children, devaluing their role and seeing it as subordinate to that of the mother. These problems are greatly exacerbated after separation, even if the father has legal Parental Responsibility.

Many hundreds of survey comments provide a rich picture of the experience of fathers and point to a fundamental underlying problem: fathers experience a state funded system that sees mothers as important while fathers are often an irrelevance or a problem.

* 1 in 6 respondents said that they felt that the role of the father was valued equally to that of the mother;
* Around 2/3rds of all respondents believed that their role wasn’t recognised or valued equally;
* Almost 80% of respondents identified that Government and Local Authorities needed to do more to engage them as parents;
* Fewer than 7% were happy with the support men received, while around 14% didn’t know;
* Many respondents reported feeling excluded and marginalised associated with separation difficulties.

Society sends fathers a mixed message: demanding their greater involvement in child rearing, whilst denying them the means to achieve it. (Table A.9.1 Part (a)).

#### 3.5.1.1 Fathers’ Engagement with Children’s Health Services

See Table 9.1 Part (b) for a selection of fathers’ comments.

The experience of fathers engaging with health services was broadly positive. Just over 51% of respondents identified a positive experience, while just 20% expressed a negative one.

Although most fathers remain content with their engagement with Health Services, nevertheless some deep rooted problems were exposed which go beyond the sorts of difficulties that might be expected when parents are divorced or separated.

While it is important to recognise that there were many examples of small acts of kindness by medical staff, taken as a whole the 131 detailed comments paint a picture of a health service that regards fathers as of secondary status to the mother at best, and an irrelevance at worst. Those attitudes harden considerably for parents who are not the primary carer when separated, but are also evident when parents are in an intact relationship.

Health Services seem to find difficulty in coping when parents are separated, and perhaps in conflict. They seem unsure about what information to disclose to fathers who are not the main carers for children despite having legal parental responsibility. Much of the problem may be where one parent develops a relationship with the health service professionals which colours their subsequent engagement with the other parent. It is, however, important to recognise the many positive comments fathers have made about their experience with health services.

#### 3.5.1.2 Fathers’ Engagement with Schools / Education

See Table 9.1 Part (c) for a selection of fathers’ comments.

Positive experiences outweighed negative by almost 3:1. The general view is that most men have a good relationship with the education sector in their role as fathers.

198 respondents indicated that their experience was positive (strongly or mainly) while 74 reported their experience was negative (strongly or mainly).

The majority issue was, as in previous years, refusal or reluctance by some schools to engage equally with fathers – particularly when they are separated from the mother. It is clear from the feedback that schools are generally positive about working with fathers. Schools are placed in a difficult situation when one parent makes allegations about the other parent to the school. A recurring theme is the issue of Parental Responsibility (PR) which mothers have automatically while fathers do not. Moreover, school staff do not always understand what rights legal PR confers on the holder.

A simple step which schools could take to improve engagement with fathers would be to ensure that they have both parents’ contact details, not just one – usually the mother’s.

##### 3.5.1.2.1 FOI Survey of Schools

A survey by FNF-BPM Cymru of all primary schools in England and Wales via FOI (Freedom Of Information Act enquiry) has been carried out. Survey results are as follows,

* Of the 17,850 primary schools in England and Wales, responses have been obtained from 4,140, representing well over a million pupils;
* For 13.2% of pupils represented by responding schools, the school holds details only for one parent: 12.0% the mother, 1.2% the father. (This contrasts with only 5% of birth registrations being by sole registrants);
* Of schools that responded, 14% of teachers were men, 86% women (7,532 and 44,876 respectively).

#### 3.5.1.3 Fathers’ Experience with Parenting Support Services

The responses received to the 2017 survey saw an improvement in the recognition of, and experience with, parenting support services. However, it is still the case that nearly 2/3rds of dads had no experience with these services, but this was reduced from the near 80% in previous years. Satisfaction with parenting support was a mixed picture: 51 individuals reported a positive experience; 34 a negative experience; 44 respondents thought the support they received was neither good nor bad.

See the [survey report](https://www.fnf-bpm.org.uk/image/upload/branch/cymru/WELSH_DADS_SURVEY_2017_report_FINAL.pdf) for fathers’ comments.

#### 3.5.1.4 Fathers’ Experience with Children’s Services

See Table 9.1 Part (d) for a selection of fathers’ comments.

The majority of respondents (60%) had no experience of Children’s Services, but those who did reported a negative experience nearly 3 times more often than a positive experience. Very few of the fathers’ comments were positive. However, it is important to remember that social workers are doing a complex and difficult job where their focus is on the protection of, and support for, the child. Many parents, of both sexes, can find that dynamic a hard one to understand and work with.

#### 3.5.1.5 Fathers’ Experience with CAFCASS Cymru and the Police

Most respondents had no experience with CAFCASS Cymru, which is a specialist arm of Welsh Government providing advice to the Family Courts. In view of the nature of the service, being involved only where there is a dispute, it is unsurprising that fathers’ experiences were overwhelmingly negative: 86 negative comments versus 24 positive comments.

Similar remarks apply for the police, virtually all the fathers’ comments relating to child contact disputes – guaranteed to provoke the very highest levels of discontent – in fact the entire gamut of negative emotions, often with very good reason. 77 negative comments versus 28 positive comments.

Dissection of the nature of the comments in this category would take the discussion too far into the operation of the Family Courts and their associated functions, which is not appropriate here. However, this area is a major social problem resulting in the alienation of tens of thousands of fathers annually in the UK. See the [2017 survey report](https://www.fnf-bpm.org.uk/image/upload/branch/cymru/WELSH_DADS_SURVEY_2017_report_FINAL.pdf) for fathers’ comments.

#### 3.5.1.6 Fathers’ Survey Reports of Mental Health Issues

The 2017 survey asked a question about mental health and well-being as a father / male carer. From a pick-list of indicators of poor mental health, respondents were asked whether they had experienced any of them. Respondents could identify with multiple indicators.

* The single largest response was that men had talked about low mood with friends, family and colleagues (41.36%);
* The second highest response (41.08%) indicated that these men did not recognise any significant problems in their role as a father;
* More worrying was the high number of fathers (75 representing 21.25% of respondents) who stated that they ‘felt suicidal and unable to cope’. In the detailed comments a significant number of respondents used the word ‘suicide’ or ‘suicidal’ overwhelmingly when they also identified child contact difficulties following separation.

In relation to the last point, see also Section 3.10.3.

See the [2017 survey report](https://www.fnf-bpm.org.uk/image/upload/branch/cymru/WELSH_DADS_SURVEY_2017_report_FINAL.pdf) for fathers’ comments.

### 3.5.2 Parenting Support Services’ Experience with Welsh Fathers

FNF-BPM Cymru’s 2014 survey “[Mapping Male Participation in Family Support & Parenting Programmes](https://www.fnf-bpm.org.uk/image/upload/branch/cymru/Male_particiation_in_Family_Support_services_March_2014.pdf)” a set of 8 questions was created to capture data on the level of participation and engagement by men in family support services and parenting programmes during the period 1st April 2012 to 31st March 2013. Several organisations that were approached and would have liked to contribute were unable to do so due to the sex of the parent accessing their services being unrecorded. The majority of mainstream projects had a woeful level of engagement by fathers (0 to 11%).

Respondents were asked to identify one or more reasons from a list of six as the greatest barrier to successful engagement, with the following results,

* Creating an environment that appeals to men as well as women 63%
* Mothers as 'gatekeepers' 59%
* Getting men to see parenting as their responsibility 48%
* Apathy by men 26%
* Lack of interest by professionals in working with men 19%
* Lack of ability by men to successfully parent 4%

One of the responders left the following, typical, remark,

‘*Fathers normally work during the hours that the parenting sessions run. Sessions in the locality are run during office hours. Fathers struggle to take time off to attend sessions. Fathers feel uncomfortable at attending sessions where the majority are females. Work is the priority for them especially during the period where there is a new baby as mum’s income has often dropped due to maternity leave. Fathers often work extra hours to generate more income for the family. Fathers make an assumption that the sessions are focused on the mother and the groups are for women only and parenting is a priority for mothers*.’

The survey led to the following recommendations,

* Welsh Government require all family support services to record the gender of the adults they engage with and support;
* Services should be encouraged to set a target (KPI) for the level of engagement with men
* Welsh Government should assess to what extent it is currently having ‘due regard’ to Article 18 of the UNCRC incorporated into the Rights of Children and Young Persons (Wales) Measure 2011 in relation to family support policy;
* Services should be able to access training and other support to assist them in improving engagement with fathers;
* A review of the gender of staff employed in front-line delivery of family support should be undertaken to determine whether a targeted programme of recruiting more men into thee roles may have a positive impact on engagement levels;
* Specific proposals should be considered to overcome barriers to male engagement identified by professionals – i.e ‘Mothers as gate-keepers’ / getting men to see parenting as their responsibility / creating an environment that appeals to men as well as women.

### 3.5.3 Alienation and ACEs

Alienation is the phenomenon in which one parent turns a child against the other parent by negative portrayal. Alienation is a form of child abuse.

Sources used in this Section are the [Welsh Adverse Childhood Experience (ACE) study](http://www2.nphs.wales.nhs.uk:8080/PRIDDocs.nsf/7c21215d6d0c613e80256f490030c05a/d488a3852491bc1d80257f370038919e/%24FILE/ACE%20Report%20FINAL%20%28E%29.pdf), and [its recent update](http://www.wales.nhs.uk/sitesplus/888/page/88517), and a presentation by [Dr Sue Whitcombe to the Male Psychology Conference 2017 at UCL](http://www.malepsychology.org.uk/wp-content/uploads/2017/08/Male-Psych-slides-edited.pdf). Dr Whitcombe is a chartered psychologist and an expert in alienation. She gave a simple definition of alienation for the lay person as follows,

* Unjustified or unwarranted rejection of a parent where there was previously a normal range, loving, “good enough” relationship;
* Intentional or unintentional actions by a parent (usually the parent with custody) to turn their child against the other parent (usually the non-resident parent).

Over time, the child becomes hostile, vitriolic and abusive, before usually rejecting the parent and refusing contact. It is important to appreciate how unnatural this is. Children are wired to attach to their parents and caregivers, even if they are neglectful or abusive. The alienated child’s mind is an induced pathology.

The alienating parent may be of either sex, and the child in question may be of either sex. Mothers are not intrinsically more likely to alienate than fathers. However, it is almost invariably the resident parent who alienates the non-resident parent, simply because the resident parent has the opportunity to do so. Because of the operation of the family courts, mothers are overwhelmingly more often the resident parent (90% to 95%). Consequently, it is most often the father who becomes the alienated parent, though alienation of mothers by fathers also occurs.

One of the mechanisms of enacting alienation is to frustrate contact with the child by the non-resident parent, for example by cancelling contact arrangements at the last moment, by blocking messages and gifts, by preventing communication, and by making the child feel bad about spending time with the other parent or his family. Because of this, alienation is sometimes presented as a child contact issue – because that is how it manifests to the non-resident parent. But it is primarily a child abuse issue.

#### 3.5.3.1 ACEs

The 11 recognised Adverse Childhood Experiences (ACEs), and their prevalence in Wales in 2017, has been reported in [this infographic](http://www.wales.nhs.uk/sitesplus/documents/888/PHW%20ACEs%20Resilience%20infographic%20%28Eng%29.pdf), summarised as follows,

* Parental separation (25%);
* Verbal abuse (20%);
* Mental illness - living with a sufferer (18%);
* Domestic violence (17%);
* Physical abuse (16%);
* Alcohol abuse - living with a substance abuser (13%);
* Emotional neglect (7%);
* Sexual abuse (7%);
* Drug abuse - living with a substance abuser (6%);
* Physical neglect (4%);
* Incarceration- (living with a sentenced person (4%).

Figures in brackets are the prevalence in Wales of these ACEs in the childhood experiences of 2,500 surveyed adults in 2017.

The most common ACE is parental separation.

Parental separation is correlated with domestic abuse (Section 3.6.4) and this will further raise the ACE-count for those affected by parental separation.

[The Welsh survey](http://www.wales.nhs.uk/sitesplus/documents/888/PHW%20ACEs%20Resilience%20infographic%20%28Eng%29.pdf) showed that 19% of the population surveyed had experienced one ACE; 17% two or three ACEs; and 14% four or more ACEs.

Compared with people who experienced no ACEs, those with four or more ACEs were found to be,

* 4 times more likely to be a high-risk drinker;
* 6 times more likely to have had, or to have caused, a teenage pregnancy;
* 6 times more likely to smoke;
* 6 times more likely to have had sex before age 16;
* 14 times more likely to have been a victim of violence in the last 12 months;
* 15 times more likely to have perpetrated violence in the last 12 months;
* 11 to 16 times more likely to have used illegal drugs, including Class A;
* 20 times more likely to have been incarcerated.

([Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population, 2016](http://www2.nphs.wales.nhs.uk:8080/PRIDDocs.nsf/7c21215d6d0c613e80256f490030c05a/d488a3852491bc1d80257f370038919e/%24FILE/ACE%20Report%20FINAL%20%28E%29.pdf))

An ACE score above six is associated with a 30-fold increase in attempted suicide ([Whitcombe, 2017](http://www.malepsychology.org.uk/wp-content/uploads/2017/08/Male-Psych-slides-edited.pdf)).

Perhaps the most dramatic of the recent Welsh survey findings is the very clear (negative) correlation between a child receiving constant support from both parents and the number of ACEs to which the child is likely to be subject. This is shown by Figure 17 of the 2018 “[Report 1: Mental Illness - Welsh Adverse Childhood Experience (ACE) and Resilience Study](http://www.wales.nhs.uk/sitesplus/documents/888/ACE%20%26%20Resilience%20Report%20%28Eng_final2%29.pdf)” and is reproduced below,



#### 3.5.3.2 Alienation

Alienation almost always occurs within the context of parental separation, and hence there is immediately one ACE inflicted on the associated children. However, other ACEs will generally also occur. Verbal abuse is highly likely, as are allegations of domestic violence and sexual abuse, and the issue of mental health arises. Consequently, alienation may impose a constellation of ACEs upon the affected children, raising them in one ‘fell swoop’ from zero ACEs to the dangerous 4+ ACEs category.

The prevalence of alienation within the general community of separating parents has been estimated from random sampling to be up to about 15%. But in high conflict samples the prevalence can be up to 40%.

In July 2016, Sarah Parsons, Principal Social Worker and Assistant Director of Cafcass, [stated that](http://www.malepsychology.org.uk/wp-content/uploads/2017/08/Male-Psych-slides-edited.pdf) “*parental alienation is responsible for around 80% of the most intransigent cases that come before the family courts*”. Dr Whitcombe has estimated that this implies that parental alienation is likely to be a feature in a minimum of 9,000 family proceeding applications per annum involving more than 18,000 children (England & Wales).

Dr Whitcombe reported the following data from her clinical practice, based on a sample of 47 men and 7 women.

* 94% family proceedings
* 70% former partner repeatedly broke orders
* 78% currently had no direct contact
* 56% had not seen their child in the last year

False allegations play a major role in the operation of the family courts (see Section 3.7), and false allegations also play a major role in the operation of alienation – the two things being inextricably linked. In answer to the question “have you been subject to false allegations of domestic violence against your partner?”, 36 (67%) clients said “yes”, 18 (33%) said “no”. In answer to the question “have you been subject to false allegations of child abuse?”, 44 (81%) clients said “yes”, 10 (19%) said “no”.

One must be cautious about assuming such very high incidence of false accusations apply across all family court cases. Dr Whitcombe’s clients are self-selected as those subject to parental alienation, for whom false allegation rates will be higher. However, it appears that the “most intransigent” cases overwhelmingly involve alienation, so these levels of false accusation are pertinent in those cases.

## 3.6 Domestic Violence: Men as Victims

### 3.6.1 Incidence of Male Victims: Survey Data

The best source of data on the incidence of domestic abuse in England and Wales is the CSEW (Crime Surveys for England and Wales). As the name implies, these data are obtained from surveys, not recorded police data or logged crimes. The latest CSEW release (November 2017) includes data to end March 2017. Data below has been taken from [Domestic abuse in England and Wales - Bulletin tables](https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/domesticabuseinenglandandwalesbulletintables) as well as the companion [Domestic abuse in England and Wales - Appendix tables](https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/domesticabuseinenglandandwalesappendixtables).

When interpreting the domestic abuse data from these surveys it is important to appreciate the questions asked which elicit positive responses recorded in the surveys. There are different sets of questions for domestic abuse, partner abuse, sexual abuse and stalking. An example of the type of question asked is illustrated for partner abuse in Table A.9.3. Not all the categories relate to physical violence, and there is a wide range of severities. The survey relates to people between ages 16 and 59, and the ‘last year’ refers to April 2016 to March 2017.

* 7.5% of women and 4.3% of men reported domestic abuse in the last year;
* 5.9% of women and 3.0% of men reported partner abuse in the last year;
* 2.0% of women and 1.6% of men reported family abuse in the last year;
* From the above, rather more than 1 in 3 victims of domestic abuse are men;
* 20% of incidents of violence against the person against men were domestic violence;
* At least 13.4% of victims in prosecutions for domestic abuse were men;
* 8.2% of defendants in prosecutions for domestic abuse were women;
* Police reported prevalence of domestic abuse is 0.8% (average over England and Wales);
* Domestic abuse prevalence estimates from the CSEW have reduced by around 30% since 2004/5, perhaps contrary to the impression one often gets from the media;
* 5% of clients using IDVA (independent domestic violence advisor) services were male.

For the first time, the 2017 CSEW on domestic abuse includes extensive data provided by Women’s Aid and Safelives, which are organisations with self-declared partisan positions (though such data is not flagged as “National Statistics”). Also for the first time, the 2017 CSEW uses the term “femicide”, a term created by this same political lobby to distinguish it from “homicide” (by implication, the mere killing of males).

#### 3.6.1.1 Severe Force

The CSEW used to report the prevalence of the most severe type of physical violence under a category “severe force”. For male victims, between 2009/10 and 2012/13 the prevalence of “severe force” increased from 0.8% to 1.0%, whilst for women it decreased from 1.5% to 1.1% (relating to prevalence in the last year). Prevalence in this category has not be reported since.

#### 3.6.1.2 Demographic Dependence of DV

The risk of domestic violence decreases with age. Teenage men are about three times more likely to suffer domestic abuse as men over 55. Teenage women are about twice as likely as women over 55 to suffer domestic abuse.

The dependence of domestic abuse on socioeconomic class has not been published in recent CSEWs. However, in 2007, the published data suggested that where household income was less than £10,000 a woman’s risk of suffering domestic abuse was about three times that for households with an income in excess of £40,000. For men, the risk would be double. [Taken from Home Office Statistical Bulletin, "Homicides, Firearm Offences and Intimate Violence 2007/08: Supplementary Volume 2 to Crime in England and Wales 2008/09 (Third Edition)", see Table 3.16].

#### 3.6.1.3 Academic Data on Partner Abuse Prevalence

The academic literature on domestic violence is huge. It would not be appropriate to attempt a review here. However, one particularly large international study is worth noting: the Partner Abuse State of Knowledge Project, or [PASK](http://www.prweb.com/releases/2013/5/prweb10741752.htm). This was published in May 2013 in the journal *Partner Abuse* and is the most comprehensive review of domestic violence research literature ever conducted. This unparalleled three-year research project was conducted by 42 scholars at 20 universities and research centres. John Hamel, PASK Director, said, “*The purpose of this project is to bring together, in a rigorously evidence-based, transparent and methodical manner, existing knowledge about partner abuse, with reliable, up-to-date research that can easily be accessed by anyone. PASK is grounded in the premises that everyone is entitled to their opinion, but not to their own facts; that these facts should be available to everyone, and that domestic violence intervention and policy ought to be based upon these facts rather than ideology and special interests*.”

The headline finding of the PASK review is that "*women perpetrate physical and emotional abuse, as well as engage in controlling behaviours, at comparable rates to men*".

Key numerical results are summarised [here](http://domesticviolenceresearch.org/pages/12_page_findings.htm) and this includes the following conclusion, “*Among large population samples, 57.9% of inter-partner violence (IPV) reported was bi-directional, 42% unidirectional; 13.8% of the unidirectional violence was male to female (MFPV), 28.3% was female to male (FMPV)*”

### 3.6.2 Reports to Police, Prosecutions and Convictions

Research by [Mankind Initiative](http://www.mankind.org.uk/statistics/) has revealed the proportion of reports to the police of domestic abuse made by male victims. In the last reported year (2016), these range from 18% (West Midlands) to 42% (Hertfordshire), with an average over England and Wales of 24%.

In the Welsh regions this source gives, for 2017 (2016): Gwent 22% (23%), South Wales 22% (22%), Dyfed Powys 21% (22%), North Wales 23% (24%).

[Mankind Initiative](https://www.mankind.org.uk/statistics/) also gives data for the number of prosecutions and convictions for domestic abuse broken down by sex of defendant. (The latest ONS report gives only the total numbers without gender breakdown). In 2015/16 there were 5,641 women convicted of domestic abuse offences, and 69,534 men (so women comprise 7.5% of the convicted). In 2016/17 these figures were 5,491 and 65,266 respectively (women being 7.8% of the convicted).

### 3.6.3 Homicides

As noted under mortality, deaths due to homicide are not a leading cause of death, for either sex in any age range. Women are more often victims of domestic homicides, whilst men are more often the victims of non-domestic homicides. The latest ONS report, based on the homicide index for England and Wales, gives data for homicides over the three year period 1st April 2013 to end-March 2016. Converting these to average annual rates (dividing by 3) gives,

* Domestic homicides of men (over 16): 45 or more per year;
* Domestic homicides of women (over 16): 106 or more per year;
* (Hence, in round terms, there is nearly one domestic homicide of men per week in England and Wales, and two domestic homicides of women);
* Non-domestic homicides of men (over 16): 235 or more per year;
* Non-domestic homicides of women (over 16): 32 or more per year;
* Homicides of boys (under 16): 23
* Homicides of girls (under 16): 22
* All homicides of males: 354
* All homicides of females: 181

The proviso “or more” in the above statistics refers to the fact that a substantial number of homicides (13%) have no suspect and hence cannot be classified as domestic or non-domestic. For the same reason, the “all homicides” figures exceed the sums of the individual categories.

Whilst there are more than twice as many domestic homicides of women as men, there are twice as many homicides of males overall – and 7 times as many homicides of men outside the domestic arena.

### 3.6.4 Domestic Violence and Marital Status

One of the most striking characteristics of the domestic abuse statistics is that only a very small percentage relates to married couples. Even if the married rates of domestic abuse, sexual abuse and stalking are added together they sum to only 7.0% for women and 5.3% for men, and none of the individual categories exceed 3.6%. (Note that these figures refer to the percentage of respondents reporting the abuse who were married at the time of the survey).

Women who were cohabiting, or single, or separated, or divorced, or widowed, at the time of the survey were 18 times more likely to report domestic abuse than married women. Men were 12 times more likely. Men or women who were separated or divorced at the time of the survey have by far the greatest risk of domestic abuse - see Figure A.9.1.

This is a very important observation, but one which goes generally unremarked. It suggests that ***either*** domestic abuse is causal in separation/divorce ***or*** that separation/divorce is causal in domestic abuse ***or*** that both are caused by some unidentified third variable. It is clearly of interest to ascertain which of these is the case, but existing data does not do so.

### 3.6.5 Welsh and UK Dads as Victims

The FNF-BPM Cymru Welsh Dads Survey 2017 provoked many comments which alluded to domestic violence against the respondents themselves, or their children, by their partner – see Table A.9.3.

FNF-BPM Cymru has recently (in 2018) conducted a survey specifically for male victims of domestic abuse, though not specific to Wales. Results are presently being analysed. Some provisional results follow.

* 681 men who responded identified as a victim / survivor of 'Domestic Violence & Abuse' as set out in the UK Government definition;
* 92.6% of the respondents were from the UK. There were some respondents from all 22 Welsh unitary authorities;
* 15% of respondents did not identify as white Welsh/British (12.2% identified as black, Asian or mixed race). 13.7% declared a disability;
* 93.75% of victims were no longer living with their abuser;
* 95% of reported abusers were identified as female, 3% as male.

Tables A.9.4(a-d) summarise respondents answers to questions relating to, (a) the nature and prevalence of any physical abuse, (b) the nature and prevalence of any non-physical abuse, (c) for those who did not seek help as a victim of domestic abuse, what prevented them from doing so?, and, (d) what sort of help would have made things better? See Tables A.9.4(a-d) for the full responses, but a few salient findings were,

* Just over half of male victims did not appreciate at the time that what they were experiencing was abuse, they didn’t know where to turn for help, and they did not expect to be believed;
* 69.7% of respondents had faced prejudice or stereotyping as a victim of abuse because they were a man (e.g., police telling them to 'man up', social workers assuming that they must be the perpetrator, DV support services asking them questions to determine whether their partner was the 'real' victim, etc.);
* When asked how important it was that services for male victims should be grounded in the experience of men and separated from services primarily designed for women, 82.3% of respondents thought this Important or Essential.

### 3.6.6 Domestic Abuse Services for Men

The first line of service delivery for those suffering domestic abuse is the helpline. Across England and Wales there are about 400 charities supporting female victims of domestic abuse, mostly affiliated to the Women’s Aid federations. These provide helpline facilities for women. Most also provide refuge accommodation for women and their children (up to a certain age). According to the ONS publication [Domestic abuse in England and Wales - Bulletin tables](https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/domesticabuseinenglandandwalesbulletintables) there are 4,094 spaces available for women in refuges in England and Wales. (This is believed to be the number of beds for adult women. Together with children there are believed to be about 7,000 places).

Helpline support for male victims of domestic abuse are provided for men in England by [Men’s Advice Line](http://www.mensadviceline.org.uk/) and by [Mankind Initiative](http://www.mankind.org.uk/help-for-victims/what-you-can-do/). In Wales, helplines are provided by the [Dyn Project](http://www.dynwales.org/) and by [FNF-BPM Cymru](https://www.fnf-bpm.org.uk/).

In 2016/17, Men’s Advice Line received some [13,953 attempts to contact them](https://www.whatdotheyknow.com/request/451079/response/1090492/attach/3/46484%20response.pdf?cookie_passthrough=1), mostly by ‘phone plus some by email and webchat. Of these, 5,949 were answered and/or the caller spoke to an advisor. Mankind Initiative receive [1,400 calls](http://www.mankind.org.uk/about-us/what-we-do/) to their helpline every year.

According to [Mankind Initiative](http://www.mankind.org.uk/wp-content/uploads/2015/05/30-Key-Facts-Male-Victims-February-2017-1.pdf), across the whole of the UK there are 23 organisations which offer refuge or safe house provision for male victims in the UK. There are 34 places dedicated to male victims, plus 76 places available for either sex. There are no refuge places available for men in London.

80% of men who contact [Mankind Initiative’s](http://www.mankind.org.uk/wp-content/uploads/2015/05/30-Key-Facts-Male-Victims-February-2017-1.pdf) helpline have never told anyone about their abuse before. All domestic abuse is under-reported, but abused men report their abuse only about one-third as often as abused women. Even some of the support services for men can act as a deterrent to reporting.

The Men’s Advice Line is operated by Respect. Respect’s Toolkit for addressing male victims of PV emphasises [vetting of male callers](http://www.mensadviceline.org.uk/wp-content/uploads/2017/01/Toolkit-for-Work-with-male-victims-of-DV-2nd-ed-3.-IDENTIFYING.-Respect%C2%A9-1.pdf) to the helpline to check that they are not, in fact, abusers masquerading as victims. This is in stark contrast to universal practice with women seeking help. “Believe the victim” is the mantra, in the case of women. With men, the Respect Toolkit applies the opposite principle of “doubt the victim”.

The Dyn Project is a [Safer Wales](http://www.saferwales.com) project, funded by the Welsh Government and by the South Wales Police and Crime Commissioner. It operates a similar methodology to the Respect Toolkit, vetting male callers against being perpetrators.

This vetting of male callers to DV helplines was challenged in 2017 via a request for a ruling from the Equality and Human Rights Commission (EHRC) in Wales. After taking independent legal advice [the EHRC appeared to agree](https://j4mb.org.uk/2017/11/22/anne-oregan-feisty-welsh-grandmother-forces-the-ehrc-to-change-its-policy-on-helplines-screening-male-victims-of-domestic-violence/) that the differing treatment of men and women by helplines was indeed discriminatory and in conflict with the requirements of the Equalities Act 2010 (letter from EHRC Wales to Anne O’Regan, 15/11/17, refers). It looked like the policy of vetting male callers was to change. However, it was also argued by the EHRC that services exclusive to male victims did not fall foul of the equality duty after all. Where this leaves, say, the Dyn Project, whose parent body is Safer Wales which also provides services to female victims, is not clear.

In the past the EHRC has attempted to rationalize the different treatment of male and female victims by reference to women being “the overwhelming majority” of victims (in itself grossly misleading). The policy basis of the ongoing *de facto* discrimination against male victims is obscure because it remains unpublished – one suspects because there is no rationalization which would withstand scrutiny.

In May 2018, the EHRC published its response to the Consultation “[Transforming the response to domestic abuse](https://www.equalityhumanrights.com/sites/default/files/consultation-response-transforming-response-to-domestic-abuse-may-2018.pdf)”. In this 26 page report there was no mention whatsoever of services to male victims. The report repeatedly raises concerns in respect of funding, data collection and specialist service provision for ethnic minorities, for migrant women, for disabled people, for LGBT people, and for individuals with complex needs – but male victims *per se* were ignored completely. The report also notes that “*a further issue for the UK Government to consider is access to support services for Trans women*”. All these classes of person are far less numerically preponderant than men. Clearly it is not their numerical significance which truly disqualifies male victims in the eyes of the EHRC, but their sex. The EHRC appear to be knowingly flouting the requirements of the 2010 Equalities Act, the upholding of which is their very *raison d'être*.

Meanwhile, the men’s help lines run by [Mankind Initiative](http://new.mankind.org.uk/) and [FNF-BPM Cymru](https://www.fnf-bpm.org.uk/article/overview_links-254/index.html#.WXr95o2WyM8) (and [Abused Men in Scotland](http://www.abusedmeninscotland.org/)) do **not** apply such vetting procedures.

### 3.6.7 Services for Male Victims in Wales Versus Need

The extent of support provided to male victims of domestic abuse in Gwent has been provided by Appendix 3 to the [Gwent Regional Violence Against Women Domestic Abuse and Sexual Violence](https://democracy.monmouthshire.gov.uk/documents/s13727/Appendix%20A_Draft%20VAWDASV%20Strategy%20Feb%202018.pdf) (VAWDASV) – Gwent Needs Assessment. Table 7.3 of that document indicates that a total of 2478 female survivors were supported by services in Gwent in 2015/16, but only 69 male survivors (just 2.7% of the total). Yet the same document, in Section 7.15, indicates that 22% of police reports concerned male victims (752 male, 2733 female). This percentage of police reports which relate to male victims is consistent with the data from by [Mankind Initiative](http://www.mankind.org.uk/statistics/) quoted in Section 3.6.2, above.

Thus, the service provision to male victims (2.7%) is massively out of proportion to the declared need (22%).

[Confusingly the Gwent Needs Assessment also gives alternative data “*provided by the Police and Crime Commissioners Office*” and derived from the “Safer Gwent” needs assessment 2016. These data imply that men account for an even larger percentage, 35.4%, of domestic abuse victims in Gwent].

Data is also available for the extent of support to male victims of domestic abuse in North Wales, namely that in 2015/16, 32 men were supported compared to 2401 women, i.e., just 1.3% of supported victims were men (“*North Wales VAWDASV Strategy 2017-2022*”, Early 1st draft by Rhiannon Edwards, quoted [here](http://www.senedd.assembly.wales/documents/s78555/18.09.18%20Correspondence%20-%20Petitioner%20to%20the%20Committee.pdf) and referenced by the [Welsh Assembly Petitions Committee 25/9/18](http://www.senedd.assembly.wales/ieListDocuments.aspx?CId=430&MId=5065) ).. This compares with 23% of police recorded victims being male. Again, there is a massive mismatch between service provision and the extent of need as indicated by police reports.

The charity FNF-BPM Cymru, which has a role as a specialist Domestic Violence support service for men, has expressed concern at this mismatch.

The 2010 Equalities Act places a duty on public sector bodies to act to reduce disadvantage where this results from certain ‘protected characteristics’, of which sex is one. The charity has argued that the local authorities clearly know the extent to which men are being failed by existing services, since the above figures appear in their own reports. Hence, if the local authorities chose to do nothing to correct the anomaly (i.e., the dearth of provision for male victims) this raises a question about whether their VAWDASV strategy complies with the legislation. This matter awaits resolution.

### 3.6.8 Male Victims of DV: The Big Picture

The big picture of how the prevalence of domestic abuse against men gradually gives way to very little service provision, via a lack of societal concern, can be summarised as follows,

* The CSEW surveys indicate ~34% of DV victims are men (international research suggests at least half of victims are men, if not more);
* Of reports of DV to the police, 24% are from men;
* 13.4% of victims in prosecutions for domestic abuse were men;
* Successful prosecutions of women for DV are 7.5% of the total convictions for DV;
* Service provision for male victims in the form of men’s refuges are around 2% of those for women.

## 3.7 Domestic Violence, family breakdown and the Family Courts

It may seem that issues relating to the courts are not within the scope of health and well-being. But the inequitable operation of justice, in both the criminal courts (Section 3.12) and the family courts is a major driver of men’s societal disadvantage. As usual, this operates particularly in those men who are already disadvantaged in other ways. The significance of domestic abuse in undermining men’s well-being, including driving suicide, cannot be fully understood until its key role in the operation of the family courts is appreciated.

A full exposition is beyond the scope of this review. However two issues require exposure. The first is the surprisingly large percentage of private family law cases which involve allegations of domestic abuse. The second is the relevance of such allegations in acquiring legal aid, a situation exacerbated by the [Legal Aid, Sentencing and Punishment of Offenders Act 2012](http://www.legislation.gov.uk/ukpga/2012/10/contents/enacted) (LASPO).

A major purpose of the LASPO Act was to reduce the financial burden of legal aid on the public purse by withdrawing legal aid from civil court cases, which includes the family courts. However, it was recognised that some types of civil case should still be supported by legal aid provision, in particular private family law cases involving allegations of domestic abuse. A “gateway” was introduced which set out precisely what would be accepted as sufficient to underwrite a claim for legal aid via a domestic abuse allegation. The stipulations within the gateway as to what constitutes ‘evidence’ does not meet the standards which one would normally associated with a court of law – after all, these provisions are intended only to guide the allocation of legal aid, not to decide upon criminal culpability.

There are many routes through the ‘gateway’, but one which is commonly deployed involves applying for an injunction. (The most common forms of injunction in this context are non-molestation orders, NMOs, and occupation orders, but details are not appropriate here). It is not surprising, then, that the volume of injunction orders increased following the introduction of LASPO in April 2013 (see Figure A.9.2, based on **d**ata from [Family Court Statistics Quarterly, July to September 2016](https://www.gov.uk/government/statistics/family-court-statistics-quarterly-july-to-september-2016), Table 14). The percentage of private law family cases involving such domestic violence injunctions also increased at this time (Figure A.9.3).

The result is that legal aid in private family law cases is now made available to women overwhelmingly more often than to men. Prior to LASPO, women were awarded 60% and men 40% of such legal aid. Following LASPO, women are now awarded 85% of the legal aid and men just 15%. (See Figure A.9.4, data provided by the Legal Aid Agency, private communication to FNF-BPM Cymru). The result is an invidious but very common situation in which the accuser has legal representation but the accused does not, thus inverting the original purpose of legal aid – to allow the impecunious accused to defend themselves in an equitable manner.

These are highly contentious issues, but to ignore them would be to ignore the source of one of the most significant causes of men’s mental health issues – including depression, substance abuse and suicide – affecting tens of thousands of men in England and Wales annually.

### 3.7.1 What Percentage of Private Family Law Cases Involve Allegations of Domestic Abuse?

A number of sources indicate that “about half” of private family law cases involve allegations of domestic abuse. Unfortunately, data is not disaggregated specifically for Wales, but is likely to be similar to that for England and Wales as a whole.

The joint [research reported by Women’s Aid and CAFCASS in July 2017](https://www.womensaid.org.uk/cafcass-womens-aid-collaborate-domestic-abuse-research/) claimed that “*62% of applications to the family court about where a child should live or spend time feature allegations of domestic abuse*.” However, this was based on a subset of cases.

A CAFCASS review “[Learning from Cafcass submissions to Serious Case Reviews](https://www.cafcass.gov.uk/wp-content/uploads/2017/12/cafcass_learning_from_scr_submissions_-_2017_-_external_version.pdf)”, made publicly available in November 2017, derives lessons to be learnt from the 97 Serious Case Reviews (SCRs) to which Cafcass contributed from 2009 to 2016. These SCRs involve known or suspected abuse or neglect of a child where the child has died or the child has been seriously harmed. The report is remarkable for providing the following information,

* The father was involved in 33% to 41% of the child deaths, whereas the mother was involved in 47% to 55% of the child deaths (and the mother’s partner in 12% of the deaths);
* Almost all allegations of domestic abuse were against men, usually fathers.
* Allegations of domestic abuse had been made in 71% of cases, but in almost half of these cases the person thought to have killed or harmed the child was not the alleged domestic abuse perpetrator.

The last observation suggests that the risk to a child posed by a parent can be obscured by an allegation against the other parent.

There is much that could be explored in the above conclusions, but to do so would take us too far from our present purpose. Note the 71% figure for the proportion of serious cases involving allegations of domestic abuse. But recall that these are the most serious cases in which a child has been seriously harmed or killed. So this 71% figure cannot be assumed to be indicative of the majority of private family law cases.

Figure A.9.3 gives the percentage of private family law cases involving domestic violence injunction orders up to 2016.

The best data on the percentage of private family law cases involving allegations of domestic violence was provided by the Ministry of Justice research team as a private communication to FNF-BPM Cymru together with HMCTS (HM Courts & Tribunals Service).

**Table 3.7.1: Percentage of private family law cases involving allegations of domestic violence (England and Wales)**



The best estimate is therefore that 49.2% of private family law cases involve allegations of domestic abuse. A figure of this order appears anomalous when compared with the prevalence of domestic abuse estimated from surveys (see Section 3.6.1). In view of the advantage that making such an allegation confers upon the accuser in the family courts, the implication is that many such allegations are fraudulent. In this context, note that it is very rare for such allegations to be subject to a “finding of fact” within the family courts.

## 3.8 Men’s Access to Health Care

One of the explanations put forward to explain men’s poorer longevity is that men “just don’t look after themselves”. Men, it is said, do not visit their GP or other health services when they should; they delay consulting a doctor when they have a medical problem, thereby disadvantaging themselves. Is this true? Or is it an instance of blaming men for their own disadvantage? Are poor health outcomes for men a product of a macho male gender script in which help-seeking is seen as weakness? Or is it a result of disadvantage imposed on men by society? Or is it biology? We have already seen that there is a biological component. In this section the research literature is examined to determine whether men’s help-seeking behaviour is also a significant factor in their health disadvantage. Evidence is taken from UK-wide studies and studies from other countries. A Wales-specific study is desirable but has not been identified.

It is certainly the case that men in the UK visit their GP less often than women. But this does not necessarily imply that men are gratuitously disadvantaging themselves. Women visit their doctor in association with contraception, pregnancy, neonatal and postnatal issues, as well as in the context of screening programmes. None of these apply to men, or apply to a much lesser extent, so less frequent visits by men to their GP is to be expected. In addition, it is known that people who work full time find it more difficult to attend GP appointments. This will affect more men than women, since more men work full time. So, are the less frequent visits by men to their GP a disadvantage imposed on them by their working patterns, rather than the fault of their self-destructive ‘hegemonic masculinity’?

In this section some of the academic publications are reviewed to shed light on the reasons for men accessing health services less often than women.

In 2008, the Men’s Health Forum together with the University of Bristol were commissioned by the Department of Health to examine [the role of gender in the access to health services](https://www.menshealthforum.org.uk/sites/default/files/pdf/gender_and_access_to_health_services_study_2008.pdf) in the UK, (Wilkins *et al*, 2008). We have seen that the gender gap in premature death rate is dominated by cardiovascular diseases and cancers. This is what Wilkins *et al* had to say about accessing health services by men and women in the context of cardiovascular problems (consult the report for supporting references),

‘*There are a number of studies which look at the gap between the onset of symptoms related to heart attack/acute myocardial infarction (MI) and the decision to seek treatment. However, the evidence is not clear cut in terms of whether women or men are more likely to delay. In addition, although delays in help-seeking have important clinical implications - increasing the risk of mortality or subsequent morbidity - research does not tell us whether differences in delay between women and men are long enough to have clinical implications.’*

*‘One review of over 100 studies of treatment-seeking delay in patients with heart attack and stroke reported that women had longer delays before seeking help when experiencing symptoms of heart attack, but there were no differences between women and men when experiencing symptoms of stroke. A 2004 meta-analysis of delays in treatment-seeking reported that larger-scale studies with greater statistical reliability were most likely to report longer delays in seeking treatment for women than men. In addition, one study suggested that, while men and women were equally likely to delay, the time elapsed before seeking treatment was longer for women than men, increasing their mortality risk*.’

Similarly, in the context of cancers, the relevant extracts from Wilkins *et al* are as follows, firstly on patient delays in seeking health care advice,

‘*For 10 different groups of cancers combined, 13 studies showed greater delay in men (10 of the studies were rated as strong methodologically, 2 moderate and 1 insufficient), 11 studies showed greater delay in women (8 strong and 3 moderate), and 23 studies found that gender had no impact (11 strong and 12 moderate). There was only one cancer where research was decisive, but this was because there was only one study for that cancer, otherwise gender had no impact or the effect of gender was inconclusive*.’

And on practitioner delay,

*‘The review by Macdonald et al (2004) of research on delay uses the term “practitioner delay” for the period between first consultation for symptoms and an appropriate referral. Overall, for the 10 different groups of cancers, four studies show greater delay when the patient was male (two strong methodologically and two moderate), six studies show greater delay for female patients (six strong), and four studies found that the gender of the patient had no impact (four strong). As with patient delay, there are conclusive results for individual cancers only when there has been a single study (on skin cancer, in which women had greater delay).*’

In summary, Wilkins *et al*, 2008 provide no support at all for the idea that men’s delay in accessing health services is responsible for their adverse outcomes in the two key areas of cardiovascular diseases and cancers.

In [*Do men consult less than women? An analysis of routinely collected UK general practice data*](http://bmjopen.bmj.com/content/bmjopen/3/8/e003320.full.pdf) Yingying Wang *et al* (2013) analysed GP consultation data from just under two million men and two million women. The crude consultation rate was 32% lower in men than women. Accounting for reproductive-related consultations substantially diminished but did not eradicate the gender gap (Figure A.11.1). However, consultation rates in men and women who had comparable underlying morbidities (as assessed by receipt of medication) were similar; men in receipt of antidepressant medication were only 8% less likely to consult than women in receipt of antidepressant medication, and men in receipt of medication to treat cardiovascular disease were just 5% less likely to consult than women receiving similar medication. These small gender differences diminished further, particularly for depression, after also taking account of reproductive consultations.

Wang *et al* were unable to control for the effect of full time working, due to limitations in the recorded data. However, as can be seen from Figure A.11.1, the sex difference in consulting rates is confined to the working years and disappears below 16 and rapidly disappears above 60. It seems likely that the effect of full-time working might be to eradicate entirely any residual sex difference. Support for this contention is obtained from other studies, discussed below.

A by-product of the analysis of Wang *et al* is the significance of socioeconomic status. The gender gap in consultation rate becomes successively greater as one moves down the deprivation quintiles. This is in line with the general trend that socioeconomic disadvantage affects men even more than women. Women in the most deprived quintile consult their GP approximately 10% *more* often than women in the least deprived quintile. In contrast, men in the most deprived quintile consult their GP about 4% *less* often than men in the least deprived quintile.

[Ian Banks and Peter Baker (2013)](https://onlinelibrary.wiley.com/doi/pdf/10.1002/tre.357) recognised the significance of full time working on men’s accessing health care services, and the exacerbation of this problem for men in relative deprivation. They note, ‘*there are some specific groups of men that are likely to face additional barriers to accessing primary care. Low-income men in employment tend to have less flexible working hours and may lose pay if they take time off to attend an appointment….We now know that men will use primary care services that meet their needs. By providing a male-specific service that is also open in the evenings, the Camelon men’s health centre in Scotland succeeded in attracting significant numbers of men, particularly from its target group: men in their 40s, living in deprived communities*.’

A report by the European Commission, [Access to Healthcare and Long-Term Care: Equal for Men and Women?](http://ec.europa.eu/social/BlobServlet?docId=5590&langId=en) (EGGSI coordinating team, 2009) observes, ‘*An additional cultural barrier that is worth mentioning mainly affects men and relates to the flexibility of services. An explanation given in the UK for men’s lower use of primary care services is that the opening hours are incompatible with the long working hours that characterise the UK labour market. Men are unable or uninclined to access primary care services because they are more likely than women to work full-time and to work more than 45 hours per week.*’

Similarly, [Alan White and Karl Witty](https://www.liebertpub.com/doi/full/10.1016/j.jomh.2009.03.001) in their 2009 discussion of men’s under use of health services, noted that, (i) 80% more men than women in the UK work full time, (ii) three times as many women work part-time, (iii) 50% more women who work full time have flexible working arrangements, and, (iv) three times as many men as women work more than 45 hours per week. They conclude that, for men, ‘*attending for health checks during the working day is at best problematic, at worst impossible’*. They go on to observe that the majority of community health promotion activities, such as weight loss groups, also take place during the working day.

The relevance of working patterns in men’s access to health services has also been raised by the National Pharmacy Association ([Doward, 2012](https://www.theguardian.com/society/2012/nov/04/men-failing-seek-nhs-help)), though the media reporting of it tends to heap blame on men rather than recognising men’s position as one of disadvantage.

There are studies which, at least superficially, appear to blame men’s under-utilisation of healthcare services on negative masculine behavior traits. For example, in a 2005 review of the literature, [Paul Galdas *et al*](https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1365-2648.2004.03331.x) concluded that, ‘*the growing body of gender-specific studies highlights a trend of delayed help seeking when they (men) become ill. A prominent theme among white middle-class men implicates “traditional masculine behavior” as an explanation for delays in seeking help among men who experience illness*.’ But a curious aspect of this conclusion is that it is based on a dismissal of gender-comparative studies. In respect of gender-comparative studies the paper includes this summary,

‘*The review of key gender-comparative help seeking studies does not fully support the hypothesis that men are less likely than women to seek help when they experience ill health. Although many studies note the relative under use of health services and symptom reporting by men in comparison with women, conversely, many also find an increase in help seeking in men compared with women, or indeed, no significant difference in help-seeking behaviour between genders. The evidence suggests that occupational and socioeconomic status, among others, as more important variables than gender alone*.’

Galdas *et al* leave one in the peculiar position of being asked to believe that men’s and women’s delay in seeking healthcare services are comparable, yet, at the same time, men’s delay is to be blamed upon “traditional masculine behaviour”. It rather begs the question: what causes women’s similar delay, then? One cannot help but be suspicious that the “gender-specific” studies Galdas *et al* cite may have suffered from an over-willingness to make individual male behaviour culpable for a socially imposed disadvantage, particularly full-time working patterns.

A similar conflict between ostensible conclusions and research content is to be found in the 2016 American study by [James Leone *et al*](http://journals.sagepub.com/doi/abs/10.1177/1557988316671637). The Abstract states that ‘*results suggest gender norms and masculine ideals may play a primary role in how men access preventative health care*’. But what we actually find within the paper is,

‘*Using hegemonic masculinity theory we explored whether predictors of men not accessing health care would be due to a threat to perceived masculinity (macho/machismo), stigma, reactivity, and weakness/vulnerability. However, stigma and weakness/vulnerability did not play a role in the prediction model. This was somewhat of a surprise seeing that male gender norms and masculinity are closely related such that endorsement of male gender role norms often prompts some men to adopt a hypermasculine (i.e., hegemonic masculinity) ideal. We found less rigid gender role norms in our participants*.’

And,

‘*We also assessed our conceptual model as to whether the TNC (theory of normative contentment) would align to men not accessing health care. Specifically, we were interested in fatalism, denial, low awareness of risks, and low knowledge; this was somewhat consistent. Fatalism and lack of knowledge did not achieve statistical significance in our model.*’

Leone *et al* do not discuss the role of working patterns in men’s health care access. A specific example where the role of work has been definitively established is [Identifying Work as a Barrier to Men's Access to Chronic Illness (Arthritis) Self-Management Programs](https://search.proquest.com/openview/62ab8c2eea2334ebd57d983cfc191924/1?pq-origsite=gscholar&cbl=25645) by Lisa Gibbs (2007). She concluded, ‘*A qualitative study was conducted involving in-depth interviews with 17 men with arthritis. This paper discusses the role of work as one of the factors affecting men's access to arthritis self-management services. Work was found to be a significant conceptual, structural, and social barrier due to: its role in relation to men's concepts of health and fitness; practical difficulties in accessing services during business hours; and sociocultural influences resulting in prioritising of work commitments over health concerns. The structural, conceptual, and sociocultural work influences were more of a constraint for men in the middle stages of life when work and family obligations were greatest.*’

In summary, the literature suggests that there is a smaller gender gap in accessing healthcare than is popularly believed, especially when the apparent gap is adjusted to allow for women’s greater access for contraceptive, pregnancy, childcare and national screening purposes. The latter is a disadvantage imposed on men, not an aspect of male behaviour. The residual gender gap in access to primary healthcare, as displayed by Figure 3.8.1, is probably due in the main to men’s working patterns, and the resulting difficulties of access to healthcare and community health programmes during the working day. This contention is supported by several studies, as detailed above.

There is a willingness to attribute men’s indisputable health disadvantages to men’s lesser use of healthcare services, and to attribute this in turn to men’s self-destructive masculine characteristics. However, this hypothesis does not survive inspection. Not only is men’s reduced access to healthcare not as marked as is often supposed, but the part of this reduced access which is not explained by valid sex differences in need may be explicable by working patterns. Whilst it might be argued that men’s working patterns are an individual choice, it would be disingenuous not to concede a societal – and practical - obligation which acts in this respect.

Finally, there are clear instances of poorer service provision for men, specifically in respect of the dearth of national screening programmes and – until very recently - the withholding of the HPV vaccination programme from boys. There are signs here that, the component of male health disadvantage which is not biological in origin, is more due to society-wide acceptance of such disadvantage than it is to self-destructive masculine traits. Adopting a stance that traditional male gender norms are responsible (essentially “it’s men’s own fault”) may be a subconscious means of avoiding acknowledging the implied empathy gap.

## 3.9 Lifestyle and Obesity (Wales)

The National Survey for Wales, 2016-17, has provided valuable information on [Population Health & Lifestyle](https://gov.wales/docs/statistics/2017/170629-national-survey-2016-17-population-health-lifestyle-en.pdf). Healthy lifestyle was surveyed against five beneficial criteria: not smoking, not drinking alcohol above weekly guidelines, eating five or more portions of fruit or vegetables daily, being physically active for at least 150 minutes per week, and maintaining a healthy body mass index (BMI). Headline findings for Wales were,

**Smoking**

* 20% of men and 17% of women reported being current smokers. (Note, however, that ONS data implies rather lower smoking prevalence in 2017, see section 2.3.4.1. Also note that the gender gap in the prevalence of smoking has decreased markedly since the 1960s, see Figure A.3.6).
* There is a very marked demographic dependence of the prevalence of smoking, from 9% in the least deprived quintile to 28% in the most deprived quintile.

**Drinking Alcohol**

* 27% of men and 14% of women reported drinking more than the recommended weekly amount of 14 units.
* The demographic dependence of drinking is reversed: 23% of the least deprived quintile exceed the recommended consumption, compared with 14% of the most deprived quintile.
* 17% of adults reported that they did not drink alcohol, and a further 36% reported drinking less than once per week.

**‘Five-a-Day’**

* 23% of men and 25% of women reported having eaten five or more portions of fruit or vegetables “the previous day”. (Note that this is not the same as the percentages of people meeting the five-a-day criterion on a typical day).
* 20% of the most deprived quintile and 29% of the least deprived quintile reported having eaten five or more portions of fruit or vegetables “the previous day”.

**Physical Activity**

* 57% of men and 51% of women were physically active for at least 150 minutes in the previous week.
* The demographic dependence was again marked, with 62% of the least deprived quintile and 47% of the most deprived quintile having been physically active for at least 150 minutes in the previous week.

**Body Mass Index**

Body Mass Index (BMI) is calculated as weight (kg) divided by squared height (m2).

* 65% of men and 53% of women had a BMI in excess of the healthy limit (25 kg/m2).
* Averaged over both sexes, 53% of the least deprived quintile and 65% of the most deprived quintile were overweight (BMI > 25 kg/m2).
* 24% of men and 22% of women were obese (BMI > 30 kg/m2).

**Overall**

* 13% of men and 8% of women had just one, or no, health lifestyle indicators (out of five);
* This was strongly demographic dependent, with the most deprived quintile being more than twice as likely as the least deprived quintile to have just one, or no, healthy lifestyle indicators.

The gender difference in smoking prevalence is slight. In contrast, smoking is about 3 times more prevalent in the most deprived quintile as compared with the least deprived.

The gender difference in diet, as regards the five-a-day criterion, is also slight.

Men do slightly better than women as regards the extent of exercise taken.

However, men drink significantly more than women, and more men are overweight than women.

There is a deprivation disadvantage in diet, in exercise and in BMI which is as great or greater than the gender disadvantage.

Overall, there are more men than women with unhealthy lifestyles, defined as achieving none, or only one, of the lifestyle indicators. This may account for part of the observed male disadvantage in health outcomes. However, it may not be gender *per se* but the intersection of gender and relative deprivation which is the cause of this disadvantage. This is suggested by the generally greater demographic than gender differences in the lifestyle ‘scores’.

It is beyond the scope of this review to determine whether the extent of the gender lifestyle differences are commensurate with the health outcome differences.

## 3.10 Suicide

It is noted that Wales has a “suicide and self harm prevention strategy, 2015-2020” ([Talk to me 2](http://gov.wales/topics/health/publications/health/reports/talk2/?lang=en)). It is also noted that Welsh regions may have their own strategies, for example the [North Wales Suicide and Self-Harm Prevention Strategic Plan 2018-21](http://www.wales.nhs.uk/sitesplus/documents/861/North%20Wales%20Suicide%20and%20Self%20Harm%20Prevention%20Strategic%20Plan.pdf). In this respect, Wales may be ahead of the rest of the UK, though the National Institute for Health and Care excellence (NICE) is currently developing guidance on preventing suicide, expected to be published in 2018. These strategies do recognise that being male is a leading risk factor, and for men in middle age (35 – 49) in particular. Combine these risk factors with poor educational achievement and low socioeconomic status, and the risk becomes even greater. It is to be welcomed that these issues are now recognised. However, the national Talk-to-me-2 [Objectives](https://gov.wales/docs/dhss/publications/150716talken.pdf) and the [Key Activities](https://gov.wales/docs/dhss/publications/150716annexesen.pdf) make no mention of the male sex.

There is also some way to go in recognising, especially in the context of men, that mental health may not be the only issue in suicide. There may be exogenous societal factors which the individual is powerless to influence.

### 3.10.1 Suicide Data (General Public)

It has already been noted in Section 2.3.2 that suicide is the largest single cause of men’s early death (before age 45). Suicide is also the most significant gender disparity in premature death, when judged in percentage terms.

Suicide is defined here as deaths classified as resulting from intentional self-harm or injury/poisoning of undetermined intent. Suicide "rates" are the number of suicides per 100,000 people of the same sex and in the same age range (i.e., 10 and over) in the population in question.

Suicide rates are plotted against year in Figure A.7.1 (Wales) and Figure A.7.4 (UK and Wales compared). Actual numbers of suicides in Wales are plotted in Figure A.7.2 and in England in Figure A.7.3. Figure A.7.5 plots the ratio of male to female suicide rates (England and Wales compared). Salient features are,

**Figures A.7.1 to A.7.4** indicate female suicide rates in Wales and in England have reduced significantly over the last 35 years, whilst male suicide rates have remained relatively unchanged. The actual number of male suicides in Wales has increased (Figure A.7.2), but not in England (Figure A.7.3).

**Figure A.7.4:** Comparison of suicide rates in Wales and the UK as a whole reveal that for women the rates are essentially the same, whilst for men the suicide rate in Wales has been rather larger than in the UK as a whole for the last 20 years. Thus, despite the well known parlous position of men as regards suicide in the UK as a whole, the position of Welsh men is even worse.

**Figure A.7.5:** In 1980 the ratio of male to female suicide rates was about 2, or just less. This ratio is now substantially larger, but this increase is due more to a reduction in the female suicide rate than to an increase in the male suicide rate.

Averaging over the five year period 2012 to 2016, the suicide rates in Wales were 20.0 per 100,000 for men and 4.7 for women (ratio 4.3). In England the suicide rates, averaged over the same 5 year period, were 15.2 per 100,000 for men and 4.6 for women (ratio 3.3). Thus, the suicide rate for men in Wales is substantially worse than in England, as can be seen from Figure A.7.5.

### 3.10.2 Why Is Male Suicide Rate So High?

Why is men’s suicide rate so much greater than women’s? Researcher into suicide, [Glen Poole, observes](https://www.telegraph.co.uk/men/thinking-man/is-machismo-the-cause-of-the-male-suicide-emergency/) that the pat response that it all comes down to men being too macho and out of touch with their feelings just does not cut it as an explanation. Consider the gender suicide paradox.

Women have a significantly higher reported incidence of mental health issues, including self-harm, than men - and also a slightly higher rate of attempted suicide than men. But male suicides outnumber female suicides by about 3.3 (England) or by x4.3 (Wales). This is the [gender suicide paradox](https://thescreen.me/2016/10/19/updated-suicide-stats-apms-2014/): if mental health indicators were indicative, women would be expected to commit suicide at greater rates than men. But the reverse is the case – and to a dramatic extent. This suggests that the causes of suicidality in men may involve exogenous factors more often than for women. In other words, mental ill-health may not always be the cause of suicide. Instead external factors may be a contributory, or dominant, reason for suicides – and this would appear from the data to be far more prevalent amongst men than women. We need to “[look beyond male suicide as a mental health issue](https://stopmalesuicide.com/2017/01/24/the-one-thing-that-can-stop-male-suicide/)”. The feeling that life is not worth living after loosing one’s whole family may not register in our social and health care systems as a mental health issue – but it may lead to death.

[Poole writes](https://www.telegraph.co.uk/men/thinking-man/is-machismo-the-cause-of-the-male-suicide-emergency/), “*All the research tells us there are multiple factors that make men of all backgrounds more vulnerable to suicide. They include exclusion from school, poor education, unemployment, low income, fatherlessness, relationship breakdown, separation from your kids, homelessness, imprisonment, substance abuse, being a victim of violence and abuse, mental health problems and a lack of male-friendly services*.”

The impact of some of these factors on male suicide are explored in the following Sections.

### 3.10.3 Suicide and Separation/Divorce

The best data-based evidence for a causal relationship between divorce or separation and an elevation in male suicide rate comes from studies in the USA. For example, the [National Institute for Healthcare Research](http://www.suicide.org/divorce-and-suicide.html) indicates that divorced people are three times as likely to die by suicide as people who are married. That it is specifically men who suffer from this elevated suicide risk is confirmed by the studies of Augustine Kposowa, J Epidemiol Community Health 2000;54:254–261, [Marital status and suicide in the National Longitudinal Mortality Study](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1731658/pdf/v054p00254.pdf). The Abstract reads,

“Divorced and separated persons were over twice as likely to commit suicide as married persons. Being single or widowed had no significant effect on suicide risk. When data were stratified by sex, it was observed that the risk of suicide among divorced men was over twice that of married men. Among women, however, there were no statistically significant differentials in the risk of suicide by marital status categories. Conclusions: Marital status, especially divorce, has strong net effect on mortality from suicide, but only among men.”

A later paper by the same author (J Epidemiol Community Health 2003;57:993 [Divorce and suicide risk](http://jech.bmj.com/content/57/12/993.full)) concludes,

“Divorced men were over eight times more likely to commit suicide than divorced women. After taking into account other factors that have been reported to contribute to suicide, divorced men still experienced much increased risks of suicide than divorced women. They were nearly 9.7 times more likely to kill themselves than comparable divorced women. Put another way, for every divorced woman that committed suicide, over nine divorced men killed themselves.”

As for the UK, [a guest blog on the CALM web site](https://www.thecalmzone.net/2014/11/guest-blog-divorce-and-male-suicide/) (Campaign Against Living Miserably) has summarised the situation regarding men and suicide after divorce as follows (extracts only),

“Divorce is difficult for everyone concerned, and a whole support network exists to help cushion the blow for some of those affected. For the wife and children there are usually endless offers of support from friends, family members and dedicated organisations, but it is still the case that comparatively few organisations exist to specifically help men cope with the often immense emotional and psychological trauma of getting divorced…..

Divorce and separation have long been connected to raised risk of suicide…….“separated men are twice as likely as separated women to have made plans about ending their lives.”

Often it is the divorced man who finds himself having to leave the marital home, particularly when children are to remain with their mother, which is more often than not the outcome from family break-ups.

Finding themselves alone, in reduced financial circumstances and no longer surrounded by their family, far too many men find themselves wondering how to cope with feelings of grief, loss and even rage. Alcohol, drugs and casual intimate relationships can often become a crutch providing instant euphoria, but failing entirely to address the deep seated problems. Worse than this, they can often lead to addictive behaviours and feelings of worthlessness and hopelessness afterwards, leading to a vicious cycle of desire, depression and low self-esteem. Such behaviour is well documented and can result in men becoming completely isolated and incapable of dealing with their situation, leading to severe depression and ultimately suicidal thoughts.

Since it is abundantly clear from the statistics that there is a significant rise in suicide rates for men following the breakdown of a relationship, then it is equally clear that more robust solutions need to be put in place to deal with the increased risk. There are no quick fixes, but steps need to be taken to make counselling, advice and practical resources more widely available for vulnerable men.”

Research reported by the Samaritans in 2014 is notable for asserting [the link between divorce/separation and male suicide is causal](http://www.samaritans.org/sites/default/files/kcfinder/files/Men%20and%20Suicide%20Research%20Report%20210912.pdf).

A complete literature review is beyond the scope of this brief report, but a few publications are worth mentioning,

The 2005 paper [Divergence in Contributing Factors for Suicide Among Men and Women in Kentucky: Recommendations to Raise Public Awareness](http://kvdrs.ky.gov/Documents/Divergence%20in%20Contributing%20Factors%20for%20Suicide.pdf) by Sabrina Walsh, Richard Clayton, Li Liu and Sue Hodges reports the following,

“In 2005, intimate partner problems were documented as a contributing factor in 128 (29%) of all suicide cases where the circumstances were known. In 54 (42%) of the 128 cases, the coroner noted that the decedent’s intimate was in the process of leaving, breaking up, had recently left, had recently separated, had recently filed for divorce, was awaiting divorce, or had a divorce recently finalized. Of those 54 cases involving intimate partner problems most (87%) of the suicide victims were men and were significantly different from the women.”

The 2009 paper [Separation as a suicide risk factor](https://www.ncbi.nlm.nih.gov/pubmed/19128839) by Ward and De Leo concludes as follows,

“During the examined period, 6062 persons died by suicide in Queensland (an average of 551 cases per year), with males outnumbering females by four to one. For both males and females separation created a risk of suicide at least 4 times higher than any other marital status. The risk was particularly high for males aged 15 to 24 (RR 91.62). This study highlights a great variation in the incidence of suicide by marital status, age and gender, which suggests that these variables should not be studied in isolation. Furthermore, particularly in younger males, separation appears to be strongly associated with the risk of suicide.”

The USA Centre for Disease Control has published the following dataset: [Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2009: Surveillance Summaries, September 14, 2012](https://www.cdc.gov/mmwr/preview/mmwrhtml/ss6106a1.htm). Table 7 gives suicide data, including causes. Consistent with observations made above, suicide is more strongly related to separation (or an ‘intimate partner problem’) in men than in women. The majority of male suicides (~60%) had no known mental health problem, possibly indicating a dominance of exogenous factors in male suicide. This contrasts with women for whom the majority of suicides did have a known mental health problem (61%). Overall there were 3.6 male suicides for each female suicide. However, for suicides identified as due to an intimate partner problem this ratio was substantially greater, over 4.6. This is qualitatively consistent with other sources, indicating that men’s suicide is enhanced more than women’s by partner separation.

### 3.10.4 Suicide and Domestic Violence

There is evidence that domestic violence is related to suicide, and that domestic violence has a greater impact on male suicide than on female suicide. Published data are still sparse, but emerging indicators are that male victims of domestic violence are more likely to kill themselves than female victims. Moreover, perpetrators of domestic violence also have a higher suicide rate – which is less surprising than it initially appears given that roughly half of domestic violence is reciprocal. Another emerging observation, as yet with little published support, is that male perpetrators are significantly more likely to kill themselves than they are to kill their partner. If true, it immediately follows that the number of male victims of domestic violence-related deaths inevitably exceeds the number of female victims, if suicides due to domestic violence are included.

Direct support for this corollary comes from the 2010 study by Richard Davis, “[Domestic violence-related deaths](http://www.emeraldinsight.com/doi/abs/10.5042/jacpr.2010.0141)“, Journal of Aggression, Conflict and Peace Research, Vol. 2 Issue 2, pp.44 – 52 which concludes,

“When domestic violence-related suicides are combined with domestic violence homicides, the total numbers of domestic violence-related deaths are higher for males than females. This paper recommends that to understand the broad scope and tragic impact of domestic violence, further research is needed concerning domestic violence-related suicide.”

This is an extremely significant finding given the powerful influence that accusations of domestic violence have in determining the outcomes of Family Court cases. In the book “[How You Can Stop Male Suicide](https://stopmalesuicide.com/book/)“, Glen Poole observes that,

“UK government data suggests that male victims of domestic violence are 50% more likely to attempt suicide than female victims, while US researchers have found that men who were sexually abused in childhood are up to 11 times more likely to suicide…..Another form of abuse that men are more prone to is false allegations of physical and sexual assault. A recent survey of 30 victims of false allegations (24 men and 6 women) by the University of Oxford’s Centre of Criminology, found that over a quarter reported being suicidal.”

The latter comment is a reference to “[The Impact of Being Wrongly Accused of Abuse in Occupations of Trust: Victims’ Voices](https://www.law.ox.ac.uk/sites/files/oxlaw/the_impact_of_being_wrongly_accused_of_abuse_hoyle_speechley_burnett_final_26_may.pdf)” by Carolyn Hoyle, Naomi-Ellen Speechley and Ros Burnett. In this excellent work there was one comment which may shed some light on the gender differences in such cases, this,

“*It is hard to conceive how someone falsely accused might consider taking their own life, knowing that they were factually innocent – and, indeed, any admission of such a thought could easily be misconstrued as an indicator of guilt*.”

As a man, the present author finds this a surprising comment. It is not at all hard for me to conceive that an accusation of sexual assault might lead to suicide, despite being innocent. On the contrary, I would expect it. One wonders whether there is a skew in the genders’ vulnerability to social shaming, and whether the surprise expressed by the Oxford criminologists is due to their sex?

### 3.10.5 Suicide in Prison

Suicide rates are vastly greater in prison than in the public, for both sexes, see Section 3.12.5.1.

## 3.11 The Homeless and Rough Sleepers

The term “homeless” is ambiguous. In particular, the term is used in different ways by local authorities and the general public. The latter often conflate the “homeless” with those sleeping rough. There are two distinct categories: the statutory homeless and so-called “single homeless”. [Local authorities](http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN01164) have a duty to secure accommodation for unintentionally homeless households who fall into a ‘priority need’ category. There is no duty to secure accommodation for all homeless people. For example, there is no statutory duty to secure housing for homeless single people or for couples without children who are not deemed to be vulnerable for some reason. The latter are often termed the “single homeless”, whilst the rest are termed the statutory homeless. The two categories are discussed in turn below.

### 3.11.1 The Statutory Homeless (Wales)

Local Authorities in Wales have duties under Part 6 (Allocations) of the Housing Act 1996 and Part 2 (Homelessness) of the Housing (Wales) Act 2014. It is beyond the scope of this brief review to discuss all the complex requirements of these Acts. However, there are criteria to assess the eligibility and priority of an applicant for local authority housing assistance. Those who meet the criteria are classed as Statutory Homeless. Those who do not are sometimes referred to as the “single homeless”.

For year 2017/18, [Stats Wales provides data on Welsh households for which housing assistance has been considered](https://statswales.gov.wales/Catalogue/Housing/Homelessness/Statutory-Homelessness-Prevention-and-Relief/householdsforwhichassistancehasbeenprovided-by-outcome-age-gender), broken down by gender and summarized in Table A.10.1. Salient features are,

* Substantially more men (6,315) than women (4,959) were deemed “eligible, homeless, and subject to a duty to help to secure housing”;
* Similar total numbers of men (13,950) and women (14,847) were assessed, but substantially fewer men (5,232; 37.5%) than women (7,188; 48.4%) were housed;
* Substantially more men (1,206) than women (360) were deemed “not in priority need” despite being homeless;
* Even for people deemed “eligible, unintentionally homeless and in priority need”, men were less likely to be housed (69%) than women (84%).

Figure A.10.4 shows there has been a reduction in statutory homelessness in Wales since its peak in 2004, but little change since 2006. In contrast, Figure A.10.5 shows a dramatic reduction in statutory homelessness in England, which is barely one-third of its peak in 2003.

### 3.11.2 Rough Sleepers

Data is available for the number of people sleeping rough in England and Wales (separately). For this purpose “sleeping rough” is defined as sleeping in the open air (such as on the streets, or in tents, doorways, parks or bus shelters). Also counted are people sleeping in places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or makeshift shelters, often comprised of cardboard boxes).

It should be noted that this definition does *not* include people in hostels or shelters, people in campsites or other sites used for recreational purposes or organised protest, nor are squatters or travelers counted.

#### 3.11.2.1 Wales

The Welsh Government conducted a count of rough sleepers in Wales in 2017. The count was conducted in two periods: a two-week period in October 2017 and a single night in November 2017. Each of [the 22 unitary authorities submitted an estimate](https://statswales.gov.wales/Catalogue/Housing/Homelessness/Rough-Sleepers/roughsleepers-by-localauthority).

Welsh data does not disaggregate by sex.

The ‘single night’ count involved teams walking through areas and visibly spotting rough sleepers.

The two-week count included such visual identifications but also involved engaging with local agencies and services, including the voluntary sector, faith groups, the police, local residents, outreach workers, health agencies and drug and alcohol misuse and treatment teams.

It is important to appreciate the limitations of the counts. One limitation is that many rough sleepers deliberately hide themselves from sight, for fear of being attacked or robbed. Another limitation is that the entire local authority area clearly cannot be searched, so some sort of estimation is inevitable. Counts in rural areas will be particularly challenging. The count will therefore be a lower bound.

Another limitation is that some people may spend some nights on the street, but other nights they may get a space indoors – for example sleeping on someone’s floor or sofa. Consequently, there is a distinction between the number of people sleeping rough on any one night, and the number of people who have slept rough at any time within a given period.

It is not surprising, therefore, that the number of rough sleepers identified in the two-week survey (345) is significantly greater than the number identified in a single night (188). The difference between these two figures suggests that the number of people who have slept rough at some time over (say) the last year will be far larger, but this figure is unknown.

On the survey night in November, there were 191 people sleeping in emergency accommodation. These people are not included in the above counts, although the people in question would have been rough sleepers had they not found space in a shelter. Including these people, the two-week survey figure increases to 536.

Assuming 1.35 million households in Wales, the counts of 188, 345 or 536 correspond to a rough sleeper rate of 0.14, 0.26 or 0.40 per 1000 households.

The rough sleeper count in Wales has not been conducted to current standards for sufficiently time to permit the long-term trend to be discerned. However, the same methodology was used in 2016. The 2017 count was 10% greater over the two-week period (and 33% greater on the single November night). We will see, below, that this is consistent with the trend in England for increasing numbers of rough sleepers.

#### 3.11.2.2 England

The UK Government has released [data on rough sleepers in England in 2017](https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2017), summarised here. Counting and estimation is subject to the same limitations as for Wales. In particular, counts will err on the low side.

The English data is based on a single night count, or an estimate for the number on a single night, in October or November. In 2017, of the 326 local authorities in England, only 54 (17%) conducted a count. The majority (272 authorities, or 83%) provided an estimate without a count. Key results were,

* Local authorities’ counts and estimates show that 4,751 people slept rough in England on a snapshot night in autumn 2017.
* Nearly one-quarter of rough sleepers in England are in London.
* 14% of rough sleepers in England are women, 84% men (2% sex not recorded).
* 16% were EU nationals from outside the UK; 4% were from outside the EU; and 8% were of unknown nationality.
* 30% of rough sleepers had alcohol support needs, 24% drug support needs and 32% mental health support needs, with 10% having all three needs. No support needs assessment was recorded for 32% of rough sleepers.
* The number of rough sleepers in England has increased rapidly, from 1,768 in 2010 to 4,751 in 2017 (see Figure A.10.2).
* In 2017 the rough sleeper rate averaged over England was 0.20 per 1000 households. Since this is based on a “single night” estimate, it compares with the Welsh figure of 0.14 per 1000 households.

The 4,751 people identified as rough sleepers in England can be increased by the number in night shelters. In severe weather this is [probably around 2,793](https://www.theguardian.com/society/2018/feb/27/emergency-shelters-opened-homeless-people-cold-hits-england), making perhaps 7,544 people who would be sleeping rough in England on any one night were it not for the night shelters.

As stressed also for Wales, there is an enormous difference between the number of people sleeping rough on any one night and the number who have slept rough at some time over (say) the last year.

The Mayor of London’s Combined Homelessness and Information Network [“CHAIN” Annual Report for 2016/17](https://housingnet.co.uk/pdf/Greater%20London%20full%202016-17.pdf) records some 8,108 people having been seen rough sleeping in London alone in that year. This compares with 964 and 1137 rough sleepers identified by single-night counts in London in 2016 and 2017. Thus, the number of people experiencing rough sleeping at some time in a given year is roughly 7 or 8 times greater than single night snap-shot numbers.

Scaling the CHAIN data for London suggests around 35,000 people in England and Wales experienced rough sleeping at least once in 2016/17.

This enormous difference between single-night snap shot data and whole-year data is explained by the large proportion of the latter who are seen sleeping rough only a few times. The CHAIN data for London (reproduced as Figure A.10.3) indicates that 59% of those identified are seen only once, 89% not more than 5 times, and only 5% seen more than 10 times. However, one should not assume that “being seen only once” means that the people in question sleep rough only once – indeed, this is statistically improbable.

The CHAIN report indicates that, of identified rough sleepers in London, 33% had been in prison, 10% had been in care, and 7% had been in the armed services.

#### 3.11.2.3 Deaths of Rough Sleepers on the Streets

In 2012, Bethany Thomas of the University of Sheffield produced a report on deaths amongst rough sleepers [*Homelessness kills: An analysis of the mortality of homeless people in early twenty-first century England*](https://www.crisis.org.uk/media/236799/crisis_homelessness_kills_es2012.pdf). It’s headline conclusions were,

* From the records of deaths in England between 2001-2009, 1,731 were identified as having been homeless people. Of these, 90% were male and 10% female;
* The average age at death of the above was 47 (43 for women).

Note that the number of deaths in this 9 year period is comparable with the number of identified rough sleepers in England in 2010 (see Figure A.10.2). The average number of rough sleepers is likely to have been smaller in the period 2001-2009. Consequently, it appears that rough sleepers have a greater than 11% chance of dying per year (though caution is required in making this interpretation due to the flux of different people through the homeless population).

Thomas’s data may still be the best available, despite the likely increase in the street death rate since 2012 (in view of the increased number of rough sleepers). It is a savage indictment that, “*no part of the UK government records homeless death statistics at a national level, and local authorities are not required to count rough sleeper deaths*” ([Patrick Greenfield and Sarah Marsh, The Guardian, 11 April 2018](https://www.theguardian.com/society/2018/apr/11/deaths-of-uk-homeless-people-more-than-double-in-five-years)). According to the Guardian’s figures, the average age of a rough sleeper at death was 43 and “*around 90% of those who died in the last five years were men, when the gender was provided*”.

[Dying Homeless](https://www.thebureauinvestigates.com/stories/2018-04-23/dying-homeless) is a long-term project by the Bureau of Investigative Journalism to count those that die homeless on UK streets. Between October 2017 and 23 April 2018, their count of the street dead in the UK was 101, or roughly 200 per year. This is broadly comparable with Thomas’s figure.

## 3.12 Men and the Criminal Justice System

The six men’s prisons in Wales will have a combined capacity of around 4,900 when Berwyn in Wrexham is fully operational. At present there are roughly 3,300 men in prison in Wales. There are no women’s prisons in Wales. Welsh women sentenced to prison are accommodated in England.

### 3.12.1 Harsher Treatment

#### 3.12.1.1 Harsher Treatment Over Time

Men commit more crimes than women. It is not surprising, then, that there are more men in prison (21 times more, in fact). In England and Wales in 2017 there were 81,650 men and 3,850 women in prison, i.e., 95.5% men and 4.5% women.

The following data is taken from House of Commons Briefing Paper “[UK Prison Population Statistics](http://researchbriefings.files.parliament.uk/documents/SN04334/SN04334.pdf)” (Sn/SG/04334/April 2017).

The percentage of prisoners in England and Wales who are women has remained in the range 3% to 5.5% since the end of the second world war (1946). At that time the number of women prisoners was about 1,000, and reached a peak of 4,467 in 2005, but has been reducing since (to 3,854 in 2016).

Figure A.8.1 shows that the prison population is five times greater now than it was in 1946. Since men have comprised ~95% of prisoners over this period, Figure A.8.1 can be taken as indicative for male prisoners alone. Whilst the population of the country has increased since 1946, this does not explain the massive increase in prison population. Figure A.8.2 shows the prison rate, i.e., the number of prisoners per 100,000 of the population. This has also increase massively, by about 3.5 times, from ~50 in 1946 to ~175 in 2016.

It is worth noting how anomalous this increasing prison population appears when compared to the crime data. Figure A.8.3 shows how the volume of crimes in England and Wales has fallen precipitously since 1995. However, this includes *all* crimes, most of which are minor in nature and would not result in a prison sentence. Figure A.8.4 shows the volume of violent and sexual offences. This also has fallen markedly, to about one-third of its 1995 level. There has been an upturn in police recorded violent crime since 2014. This may be real or it may be an improvement in police recording procedures.

Homicides had also been falling until 2015, but homicides of males have shown an increase in 2016 and 2017 (Figure A.8.5). [The data for homicides plotted in Figure A.8.5 have been adjusted by subtracting certain exceptional homicides. These were, (i) in year 2002/3, 172 homicides attributed to Harold Shipman in previous years but coming to light in the official inquiry in 2002; (ii) in year 2005/6, 52 homicide victims of the 7th July 2005 London bombings; (iii) in year 2016/17, 96 victims of the 15th April 1989 Hillsborough stadium fire, which were classified as unlawful killings at the inquest in 2016; (iv) in year 2017/18, 35 homicide victims of the Manchester Arena bombing together with the London Bridge/Borough Market and Westminster attacks. All those figures have been subtracted from the raw data before plotting Figure A.8.5].

The increase in violent crime and homicide in the last 2 or 3 years has been driven by increases in a few inner cities, especially London and Manchester.

Focusing on domestic violence shows this has also reduced since 205 (Figure A.8.6).

The reasons for this gross mismatch between plummeting crime rates and the rising prison population are beyond the scope of this review to elucidate. However, clarification of the reasons is clearly called for, especially in view of the concentration of disadvantage in the secure estate, as outlined below.

#### 3.12.1.2 Harsher Treatment by Sex

The massive preponderance of male over female prisoners (21 to 1) is only partly, but not entirely, due to men’s greater criminality. In round numbers men commit 3 times more crimes than women. However, this includes the more minor “summary” offences, for which a prison sentence is unlikely, and, if so, would only be a very short sentence. Perhaps about 95% of prisoners have been sentenced for the more serious “indictable” offences. In round numbers, men commit about 6 times more indictable offences than women. There is therefore a mismatch between the 6 times more serious crimes committed by men and the fact that 21 times more men are in prison.

In fact this mismatch appears to be gender bias (a disparity factor of 3.5). There has been a popular mythology that women are treated more harshly in the criminal justice system, but the evidence is very much in the opposite direction. For example, the oft-repeated claim that women are twice as likely as men to be imprisoned for a first offence is the opposite of the truth. In fact, men are nearly twice as likely to be imprisoned for a first offence, whilst women are twice as likely to be conditionally discharged (see Figure A.8.7).

The Ministry of Justice has published a report “[Associations between being male or female and being sentenced to prison in England and Wales in 2015](https://data.gov.uk/dataset/women-and-the-criminal-justice-system/resource/d87022d8-0b3d-4b20-9ac2-92282613050b)”. It is important to note that the MoJ have controlled for offence type, via multivariate logistic regression, albeit across a rather coarse set of only 20 crime categories. The MoJ’s headline finding was “*under similar criminal circumstances the odds of imprisonment for males were 88% higher than for females*”, i.e., an imprisonment disparity factor of 1.88.

The MoJ rightly note this disparity might not be gender bias but rather that there could be systematic differences in offending severity even within the same offence category. Essentially this is a recognition that 20 categories may provide insufficient granularity. This does need further investigation, though it is worth noting that analyses of USA data, e.g., that by [Sonya Starr of the University of Michigan](https://repository.law.umich.edu/cgi/viewcontent.cgi?referer=http://mra-uk.co.uk/?p=215&httpsredir=1&article=1164&context=law_econ_current) in 2012, indicated a similar gender sentencing disparity factor based on far greater granularity. Table A.8.1 records some of the findings of the MoJ report for specific offence types. Women are systematically less likely to be imprisoned in every offence category. It is rather hard to understand why women’s offending should be less serious in every category, including such things as fraud, forgery, handling stolen goods, vehicle related theft or jumping bail.

The argument is sometimes made that women’s pattern of offending is different from men’s, implying that it is generally less serious. But actually women’s and men’s patterns of offending are very similar, as shown by Figure A.8.8 (arrests) and Figure A.8.9 (prisoners), the only major difference being for sexual offences. Few people would be surprised that the commonest reason for a man to be arrested is for violence. Rather more might be surprised to learn that the same is true for women (Figure A.8.8). Similarly, few would be surprised that the largest proportion of male prisoners were sentenced for violence against the person. Rather more might be surprised that the same is again true for women (Figure A.8.9).

One must not lose sight of the fact that, in terms of absolute numbers, far more men are convicted – of virtually all offence categories, and violence in particular. Nevertheless, ***patterns*** of offending between the sexes are similar, including violence. The MoJ report “[Statistics on Women and the Criminal Justice System 2015](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/572043/women-and-the-criminal-justice-system-statistics-2015.pdf)”, states, “*For both male and female prisoners, the most common offence group for which they were convicted at 30 June 2015 was violence against the person (25% and 27% respectively)*”.

Even when women are sentenced to prison, their sentence length is significantly shorter than men’s on average – see Figure A.8.10. This Figure also shows, worryingly, that whilst women’s average sentence length has not increased since 2005, men’s average sentence length has increased markedly. The gender disparity on sentence length reached 1.7 in 2015.

In summary, there appears to be a gender disparity on imprisonment of times 1.88 and a gender disparity on sentence length of times 1.7. Men also tend to be paroled some 10% later than women. These factors account for the overall 1.88 x 1.7 x 1.1 = 3.5 gender disparity which takes men’s 6 times greater number of serious crimes to 3.5 x 6 = 21 times more men in prison. There is therefore a strong *prima facie* case of serious gender bias in criminal justice.

The origins of this gender bias are easy to understand. They arise from our traditional gendered psychology and also from policy. And the latter is a result of the former.

Policy in imprisonment is driven by two themes. Firstly, a powerful lobby arguing for dramatic reductions in women’s imprisonment. This has been gaining ground since the [Corston Report of 2007](http://webarchive.nationalarchives.gov.uk/20130206102659/http%3A/www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf). It is effectively underwritten by judicial policy as exemplified by the [Equal Treatment Bench Book](https://www.judiciary.uk/wp-content/uploads/2018/02/equal-treatment-bench-book-february2018-v5-02mar18.pdf) which emphasises an understanding and compassionate approach – for women. Secondly, there is the political appeal of being seen to be ‘tough on crime’ – always a vote winner. Indeed, more severe sentencing guidelines have been adopted over successive recent years. So, given these twin facets of policy: to reduce the number of women prisoners whilst ‘being tough on crime’ – who gets the tough end of the bargain?

It is not only the number of men in prison which is increasing, against a background of falling crime, but the gender disparity in imprisonment is also increasing.

The traditional gendered psychology regarded men as agentic, powerful and responsible, whilst women were regarded in this outmoded view as non-agentic, vulnerable and in need of protection. The ultimate expression of this mindset in the legal sphere was the law of coverture, in which a married couple were regarded as a single legal entity – embodied by the husband. This could lead, for example, to the man being imprisoned for his wife’s crimes. Is what we see in the criminal justice system today this same traditional gendered psychology hanging on, indeed becoming further entrenched, rather than defeated? Equality demands equal responsibility before the law, and hence equal punishment. At present one sex receives more of the compassion and the other more of the punishment.

Any controversy there might have been in the contention that men are treated more harshly than women in our criminal justice system can now be definitively rebutted. In June 2018, [the Secretary of State for Justice, David Gawke, announced](https://www.gov.uk/government/news/secretary-of-state-launches-dedicated-strategy-to-break-the-cycle-of-female-offending) the scrapping of plans to build new women’s prisons – essential as a replacement for the closure of Holloway – in favour of a new strategy for female offenders. The new strategy will be to avoid prison sentences for women except as a last resort. Meanwhile, plans to build new men’s prisons, to accommodate a further 10,000 men, will continue. Whilst some individuals in the Prison Reform Trust suggested that the new approach for women could also be rolled out to men, there has been absolutely no indication from Government that they would countenance such an idea. The gender ratio of prisoners is set to rise above its current 21 to an almost limitless magnitude.

### 3.12.2 Who Are These Prisoners?

Prisoners – and ex-prisoners - are not a representative cross-section of society. They are a separate demographic, strongly skewed to multiple disadvantages. The 2012 Ministry of Justice report "[*Prisoners’ childhood and family backgrounds*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278837/prisoners-childhood-family-backgrounds.pdf)*: Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners*" provided the following results, based primarily on a survey of 1,435 prisoners serving sentences between 1 month and 4 years,

* 24% had been in care as a child;
* 29% had been abused as a child;
* 41% had observed violence as a child;
* 30% had a family member who had been imprisoned;
* 27% had a family member with a drug or alcohol problem;
* 59% had regularly played truant from school, 63% had been suspended, and 42% had been permanently excluded or expelled;

The following responses on living arrangement refer to arrangements which applied “most of the time until age 17”. Other arrangements might prevail at other times.

* 47% lived with both natural parents as a child;
* 34% lived with one natural parent only;
* 6% lived with one natural and one step parent as a child;
* rest lived with Grandparents, Foster parents, in institutions, etc

The 2014 [British Academy report](http://www.britac.ac.uk/sites/default/files/A%20Presumption%20Against%20Imprisonment%20updated%202016.pdf) “A Presumption Against Imprisonment: Social Order and Social Values” tells us that,

* 68% of prisoners were not in paid employment prior to being imprisoned
* 59% of young offenders have learning difficulties or borderline learning difficulties
* 47% of prisoners have no educational qualifications
* 41% of male prisoners were permanently excluded from school
* 27% of men in prison are victims of child abuse
* 24% of men in prison were removed from their families and spent time in care
* 15% of male prisoners were homeless prior to being imprisoned

Research conducted in both the UK and US has suggested that adverse childhood experiences (ACEs) lead to an increased likelihood of future criminality and antisocial behaviour. Such risk factors for future offending included low family income, delinquent or convicted family members, histories of violence, parental mental illness, poor relationships with parents, low IQ and low school attainment. That these ACEs are disproportionately present in child offenders can be seen in the next Section.

#### 3.12.2.1 Children in Prison

The secure estate for children consists of secure children’s homes (for age range 12 – 16), secure training centres (up to 17), and young offender institutions (15 – 18). The total number of children under 18 in custody, including both sentenced and remanded children, peaked at 3,195 in 2002. Thankfully this has been reduced dramatically since then, due to adopting policies based on prevention and more flexible community sentencing. [As of July 2018](https://www.gov.uk/government/statistics/youth-custody-data) there were 883 under 18s in custody, of which 854 were boys and just 29 were girls, i.e., 96.7% are boys and 3.3% girls.

Anne Longfield is the Children’s Commissioner for England. In her [2017/18 Business Plan](https://www.childrenscommissioner.gov.uk/publication/business-plan-2017-18/) she reported that she, together with Dame Louise Casey, had visited 10 of the children in the secure estate “*to learn about their lives before entering custody and understand the factors that led to them being imprisoned and what, if anything, could have been done to change their trajectory*”. Very laudable. They picked only girls despite 96.7% of the children in question being boys. We hear a great deal about sexism. Why do we not hear about this?

Ministry of Justice data from 2010 indicated that nearly three-quarters of children who are imprisoned reoffend within a year of release.

The 2013 Centre for Social Justice report "[Fractured Families](http://www.centreforsocialjustice.org.uk/core/wp-content/uploads/2016/08/CSJ_Fractured_Families_Report_WEB_13.06.13.pdf)", quotes that “their extensive research conducted for *Rules of Engagement* showed that 76% of children and young people in custody had an absent father and 33% an absent mother”. The [Prison Reform Trust](http://www.prisonreformtrust.org.uk/Portals/0/Documents/Prisonthefacts.pdf) quotes the same figures. Those are notably higher figures than for adult offenders (Section 3.12.2).

The 2010 Prison Reform Trust report "[*Punishing Disadvantage: a profile of children in custody*](http://www.prisonreformtrust.org.uk/uploads/documents/PunishingDisadvantage.pdf)" used a sample of 200 children receiving custodial sentences in 2008 to conclude the following description of the multi-facetted disadvantages of this demographic,

* Around three-quarters of the sample of are known to have had absent fathers;
* One third had an absent mother;
* Around half were living in a deprived household or unsuitable accommodation prior to imprisonment;
* Just under half had run away or absconded at some point in their lives;
* Two-fifths are known to have been on the child protection register or had experienced abuse or neglect;
* More than a quarter had witnessed domestic violence;
* Over half had truanted or regularly failed to attend school, and around half had been excluded from school;
* 31% had the literacy level, and 38% the numeracy level, expected of a seven year old;
* Around one-quarter of boys and one-half of girls had been in care.
* 20% had self-harmed;
* 11% had attempted suicide

There is a further disadvantage which receives less attention but should not be hidden: IQ. Harrington and Bailey in “*Mental Health Needs and Effectiveness of Provision for Young Offenders in Custody and Community*” (Youth Justice Board, London, 2005) assessed the IQ level of 301 children and young people in trouble with the law (in custody and in the community) aged between 13 and 18 years. 36% were found to have a low IQ (70-79) and 23% to have an extremely low IQ (under 70). Note that in the general public, IQs in these ranges would apply for only 6.8% and 2.3% of the population, so 59% of young offenders have an IQ that would have a prevalence in the general public of only 9.1%.

Whilst a fractured family background and the other disadvantages itemised above will contribute to the educational failure of imprisoned children (and adults), it would be unwise to ignore the intractable issue of innate intelligence. This will be an uncomfortable truth in some quarters. But the challenge for society is to find a beneficial and fulfilling occupation for everyone, regardless of intrinsic capacities.

### 3.12.3 Male Prisoners and Their Families

The 2012 Ministry of Justice report "[*Prisoners’ childhood and family backgrounds*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278837/prisoners-childhood-family-backgrounds.pdf)*: Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners*" provided the following information,

* 54% of all prisoners reported having children under the age of 18;
* 61% of prisoners reported being single when they entered custody;
* 24% were living with a partner;
* 8% said they were married;
* 74% of prisoners reported being close to their families;
* Approximately 200,000 children have a parent in prison at some point during a given year;
* Approximately 90,000 children have a parent in prison at any given time;
* 63% of prisoners reported providing, and 73% receiving, emotional support from their families;
* 88% reported wanting their families involved in their lives;
* 40% saw the support of their families as important to preventing them reoffending in future;
* 36% considered being able to see their children as important to preventing them reoffending in future;

These findings are echoed by the [Prison Reform Trust](http://www.prisonreformtrust.org.uk/Portals/0/Documents/Prisonthefacts.pdf). The vast majority of prisoners felt they had let their family down by being sent to prison (82%). The Prison Reform Trust quoted research indicating that the likelihood of reoffending was 39% higher for prisoners who had not received visits whilst in prison compared to those who had.

Unfortunately, despite the evident importance of contact with their families, the 2002 [Social Exclusion Unit report](http://webarchive.nationalarchives.gov.uk/%2B/http%3A/www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/publications_1997_to_2006/reducing_summary.pdf), “*Reducing re-offending by ex-prisoners*”, notes that 43% of sentenced prisoners and 48% of remand prisoners lose contact with their families after entering prison. Moreover, 22% of prisoners who are married on entering prison are divorced or separated whilst inside.

The isolation of men in prison from any meaningful contact with the outside world is crushing for many. Only about two-thirds of prisoners in local prisons and just over half of those in training prisons received the minimum statutory entitlement of two visits per month.

### 3.12.4 Self-Harming in Prison

Women prisoners have a higher incidence of self-harm, short of suicide, than male prisoners. [In the year ending March 2016](https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-june-2016), 29% of female prisoners in England self-harmed, on average 6.7 times each, compared to 11% of male prisoners, an average of 3 times.

However, this disguises the scale of the problem with male prisoners. The numerical preponderance of male prisoners means that nearly eight times more male prisoners than female prisoners self-harmed in the year to March 2016 (8,842 men cf 1,170 women).

Moreover, whilst the number of female prisoners self-harming has decreased somewhat over the last ten years, the number of men self-harming is rising steeply (Figure A.8.13) – nearly doubling in ten years.

Similarly, whilst the number of incidents of women prisoners self-harming has been decreasing, the number of incidents of male prisoners self-harming is rising steeply (Figure A.8.14) – doubled in the last seven years.

These bald statistics on self-harm and suicide are symptomatic of a rapidly increasing degree of despair within overcrowded prisons. The number of incidents of self-harm exceeds the number of assaults on other prisoners, which in turn is four times higher than the number of assaults on prison staff.

#### 3.12.4.1 Self Harming in Welsh Prisons

There is some evidence that suicide and self-harm is rising more steeply in Welsh prisons than in men’s prisons in England. In 2013, there was one suicide in Welsh prisons but [this rose to seven by 2016](http://www.bbc.co.uk/news/uk-wales-39733146). Swansea and Parc Prison in Bridgend both had three self-inflicted deaths in 2016 after none in 2013, while Cardiff had one in each year. Usk/Prescoed had none in both years. However some caution is needed in comparing two points in time, which can grossly misrepresent trends. Also, 7 suicides in Welsh prisons is broadly consistent with the suicide rate in English prisons.

Rates of self-harm in Welsh prisons rose by more than three times in the 2013 - 2016 period. Rates of self-harm rose from 440 to 1,452 in Parc, 43 to 201 in Cardiff and 34 to 149 in Swansea. Usk/Prescoed had none in 2013 but 29 in 2016. This appears even worse than in England, but again one must be cautious about judging from just two points in time.

Parc Prison also had one of the highest rates of prisoner-on-prisoner assaults in the UK, at 641 in 2016.

The number of assaults on prison staff in Wales has also more than doubled over a year, compared to an increase of 40% across England and Wales. The vast majority of Welsh incidents were in Parc Prison, which saw 245 attacks on officers, the second highest number of all prisons in the UK. Only Birmingham, which saw riots in December 2016, had more incidents. In Cardiff there were 86 assaults on staff, up from 33 the previous year, while Swansea saw another big rise, with 50 assaults in 2016 compared with 15 the previous year. Usk/Prescoed remains one of the safest prisons for officers with just one incident reported in 2016 and in 2015.

The differences between the prisons will be partly explained by their Category: Parc and Cardiff are Category B; Swansea is mixed categories B and C; Berwyn is Category C; Usk is Category C and Prescoed is Category D (open prison).

### 3.12.5 Deaths in Prison

Data on deaths in prions in England and Wales have been taken from the charity [INQEST](https://www.inquest.org.uk/deaths-in-prison). Key Figures are A.8.11 and A.8.12. Self-inflicted and non-self-inflicted deaths are discussed separated below.

#### 3.12.5.1 Suicide in Prison

108 men have been identified as having killed themselves by deliberate act in prisons in England and Wales in 2016. This is easily the highest number of prison suicides on record. However, the true figure may be worse as 12 deaths of men in prison that year are still awaiting classification. So far the numbers of prison suicides in 2017 appears substantially smaller, so 2016 may have been anomalous. However, 29 prison deaths in 2017 remain to be classified so it is too early to give suicide data for 2017. The male prisoners’ suicide rate in 2016 was 1.33 per thousand prisoners per year.

Figure A.8.11 suggests a trend upwards in male prisoners’ suicide rate over the last 5 years. However, this may be less convincing if the 2017 out-turn is substantially less than in 2016, as appears likely. Hence, whilst a long term upwards trend would still be apparent, it may be less marked than it currently seems. The ten-year average (2007-2016) is 73 male prisoners’ suicides per year, or an average rate of 0.9 per thousand per year.

2016 was also a very bad year for self-inflicted deaths of women in prison, namely 12 cases in England (recalling there are no women’s prisons in Wales). However this is unusual (see Figure A.8.12). The average suicide rate in women’s prisons in England over the 10 years period 2007-2016 is 3.7 per year, or roughly 0.9 per thousand women prisoners, essentially the same suicide rate as male prisoners.

However, one should not lose sight of the fact that, with 21 times more men in prison, there are far more men than women killing themselves in the secure estate (108 men versus 12 women in 2016, and 73 men versus 3 or 4 women on average).

For both male and female prisoners, the rate of suicide far exceeds that of free individuals. In 2014 the UK wide average (age adjusted) suicide rates were 0.159 per thousand and 0.046 per thousand for males and females respectively (Figure A.7.2). Thus, a man in prison is about 20 times more likely to kill himself than a free women (0.9/0.046). In 2016 this peaked at a man in prison being up to 29 times more likely to kill himself than a free women (1.33/0.046).

#### 3.12.5.2 N0n-Self-Inflicted Deaths in Prison

Whilst self-inflicted deaths in prison rightly receive some attention, rather less attention tends to be given to non-self-inflicted deaths (NSDs). (One recoils from describing these deaths as “natural” in the circumstances). This is unfortunate because, not only does the volume of men’s NSDs exceed that of suicides, but men’s NSDs are trending steeply upwards (Figure A.8.11). At the start of the millennium there were about 50 NSDs per year in England and Wales. By 2016 this had increased to a formally reported 169. However, accounting for deaths awaiting classification, that might be more like 200 NSDs of men in 2016, four times greater than 17 year earlier. Whilst the increasing male prison population since 2000 contributes to this, the factor of four increase is wildly out of proportion with the population increase of ~45% (see Figure A.8.1).

To this one can add an average of about 3 male prisoners’ deaths by homicide per year.

Women prisoners’ NSDs average at about 4 per year. Consequently, men’s NSDs are out of proportion with women’s, even taking account of the 21-to-1 prison population ratio.

The reason for the huge increase in male prisoners’ NSDs is almost certainly due to the larger proportion of older prisoners in gaol. The number of men over 60 in prisons in England and Wales has [doubled in the last decade](https://www.theguardian.com/society/2014/jul/23/number-prisoners-over-60-england-wales-doubles-10-years). It has been suggested that [convictions for historic sex offences are the major contributor](https://www.theguardian.com/society/2014/jul/23/number-prisoners-over-60-england-wales-doubles-10-years) to this ageing male prison population. Notoriously[, some prisoners are now hobbling around on Zimmer frames](https://www.theguardian.com/news/2017/jun/20/buried-alive-the-old-men-stuck-in-britains-prisons?CMP=share_btn_tw), unable to negotiate stairs and unable to access the exercise yard – which can hardly do their health much good. The ones with dementia do not even know where they are.

## 3.13 Men as Unpaid Carers

The popular perception is that most unpaid caring is done by women. This is true, though not by the margin that most would imagine. And this perspective fails to give credit to those who work full time whilst also caring for 50 hours or more per week, most of whom are men. In 2014 [Men’s Health Forum reported a survey](https://www.menshealthforum.org.uk/male-carers-husband-partner-dad-son-carer) which indicated that 42% of unpaid carers in the UK are men. (For comparison, men in the UK do 61% of paid work). Headline findings from the report were,

* More than one in four male carers in employment would not describe or acknowledge themselves as a carer to others, meaning they may not get the support they need at work;
* Over half of the male carers (53%) surveyed felt that the needs of male carers were different to those of female carers, many citing that men find it harder to ask for help and support and that balancing work and caring is challenging, particularly if they are the main earner;
* One quarter (26.3%) of men surveyed cared for more than 60 hours per week as well as being in work;
* Four in ten male carers said that they never had a break from their caring role;
* 56% of male carers aged 18-64 said being a carer had a negative impact on their mental health and 55% said that their health was “fair or poor”.

[ONS data, released May 2013](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/articles/fullstorythegendergapinunpaidcareprovisionisthereanimpactonhealthandeconomicposition/2013-05-16), reveals the following,

* In 2011 in England, 116,801 men and 81,812 women were in full-time employment while providing 50 hours or more unpaid care; in Wales the equivalent numbers were 9,320 and 5,068 respectively;
* A greater percentage of men between the ages of 50-65 than women aged 25-49 perform caring roles.

The popular image of men as slackers when it comes to caring is seriously at odds with reality.

## 3.14 Loneliness

The National Survey for Wales, 2016-17, has provided valuable information on [loneliness in Wales](http://gov.wales/docs/statistics/2018/180213-national-survey-2016-17-loneliness-en.pdf). Loneliness was measured for the first time in the 2016-17 National Survey, using the De Jong Gierveld loneliness scale.

The likelihood of being lonely decreases with age, from 20% in the 16 to 44 age range, to 11% or less for the over-65s.

Physical ill health substantially exacerbates the likelihood of being lonely, but this effect disappears in the oldest age group. For the youngest age group (16-24), having a limiting long-term illness increases the probability of loneliness from 15% to 46%. For the over 75s, the probability of loneliness is 10% irrespective of health issues.

A strong association was found between loneliness and mental well-being as measured using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). Lower WEMWBS scores indicate worse mental well-being. The average mental well-being score for those who were not lonely was 55.8, compared with 42.3 for those who felt lonely.

Household type is a major factor in the prevalence of emotional loneliness. (Emotional loneliness refers to loneliness which relates to the absence of close relationships or emotional attachments). 43% of single parents reported emotional loneliness compared with 16% of adults in a two-adult household with children (reducing to 10% for married pensioners without children) – see Figure A.10.1.

As regards the overall loneliness scale, there was no significant effect of gender when controlling for other variables: “*When controlling for other factors, characteristics not identified as related to loneliness were: gender, household type, economic status, tenure, car availability, using Welsh daily, religion, having fewer than two healthy behaviours, whether the area they lived in was urban or rural, the level of local area deprivation, and the local authority area.*

However, a gender effect was found in respect of social loneliness. The social loneliness subscale is based on the statements such as: “there are plenty of people I can rely on when I have problems”, “there are many people I can trust completely”, and, “there are enough people I feel close to”. When controlling for other factors, social loneliness was found to be increased by being a man, being middle aged, and being single, separated, divorced or widowed (amongst other things).

# 4. Mental Health

**Mental Health Section outline**

* 4.1 Statistics on mental health of men in Wales vs UK
* 4.2 Drugs & Alcohol Abuse
* 4.3 Promoting men’s mental health – services and access?

This section provides an overview of the evidence available on the main aspects which highlight the inequalities in the mental health of men in Wales and drugs & alcohol abuse. Aspects covered include the overarching legal framework, funding, statistics depicting prevalence and the data gaps identified in the mental health situation awareness in Wales as compared to England**.**

## 4.1Mental Health

### 4.1.1 Introduction: Mental Health legal safeguards and funding in Wales

Human Rights provide a framework for developing safeguards for [people who need mental health treatment in hospital](https://rightsinfo.org/five-times-human-rights-helped-people-mental-health-issues/), by ensuring there is a duty of care and that there is no delay to their release.

The responsibility of providing mental health services in Wales is framed within on two main legal instruments advocating for human rights that entail the safeguarding of men’s mental health.The **UK Human Rights Act 1998 and Equality Act 2010** Section 149(1) complement each other by contributing to the understanding of men’s mental health as a basic human right to be protected. The **UK Human Rights Act 1998** incorporating the rights in the European Convention on Human Rights compels public organisations (including the Government, police and local councils) to treat everyone equally, with fairness, dignity and respect. Section 149(1) of **the Equality Act 2010** (“the Act”) provides that a public authority listed in Schedule 19 to the Act must in exercising its functions have due regard to the need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act; advance equality of opportunity. *Wellbeing of Future Generations Act* (Wales) 2015 outcome measures point out the high number of mental health occurrence resulting from assessments, versus low uptake of mental health services (FGCW, 2017, p.19-\*)

* The *Social Services and Wellbeing (Wales) Act 2014* emphasises the importance of emotional wellbeing in children and adults and introduces key duties for health boards and local authorities.

Whereas only 5.5% of health research funding goes to mental health in the UK, mental health is one of the top priorities of the Welsh Government (*WalesOnline* Survey website). This is reflected in Welsh Government budgetary allocations. The Welsh Government invests around £600m p.a. in mental health services (Welsh Government, 2016a).

* *Suggestion*: “Welsh Government needs to invest in research and data collection” (*Mental Health Foundation*, 2016, p.3).

### 4.1.2 Facts supported with research evidence about the prevalence of mental health inequalities among men (versus women) in Wales

1. Wales Health Survey Trend analysis for the 2003-2015 period showed that between 2003 and 2015, the percentage of men being treated in Wales for a mental health problems was consistently lower than that of women *Appendix A* (Welsh Health Survey website 03/03/2018). However, men may be less-likely to seek help for mental health issues due to the reinforcement of traditional gender roles, whereby men are *expected* to be tough, resilient and not talk about their fears and feelings (Chapman, 2017).
2. **Links between Parental Alienation of men, mental health deterioration and Suicide:** Fathers experiencing reduced contact or no contact with their children as a consequence of marital breakdown, separation or divorce and subsequent parental alienation, often experience varying degrees of mental distress and emotional trauma. The extent to which the ripple effect of these mental health consequences can impact upon the men’s lives largely depends on their accessing (or not) of mental health services. If no timely mental health intervention occurs, this could lead to a severe suicidal crisis (Johnston, 2003; Boch - Galhau, 2003). (See also Sections 3.5.2 and 3.10.3)
3. “The rate of suicide in Wales is higher amongst men than amongst women, yet men are less- likely to access support and therapies” ([Cambule](http://www.timetochangewales.org.uk/en/blogs-stories/?author=Lee+Cambule), 20/02/2017).
4. “Many assessments highlight mental health as a key issue, providing data about the number of adults reporting being treated for a mental illness, suicide rates and self-harming rates. Many of the assessments compare the number of adults being treated for a mental illness against the mental wellbeing score used in the Welsh Health Survey. This comparison suggests that in many areas there are significantly more people experiencing mental health issues than those reporting being treated for mental health issues”
5. Studies on older people with mental health issues, have shown that depression affects around 22% of men and 28% of women above 65 years of age (Welsh Government, 2016b).
6. “Men reported a significantly lower life satisfaction than women, with those aged 45 to 59 reporting the lowest levels” (Welsh Government National Wellbeing Survey)
7. When distressed, some male youth and men find it easier to talk to female mental health support worker about their condition, than to talk to their peers or their fathers about their feelings when they feel that they need mental health support for fear of mental health stigma and discrimination (Cambule, 2017).
8. *Misguided mental health narrative:* Public Health Wales commented that whilst the majority of the Assessments highlight the importance of mental health, the approach taken is largely to focus on mental illness as a problem that needs to be solved rather than good mental well-being as an asset for people and communities. A focus on problems and challenges rather than assets and opportunities appeared to be a common approach in many assessments (FGCW, 2017, p.21).
9. *Policy Strategic re-orientation*: As PSBs move to well-being planning more thought needs to be given to how communities and services can foster good mental well-being, as well as addressing mental health problems. A key part of this links to one of the recommendations in Part 2 of this report – building a deeper understanding of people’s lived experiences, in this case specifically about what supports good mental well-being, through using all of the information that PSB organisations hold about people’s well-being (FGCW, 2017, p.21).
10. The National Survey for Wales 2016-17: [Mental Wellbeing Tables](https://gov.wales/statistics-and-research/national-survey/?tab=el_home&topic=population_health&lang=en) report results of a mental health survey using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). A total of 8,684 people were surveyed. The mean WEMWBS score for men was 51.3 and for women 50.4. Hence, men report better mental well-being, though only marginally.
11. A higher percentage of women report being treated for a mental health problem than men, 16% vs 10% ([Mental Health Foundation 2016](https://www.mentalhealth.org.uk/sites/default/files/FF16%20Wales.pdf)).

### 4.1.3 Data shortfalls: Data Gaps, Information scarcity and dated nature of some existing data

1. **Data Gaps:** This brief literature search noted an acknowledgement by the Welsh Government that there was very limited data and information on the following factors:
2. Mental ill health trend in Wales;
3. The societal, economic and personal impact of mental health problems in Wales
4. Where statistics exist, “there are many data gaps that make it very challenging to understand the real consequences of mental ill health in Wales. For instance, while the Welsh Health Survey 2015 provides details on the number of people who experience mental health problems in Wales, there is scanty information on mental health diagnosis, treatment and support”.

(Welsh Government, 2016b).

1. **Scarcity of information captured at the mental health Local (Community) Health Boards fit into the national picture?**

Whereas the *Mental Health (Wales) Measure (2010)* places legal duties on health boards and local authorities to improve support for people with mental ill-health, a) there is a scarcity of available information in terms of what is captured at the Local (Community) Mental Health Board level and b) how does the information captured at Local (Community) Mental Health Boards fit into the national picture (Mental Health Foundation, 2016, p.2)?

1. **Lack of up-to-date mental health empirical data on in Wales** (vs England)

Between 01 January 1993 and 31 December 2014 Office of National Statistics (ONS) conducted four Adult Psychiatric Morbidity Survey (APMS) surveys in 1993, 2000, 2007 and 2014 in England to assess the prevalence of both treated and untreated psychiatric disorders, provide data on the mental health situation among the adult population accessing mental health support and at what point. While the first two studies covered Wales and Scotland as well, the 2007 study only assessed the situation in England.

Observations: Unlike England that has conducted four studies on the trend of psychiatric disorders since 1993, no Wales nationwide mental health survey of the adult population was carried out during the 15-year period 2000-2015 to ascertain the trend, the prevalence of mental health, availability of support services, the number of adults receiving mental health treatment and those accessing mental health services (NHS Digital,29/9/2016).

### 4.1.4 Recent Suicide statistics that are raising questions about the mental health of men and boys in Wales

“The gender differences in suicide are important and need to be considered. There have been suggestions that this is due in part to the changing nature of society but records suggest that across England male suicides have been considerably higher than female suicides since the 1860s, with the male to female ratio fluctuating from 4:1 in the 1880s to 1.5:1 in the 1960s (Thomas & Gunnell, 2010 in North Wales Suicide and Self-Harm Prevention Strategic Plan 2018-2021 p. 16).

In North Wales over the registration period 2006 and 2015 (calendar years), 580 recorded suicides out of 741 (78%) were in males and 162 in females (22%) (Source: ONS).

April 2017, Betsi Cadwaladr University Health Board published its mental health strategy, the overall aim of the North Wales Suicide and Self-harm prevention strategic action plan is to reduce suicide and self- harm in the general population in North Wales.

*Questions arising*: -

* Do we have gender disaggregated suicide and self-harm statistics for the whole of Wales?
* What factors underlie the relatively higher statistics for males?
* Why not focus on the male population as a significant ‘high risk’ segment of the population

## 4.2 Drugs and Alcohol Abuse

**Statistics**

 Data sources: -

* Analyses from NHS Digital Hospital Episode Statistics (HES).
* The Office for National Statistics (ONS) on deaths related to drug misuse.
* National drug treatment monitoring system (NDTMS).
* Crime survey for England and Wales (CSEW).
* Adult Psychiatric Morbidity Survey (APMS),
* Smoking, Drinking and Drug Use (SDD).
* What About Youth (WAY).

### 4.2.1 Drug Abuse

Drug use prevalence among male adults in England and Wales

For males, since reaching a peak in the early 2000s, there has been a marked decrease in rates of alcohol-related deaths in Scotland. This decrease is greater than that for England, Wales or Northern Ireland as illustrated in Appendix C.

“In 2015/16, around 1 in 12 (8.4 per cent) adults aged 16 to 59 had taken an illicit drug in the last year. This equates to around 2.7 million people. This level of drug use was similar to the 2014/15 survey (8.6 per cent), but is significantly lower than a decade ago (10.5 per cent in the 2005/06 survey)” (NHS Digital,28/2/2018)

#### 4.2.1.1 Drugs-related deaths in England, Wales vs Europe

**In England and Wales:**

ONS reported that in 2016 there were 3,744 drug poisoning deaths (involving both legal and illegal drugs) were registered in 2016 in England and Wales. Majority of these registered drug-related deaths England and Wales were males (2,572 male deaths and 1,172 female deaths) [(ONS, 2017)](http://www.emcdda.europa.eu/publications/edr/trends-developments/2017).

The mortality rate for all drug poisoning deaths for males had increased from 51.5 deaths per 1 million populations in 1993 to 91.4 deaths per 1 million populations in 2016 (a 78% increase). For females, the mortality rate for all drug poisonings has increased from 34.2 deaths per 1 million population in 1993 to 40.6 deaths per 1 million in 2016 (a 19% increase)[(ONS, 2017)](http://www.emcdda.europa.eu/publications/edr/trends-developments/2017).

**UK verses Europe:**

“The latest figures show that the drug-related mortality rate among adults in the UK (aged 15 to 64 years) was almost three times greater than the average European rate. However, figures for other countries (which in turn influence the European rate) may not be comparable with those presented for England and Wales, due to differences in data collection methods and in the death registration system” [(EMCDDA, 2017)](http://www.emcdda.europa.eu/publications/edr/trends-developments/2017).

### 4.2.2 Alcohol: Consumption Guidelines and Alcohol Abuse

NHS provides guidelines that help in understanding the official definitions for alcohol drinking as illustrated in *Table 1* below.

**Table 1: Number of units in common alcoholic drinks**

|  |  |  |
| --- | --- | --- |
| Drink (and unit strength (ABV)) | Quantity | Units |
| Small glass red/white/rosé wine (12%) | 125 ml | 1.5 units |
| Standard glass red/white/rosé wine (12%) | 175 ml | 2.1 units |
| Large glass red/white/rosé wine (12%) | 250 ml | 3 units |
| Pint of lower-strength lager/beer/cider (3.6%) | Pint (568 ml) | 2 units |
| Pint of higher-strength lager/beer/cider (5.2%) | Pint (568 ml) | 3 units |
| Bottle of lager/beer/cider (5%) | 330 ml | 1.7 units |
| Can of lager/beer/cider (4.5%) | 440 ml | 2 units |
| Alco pop (5.5%) | 275 ml | 1.5 units |
| Single small shot of spirits (Gin, rum, vodka, whisky, tequila, sambuca) (40%) | 25 ml | 1 unit |

Source: NHS Live Well website

Additional NHS drinking guidelines state that “men should not regularly drink more than 3 to 4 units per day and women not more than 2 to 3 units per day”. ‘Regularly’ is defined as drinking this amount every day or most days of the week. It also recommends taking a break from alcohol for 48 hours after a heavy drinking session (NHS Choices).

#### 4.2.2.1 Definitions of Alcohol drinking

*Drinking above guidelines:* Drinking above guidelines from surveys is usually measured as men drinking more than 4 units and women drinking more than 3 units on their heaviest drinking day in the previous week.

*Heavy (binge) drinking*: The term ‘binge drinking’ usually refers to drinking lots of alcohol in a short period of time or drinking to get drunk6. In surveys, it is usually measured as drinking more than twice the daily guidelines, which for men is more than 8 units and women more than 6 units on their heaviest drinking day in the previous week. In Welsh Health Survey (WHS) publications this measure has been referred to as either ‘heavy drinking’ or ‘binge drinking’. To avoid any confusion with the new ‘very heavy drinking’ category, both terms ‘heavy (binge) drinking’ are used throughout this report for Wales or Great Britain data (see Table 2).

*Very heavy drinking:* The new measure ‘very heavy drinking’ has no formal definition, but has recently been used in Office for National Statistics (ONS) publications and referred to as men drinking more than 12 units and women drinking more than 9 units on their heaviest drinking day in the previous week. This definition, listed in Table 2, is used throughout this report where survey results are reported for Wales and Great Britain.

*Abstainers:* Abstainers in this report refer to WHS respondents who report not having drunk alcohol in the past 12 months (Table 2). It includes those abstainers who have not consumed alcohol during this fixed period of time regardless of whether they have drunk alcohol before this 12-month period.

A 2016  [*Opinions and Lifestyle Survey*](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/qmis/opinionsandlifestylesurveyqmi) (OPN) on the adult alcohol drinking habits of adults above 16 years of age in Great Britain between 2005 and 2016, provided the following overview of drinking habits:

7.8 million people “binged” on alcohol on their heaviest drinking day.

Young people aged 16 to 24 years in Great Britain are less likely to drink than any other age group; when they do drink, consumption on their heaviest drinking day tends to be higher than other ages.

The highest earners, those earning £40,000 and above annually, are more likely to be frequent drinkers and “binge” on their heaviest drinking day when compared with the lowest earners.

In 2016, similar patterns of drinking were observed in England, Scotland and Wales; of the English regions, binge drinking was more common in the north.

Among men who “binged”, normal strength beer was the most popular choice of alcohol, for females, wine was the most popular choice.

(ONS, 2016c)

Inequalities in drinking habit in Wales: variations by gender disaggregation, age and geographic location

The 2016  [*Opinions and Lifestyle Survey*](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/qmis/opinionsandlifestylesurveyqmi) *(OPN)* further revealed a gender disaggregation of drinking habits as illustrated in *Appendix D,* stating that:

Men were more likely to be drinkers than women.

62.8% of men drank in the previous week compared with 51.3% of women.

Sex-specific patterns of binge drinking: 28.2% of males stated they exceeded 8 units of alcohol on their heaviest day, whereas 25.3% of females stated that they exceeded 6 units of alcohol.

When looking at binge drinking by age and sex (*Appendix D*), for males aged 16 to 64 years, there tends to be very little difference in the proportion of those who “binged” on their heaviest drinking day. For females aged 16 to 24 years, the proportion of those binge drinking tends to decrease across these age bands.

There has been a significant reduction in drinking above guidelines in the younger age groups (16-24, 25-34 and 35-44) in Wales, and particularly among the males (Appendix D). For example, the percentage in young males aged 16-24 has fallen from 51% to 42% as compared to the 46% to 39% reduction among females (PHWNHST, 2014, p.14)

There was a geographic variation in the percentage of adults aged 16 and over who reported very heavy drinking. The variations were international, regional, between health boards and also at sub-local authority level as follows: -

Alcohol drinking has social and cultural roots and thus drinking patterns vary considerably among continents, countries, cities, suburbs, neighbourhoods and even among family members. A 2014 report stated that on a global level, people aged 15 and over drink on average 6.2 litres of pure alcohol per year. The consumption in the UK was estimated at 11.6 litres of pure alcohol in 2010 which was lower than some other Western countries e.g. 12.2 litres in Australia and France, but higher than 9.9 litres in Netherlands and 6.7 litres of alcohol in Italy (PHWNHST, 2014, p.22)

“The percentages of drinking for the three definitions in Wales are higher than in England, but lower than in Scotland (Figure 10). According to the Opinions and Lifestyle Survey (OPN), 27% of adults in Wales reported heavy (binge) drinking on the heaviest drinking day in the past week, higher than in England with 25% and lower than in Scotland with 33%. In Wales, 16% reported very heavy drinking compared to 13% in England and 19% in Scotland”.

There is percentage variation between health boards. For instance, the percentage for persons in Powys tHB (12.6%) & Hywel Dda UHB (13.3%) was statistically significantly lower than the national percentage for Wales, whilst Cwm Taf UHB (17.6%) was found to be statistically significantly higher than the national figure (PHWNHST, 2014, p.18).

The variations percentages were most noticeable at sub-local authority level, with the highest percentages of adults reporting very heavy drinking identified in Upper Super Output Areas (USOAs) within Rhondda Cynon Taf, Caerphilly, Bridgend and Blaenau Gwent (PHWNHST, 2014, p.18)

Some Key facts emerging from a socio-economic analysis of alcohol abuse in males and alcohol- related deaths in Wales and the UK

Alcohol is a source of socio-economic inequalities in health (PHWNHST, 2011, p.41)

There is little difference in alcohol consumption between the deprivation fifths for heavy (more than 8 units for males, 6 units for females) and very heavy drinking (more than 12 units for males, 9 units for females) (WIMD, 2011)

Deprivation acts differently on the risk of binge drinking between males and females at different age groups (Fone et al.2013)

There is an inverse relationship for drinking above guidelines among males and females, with more than 4 units for males and 3 units for females. There is a higher proportion of males drinking above guidelines in the least deprived areas (52% in males) than in the most deprived areas (45% in males). This is slightly stronger in females with 44% in the least deprived areas compared to 32% in the most deprived areas

Binge drinking increased with increasing deprivation (PHWNHST, 2011, p.43)

Mortality and hospital admissions are strongly related to deprivation. In contrast self-reported heavy and very heavy drinking is similar between the deprivation fifths. The pattern in alcohol consumption is in stark contrast to outcomes in both mortality and hospital admissions which show a strong relationship to deprivation where rates in the most deprived areas are much higher than in least deprived areas (PHWNHST, 2011, p.43)

Alcohol-specific indicators are more strongly related to deprivation than alcohol-attributable indicators. The rates of individuals being admitted to hospital with alcohol-specific conditions varies over time, but rates have overall been rising in both the most and the least deprived areas

 Alcohol-specific mortality and hospital admissions have the largest rate ratios, with the rates in the most deprived areas for males between 3.3 and 4.6 times higher than the rates in the least deprived areas (between 2.5 and 3.1 times higher for females) (PHWNHST, 2011, p.46)

The rates of individuals being admitted to hospital with alcohol-specific conditions varies over time, but rates have overall been rising in both the most and the least deprived areas. However, a decrease in the most deprived areas of Wales in recent years may have contributed to a slight narrowing of inequalities in the rate of alcohol-specific hospital admissions. The rate in the most deprived areas for males has dropped from 4.4 times in the first period to 3.4 times the rate in the least deprived in the most recent period (3.4 to 2.8 in females).

Researchers have explained the regional differences in the alcohol-related deaths in the UK in the 1994 and 2015 period as illustrated in Appendix C, in which the following key trends in alcohol –related deaths in England and Wales were revealed:

A strong link was identified between higher alcohol-related death rates and those living in the most deprived neighbourhoods of England and Wales ([Breakwell et al. (2007)](http://www.ons.gov.uk/ons/rel/hsq/health-statistics-quarterly/no--33--spring-2007/health-statistics-quarterly.pdf).

A harm paradox was identified that showed that that harm due to alcohol consumption was higher in more deprived areas, due to the existence of other health problems, differences in drinking habits and access to healthcare ([Jones et al, 2015](http://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-015-1720-7)).

Those living in the most deprived areas of Wales were more likely to demonstrate harmful binge drinking behaviour than those in the least deprived areas ([Fone et al. (2013)](http://bmjopen.bmj.com/content/3/4/e002337.full)

There was a higher risk of alcohol-related deaths in urban areas (ONS, 2016).

**Alcohol-linked Hospital Admissions**

Hospital admission relating to alcohol is an important indicator of morbidity and the effect of alcohol misuse on the health of the population.

The three current definitions of alcohol-attributable admissions in use: are summarised in *Table 2* below.

Alcohol –attributable conditions include ethanol poisoning, mental and behavioural disorders, alcohol liver disease, other chronic and pancreatitis, among others.

In the 2003 to 2013 period the following trend was observed in the alcohol-attributable hospital admissions in Wales: -

Around 6,700 males and 3,500 females were admitted to hospital in Wales with an alcohol-specific condition.

An estimated 21,700 males and 12,300 females were admitted to hospital with an alcohol-attributable condition, but not necessarily the main reason for attendance.

Almost half of the admissions had a diagnosis of cardiovascular disease, where a relatively high proportion are linked to alcohol and which is a common diagnosis.

The rate for children and young people aged under 18 admitted for alcohol-specific (wholly attributable) conditions has statistically significantly decreased since the period 2005-07 in both males and females

**Table 2: Overview of definitions for person-based hospital admission indicators**

|  |  |
| --- | --- |
| Admissions indicator | Brief definition |
| Alcohol-specific hospital admissions | Measures individuals admitted with alcohol-specific (wholly attributable) conditions, either in the primary diagnosis (main reason) or in secondary diagnoses. This list of conditions has been revised. |
| Alcohol-attributable hospital admissions (person-based, narrow) | Measures individuals admitted with alcohol-attributable conditions (either wholly or partly attributable to alcohol) at least once a year, either as the primary diagnosis (main reason) or an external cause (e.g. injuries) as a secondary diagnosis, whichever is most linked to alcohol (highest fraction). This is a new measure. |
| Alcohol-attributable hospital admissions (person-based, broad) | Measures individuals admitted with alcohol-attributable conditions (either wholly or in part attributable to alcohol) at least once a year, either as the primary diagnosis (main reason) or a secondary diagnosis, whichever is most linked to alcohol (highest fraction). This measure has been revised. |

Source: *Alcohol and Health in Wales,* 2014 p. 21

The trend in admissions with cardiovascular disease linked to alcohol has been rising over time

Over half of females and over two thirds of males had a diagnosis of mental and behavioural disorder, including for example acute intoxication. Just over 1 in 5 females had a diagnosis of ethanol poisoning, twice the proportion in males. This measure underestimates admissions due to alcohol as only those entirely down to alcohol are included.

The rate for males in Powys tHB and Hywel Dda UHB is statistically significantly lower than for Wales, and statistically significantly higher in Aneurin Bevan UHB and Cwm Taf UHB;

Alcohol-specific hospital admission rates vary locally, amongst health board areas and upper super output areas. The rate for males in Powys tHB and Hywel Dda UHB is statistically significantly lower than for Wales, and statistically significantly higher in Aneurin Bevan UHB and Cwm Taf UHB;

Rates for alcohol-specific hospital admissions vary considerably in smaller areas of Wales (upper super output areas) and range from 165 to 613

Data Gaps: The absence of suitable individual level socio-economic data that could help to explain key alcohol indicators and their relationship to areas deprivation (PHWNHST, 2014, p.43)

# 5. Recommended Actions or Future Research

## 5.1 Physical Health

1. Stats Wales data on mortality by age group extends only as far as 2011. Updating to the present would be useful.
2. The health authorities in Wales may wish to review the value of repeat prostate cancer PSA testing following a “fingerprinting” methodology, as a means of offsetting the uncertainty of the test as an absolute indicator.
3. Should the improved diagnostic protocol for prostate cancer centred around the mpMRI technique, currently being trialed in England, prove as successful as anticipated, the method should be considered for adoption in Wales.
4. For male health care generally, initiatives such as [Men’s Health Week](https://shop.menshealthforum.org.uk/collections/mens-health-week-2017) require more promotion. The excellent material available from the [Men’s Health Forum](https://shop.menshealthforum.org.uk/collections/man-manuals) could be used as a starting point.
5. The NHS could be pro-active in surveying for the likely uptake of a convenient “persistent, reversible” male contraceptive.
6. Men have lower rates of accessing primary healthcare services. The literature suggests this may be due to men’s working hours. Research is needed to confirm or refute this hypothesis, including within Wales.
7. It may be worth considering trials of well-advertised out-of-hours services to promote the health of this disadvantaged sector, i.e., people who work full time.
8. It is more common for men than women to exceed the recommended BMI (body mass index), with adverse health implications, e.g., higher rates of diabetes. Research is needed to determine whether men’s higher BMI is exacerbated by full time working, limited time for exercise, or lack of access to weight reduction programmes.
9. It would be of interest to determine whether the observed extent of the gender/deprivation lifestyle differences are commensurate with the health outcome differences.
10. If the reported rate of decline in sperm counts is correct and persists, the average man in Western countries could be infertile in 25 years’ time. One might have expected this issue to be receiving more attention.
11. A number of subjects were not covered in this report but require addressing in any future revisions, including: the effectiveness of the colorectal cancer screening programme, the impact of occupational diseases, especially on men (e.g., pneumoconiosis, mesothelioma, skin cancers), and men’s personal experiences with healthcare services.

## 5.2 Social Wellbeing

1. More research is needed to ascertain the incidence of alienation.
2. More research is needed to determine the incidence of false allegations within private family law cases.
3. The family courts and their ancillary functions need to recognise the nature of alienation and be trained to recognise it in practice. In February 2017 CAFCASS CEO, Sir Anthony Douglas, acknowledged that parental alienation is “*undoubtedly a form of neglect or child abuse*”. That being the case, the family courts need to identify cases of alienation, and act accordingly in conformity with the paramountcy principle.
4. The sex of parents accessing parental and children’s services in Wales is not currently recorded. The Welsh Government should mandate that this be done, particularly in the context of Families First. Services should set targets (KPIs) for their level of engagement with fathers. Actions to facilitate this include,
* Suitable training of personnel to improve engagement with fathers;
* Consider increasing the employment of men in these services to facilitate this objective;
* Specific proposals to overcome barriers to fathers’ engagement as identified by professionals in this review;
* Having due regard to Article 18 of the UNCRC as incorporated into the Rights of Children and Young Persons (Wales) Measure 2011.
1. Men or women who were separated or divorced when surveyed reported by far the greatest prevalence of domestic abuse. This suggests that either domestic abuse is causal in separation/divorce or that separation/divorce is causal in domestic abuse or that both are caused by some unidentified third variable. It is clearly of interest to ascertain which of these is the case, but existing data does not do so.
2. A formal ruling is required on whether the lack of proportion between the level of demand and the level of service provision for male victims of domestic abuse places local authorities in violation of the public sector equality duty in relation to the protected characteristic ‘male’.
3. Support for male victims of domestic abuse should be provided via separate services tailored to men’s specific needs, without re-allocation or diminution of resources from the women’s sector.
4. Quantitative research into the underlying causes of male suicide is required. There is a persistent tendency to assume that mental health issues are the sole cause. However, it is known that male suicide is sensitive to partnership dissolution, to child contact problems and to domestic abuse. There is an informed opinion that we “need to look beyond male suicide as a mental health issue”. Quantification of the importance of exogenous factors is key to establishing whether this is a valid perspective.
5. There is a need for greater detail in data on mental health in Wales, covering mental health diagnosis, treatment and availability of support services. Data should be disaggregated by sex.
6. As well as the above data, there is a need to understand the real consequences of the mental ill health identified.
7. Drugs and alcohol feature strongly as causes of adverse outcomes, for both sexes but significantly more so for men. Specific proposals in this area are beyond the scope of this review but their importance is noted, as is the demographic dependence of these substance abuse issues.
8. The annual Welsh surveys of rough sleepers, carried out by the 22 unitary authorities, should be disaggregated by sex. (It is believed that the data is collected but not reported).
9. No part of the UK or Welsh governments record homeless death statistics at a national level, and local authorities are not required to count rough sleeper deaths. This should be considered.
10. Data in Section 3.12 on prisons is dominated by England. Further details specific to Welsh prisons is desirable but lacking in this rapid review.
11. The issue of sexual assault in prison should be addressed in any future revision.

## 5.3 Employment

1. There is a need for Welsh data on young people not in education, employment or training (NEETs) to be disaggregated by sex.
2. The numbers of school teachers in Wales has not been found disaggregated by sex and by category (primary v secondary schools, heads v classroom teachers). This may be available but simply not yet discovered by the author.
3. Detailed break-down of the numbers of people in various occupations are available for the UK as a whole, disaggregated by sex. (Table A.5.2 lists some of these). Similar data specific to Wales is desirable. This may be available but simply not yet discovered by the author.
4. There are roughly half a million people of each sex in the UK whose economic inactivity is classed in national statistics simply as “other”. This catch-all category may hide significant disadvantage. An outstanding issue is to clarify the nature of people in this category.

In any future revision, access to the [SAIL Databank](https://saildatabank.com/) may be useful for the above, or other, purposes.

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