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Men's mental health in Scotland

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This briefing summarises emerging trends in mental health challenges affecting men in Scotland. Drawing on current research findings, it highlights gender-specific patterns in areas such as suicide, loneliness and social isolation, the mental health impacts of fatherhood, and drug, alcohol, and gambling-related harm. This briefing also outlines existing Scottish policy approaches and shares international examples of more targeted approaches to men's health.

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Executive Summary

- Mental health is an important aspect of health for everyone and is influenced by an array of social, biological, and environmental factors. Poor mental health has a profound and far-reaching impact on quality of life and life expectancy and the negative consequences of poor mental health often extend beyond individuals to impact families, communities, and wider society.

- Poor mental health represents a significant and growing public health concern in Scotland, with one in five people in Scotland demonstrating symptoms of a possible mental health problem throughout their lifetime and Scotland recording the highest suicide rate in the UK.

- There are consistent global gender differences in the prevalence and symptom patterns of many mental health disorders. For example, while women are more likely to be diagnosed with many common mood disorders, such as depression and anxiety, men are more likely to be diagnosed with substance and alcohol use problems and personality disorders. Crucially, men around the world account for approximately 72% of suicides. In Scotland, men account for 74% of suicides.

- However, recent research has questioned these prevalence distinctions, highlighting the important role that gender norms play in determining the expression, reporting of, and subsequent diagnosis of many mental health problems.

- This briefing provides an overview of some of the key trends in mental health challenges that may be particularly problematic for men, including suicide, loneliness and social isolation, fatherhood and mental health, alcohol and drug-related harm, and gambling-related harm. While many of these issues also impact women, this briefing shares research findings highlighting gendered dimensions.

- This briefing outlines existing policy approaches in place in Scotland. It also highlights international targeted men’s health policies, including the recent call for a national UK men’s health strategy.

Background

Definitions and impact

According to the World Health Organisation (WHO), mental health is defined as “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community”[1]. Mental health is an essential component of health and a vital part of living a fulfilled life, equally important as physical health though often overlooked. The quality of an individual’s mental health is influenced by an array of social, biological, and environmental factors [1] .

Poor mental health has a profound and far-reaching impact on quality of life. Individuals living with mental health difficulties are at greater risk of developing physical illnesses and are more likely to experience adverse educational, occupational, and social outcomes across their lives, particularly when poor mental health begins early in life [2 3] . Studies indicate that individuals with serious mental illness are up to three times more likely to be victims of crime and are at five times greater risk of experiencing violence [4 5] . Critically, serious mental illness is associated with reduced life expectancy, with affected individuals dying, on average, 5-20 years earlier than those with good mental health [6 7] .

In addition to the considerable impact on the individual, the negative consequences of poor mental health often ripple across families, communities, and wider society. Parental mental health also plays a crucial role in shaping the wellbeing of children. Numerous studies have found that children whose parents live with a mental illness are at heightened risk of experiencing emotional, social, and developmental difficulties and are more likely to develop mental health difficulties themselves later in life [8 9] .

The economic burden of poor mental health is substantial, with the annual cost to the economy estimated at approximately £117.9 billion across the UK and £8.8 billion in Scotland alone [10] . These costs stem from the significant demand on health services and broader socioeconomic costs such as unemployment, reduced productivity, and lower educational attainment [2] .

Mental health in Scotland

Poor mental health represents a significant and growing public health concern in Scotland. According to the Scottish Health Survey (2023), 21% of adults (approximately one in five) met clinical thresholds indicative of a possible psychiatric disorder [11] . Data from the 2022 Scottish Census also identified that mental illness was the second most commonly reported health condition that year, with the prevalence of individuals living with a mental health condition in Scotland increasing from 4.4% (232,900 people) in 2011 to 11.3% (617,100 people) in 2022, the greatest increase across all health condition types [12] . The most substantial rise was observed among young people aged 16-24, whose self-reported rates of poor mental health increased by 12.9 percentage points since 2011. However, it is important to interpret these figures with caution. While some measures of poor mental

health peaked in 2022 and overall wellbeing indicators have yet to recover to pre-pandemic levels, annual data from the Scottish Health Survey (2023) suggests that certain measures of mental illness prevalence have decreased in recent years. These discrepancies highlight the importance of considering broader contextual factors, including increasing public awareness and reduced stigma around poor mental health, and greater willingness to disclose mental health issues, as well as increasing prevalence.

Scotland consistently records the highest suicide rate among the UK nations [13] . In 2023, the age-standardised mortality rate for suicide was 14.6 deaths per 100,000 people in Scotland [14] , compared to 14.0 in Wales [15] , 11.2 in England [15] and 13.3 in Northern Ireland [16]

Gendered patterns in mental health

Mental health problems affect individuals across all genders, however research demonstrates significant gender-based differences in both the typical age of onset and the presentation of symptoms across a range of conditions [17] . Cross-national data from 15 countries participating in the WHO World Mental Health (WMH) Survey initiative reveal consistent patterns, with women and girls significantly more likely to report internalising symptoms which are directed inward and associated with internal experiences of emotional distress, such as anxiety and mood-related disorders. In contrast, men and boys more often exhibit externalising symptoms, which show distress through outward behaviours, including engaging in high-risk activities and a higher prevalence of substance use disorders [18] [19] .

Gender differences following these patterns are observed across the life course. In childhood, boys are more likely than girls to display aggressive and antisocial behaviours, while in adolescence, reported rates of eating disorders and mood disorders, particularly depression, are notably higher among girls [18] . Adolescent girls are also more likely to report experiencing suicidal thoughts and engage in more suicide attempts than adolescent boys [18] . Despite this, men account for a significantly higher proportion of suicide deaths globally, comprising approximately 72% of all suicides [20] . There are also no significant gender differences in the overall prevalence of several severe mental disorders, including schizophrenia and bipolar depression [17] , although there is still gender-based variation in specific aspects of these conditions. For example, men typically experience earlier onset of schizophrenia symptoms, while women are more likely to present with more severe symptoms of bipolar depression [17] .

While mental health problems are often multifaceted and arise from the interplay of diverse psychological, biological, and environmental factors, evidence suggests that the expression and reporting of these conditions is significantly shaped by gender norms. Gender norms are the societal expectations learned early in life that influence how individuals of different genders behave, communicate, and seek help [21] . For example, research shows that gender differences are narrowing in the prevalence of mental health conditions such as major depressive disorder and substance use disorder among younger generations, with this shift thought to reflect changes in traditional gender roles and societal expectations, particularly for women [18] .

Social and cultural influences on men's mental health

Gender norms play an important role in shaping the behaviours that are considered socially acceptable for men and women [21] [22] [23] . In Western cultures, traditional male gender norms often emphasise that ideal behaviour for men involves being strong, staying in control and demonstrating an ability to handle challenges confidently and independently without needing help from others, in addition to avoiding engaging in behaviours traditionally viewed as 'feminine', such as openly discussing emotions or sharing feelings of mental distress [21] [22] [23] . These gender norms create considerable pressure and can discourage many men from engaging in behaviours that could support mental and physical wellbeing, including seeking support for poor mental health. Additionally, gender norms that associate masculinity with bravery and fearlessness can also encourage men to engage in more risk-taking behaviours, many of which can be detrimental to health. This dynamic contributes to the markedly higher mortality rates observed for men across a wide range of physical and mental health conditions, including many leading causes of death [24] .

There is substantial evidence that gender norms significantly shape men's likelihood of reporting and seeking help for mental health difficulties, largely due to the stigma these norms create around emotional vulnerability and help-seeking [25] [26] [27] [28] [29] . This stigma is widely implicated in the paradoxical pattern of lower rates of diagnosed depression among men compared to women, yet significantly higher rates of male suicide. Depression, in particular, is often perceived as conflicting with traditional masculine norms due to the feelings of helplessness and loss of control it creates, which are commonly viewed as 'feminine' experiences [30] . Many men report feeling fear of being judged as less masculine for seeking support, with concerns about appearing weak acting as a major barrier to help-seeking [31] [32] [33] [34] . The social pressure reduces men's likelihood of openly discussing emotional distress and poor mental health and, critically, links to the consistent findings that men are significantly less likely to access psychological therapies than women [35] [36] [37] . Furthermore, common societal expectations that men should fulfil roles as providers and protectors can further discourage men from seeking professional help for poor mental health, due to concerns this may reduce reducing confidence in their abilities among families and communities [38] .

Men's mental health and non-communicable diseases (NCDs)

Epidemiological data from multiple countries reveals a strong link between men's mental health and the prevalence of non-communicable diseases (NCDs) [39] . NCDs are chronic conditions, such as cardiovascular disease, diabetes, and respiratory illness, that are caused from a combination of genetic, physiological, environmental, and behavioural factors [40] [40]. Men experiencing poor mental health face significantly elevated mortality risks, with life expectancy reduced by a median of 10-20 years compared to the general population [39] . Many of these deaths stem from preventable NCDs, often exacerbated by modifiable behavioural risk factors and inequalities in health care access. Importantly, gender norms play a critical role in shaping men's coping strategies for mental distress. These norms increase the likelihood that men engage in health-damaging behaviours as a means of managing stress, such as increased alcohol consumption, which increases the

risks of liver disease, hypertension, and other NCDs [39] . There is also evidence that men are disproportionately impacted by the marketing of alcohol, tobacco, ultra-processed food, and gambling, increasing their risks of experiencing mental health difficulties and developing NCDs [39] . For example, numerous studies have evidenced that alcohol marketing frequently reinforces links between alcohol consumption and stereotypes of masculinity to encourage sales of alcoholic products among men, contributing to the heightened risks of alcohol-related harm [41] [42] .

Mental health disparities among gay, bisexual, transgender men

Research consistently highlights disparities in the mental health experiences of gay, bisexual, and transgender (GBT) men compared to their heterosexual cisgender counterparts. A 2022 systematic review found that sexual and gender minority men reported significantly higher rates of many common mental health conditions, with depression identified as the most prevalent concern, followed by anxiety, suicidal ideation, and suicide attempts [43] . Studies examining the presenting concerns of gay and bisexual men seeking mental health treatment have similarly identified depression and anxiety as the most frequent issues, in addition to relationship problems and harm from substance and alcohol consumption [44] . Recent national cross-sectional research from the United States involving over 269,000 participants further reinforces these findings [45] . The study reported that cisgender sexual minority men experienced significantly higher rates of many commonly diagnosed mental health conditions, including depression, anxiety, bipolar disorder, and post-traumatic stress disorder, compared with cisgender heterosexual men [45] . They were also more likely to report multiple concurrent mental health problems [45] . Transgender men of any sexual orientation were found to have significantly higher prevalence of many mental health conditions compared to cisgender heterosexual men [45] .

GBT men also face a disproportionately higher risk of suicidality. Some studies suggest they are up to four times more likely to attempt suicide than heterosexual cisgender men [46] [47] [48] . These elevated risks have been linked to experience of homophobia, biphobia, transphobia, as well as broader social inequalities impacting sexual and gender minority communities [49] [50] [51] .

In 2018, UK LGBTQ+ charity Stonewall published findings from a national survey of 5,375 LGBT people across England, Scotland and Wales [51] . Among male respondents (50% of the sample), 54% of GBT men reported experiencing anxiety, with bisexual men showing the highest rates (56%) compared to gay men (53%). Depression affected 46% of GBT men, and 43% of bisexual men and 32% of gay men reported feeling that life was not worth living. Additionally, 12% of GBT men reported engaging in self-harm in the previous year and 9% reported experiencing eating disorders. While the report does not disaggregate findings specifically for transgender men, it indicates that transgender individuals overall reported worse mental health than all other groups, including significantly higher rates of self-harm and suicidality.

GBT men are also disproportionately impacted by alcohol and drug-related harm compared to heterosexual cisgender men. Research from several countries, including Australia, Canada, and the United States, indicates that rates of recreational substance

use for drugs such as cannabis, ecstasy, ketamine, and methamphetamine, are higher among GBT men than heterosexual cisgender men [52 53 54] . These elevated patterns of substance use are associated with increased levels of drug-related harm, including higher prevalence of substance use disorders [52 53 54] . Similarly, large scale national research from the United States shows significantly higher prevalence of alcohol use disorders among GBT men compared to heterosexual cisgender men [55] . The 2018 Stonewall report further highlights high-risk patterns of consumption among GBT men in the UK, with one in five GBT men (20%) reporting alcohol consumption every day over the previous year [51] .

The disproportionately high rates of poor mental health and drug and alcohol problems reported among GBT men, and LGBTQ+ individuals more broadly, compared to heterosexual cisgender individuals have been partly attributed to minority stress theory [56] . This indicates that LGBTQ+ individuals experience greater levels of social stigmatisation, discrimination, and violence due to their sexual orientation and/or gender identity. These stressful experiences contribute to chronic psychological distress and the internalisation of societal prejudices, including homophobia, biphobia, and transphobia. Research consistently supports minority stress theory as a key factor influencing the heightened prevalence of mental health conditions among LBGTQ+ individuals. Studies have shown that experiences of stigma are strongly associated with adverse mental health outcomes, including anxiety, depression, and increased rates of alcohol and substance use disorders [57 58 59 60 61] . Furthermore, these challenges are compounded by a lack of understanding among healthcare staff and mental health professionals regarding the treatment needs of LGBTQ+ individuals. Research indicates that many LGBTQ+ individuals encounter significant barriers when seeking mental health support due to inadequate staff understanding [51] .

Strengths-based approaches to improving men's mental health

Research emphasises the importance of adopting person-centred and culturally relevant therapeutic interventions to improve men's mental health, while avoiding one-size-fits-all models. While traditional gender norms can discourage men from seeking help for mental health difficulties, emerging qualitative research suggests that certain aspects of these norms may also be constructively reframed to promote men to take a more active role in managing their mental health. For example, some studies have shown that emphasising positive traits associated with traditional masculinity, such as perseverance, strong-discipline, and a strong work ethic, can support men in developing resilience and adaptive coping strategies for managing mental distress [62] . Rather than viewing mental health challenges as a sign of weakness, some men reinterpret these experiences as personal struggle that, once overcome, reinforce their sense of strength [63 64 65 66 67 68 69] .

Building on this, strengths-based approaches that integrate selected masculine norms into therapeutic contexts, rather than focusing solely on men's limitations in help-seeking and emotional wellbeing, may offer more culturally relevant and effective interventions for men [70] . For instance, framing emotional expression and help-seeking as a show of strength and bravery may reduce stigma and contribute to positive help-seeking behaviours among men [70] . Similarly, highlighting men's involvement in certain masculine roles, such as fathers and caregivers, can be a particularly powerful motivator for positive mental health engagement for men [71 72 73] .

Although these approaches show promise, further research is needed to fully understand what methods work best for different groups of men. Flexibility in therapeutic approaches is essential. While some men may respond well to approaches aligned with traditional masculine norms, such as goal-setting, structured problem-solving, and achievement-orientated strategies, others may benefit more from approaches that embrace vulnerability and encourage open emotional discussions about mental health [73] . This nuance is particularly important given that mental health risks are not evenly distributed among men. Those facing socioeconomic disadvantage, men from ethnic minority or culturally diverse communities, and men who identify as gay, bisexual, transgender, or queer often face increased risk of experiencing mental health challenges [74] [75] [76] [77] . Tailoring interventions to reflect these diverse needs is therefore critical for effective prevention and treatment.

Key Issues: Prevalence and Trends

This section outlines the prevalence, emerging trends, and gendered dimensions of several challenges affecting men's mental health in Scotland. While not an exhaustive account of all issues impacting men, it provides an overview of key areas of concern. It is also important to note that many of these issues affect individuals across genders, however, several demonstrate distinct patterns among men that may warrant specific consideration from a policy and service delivery perspective.

Suicide

The Gender Paradox

Gender plays a critical role in suicide, with global research consistently highlighting a 'gender paradox'. Women are more likely to report suicidal thoughts and attempt suicide [78] [79] . They are also more likely to engage in self-harm behaviours. Studies show that 21% of women aged 18-34 years have a lifetime history of non-suicidal self-harm, compared to 12% of men in the same age range [80] . Despite this, men account for the majority of suicide deaths worldwide and are significantly more likely to die by suicide [20] . Data from the most recent analysis of the global burden of disease reveals that men represent approximately 72% of all suicides worldwide, with an age-standardised rate of 13.9 deaths per 100,000, compared to 5.0 per 100,000 for women [81] . Suicide remains one of the leading causes of death among men under 50, with over half of all male suicides occurring before reaching this age.

Consistent with broader global trends, men in the UK and Republic of Ireland are significantly more likely to die by suicide than women, a pattern that has persisted for decades [82] . Men have accounted for three quarters of suicide deaths across all UK nations since the 1990s [82] . Suicide rates in the UK remained the highest among middle-aged individuals since the 1980s, with those aged 45-49 years identified as most risk among both men and women. However, the disparity is stark, with men in this age group facing a suicide rate three times higher than women, with 27 deaths per 100,000 compared to 9.2 per 100,000 for women [82] .

In Scotland, there were 792 probable suicide deaths recorded in 2023, an increase of 30 (4%) from the previous year [14] . Of these, 590 (74%) were male and 202 (26%) were female. That year, the suicide rate for men in Scotland was 3.2 times higher than for women. This disparity has persisted since records began in 1994, with male suicides consistently ranging from 2.6 to 3.6 times those of women. The highest number of suicide deaths occurred among people aged 25-44 and 45-64.

These trends suggest that suicidal ideation (experiencing persistent suicidal thoughts, fantasies, or contemplating suicide) may be markedly under-reported among men. They also highlight a concerning tendency where men are more likely to act on suicidal thoughts without seeking help or speaking about them. Relatedly, men are more likely to die by suicide without ever having been in contact with formal mental health services [83] .

Methods

Cross-national research consistently highlights significant gender differences in the methods of suicide used by men and women [84 85 86 87 88 89] . Men are more likely to choose violent and highly lethal methods, such as hanging and use of firearms, whereas women are more likely to use poisoning [87 88] . This pattern is an important factor in the gender gap in suicide deaths, as men's use of more violent methods increases the risk of fatality. Consequently, men's suicide attempts are more frequently classified as 'Serious Suicide Attempts' [86] .

Risk Factors

Research indicates that the factors contributing to elevated risks of suicide attempts and deaths by suicide also differ between men and women. Among women, specific risk factors for suicide attempts include eating disorders, post-traumatic stress disorder (PTSD), mood disorders such as depression and bipolar disorder, experiences of domestic violence, interpersonal difficulties, and a history of abortion [90] .

In contrast, suicide attempts among men have been linked to disruptive behaviour and conduct disorders, feelings of hopelessness, parental separation or divorce, having friends who exhibit suicidal behaviour, and access to means of suicide [89] . Male-specific risk factors for suicide death include drug use, externalising disorders, and access to lethal methods [89] .

Family and romantic relationships also play an important role in increasing or mitigating suicide risks for both sexes. Being single, experiencing relationship/marriage breakdown or death of a partner is associated with increased suicide risk among men [90] . Parenthood may also provide a protective effect against the risk of suicide in both men and women, although research indicates that this effect is more pronounced among women [90 91] .

Economic hardship, such as unemployment and low income, also increases suicide risks more substantially for men than for women [90 91] . Social inequality is a particularly potent driver, with men living in in the UK's most deprived communities facing a suicide risk up to 10 times higher than those in wealthier areas [92] . In Scotland specifically, suicide deaths are 2.4 times more common in the most deprived areas compared to the least deprived, a disparity that exceeds the general deprivation gap of 1.8 times seen across all causes of death in 2023 [14] .

Some risk factors are common for both sexes. For example, being hospitalised for psychiatric illness is the most marked risk factor for suicide for both men and women [90] . Other risk factors common for both sexes for suicide attempts include experience of bullying, childhood trauma, substance use problems, a family history of mental illness and substance use problems, and exposure to interpersonal or community violence [89 90] . Risk factors for both sexes specifically linked to suicide death include childhood mistreatment, negative life events, and a family history of suicidal behaviour [90] .

Self-harm

Existing research indicates that self-harm is a strong predictor of future suicidal behaviour [93 94 95] . Studies consistently report higher rates of self-harm among adolescent girls compared to boys [96] . However, some researchers have emphasised that boys and men may be less likely to disclose self-harming behaviours [97] . Furthermore, traditional measures of self-harm may overlook indirect risky behaviours that could constitute self-harm [98 99] , such as self-poisoning through excessive alcohol consumption or intentionally engaging in emotionally harmful situations. It is therefore possible that gendered patterns in self-harming behaviours may exist but are not fully captured by current prevalence studies [98] .

Research exploring the motivations behind self-harming behaviours indicate gender differences. Women and girls are more likely to engaging in self-harm for intrapersonal reasons- to cope with difficult emotions and mental states such as depression or to punish themselves [96 97 98] . By comparison, men and boys often report interpersonal motivations, including coping with external stressors like peer conflict and bullying, as well as grappling with feelings of a lack of control [96 97 98] . Some studies also suggest that self-harm may serve as a form of communication for some men who lack the skills to verbally express difficult emotions [100 101 102] .

Gendered Stigma around suicidal behaviour and self-harming

There is evidence that gendered stigma shapes how suicidal and self-harming behaviours are perceived across genders. Some research suggests that men's non-fatal suicide attempts and self-harm may be viewed as 'feminine' or weak, often interpreted as 'failed suicide' or cries for help, which are culturally associated with femininity [103 104] . In contrast, women and girls may experience more sympathy and understanding for similar behaviours [103 105] . Such stigma can extend into healthcare settings with implications for care and treatment outcomes. Some studies report that healthcare professionals can hold more negative attitudes towards male patients who engage in self-harm and suicidal behaviour, perceiving these actions as attention-seeking or manipulative [106 107 108] .

Stigma surrounding suicide and self-harm not only shapes public attitudes, but also influences how men perceive their own mental health, potentially affecting their likelihood to seek support for suicidal thoughts and self-harming behaviours. Research suggests that men are more likely than women to endorse negative and stigmatising beliefs about male depression and suicide [109 110] . This trend is particularly pronounced among young men, who show the highest levels of endorsement of public stigma towards male mental health struggles [111 112] . Additionally, men and boys have also demonstrated greater concern than women about how others might respond to suicidal thoughts, particularly fears of disapproval [105] . These findings highlight why men may be less likely to disclose self-harm, have fewer reported suicide attempts, and may be more inclined to opt for more lethal methods.

Loneliness and social isolation

Definitions

Loneliness and social isolation are related yet distinct experiences which can both negatively impact mental and physical health. Loneliness refers to the distress that arises when the quality or quantity of an individual's current interpersonal relationships do not fulfil their desire for meaningful social connection [113] [114] . This complex, multifaceted feeling can stem from limited integration into a cohesive social network (social loneliness) or from the subjective perception that an individual lacks emotionally intimate social relationships with others, irrespective of the number of social connections they have (emotional loneliness) [115] [116] [117] [111-113]. In contrast, social isolation is considered in relation to objective measures of social contact with others, including the size of an individual's social support network and the frequency of contact shared with them [118] [119] . However, prolonged social isolation can contribute to increased loneliness over time [118] .

Impact of loneliness and social isolation

Although occasional feelings of loneliness are a natural and often inevitable part of life, frequent or prolonged loneliness can shift from being a transitory experience to a chronic issue without timely support or intervention. This carries serious implications for both mental and physical health.

The severity of the health impact of chronic loneliness has been compared to smoking 15 cigarettes a day, emphasising its harmful impact on health [120] . Prolonged loneliness and social isolation have been linked to a wide range of adverse physical and mental health outcomes, including cardiovascular disease, depression, cancer, sleep problems, immune system deficiencies, and cognitive decline issues such as dementia [121] [122] [123] [124] [125] . Critically, studies indicate that chronic loneliness is associated with a 26% increased risk of mortality and premature death [126] . While both loneliness and social isolation contribute to elevated mortality risk, social isolation appears to be the stronger predictor, associated with a 29% increase in mortality risk [126] [127] .

Prevalence of loneliness and social isolation

Loneliness and social isolation present a significant public health challenge in the UK. According to the 2025 Opinions and Lifestyle Survey from the Office for National Statistics (ONS), 8% of people aged 16 and older across the UK reported feeling lonely "often or always", while 18% said they felt lonely "some of the time" [128] . The highest levels of reported loneliness were among those aged 16-29 years, followed by individuals aged 30 to 49. Similarly, findings from the Department for Culture, Media and Sport's Community Life Survey (2021/22) highlighted the scale of the issue, with 47% of adults aged 16 and older reported some experience of loneliness, and 10% of those aged 16-24 identifying as experiencing frequent or chronic loneliness [129] . Earlier research has estimated that between 15-30% of the population are impacted by chronic loneliness, while as many as

60-80% experience loneliness occasionally [126] .

In Scotland, self-reported data on loneliness is collected through the Scottish Household Survey. The most recent figures from 2022 show that nearly a quarter (23%) of adults reported feeling lonely in the last week, an increase from 21% in 2018, when loneliness data was first gathered by the survey [130] . Older adults reported the highest levels of loneliness, with 29% of those aged 75 and older reporting feeling lonely in the previous week. Socioeconomic deprivation was also an important contributing factor, with individuals living in the 20% most deprived areas twice as likely to report loneliness (30%) compared to those in the least deprived areas (16%). Disabled people were also disproportionately affected, with 40% reporting loneliness, more than double the rate among non-disabled individuals (17%). Finally, single pensioners, single adults, and single parents were also reported higher rates of loneliness than any other household type. As the survey does not collect data on sex or gender, it is not possible to compare reported loneliness between men and women within this dataset.

Gendered reporting of loneliness

Previous research consistently shows that women are more likely to report experiences of loneliness and report higher rates of loneliness than men [131] [132] . However, as with suicide, research that delves beyond prevalence data provides a more nuanced understanding of how gender interacts with experiences of loneliness.

The way loneliness is assessed can significantly impact observed gender differences in reported prevalence. Some studies suggest that male respondents may be less likely to disclose feelings of loneliness when asked directly, as is common in survey-based methods [132] [133] [134] . This under-reporting of loneliness among men has been linked to gendered social norms which create pressure for men to appear strong and avoid openly expressing emotions, aligning with the stereotype of the ‘strong, silent type’ [135] [136] . These norms contribute to greater stigma for men around discussions of mental health challenges, including feelings of loneliness, reducing the likelihood that men will report this [35] . However, relying on more indirect methods of assessment may introduce bias by relying on the assessor’s interpretation of loneliness, which may not align with how respondents themselves define or experience it [137] .

Loneliness ratings also vary considerably depending on the assessment tool used. For example, the De jong-Gierveld scale [138] , which emphasises social rather than emotional aspects of loneliness, has been shown to report higher loneliness among men, while other assessments like the University of California, Los Angeles (UCLA) scale [139] tend to find no significant differences between men and women [140] .

These findings highlight the importance of considering gender when interpreting loneliness data and identifying at-risk groups within the general population. In response to these complexities, some researchers advocate for the use of multiple assessment methods for loneliness rather than relying on a single measure.

Gendered patterns of loneliness and social isolation

Research examining loneliness and social isolation among men and women reveals complex patterns across the life course with critical implications for health and wellbeing. While women typically report higher rates of loneliness than men [128] [131], men face greater risk of social isolation, often reporting fewer sources of emotional support and less frequent contact with friends [141] . [131] This disparity begins in adolescence and continues to widen across the life course, becoming particularly pronounced for men who never marry or who have inconsistent relationships [142] .

Research suggests that men may be more prone to experiencing social loneliness, with their sense of loneliness more closely related to the quality and quantity of social interactions with friends. Factors such as the size of one's social network, feelings of social integration with peers, having emotional support from friends, and physical distance from friends and family appear to play a more significant role in determining loneliness among men than among women [143] [144] [145] . By contrast, some studies find that women may be more likely to report experiences of emotional loneliness, often associating it with internal emotional states such as feeling excluded, misunderstood, or disconnected from others [146] [147] [148] [149] .

Men are often more likely to depend on romantic partners as their primary source of emotional support and meaningful social interaction, with social networks tending to be smaller and more reliant on a spouse or partner [150] [151] [152] . This can place them at greater risk of experiencing loneliness when not in a relationship or following the breakdown of a romantic relationship. Numerous studies have documented notable differences in the prevalence of loneliness between single and married men, with marriage frequently acting as a buffer against loneliness [153] [154] [148] [147] [145] [155] . However, the protective effect of marriage appears to differ across genders, with married women reporting significantly higher levels of loneliness than married men and single women [147] .

Research indicates that employment also plays an important role in shaping men's experiences of loneliness and social isolation. Some studies have found that men may be more vulnerable to the psychological distress associated with job loss [156] and face heightened risks of social isolation following long-term unemployment [157] . It is suggested that this may be linked to traditional gender roles which position men as primary breadwinners and tie men's sense of masculine identity and self-esteem with career achievement, creating feelings of shame when they are unable to fulfil this role [158] [159] . At the same time, men may be less inclined than women to seek emotional support from friends during difficult periods of unemployment, further exacerbating their risk of social isolation [155] .

Fatherhood and mental health

Around 80% of men become fathers, yet research on the mental health impact of fatherhood remains relatively limited [160] [161] . Existing research does show that, much like new mothers, many fathers face significant challenges during the transition to parenthood. Up to 45% of fathers report experiencing postnatal stress and anxiety [160] , highlighting the

intensity and complexity of this period. However, many fathers report feeling invisible and unsupported during childbirth and the perinatal period [162] . Some fathers may question the legitimacy of their need for support and worry that seeking help for themselves would detract from the needs of their partners [163] . However, evidence suggests that supporting fathers to improve their mental health can have a positive impact upon the wellbeing of their partners and children [164] .

Paternal perinatal mental health

The perinatal period refers to the time from conception until the end of the first year following childbirth [165] . The challenges and stresses associated with becoming a new parent can trigger mental health difficulties, and the emotional and mental wellbeing of parents during the perinatal period has a significant and lasting impact on the entire family [166] . Critically, paternal mental health is directly linked to child developmental outcomes and mental health from infancy onwards [161] . Poor mental health among fathers has been shown to negatively impact children's social and emotional development, behavioural regulation, and the quality of early attachment relationships [167] [168] [169] [170] .

A 2024 evidence review commissioned by the Scottish Government on paternal perinatal mental health identified a broad range of psychological, social, and physiological factors contributing to poor mental health outcomes for fathers during the perinatal period [164] . These included stress associated with pregnancy and childbirth, lifestyle changes driven by increased responsibilities and financial pressures, and hormonal shifts linked to stress. Poor paternal health was also linked with emotional struggles while fathers adjusted to parenthood, including feelings of inadequacy and a reluctance to seek help often shaped by societal expectations surrounding masculinity and fatherhood, with gender norms positioning men primarily as providers intensifying pressures. Additionally, changes in relationship dynamics with partners, including experiences of intimate partner aggression, can further compound mental health challenges during this critical time.

A national survey conducted by the Fathers Network in 2023 captured the experiences of 1,054 Scottish fathers [160] . This revealed a strong desire among men to play an active role in parenting, with nearly half (49%) reporting spending 25 hours or more a week engaging in play or supporting their children's learning. Fathers from the most deprived areas of Scotland (SIMD 1) were the most likely report this level of involvement (64%), almost double the rate of fathers from the least deprived areas (SIMD 5), and a 17% increase from the previous year. Among the 89% of respondents who were currently employed, 25% reported being unhappy with the amount of quality time they could spend with their children, citing work commitments and a lack of support from employers to meet their childcare responsibilities. Fathers from the most deprived areas (SIMD 1) were particularly affected, with 45% feeling unsupported by their employers, often leading to feelings of guilt and regret as they struggled to balance work and family life.

The Father's Network survey also highlighted a concerning rise in poor mental health among fathers, with 11% reporting very poor mental health- twice the number recorded in 2022. Among those struggling with their mental health, 62% identified work pressures, financial concerns, and difficulty managing competing demands on their time as key contributors. Fathers with children under one year old and those from the most deprived areas reported the highest levels of poor mental health (25% and 27% respectively), while single fathers and those living apart from their children's other parent were also more likely

to report poor mental health. Most respondents struggling with mental health demonstrated limited awareness of available support services for fathers.

Paternal perinatal depression

Parents and parents-to-be can experience perinatal depression, a non-psychotic mood disorder that can develop both before and after childbirth. Perinatal depression can affect all new parents irrespective of gender, but persistent misconceptions often frame it as a condition exclusive to mothers. This overlooks the growing body of evidence showing that symptoms of perinatal depression experienced by fathers are no less severe or disruptive than those experienced by mothers [171] .

A recent systematic review found that prevalence of postnatal depression (symptoms occurring after childbirth) among new fathers ranged from 4 to 25% across studies, with symptoms most commonly emerging between three and six months after the child's birth [171] [172] [173] [174] [175] . This rate is notably higher than the general reported prevalence of depression among adult men (4.8%), highlighting both the significance of perinatal and postpartum (after the child's birth) depression as a public health concern for fathers [176] [177] .

The symptoms of perinatal depression can present differently in mothers and fathers [178] . While fathers may show fewer traditional signs of depression, they are more likely to experience elevated anxiety, irritability, hostility, or aggression. These emotional shifts can be accompanied by externalising behaviours, such as increased use of alcohol or other substances or engaging in risky behaviours as distraction or methods of coping [179] .

The strongest predictor for paternal perinatal depression is having a partner who is also experiencing depression [171] . Additional key risk factors include a prior history of depression, limited social support, unemployment, low educational attainment, poor relationship quality, and experiencing an unplanned pregnancy [180] [181] [182] . Fathers living in the most deprived areas and those on low incomes also face heightened risks of experiencing poor mental health during the transition to fatherhood [164] . Financial instability, insecure employment, and the pressure to fulfil provider roles can generate significant stress and strain during this period, increasing risks of poor mental health [164] . Like many men, fathers often rely on their partner as their primary source of emotional support, which can increase their vulnerability to mental health difficulties during the perinatal period, particularly if their partner is also struggling [164] . Fathers may also experience limited support from friends, especially those who are not fathers themselves, increasing feelings of isolation [164] .

Barriers to diagnosis, treatment, and support

Given the serious adverse effects of poor paternal perinatal mental health, not only on individual fathers, but also on children and partners, early identification and intervention are crucial to safeguard the wellbeing of the entire family.

One of the key barriers to identifying and treating poor paternal mental health arises from

the reluctance among many fathers to seek support [164] . Research suggests that fathers may be less likely to disclose mental health difficulties during pregnancy and the perinatal period, often due to societal expectations that they should be a source of emotional strength and provide financial stability for their families [183] [184] [185] [186] . Studies indicate that fathers frequently prioritise the needs and wellbeing of their partner and child during this time, perceiving their primary role as supportive for the mother [187] . As a result, many are unaware of available support for fathers or assume that it will not be offered [164] . Professional help is often only sought when symptoms become severe or when prompted by a partner [183] [188] .

Fathers who do seek support may encounter additional barriers to effective screening, diagnosis and treatment. The 2024 evidence review commissioned by the Scottish Government on paternal perinatal mental health highlighted a relative lack of attention in research, policy and service provision regarding the mental health impacts of fatherhood. Although health professionals are increasingly recognising the challenges faced by new fathers, a persistent lack of awareness and limited training regarding these issues means that fathers are still infrequently screened, diagnosed, and treated for perinatal mental health [189] [190] . Notably, despite perinatal depression often presenting differently between mothers and fathers, symptoms among men remain poorly understood by health professionals and many assessment tools rely on maternal symptom profiles [179] [191] . This diagnostic mismatch increases the risk that paternal perinatal depression may go undetected and under-diagnosed [183] .

Finally, there remains a lack of evidenced-based perinatal mental health services that specifically address the needs of fathers, alongside limited inclusion of fathers within existing support services [164] [161] [192] [193] [170] . Previous research indicates that the reluctance of fathers to seek support for poor mental health is exacerbated by perceptions that maternity services are designed primarily around mothers' wellbeing and are therefore not for them [162] . Father-focused support, including antenatal classes tailored to improving men's confidence around parenthood, remain limited [194] . Furthermore, many key clinical guidelines on treatment for perinatal mental health, including those produced by the National Institute of Clinical Excellence (NICE), continue to lack provision for fathers [195] .

Alcohol and drug-related harm

Alcohol/drug use and mental health

The link between alcohol and drug use and mental health difficulties is well established, with research consistently demonstrating a strong relationship between the two in both directions. Individuals experiencing poor mental health may turn to alcohol or substances as a way of coping with mental distress, while alcohol and substance use itself can in turn exacerbate and increase the risk of developing mental health problems [196] [197] . Data from national population surveys suggest that around half of individuals who experience mental illness across their lifetime will also develop a substance use disorder and vice versa [198] [199] . Similarly, it is estimated that more than half of individuals receiving alcohol treatment also require support for mental health difficulties [200] , although these figures are likely to

be underestimated [201] .

Gendered patterns of alcohol and drug use

Gender disparities in alcohol consumption are well documented globally. Men are more likely to drink than women, with 54% of men over the age of 15 reporting that they consume alcohol compared to 32% of women [202] . Men also tend to consume significantly more alcohol than women, with global estimates indicating an average intake of 19 litres of pure alcohol per year for men compared to 7 litres among women [202 203 204 205] . In addition to drinking larger volumes of alcohol, men also drink more frequently and are more likely to engage in high-risk drinking behaviours, such as heavy episodic drinking [206] .

Due to significantly higher levels of alcohol consumption and a greater tendency to engage in risky patterns of drinking, men experience a disproportionate burden of alcohol-related harm. Globally, men are nearly three times more likely to develop alcohol use disorders and twice as likely to be hospitalised for alcohol-related injuries or health complications caused by drinking. Critically, men also face a markedly higher risk of alcohol-attributable mortality, accounting for 7.7% of global deaths compared to 2.6% among women [207 208 209 73] .

A similar pattern is evident in drug-related harm, with men reporting frequent drug use at three times the rate of women (4.2% compared to 1.4%), experiencing higher prevalence of substance use disorders, and accounting for more than two-thirds of global drug-related deaths (0.4 million among men compared to 0.2 million among women) [209 73] . Historically, the majority of drug-related deaths have occurred among young men aged between the age of 15 and their early 30s [210] . However, more recent data indicates a shift in this trend, with the average age of those dying from drug use increasing over time and evidence indicating that drug-deaths among women have been rising [211] .

The Scottish context

In Scotland, harmful alcohol consumption and illicit drug use remain major public health concerns. Nearly one in ten adults in Scotland experience problems with alcohol and 22% of adults consume alcohol at levels that elevate their risk of serious health conditions, including breast cancer and other cancers, stroke, heart disease and type 2 diabetes [212 213] . In 2023, 1,277 alcohol-specific deaths were registered in Scotland, the highest total since 2008 [213 214] . This was also the highest rate of alcohol-specific deaths among all UK nations, with 22.6 per 100,000, compared to 18.5 in Northern Ireland, 17.7 in Wales, and 15.0 in England [213 214] .

Although drug-related deaths in Scotland have been declining since their peak in 2017, they were 4.2 times higher in 2023 than in 2000 [213] . In 2023, 1,172 drug-related deaths were registered, an increase of 12% (121 deaths) compared to 2022 [213] . Estimates from 2019/2020 indicate that approximately 47,100 people aged 15-64 in Scotland were living with opioid dependence. Recent evidence highlights shifting patterns of drug use, including

rising poly-drug use and the emergence of new lethally potent synthetic drugs that have been linked to the increased mortality rates observed [215] .

The wider global gendered patterns of consumption and associated harm are similarly reflected in Scotland. Two-thirds of alcohol-specific deaths in 2023 were among men. Men also accounted for twice as many alcohol-related hospital admissions and were twice as likely to report hazardous or harmful drinking (28% compared to 14% of women) [212] . Although the gender gap in drug deaths has narrowed over time, men continue to be disproportionately affected, with significant male deaths linked to the recent spikes in overall drug-related deaths. In 2023, 805 men died from drug use, an increase of 16% (113 deaths) from the previous year, compared to 367 women, whose deaths from drug use rose by 2% (8 deaths) [213] .

The impact of deprivation

Deaths caused by alcohol and drug consumption have been referred to by some researchers as “deaths of despair”, highlighting their strong links to socioeconomic deprivation [216] . The cumulative strain caused by unemployment, economic insecurity, breakdown in traditional support structures, and diminished opportunities for social mobility associated with deprivation significantly increases the risks for poor mental health and harmful coping behaviours [216] . Relatedly, drug-related deaths are 15 times higher among individuals living in the most deprived areas in Scotland, compared to those living in the least deprived areas [217] [218] .

Causes of gender differences in alcohol and drug harms

While a range of biological, social, and psychological factors likely contribute to the significant gender disparities in alcohol and drug consumption and related harms, culturally embedded gender norms have been identified as a particularly influential driver [203] . Research indicates that men are more likely to cope with mental distress through behaviours that may be detrimental to health, including alcohol and drug use [73] . For example, men experiencing depression are more likely to exhibit externalising symptoms, such as increased alcohol and/or drug use [73] . Heavy drinking and drug use may serve as a form of escapism, enabling some men to suppress or mask emotional distress, rather than openly addressing this, an approach that aligns with traditional masculine gender norms which discourage emotional vulnerability [219] [220] .

Alcohol consumption in particular is also deeply ingrained within men’s social experiences, particularly within male friendships. While traditional gender norms often discourage men from openly discussing emotions and being vulnerable, these behaviours can be perceived as more socially acceptable within the context of drinking [221] . In this way, alcohol and intoxication can temporarily foster feelings of closeness and bonding among male friends [221] . However, this dynamic can reinforce a cycle in which alcohol becomes central to maintaining male friendships, creating pressure on men to drink to access social connection. Men who choose not to drink can also experience feelings of social exclusion [222] , and this pattern contributes to the disproportionate alcohol-related harms experienced

by men. The relationship between alcohol consumption, masculinity, and male bonding friendships is further reinforced by extensive alcohol marketing across many leisure and sporting contexts, for example through alcohol brands frequently sponsoring major sporting events or creating high-profile partnerships with popular sports teams [223] .

Gambling-related harm

Gambling has been recognised as a significant public health problem by the World Health Organisation [224] . It is a relatively common activity that people engage in for fun, involving risking money or other valuable items on events of uncertain outcomes in the hope of winning an increased return. Common methods of gambling including betting, card games, slot machines, casino games, lotteries and bingo. Gambling is widely available and legally permitted in many countries across the world, with its increasing normalisation linked to commercial associations and strong promotions through sport and various cultural activities [224] . Over half the population across the UK participates in some form of gambling, with recent surveys indicating that approximately 48% of adults gambled in 2023 [225] .

Gambling and mental health

It is estimated that one in every 100 people meet the criteria for a gambling disorder [226] . Gambling disorders, also referred to as compulsive gambling, problem gambling, or gambling addiction, is characterised by a repeated pattern of gambling behaviour in which an individual feels unable to control their actions, continues to gamble regardless of negative consequences, and prioritises gambling over other interests and responsibilities [226] . This behaviour can be disruptive and damaging, not only to the individual but also to their family, causing intergenerational problems such as financial debt [225] . Problematic gambling can interfere with an individual’s everyday life and wellbeing, leading to financial hardship, strain in their relationships, creating difficulties at work, potentially resulting in unemployment [225 227 224] . In severe cases, it can increase risks of individuals becoming involved in criminal activity to fund their gambling behaviour [224 225] . It is important to note that gambling-related harm can still occur even when an individual does not meet the clinical thresholds for a gambling disorder. Individuals may experience significant harm due to gambling money needed for essential household spending, resulting in food insecurity, housing instability, and a range of broader social and health issues [224] .

Individuals experiencing problems with gambling are also at significantly increased risk of suicide [226 224 225] . Research shows that those who struggle to control their gambling behaviour are far more likely to experience suicidal thoughts, attempt suicide, and report feelings of hopelessness than those without gambling problems [228 229] . Some studies report that individuals with gambling problems were up to 15 times more likely to die by suicide compared to the general population [230] .

Gender and gambling-related harm

Research indicates that men are more likely to gamble than women and spend longer gambling when they do [225] [231] . Men are more likely to engage in multiple forms of gambling, including online gambling [225] [232] [233] [234] [235] . There are also differences in the way men and women gamble, with men more likely to prefer higher risk forms of gambling, such as sports betting, animal racing, and high-stakes games such as poker and blackjack [236] [237] , while women tend to prefer to gamble via bingo, lottery activities and slot machines [238] [239] [240] , although young men in the UK also demonstrate a preference for slot machines [241] .

Research consistently demonstrates that men are more likely than women to develop problems with gambling, both online and offline [242] [243] [244] [245] .Globally, approximately 11.9% of men and 5.5% of women worldwide experience some degree of harm from gambling [246] . Men are twice as likely as women to be classified as ‘moderate-risk’ gamblers and a greater proportion of men meet the diagnostic criteria for gambling disorders [225] . Men also account for the majority of calls to gambling support services [239] .

Research exploring the motivations behind men and women’s gambling suggests that men demonstrate more sensation-seeking and risk-taking behaviours, along with more impulsivity, including impulsive style of coping with distress (i.e. more likely to respond rashly when upset), all of which are linked with greater likelihood of gambling and gambling-related harm [247] [248] [249] . Additionally, women often report more feelings of shame when engaging in gambling, suggesting that gambling may be more normalised among men [247] .

Current Policy Approaches

This section provides an overview of the current policy approaches, including current Scottish Government strategies, related to the mental health issues highlighted in the previous section. It will then summarise some of the wider policy approaches elsewhere in the UK and international approaches too.

Scottish Policies and Strategies

Currently, Scotland does not have a dedicated strategy or policy that specifically addresses men's mental health. Instead, support for men tends to be included within broader mental health frameworks that focus on population-wide wellbeing or particular mental health issues, such as suicide prevention. This section highlights key Scottish Government strategies and policies that relate to the issues outlined in this briefing, alongside UK-wide and international policies which offer a more targeted focus on men's health.

Mental Health & Wellbeing Strategy

In June 2023, the Scottish Government published the Mental Health and Wellbeing Strategy [250] which sets out the following vision:

> " "…A Scotland, free from stigma and inequality, where everyone fulfils their right to achieve the best mental health and wellbeing possible." "

The accompanying delivery plan for 2023-2025 identifies 10 key priorities to achieve this vision. These include:

1. Tackle mental health stigma and discrimination where it exists and ensure people can talk about their mental health and wellbeing and access the person-centred support they require.

2. Improve population mental health and wellbeing, building resilience and enabling people to access the right information and advice in the right place for them and in a range of formats.

3. Increase mental health capacity within General Practice and primary care, universal services and community based mental health supports. Promote the whole system, whole person approach by helping partners to work together and removing barriers faced by people from marginalised groups when accessing services.

4. Expand and improve the support available to people in mental health distress and crisis, and those who care for them, through the national approach on Time, Space, Compassion.

5. Work across Scottish and Local Government and with partners to develop a collective approach to understanding and shared responsibility for promoting good mental health and addressing the causes of mental health inequalities, supporting groups who are particularly at risk.

6. Improve mental health and wellbeing support in a wide range of settings with reduced

waiting times and improved outcomes for people accessing all services, including Child and Adolescent Mental Health Services (CAMHS) and psychological therapies.

7. Ensure people receive the quality of care and treatment required for the time required, supporting care as close to home as possible and promoting independence and recovery.

8. Continue to improve support for those in the forensic mental health system.

9. Strengthen support and care pathways for people requiring neurodevelopmental support, working in partnership with health, social care, education, the third sector and other delivery partners. This will ensure those who need it receive the right care and support at the right time in a way that works for them.

10. Reduce the risk of poor mental health and wellbeing in adult life by promoting the importance of good relationships and trauma-informed approaches from the earliest years of life, taking account where relevant adverse childhood experiences. We will ensure help is available early on when there is a risk of poor mental health, and support the physical health and wellbeing of people with mental health conditions.

Creating Hope Together: Suicide Prevention Strategy 2022 to 2032

Scotland's Suicide Prevention Strategy [251] was published in 2022 and sets out the following vision:

> " "Our vision is to reduce the number of suicide deaths in Scotland, whilst tackling the inequalities which contribute to suicide. To achieve this, all sectors must come together in partnership, and we must support our communities so they become safe, compassionate, inclusive, and free of stigma. Our aim is for any child, young person or adult who has thoughts of taking their own life, or are affected by suicide, to get the help they need and feel a sense of hope." "

The strategy focuses on four key areas identified by people with lived experience and stakeholders as important priorities for suicide prevention. These include:

1. Building a whole of Government and Society approach to address the social determinants which have the greatest link to suicide- Focusing action on addressing the causes of suicide, such as poverty, debt, addictions, homelessness, trauma, and social isolation. Reducing access to means of suicide. Undertaking work to ensure sensitive media reporting.

2. Strengthening Scotland's awareness and responsiveness to suicide and people who are suicidal- Campaign work to address stigma and raise awareness. Build skills and knowledge of suicide across the whole population, target people working in sectors and settings who play a role in preventing suicide. Make resources and information on suicide prevention accessible.

3. Promoting and providing effective, timely, compassionate support that promotes wellbeing and recovery- Build understanding of effective support (for different groups and people) and translate into practice. Develop approaches on self-management,

psychosocial assessment, safety planning, responding to distress and crisis, enabling recovery, and postvention support (after a suicide attempt or bereavement). Support people to seek help, while ensuring compassionate responses are in place, including considering the use of digital means.

4. Embedding a coordinated, collaborative and integrative approach- Support innovation and scaling up through continuous improvement. Improve planning and delivery through improved data, evaluation, evidence, and learning opportunities within and across sectors. Ensure the voices of people with lived experience are central to all decisions and developments.

The strategy specifically acknowledges that men are disproportionately impacted by suicide, noting the significantly higher suicides among men compared to women. It highlights the need to address inequalities and commits to developing understanding of how different groups, including men, experience suicide risks differently. While the strategy does not outline any actions or programmes that specifically focus on men or men's experiences, it advocates for a whole-population approach in which interventions are tailored according to local needs and lived experience. The accompanying action plan published in September 2024 outlines several actions the Scottish Government would undertake to effectively deliver its suicide prevention strategy. While these do not specifically mention men, the plan identifies several priorities which would have a positive impact on men who are disproportionately impacted by these issues, including: supporting mentally healthy workplaces and identifying workforce sectors who may be at increased risk of suicide (e.g., health and social care, transport and construction) and continued work to address homelessness, and harms caused by drugs, alcohol, and gambling.

In February 2024, the Scottish Government provided an update to the Scottish Parliament regarding the implementation of the strategy [252] .This highlighted several actions the Scottish Government had taken since its publication, including the establishment of a National Suicide Prevention Advisory Group (NSPAG) to champion and drive suicide prevention work in Scotland. NSPAG provides independent guidance and advice on the strategy's progress and aims to provide better understanding of the inequalities and intersectional factors contributing to suicide. NSPAG comprises of experts from a range of sectors who are leading work on the social determinants of suicide and members representing groups who are at higher risk of suicide.

In August 2024, the Scottish Government published their first annual report outlining progress on the first year of delivery of Scotland's Suicide Prevention Strategy for the period of 2023-2024.

A Connected Scotland: Strategy for tackling social isolation and loneliness and building stronger social connections

In December 2018, the Scottish Government published its first national strategy to tackle social isolation and loneliness [253] . This set out the following vision:

> " "A Scotland where individuals and communities are more connected, and everyone has the opportunity to develop meaningful relationships regardless of age, stage, circumstances or identity.""

It identified four key priorities to achieve this vision:

1. Empower and communities and build shared ownership.
2. Promote positive attitudes and tackle stigma.
3. Create opportunities for people to connect.
4. Support an infrastructure that fosters connections.

In March 2023, the Scottish Government published Social isolation and loneliness: Recovering our Connections 2023 to 2026 [254] , which sets out the delivery plan to support the strategy. The strategy highlights the need to consider intersectionality on individual's experiences and risk of experiencing loneliness. Specifically, it states, "We need to recognise the effects of intersectionality – in other words, that our experiences are shaped by the different overlapping social categories that we all fall into, including our protected characteristics under the Equality Act 2010, such as sex, age, race, and disability; our socio-economic background; the place we live; or our employment status or occupation".

The strategy highlights several groups who may be at particularly high-risk for experiencing loneliness, including: young people aged 16-24; disabled people and those with existing mental health conditions; people on low-incomes and those living in areas of high deprivation; people living alone; and those who may have limited access to digital technologies, such as minority ethnic communities, parents with young children and young people, people on low income and individuals with long-term conditions.

Alcohol and Drugs Policy

Addressing the significant harms caused by alcohol and drugs is a key policy priority for the Scottish Government. Scotland's national strategy on alcohol and drugs emphasises prevention, reducing health inequalities, and promoting recovery. The Scottish Government's overall vision for addressing these issues was first outlined in Alcohol Framework 2018: Preventing Harm [255] and Rights, Respect and Recovery (2018) [256] . These set national prevention goals for alcohol and drug-related harm in Scotland and stated that individuals have a right to live a life free from alcohol and drug-related harms, to be treated with dignity, and to access community-based support tailored to their needs. Since then, the Scottish Government has undertaken a number of key policy actions to further these objectives, including:

- In 2019, the Scottish Government established the Drug Deaths Taskforce [257] to conduct a three-year investigation into the primary drivers of drug-related deaths in Scotland and provide evidence-based recommendations to reduce harm and save lives.
- The National Mission on Drug Deaths: In January 2021 the Scottish Government announced the Mission on Drug Deaths [258] , backed by significant financial investment of £250 million over five years (2021-2026). It aimed to reduce drug-related deaths and improve the lives of those impacted by drug use.
- In 2022, the Scottish Government published the accompanying National Mission on Drug Deaths Plan and established a National Mission Oversight Group to overview the mission on drug deaths and provide challenge and scrutiny.

- In 2023, the Drug Deaths Taskforce published the Drug Deaths Taskforce response: cross government approach ,which made 139 recommendations and outlined the need for a holistic approach to reduce drug and alcohol-related harm. It recommended integrating mental health, housing, justice, and employment policy. The Scottish Government also established the Clinical Advisory Group (CAG) to provide clinical expertise on the mission and policy guidance.

In 2025, the Scottish Government committed to continue its work to prevent and reduce health inequalities arising from alcohol and drug-related harm by:

- Implementing Medication Assisted Treatment (MAT) Standards, which mandate that individuals must be offered same-day access to treatment for a range of mental and physical health needs. These aim to ensure consistent, person-centred care across Scotland.
- Increasing access to residential rehabilitation by increasing capacity by 50% and increasing funding for rehabilitation placements each year by 2026.
- Launching a National Specification to raise awareness of available treatments across Scotland.
- Expanding early intervention initiatives for young people at risk of drug and alcohol-related harm, with a focus on reducing stigma, integrating accessible mental health support, and ensuring dedicated funding for specialist residential rehabilitation services tailored to the needs of families and perinatal women.
- Strengthening collaboration between Police Scotland and mental health services to ensure that individuals experiencing mental distress can access appropriate support.

The Scottish Government has also implemented several key pieces of legislation which aim to reduce alcohol-related harms through limiting the availability, affordability, and marketing of alcoholic products. These include:

- The Licensing (Scotland) Act 2005 is the primary legislation controlling the sale of alcohol in Scotland. It sets out a comprehensive framework aimed at promoting responsible alcohol consumption and reduce alcohol-related harm and prohibits the unlicensed sale of alcohol.
- The Alcohol (Scotland) Act 2010 established a ban on all multi-buy discounts on alcohol products.
- The Alcohol Minimum Pricing Scotland Act 2012 which created provision for a minimum price of 50p per unit of alcohol. The Alcohol (Minimum Price per Unit) (Scotland) Order 2018 then came into force in May 2018. In 2024, the minimum price was increased from 50p to 65p per unit of alcohol.

Gender Equality Policy

While the Scottish Government's gender equality policy focuses predominantly on addressing challenges experienced by women as a result of the disproportionate discrimination and inequality women face, it does highlight specific challenges that may be encountered by men with children. Specifically, it notes that men may not always be

recognised as active parents by family services and can experience challenges in workplace cultures that do not recognise their family or childcare responsibilities. To this end, the policy highlights specific areas of work to improve men's health and wellbeing across these areas, including:

- Supporting fathers to become more actively involved in the care of their children through the National Parenting Strategy .
- Establishing a Fathers National Advisory Panel.
- Supporting Fathers Network Scotland to deliver the national campaign 'Year of the Dad' [259] . This celebrated the difference a great father can make and the important role fathers play in child development.
- Funding Families Need Fathers . This organisation provides information and support for fathers and family members experiences contact problems after separation, works to improve understanding of existing legal rights, and promotes non-resident fathers' involvement in their children's education.

However, the policy does not address challenges experienced by men who are not fathers.

Perinatal Mental Health Policies and Strategies

National Parenting Strategy 2012

The National Parenting Strategy (2012) [260] outlined the Scottish Government's vision for more inclusive and supportive parenting in Scotland. This provided several commitments focused specifically on improving support and visibility of fathers and male carers in perinatal policies and services and addressing the lack of men employed in early years and children and families workforces. Examples included providing funding to organisations such as Men in Childcare, Families Need Fathers, in addition to targeted projects such as the Caring Dad's Programme through the Caledonian System.

In 2018, the Scottish Government announced a new £50,000 Men in Early Years Challenge Fund for pilot projects which aimed to increase the number of men enrolling on NC and HNC Childhood Practice courses in Scottish colleges.

Perinatal Mental Health Fund

In August 2020, the Scottish Government launched the Perinatal and Infant Mental Health Fund , an 18-month funding programme for third sector organisations supporting babies, parents, and carers who are affected by or at risk of perinatal mental health issues in Scotland. Through the Perinatal and Infant Mental Health Fund and Small Grants Fund, funding is provided for both father specific and whole family work, including funding for peer support groups for new fathers, which can provide a valuable source of support. A variety of information and advice is provided on Parent Club, including content specifically focused on the needs of new fathers.

In March 2023, the Scottish Government published an update on the expansion and

development of perinatal and infant services [261]. In relation to support for fathers, the Scottish Government advised:

- The NHS Greater Glasgow and Clyde Mother and Baby Unit (MBU) has been expanded. The update advises that the MBU also provides support for fathers and partners.
- The Maternity and Neonatal Psychological Interventions team have established links with the Fathers Network Scotland and Dad's Rock and received training from Fathers Network Scotland.

Scottish Government funding for community support

Communities Mental Health and Wellbeing Fund for Adults

Provides £81 million for the Communities Mental Health and Wellbeing Fund for Adults [262] This aims to address social isolation, loneliness and mental health inequalities made worse by the pandemic and the cost-of-living crisis by supporting local communities to address their mental health at an early stage. Since 2021, the fund has supported more than 4,700 local projects across Scotland, including projects related to men's mental health such as Scottish Men's Sheds.

The Changing Room: Extra Time

The Scottish Government provided £100,000 between 2024-2025 (shared with population health policy) to support The Changing Room: Extra Time [263] , an extension of the Scottish Association for Mental Health's (SAMH) The Changing Room project. This aims to promote men's mental health and wellbeing through football by providing opportunities for men to participate in activities, engage with others and explore specific areas which impact on their mental health. The project is run in partnership with the SPFL Trust and associated community trusts.

National Learning Network for Employers

The Scottish Government, in collaboration with See Me and Public Health Scotland, established a national learning network for employers across Scotland. Meeting quarterly, the network provides a platform to share practice and experiences around supporting mental health and wellbeing in the workplace. Previous meetings have explored themes such as supporting men's mental health and have included spotlight sessions and panel discussions with employers and mental health support organisations, such as Andy's Man Club. The most recent meeting on 30th January 2025 focused on suicide prevention, mental health and financial worries, discussing the high rates of male suicide as a key consideration within typically male-dominated workforces.

Mental Health and Financial Stress

- In partnership with Change Mental Health, the Scottish Government developed an advice pack for frontline workers who support individuals struggling with financial worries and poor mental health. The pack provides a range of advice and resources for support advisers.
- The Scottish Government also developed a Money and Mental Health Toolkit in collaboration with Change Mental Health and the Money and Pensions Service. This provides support for individuals to understand, manage, and improve their financial health and mental wellbeing.

Wider UK and international policy

Commitment to the UK's first Men's Health Strategy

Following the publication of the Women's Health Strategy in England in 2022, the Men's Health Forum, a UK-wide third sector organisation which supports men's health, highlighted the absence of an equivalent strategy addressing men's health. It called for the development of the first dedicated national Men's Health Strategy.

In response, the UK Health and Social Care Secretary Wes Streeting announced plans for the UK's first men's health strategy at a Men's Health Summit held in partnership with men's health charity Movember and the Premier League. The strategy will aim to address major health challenges disproportionately affecting men, cardiovascular disease, prostate cancer and testicular cancer, as well as a focus on improving men's mental health and preventing suicide. It is expected to form a key part of the UK Government's 10-year Health Plan to improve and sustain the NHS. To inform the development of the Men's Health Strategy, the UK government launched a 12-week call for evidence [264] in April 2025, inviting contributions from members of the public, social care professionals, academic researchers, healthcare experts, and employers to identify the most pressing issues and effective interventions for men's health in England.

Make Work Pay: Employment Rights Bill

On 1st July 2025, the UK Government launched a call for evidence to gather views on proposed reforms to the parental leave system, as part of the wider Make Work Pay: Employment Rights Bill. The proposed Bill plans to make paternity leave a statutory 'day one' right, removing the qualifying period. It also proposes to allow paternity leave and pay to be taken after shared parental leave and pay, offering greater flexibility in how families structure their leave to promote co-parenting.

World Health Organisation Strategy on Men's Health and Wellbeing

The WHO European policy framework for health and wellbeing, Health 2020, identified

improving health for all, reducing health inequalities and promoting gender equality as key priorities for all Member states in the WHO European Region. In line with these goals, the WHO Office for Europe published its *Strategy on Women's Health and Wellbeing* in 2016 [265] , followed by the *Strategy on Men's Health and Wellbeing* in 2018 [266] . The men's health strategy and accompanying report provided an epidemiological overview of men's health across the region, an analysis of the gendered, social, economic, cultural, and environmental determinants impacting men's health outcomes. The strategy and report identified the following recommendations for achieving the goal of gender equality and improving men's health and wellbeing:

1. Acknowledging that improving the health and well-being of men and contributing to gender equality are complementary objectives.
2. Developing policies and actions that focus on the promotion and protection of men's health alongside that of women, and breaking down barriers between different programmes instead of reinforcing them.
3. Strengthening intersectoral mechanisms between the health and education sectors to eliminate gender stereotypes that are harmful to health at all levels of education.
4. Promoting and facilitating participation of men to take transformative action to improve their own health and the health of communities through collaboration with civil society and the use of places and settings where boys and men can be reached.
5. Ensuring that measures for health equity specifically consider that gender norms and roles may exacerbate social exclusion, particularly in relation to men who are unemployed, homeless, prisoners, veterans, migrants, of a different ethnic origin from the majority, gay, bisexual, transgender and/or intersex, or who are living with mental illness or disability.
6. Engaging men in gender equality through learning from positive experiences, transforming patterns of care (including self-care, parenting, care of family and unpaid care), and acting to prevent gender-based violence and improve sexual and reproductive health.
7. Strengthening gender-responsive health systems that ensure a model of care that makes health services more accessible for boys and men, and which recognize their health needs and health-seeking patterns and address the impact of masculinities on health across the life-course.
8. Promoting inclusive services and eliminating discriminatory practices, particularly in relation to men who experience social exclusion and marginalization because of their age, ethnicity, sexual orientation, gender identity, homelessness, disability or mental health conditions.
9. Developing health promotion initiatives that focus on positive images of boys and men, eliminate the use of gender stereotypes, use important life transitions such as adolescence, fatherhood and retirement, and promote more equitable gender roles and relationships.
10. Prioritising interventions to reduce the disproportionate exposure of boys and men to alcohol and tobacco use, substance abuse, road-traffic injuries and suicide.

International policies

In 2008, Ireland launched the world's first national men's health policy and action plan (2008-2013) [267] . This adopted a 'gender-mainstreaming' approach, which "recognises

that gender equality is best achieved through the integration of health concerns of men and women in the development, implementation and evaluation of policies, both within and beyond health". It embraced a holistic and comprehensive framework, engaging both government agencies and community-based organisations to address the social determinants underlying many men's health challenges. Additionally, the policy was grounded in a strengths-based perspective of men's health, emphasising the importance of recognising and building upon men's existing strengths. It advocated for the involvement of men as active agents and advocates for their own health, rather than dependence on the healthcare system. It outlined six broad key priorities for policy, including:

1. Strengthening public policy around men's health
2. Developing promotional and marketing strategies and programmes for men's health that both challenge and support traditional notions of masculinity
3. Developing strategies to promote gender competency in the delivery of health and social services
4. Building gender-competent health services with a focus on preventative health
5. Developing supportive environments for men's health: This priority highlights the need for targeted health policy initiatives that create supportive environments across key life domains, including promoting the home as a setting for men's health by elevating fatherhood in both policy and service frameworks (e.g., implementing father-inclusive approaches and creating structures that enable men to participate as more active fathers); introducing a visible and integrated focus on boys' and men's health within primary and post-primary school curricula to foster early awareness and long-term wellbeing; promoting men's health in the workplace by recognising the gendered nature of occupational health and safety and addressing unemployment, lack of job security, and involuntary early retirement; and addressing the lack of recreational facilities and safe social spaces for young people.
6. Community development and strengthening community action to support men's health

Reviews evaluating the impact of Ireland's men's health policy concluded that it had made a meaningful and substantial contribution to improving men's health across Ireland. However, multiple reviews noted that the policy's broad and ambitious scope posed implementation challenges which would require additional time for services to fully adapt to the policy's innovative approaches [268] [269] . In 2024, Ireland launched its third National Men's Health Action Plan (2024-2028), building on the foundations established in its first and second strategies.

Since then, several countries across the world have developed dedicated men's health policies, including Australia, Brazil, Malaysia, South Africa, and Mongolia, though the focus and scope of these policies vary considerably. For example, in 2009 the Brazilian Government launched the National Policy for Comprehensive Men's Health Care (PNAISH) [270] , the first policy of its kind in South America. The primary focus of PNAISH was to address gendered health inequalities, particularly men's low engagement with preventative and primary healthcare services. It focused on men aged 20-59 years and sought to improve access to care, raise awareness and promote responsible health behaviours [271] . PNAISH has been credited with increasing visibility of men's health issues and contributing to a modest rise in male attendance at primary care services [272] [273] .

However, critiques have placed disproportionate emphasis on individual responsibility in determining health outcomes, while under-addressing broader intersectional, social, and structural determinants of health in addition to concerns about limited investment in implementation and evaluation mechanisms [273] [269] .

Australia's National Male Health Policy [274] , published in 2010, adopted a comprehensive social determinants of health framework, aligning with the approach taken by Ireland's 2008 national strategy. A key strength was its targeted focus on several priority population groups, including men living in rural and remote areas; Aboriginal and Torres Strait Islander men; those from socioeconomically disadvantaged backgrounds; disabled men and those experiencing poor mental health; men from migrant and asylum seeker backgrounds and their children; gay, bisexual, transgender, and queer men; male veterans; socially isolated men; and men involved in the criminal justice system [269] . The policy also outlined support for longitudinal research on men's health and promoted the development of community-based initiatives such as Men's Sheds. In 2019, the policy was updated and reissued as the Australian National Men's Health Strategy (2020-2030) [275] , which places greater emphasis on developing a gender-responsive health system. This includes tailoring the design, delivery, promotion, and improvement of health services to better reflect the specific needs and preferences of different groups of men.

In Mongolia, a national men's health strategy [276] was approved in 2014 by the Minister of Heath and Sports of Mongolia in response to a widening gender gap in life expectancy. The policy aims to reduce premature male mortality by promoting preventive screening and addressing risk behaviours, such as smoking, alcohol consumption, and low health service attendance.

Iran's national men's health policy [277] , formalised in 2016, aims to address the growing burden of non-communicable diseases (NCDs) among men, including cardiovascular disease, diabetes, and mental health challenges, through gender-sensitive approaches to health service delivery.

Malaysia's National Men's Health Plan of Action (2018-2023) [278] adopts a life-course approach, emphasising men's roles as fathers and spouses and aims to improve access to care through the development of 'male-friendly' services . It also prioritises targeted interventions for high-risk behaviours among men.

Community Interventions for Men's Mental Health

While there is currently limited direct policy focus on men's mental health in Scotland, a range of community-led interventions and third sector initiatives have emerged to raise awareness and support men experiencing poor mental health. The following section provides an overview of several key organisations operating within Scotland that are actively working to address these issues. While not exhaustive, the organisations highlighted reflect the diversity of community-led engagement and preventative interventions across Scotland. These grassroots efforts offer valuable insights into how local action is supporting men's mental health and wellbeing.

Scottish Men's Sheds Association

The Scottish Men's Sheds Association (SMSA) is a charity which aims to create a grassroots male wellbeing movement, reduce loneliness, and prevent suicide among men. It supports this by providing informal, safe community spaces for men to engage with one another in meaningful ways and foster a sense of connection and purpose. SMSA offers opportunities for men to become socially integrated within local communities and take part in 'masculine engagement' and communication through a diverse range of 'shoulder to shoulder' activities, such as woodworking, metalwork, crafting, gardening, and more. SMSA aims to empower men to be actively involved in running the charity, which they advise is run by men and for men.

The concept of Men's Sheds began in Australia in 1999, emerging as a grassroots response to the impact of de-industrialisation and the rising number of men experiencing isolation and social exclusion due to unemployment. Men's Sheds has since grown into a global movement with branches operating internationally [279] . In Scotland, the development, scaling, and sustainability of the movement is facilitated by the sole SMSA central hub and there are currently 135 operational Scottish Men's Sheds, with a further 65 in development. Altogether, these spaces support 10,267 men across the country.

The mental and physical health benefits of participating in Men's Sheds have been well documented in existing research. Involvement in Men's Sheds has been linked to improved mental health and wellbeing, reduced social isolation, and reduced depressive symptoms, with participants reporting a renewed sense of purpose [280] [281] . Crucially, Men's Sheds have proven particularly effective in engaging 'hard to reach' men who might otherwise avoid formal healthcare and support services [282] [283] [284] . One extensive evaluation which examined Men's Shed's projects across multiple European countries found that these initiatives not only enhanced men's self-esteem, but also helped men to develop skills that could reduce unemployment and increase productivity [285] . The evaluation also evidenced the potential of Men's Sheds to reduce public expenditure on mental and physical health services as well as on welfare support.

Andy's Man Club

Andy's Man Club is a UK-based charity dedicated to preventing male suicide. Since its establishment in 2016, it has provided free community spaces for men aged 18 and over to take part in peer-to-peer support groups, held both in-person and online. These groups offer a safe and informal setting where men can talk openly about their mental health, emotions, and wellbeing. Today the charity runs groups in over 270 locations across the UK, with more than 5,800 men attending weekly sessions and over 2,500 volunteers as of July 2025 (Andy's Man Club). Its national public campaign #ItsOkayToTalk aims to challenge stigma surrounding men's mental health and suicide and is regularly featured in public spaces across the UK.

Movember

Movember is a global men's health charity and advocacy movement that was founded in Australia 2003. It is widely known for its annual public campaign which encourages men to grow moustaches during the month of November to raise awareness for men's health issues, including testicular and prostate cancer and male suicide. Alongside this flagship initiative, the charity has run a number of targeted health promotion efforts. These include *The Mental Game*, a campaign designed to shift Canadian men's attitudes towards self-care and mental health; *Like a Man*, a Movember-funded documentary exploring male suicide in New Zealand; and *Dads in Progress*, a podcast series supporting new fathers in managing their mental health.

To date, Movember has funded over 1,320 men's health projects worldwide and established the Movember Institute of Men's Health, a research initiative that fosters collaboration between leading experts to research key challenges to men's mental and physical health.

In the UK, Movember funds several mental health and suicide prevention initiatives through local partnerships. Examples include:

- The Social Innovators Challenge : which funds creative programmes which promote men's social connections, particularly those at risk of loneliness and isolation.
- The Changing Room : A collaboration between the Scottish Professional Football League Trust and Hibernian Football Club which aims to engage men and promote good mental health.
- Brothers Through Boxing : A boxercise fitness programme for men aged 16-25 which aims to promote male friendships and break male stereotypes through peer-led discussions and fitness.
- Ahead of the Game : An evidence-based mental health programme for adolescents delivered in partnership with community sports clubs, aimed at athletes, coaches, and parents to build mental health literacy.
- Ex-Cell 50+: A programme aimed at helping older male ex-offenders to build social connections through mutual aid.

Men Matter Scotland

Men Matter Scotland is a peer-support-based men's mental health charity offering weekly groups and activities that create space for men to connect and speak openly in a welcoming, confidential environment. Their schedule includes psychoeducational sessions and a holistic health focus, including sessions focused on breathing meditation practices and PTSD and trauma-awareness sessions. As of 2025, the organisation recorded 700 members, with around 150 attending their Glasgow-based hub each week.

Brothers in Arms

Brothers in Arms Scotland is a men's mental health charity and online platform based in Scotland that supports men's emotional wellbeing through funding research, innovative initiatives, and tailored digital interventions. Its confidential online platform is designed to engage and support men in managing their mental health. The charity has also partnered with the Scottish Violence Reduction Unit (SVRU) and local Glasgow barbershop Rebel Rebel to deliver the *Shearing Stigmas* project, a community initiative that trains barbers to engage male clients in discussions about mental health. This approach has since been adopted by Glasgow Clyde College, which now includes the workshops in its hairstyling courses. Additionally, Brothers in Arms was also instrumental in developing a new SCQF Level 5 accredited course, *'Introduction to Conversations for Male Mental Health'* [286] , which is set to be rolled out across selected Scottish colleges.

Street Soccer Scotland

Street Soccer Scotland is a charity that uses football as a tool to support people affected by social exclusion and socioeconomic disadvantage. It offers free, inclusive, and trauma-informed football sessions open to individuals of all ages and backgrounds, with the aim of building communities of support through sport. Football serves as an 'engagement hook' to connect participants with a range of tailored support services. These include education, housing assistance, employment support, poverty relief and food provision, specialist mental health and emotional support, food provision, and signposting to relevant external organisations. In addition, the charity runs personal development programmes in prisons across Scotland, working directly with men preparing for release. The initiative works directly to engage men at risk, including those with experience of homelessness, alcohol and substance use challenges, or involvement with the criminal justice system.

Dads Rock

Dads Rock is a Scottish charity dedicated to supporting new fathers and fathers-to-be. It offers free workshops, playgroups, and one-to-one support to designed to help men feel confident, resilient, and well supported during the transition to parenthood and beyond. Through community walks and family-focused events, the organisation fosters opportunities for fathers to build friendships and social networks. In addition to practical toolkits and antenatal workshops, Dads Rock helps fathers explore creative ways to bond

with their children and build nurturing, stable environments for their families. Notably, it runs Scotland's only peer-support service for fathers in the perinatal period (from pre-birth to one year postpartum), pairing new fathers with trained volunteers who are also parents, offering a relatable and empathetic form of support.

Fathers Network Scotland

Established in 2008, Fathers Network Scotland is a charity dedicated to improving children's wellbeing by promoting the positive involvement of fathers, father-figures, and families as a whole. The organisation provides support, information, resources, and signposting for fathers and families and delivers training to professionals and organisations regarding father-inclusive practice. It also advocates for improvements in workplace policy and culture, and conducts research into the needs and experiences of fathers, families, and the services that support them. In 2016, Fathers Network Scotland led the Scottish Government sponsored campaign 'Year of the Dad' . This raised awareness of the vital role fathers play in children's development, highlighted the organisational benefits of supporting men to fulfil family roles, and encouraged the adoption of father-friendly practices across organisations and services.

Bibliography

1 World Health Organization . (2022). Mental health. Retrieved from https://www.who.int/data/gho/data/themes/theme-details/GHO/mental-health

2 Gondek, D., Ploubidis, G.B., Nasim, B., & Goodman, A. (2018). The impact of health on economic and social outcomes in the United Kingdom: A scoping literature review. *PLOS ONE*, *13*(12). doi: https://doi.org/10.1371/journal.pone.0209659.

3 Doherty, A.M., & Gaughran, . (2014). The interface of physical and mental health.. *Social Psychiatry and Psychiatric Epidemiology*, *49*(5). doi: https://doi.org/10.1007/s00127-014-0847-7.

4 Pettitt, B., Greenhead, S., Khalifeh, H., Drennan, V., Hart, T., Hogg, J., … Borschmann, R. (2014). At risk, yet dismissed: The criminal victimisation of people with mental health problems . *https://www.mind.org.uk/media-a/4121/at-risk-yet-dismissed-report.pdf*.

5 de Mooij, L.D., Kikkert, M., Lommerse, N.M., Peen, J., & Meijwaard, S.C. (2015). Victimisation in adults with severe mental illness: Prevalence and risk factors.. *British Journal of Psychiatry*, *207*(6). doi: https://doi.org/10.1192/bjp.bp.113.143370.

6 Chang, C., Hayes, K., Perera, G., Broadbent, M.T.M., Fernandes, A.C., Lee, W.E., … Stewart, R. (2011). Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Care Case Register in London. . *PLoS ONE*, *6*(5). doi: https://doi.org/10.1371/journal.pone.0019590.

7 Mental Health Taskforce. (2016). The Five Year Forward View for Mental Health. . Retrieved from https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

8 Tunnard, J. (2004). Parental mental health problems: Messages from research, policy and practice. . *Research Review: Research in Practice*, *7*. doi: https://sid.usal.es/idocs/F8/FDO19144/mentalhealth.pdf

9 Maybery, D., Ling, L., Szakacs, E., & Reupert, A. (2005). Children of a parent with a mental illness: perspectives on need. . *Australian e-Journal for the Advancement of Mental Health*, *4*(2). doi: https://doi.org/10.5172/jamh.4.2.78.

10 Mental Health Foundation. (2022). Mental health problems cost the Scottish economy at least £8.8 billion a year – new research. Retrieved from https://www.mentalhealth.org.uk/about-us/news/mental-health-problems-cost-scottish-economy-least-gbp-88-billion-year-new-research

11 Scottish Government. (2024). Scottish Health Survey 2023 – Volume 1: Main Report.. Retrieved from https://www.gov.scot/publications/scottish-health-survey-2023-volume-1-main-report/pages/7/

12 National Records of Scotland. (2024). Scotland's Census 2022 – Health, disability and unpaid care. . Retrieved from https://www.scotlandscensus.gov.uk/2022-reports/scotland-s-census-2022-health-disability-and-unpaid-care/#section3

13 Kirk-Wade, E. (2025). Suicide statistics. House of Commons Library Research Briefing CBP-7749. Retrieved from https://researchbriefings.files.parliament.uk/documents/CBP-7749/CBP-7749.pdf.

14 National Records of Scotland. (2024). Increase in deaths by suicide. . Retrieved from https://www.nrscotland.gov.uk/latest-news/increase-in-deaths-by-suicide/

15 Office for National Statistics (ONS). (2024). Suicides in England and Wales: 2023 registrations. . Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2023

16 Northern Ireland Statistics and Research Agency (NISRA). (2025). Northern Ireland suicide statistics, 2023. . Retrieved from https://www.nisra.gov.uk/news/northern-ireland-suicide-statistics-2023

17 Seedat, S., Scott, K.M., Angermeyer, M.C., Berglund, P., Bromet, E.J., Brugha, T.S., … Kessler, R.C. (2009). Cross-national associations between gender and mental disorders in the WHO World Mental Health Surveys . *Archives of General Psychiatry*, *66*(7). doi: https://doi.org/10.1001/archgenpsychiatry.2009.36

18 Boyd, A., Van de Velde, S., Vilagut, G., de Graaf, R., O'Neill, S., Florescu, S., … Kovess-Masfety, V. (2015). Gender differences in mental disorders and suicidality in Europe: Results from a large cross-sectional population-based study. . *Journal of Affective Disorders*, *173*. doi: https://doi.org/10.1016/j.jad.2014.11.002

19 World Health Organization. (2002). Gender and mental health. Retrieved from https://iris.who.int/handle/10665/68884

20 World Health Organization. (2025). Suicide. Retrieved from https://www.who.int/news-room/fact-sheets/detail/suicide

21 Pearse, R., & Connell, R. (2015). Gender Norms and the Economy: Insights from Social Research.. *Feminist Economics*, *20*(1). doi: https://doi.org/10.1080/13545701.2015.1078485.

22 Connell, R., & Messerschmidt, J. (2005). Hegemonic Masculinity: Rethinking the Concept. . *Gender & Society*, *19*(6). doi: https://journals.sagepub.com/doi/10.1177/0891243205278639

23 Connell, R. (1995). Masculinities. *Cambridge: Polity Press*.

24 Pleck, J.H. (1995). The Gender Role Strain Paradigm. *In Levant & Pollack (eds.), A New Psychology of Men*.

25 Courtenay, W.H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science & Medicine*, *50*(10). doi: https://pubmed.ncbi.nlm.nih.gov/10741575/

26 Oliffe, J.L., Ogrodniczuk, J.S., Gordon, S.J., Creighton, J., Kelly, M.T., Black, N., … Mackenzie, C. (2016). Stigma in Male Depression and Suicide: A Canadian Sex Comparison Study. *Community Mental Health Journal*, *52*(3). doi: https://doi.org/10.1007/s10597-015-9986-x

27 Livingston, J.D., & Boyd, J.E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine*, *71*(12). doi: https://www.sciencedirect.com/science/article/abs/pii/S0277953610006945

28 Johnson, J.L., Oliffe, J.L., Kelly, M.T., Galdas, P., & Ogrodniczuk, J.S. (2011). Men's discourses of help-seeking in the context of depression. *Sociology of Health & Illness*, *34*(3). doi: https://doi.org/10.1111/j.1467-9566.2011.01372.x

29 Mokhwelepa, L.W., & Sumbane, G.O. (2025). Men's mental health matters: The impact of traditional masculinity norms on men's willingness to seek mental health support; a systematic review of literature. . *American Journal of Men's Health*. doi: https://doi.org/10.1177/15579883251321670

30 Staiger, T., Stiawa, M., Mueller-Stierlin, A.S., Kilian, R., Beschoner, P., & Krumm, S. (2020). Masculinity and Help-Seeking Among Men With Depression: A Qualitative Study.. *Frontiers in Psychiatry*, *11*(11). doi: doi:https://doi.org/10.3389/fpsyt.2020.599039

31 Emslie, C., Ridge, D., Ziebland, S., & Hunt, K. (2006). Men's accounts of depression: Reconstructing or resisting hegemonic masculinity?. *Social Science & Medicine*, *62*(9). doi: https://pubmed.ncbi.nlm.nih.gov/16289741/

32 Barragan, J. (2024). Beyond 'Manning Up': The impact of hegemonic masculinity & gender norms on mental health help-seeking among college men. . *Master's thesis. San José State University.* . doi: https://doi.org/10.31979/etd.5vfn-3dca

33 Clary, K.L., Pena, S., & Smith, D.C. (2021). Masculinity and stigma among emerging adult military members and veterans: implications for encouraging help-seeking. *Current Psychology,*, *42*. doi: https://doi.org/10.1007/s12144-021-01768-7

34 Mostoller, A.M., & Mickelson, K.D. (2024). Masculinity and Mental Well-Being: The Role of Stigma Attached to Help-Seeking Among Men. *Sex Roles*, *90*(3). doi: https://doi.org/10.1007/s11199-024-01457-2

35 O'Brien, R., Hunt, K., & Hart, G. (2005). 'It's caveman stuff, but that is to a certain extent how guys still operate': Men's accounts of masculinity and help-seeking. *Social Science & Medicine*, *61*(3). doi: https://doi.org/10.1016/j.socscimed.2004.12.008

36 Vogel, D.L., & Heath, P.J. (2016). Men, masculinities, and help-seeking patterns. *In Y.J. Wong & S.R. Wester, eds. APA handbook of men and masculinities. Washington, DC: American Psychological Association*. doi: https://doi.org/10.1037/14594-031

37 Courtenay, W.H. (2010). Dying to be Men: Psychosocial, Environmental, and Biobehavioral Directions in Promoting the Health of Men and Boys. *Routledge*.

38 Seidler, Z.E., Dawes, A.J., Rice, S.M., Oliffe, J.L., & Dhillon, H.M. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. . *Clinical Psychology Review*, *49*. doi: https://doi.org/10.1016/j.cpr.2016.09.002

39 Global Mental Health Action Network. (2024). Need2Know – Men, mental health and non-communicable diseases. Retrieved from https://gmhan.org/news/need2know-mens-mental-health

40 World Health Organization. (2024). Noncommunicable diseases. Retrieved from https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases

41 Lyons, A.C., Kersey, K., Emslie, C., Dimova, E., & Burrows, A. (2024). Digital alcohol marketing and gender: A narrative synthesis. *Drug and Alcohol Review*, *43*(6). doi: https://doi.org/10.1111/dar.13849

42 World Health Organization. (2024). Gender-responsive approaches to the acceptability, availability and affordability of alcohol. Snapshot series on alcohol policies and practice: Brief 11. Retrieved from https://www.who.int/publications/i/item/9789240090125

43 Khouadja, S., Zaouali, F., El Echi, M., Najjar, C., & Zarrouk, L. (2022). Mental disorders among sexual and gender minorities. *European Psychiatry*, *65*(1). doi: doi:https://doi.org/10.1192/j.eurpsy.2022.2286.

44 Berg, M.B., Mimiaga, M.J., & Safren, S.A. (2008). Mental health concerns of gay and bisexual men seeking mental health services. *Journal of homosexuality*, *54*(3). doi: https://doi.org/10.1080/00918360801982215.

45 Lu, J.A., Soltani, S., Austin, S.B., Rehkopf, D.H., Lunn, M.R., & Langston, M.E. (2025). Mental Health Disparities by Sexual Orientation and Gender Identity in the All of Us Research Program. *JAMA Network Open*, *8*(1). doi: https://doi.org/10.1001/jamanetworkopen.2024.56264.

46 Hottes, T.S., Bogaert, L., Rhodes, A.E., Brennan, D.J., & Gesink, D. (2016). Lifetime Prevalence of Suicide Attempts Among Sexual Minority Adults by Study Sampling Strategies: A Systematic Review and Meta-Analysis. *American Journal of Public Health*, *106*(5). doi: https://doi.org/10.2105/ajph.2016.303088.

47 Ferlatte, O., Dulai, J., Hottes, T.S., Trussler, T., & Marchand, R. (2015). Suicide related ideation and behavior among Canadian gay and bisexual men: a syndemic analysis. *BMC Public Health*, *15*(1). doi: https://doi.org/10.1186/s12889-015-1961-5.

48 Haas, A.P., Eliason, M., Mays, V.M., Mathy, R.M., Cochran, S.D., & Brown, G.K. (2010). Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations. *Journal of Homosexuality*, *58*(1). doi: https://doi.org/10.1080/00918369.2011.534038.

49 Hottes, T.S., Ferlatte, O., & Gesink, D. (2016). Suicide and HIV as leading causes of death among gay and bisexual men: a comparison of estimated mortality and published research. *Critical Public Health*, *25*(5). doi: https://doi.org/10.1080/09581596.2014.946887.

50 King, M., Semlyen, J., Tai, S.S., Killaspy, H., Osborn, D., Popelyuk, D., … Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC psychiatry*, *8*(1). doi: https://doi.org/10.1186/1471-244X-8-70.

51 Bachmann, C.L., & Gooch, B. (2018). LGBT in Britain: Health Report. Retrieved from https://files.stonewall.org.uk/production/files/lgbt_in_britain_health.pdf?dm=1724230505

52 Roxburgh, A., Lea, T., de Wit, J., & Degenhardt, L. (2016). Sexual identity and prevalence of alcohol and other drug use among Australians in the general population. *The International journal on drug policy*, *28*(1). doi: https://doi.org/10.1016/j.drugpo.2015.11.005.

53 Chow, C., Vallance, K., Stockwell, T., Macdonald, S., Martin, G., Ivsins, A., … Duff, C. (2013). Sexual identity and drug use harm among high-risk, active substance users. *Culture, Health & Sexuality*, *15*(3). doi: https://doi.org/10.1080/13691058.2012.754054.

54 Stall, R., Paul, J.P., Greenwood, G., Pollack, L.M., Bein, E., & Catania, J.A. (2001). Alcohol use, drug use and alcohol-related problems among men who have sex with men: the Urban Men's Health Study. *Addiction*, *96*(11). doi: https://doi.org/10.1046/j.1360-0443.2001.961115896.x.

55 Fish, J.N., & Exten, C. (2020). Sexual Orientation Differences in Alcohol Use Disorder Across the Adult Life Course. *American Journal of Preventive Medicine*, *59*(3). doi: https://doi.org/10.1016/j.amepre.2020.04.012.

56 Meyer, I.H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5). doi: https://doi.org/10.1037/0033-2909.129.5.674.

57 Hart, T.A., Noor, S.W., Vernon, J.R.G., Kidwai, A., Roberts, K., Myers, T., … Calzavara, L. (2017). Childhood Maltreatment, Bullying Victimization, and Psychological Distress Among Gay and Bisexual Men. *The Journal of Sex Research*, *55*(4). doi: https://doi.org/10.1080/00224499.2017.1401972.

58 Schwartz, D.R., Stratton, N., & Hart, T.A. (2016). Minority stress and mental and sexual health: Examining the psychological mediation framework among gay and bisexual men. *Psychology of Sexual Orientation and Gender Diversity*, *3*(3). doi: https://doi.org/10.1037/sgd0000180

59 Lachowsky, N.J., Dulai, J.J.S., Cui, Z., Sereda, P., Rich, A., & Moore, D.M. (2017). Lifetime Doctor-Diagnosed Mental Health Conditions and Current Substance Use Among Gay and Bisexual Men Living in Vancouver, Canada. *Substance Use & Misuse*, *52*(6). doi: https://doi.org/10.1080/10826084.2016.1264965.

60 Sandfort, T.G.M., de Graaf, R., ten Have, M., Ransome, Y., & Schnabel, P. (2014). Same-Sex Sexuality and Psychiatric Disorders in the Second Netherlands Mental Health Survey and Incidence Study (NEMESIS-2). *LGBT Health*, *1*(4). doi: https://doi.org/10.1089/lgbt.2014.0031.

61 Zahran, A., Dermody, S.S., Berlin, G.W., Palma, P.A., & Hart, T.A. (2024). Problematic alcohol use among gay, bisexual, and other men who have sex with men in Canada: the role of proximal stressors and anxiety. *Substance abuse treatment, prevention, and policy*, *19*(1). doi: https://doi.org/10.1186/s13011-024-00597-8.

62 Addis, M.E., & Mahalik, J.R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist*, *58*(1). doi: https://pubmed.ncbi.nlm.nih.gov/12674814/

63 Mahalik, J.R., Locke, B.D., Ludlow, L.H., Diemer, M.A., Scott, R.P., Gottfried, M., … Freitas, G. (2003). Development of the conformity to masculine norms inventory. *Psychology of Men & Masculinity*. doi: 10.1037//1524-9220.4.1.3

64 Griffith, D.M., Gunter, K., & Watkins, D.C. (2012). Measuring masculinity in research on men of color: Findings and future directions. *American Journal of Public Health*, *102*(2). doi: https://doi.org/10.2105/AJPH.2012.300715

65 Walther, A., Ehlert, U., Schneeberger, M., Eggenberger, L., Flückiger, C., Komlenac, N., … Zimmermann, D. (2023). Evaluation of a male-specific psychotherapeutic program for major depressive disorder compared to cognitive behavioral therapy and waitlist: Study protocol for a six-arm randomized clinical superiority trial examining depressed eugonadal and hypogonadal men receiving testosterone. *Frontiers in Psychiatry*, *14*. doi: https://doi.org/10.3389/fpsyt.2023.1129386

66 Christensen, A., Krohn, S., Høj, M., Poulsen, S., Reinholt, N., & Arnfred, S. (2023). “Men are not raised to share feelings”: Exploring male patients’ discourses on participating in group cognitive-behavioral therapy. *The Journal of Men’s Studies*, *3*(11). doi: https://doi.org/10.1177/10608265221077298

67 Chen, C.K., & Dognin, J.S. (2017). Addressing the influence of hegemonic masculinity on veterans through brief dynamic interpersonal therapy. *Psychology of Men & Masculinity*, *18*(3). doi: https://doi.org/10.1037/men0000118

68 Robertson, S., Gough, B., Hanna, E., Raine, G., Robinson, M., Seims, M., … White, A. (2018). Successful mental health promotion with men: The evidence from “tacit knowledge". *Health Promotion International*, *33*(2). doi: https://doi.org/10.1093/heapro/daw067

69 Schlichthorst, M., King, K., Turnure, J., Phelps, A., & Pirkis, J. (2019). Engaging Australian men in masculinity and suicide: A concept test of social media materials and a website. *Health Promotion Journal of Australia*. doi: https://doi.org/10.1002/hpja.246

70 Vickery, A. (2022). “It’s made me feel less isolated because there are other people who are experiencing the same or very similar to you”: Men’s experiences of using mental health support groups. *Health & Social Care in the Community*, *30*(6). doi: https://doi.org/10.1111/hsc.13788

71 Lukersmith, S., Salvador-Carulla, L., Woods, C., Niyonsenga, T., Gutierrez-Colosia, M.R., & Aryani, A. (2025). An ecosystem approach to the evaluation and impact analysis of heterogeneous preventive and/or early interventions projects for veterans and first responders in seven countries. *Comprehensive Psychiatry*, *138*. doi: https://doi.org/10.1016/j.comppsych.2025.152578

72 Roy, P., Tremblay, G., & Robertson, S. (2014). Help-seeking among Male Farmers: Connecting Masculinities and Mental Health. *Sociologia Ruralis*, *54*(4). doi: https://doi.org/10.1111/soru.12045.

73 Bilsker, D., Fogarty, A.S., & Wakefield, M.A. (2018). Critical Issues in Men’s Mental Health. *The Canadian Journal of Psychiatry*, *63*(9). doi: https://doi.org/10.1177/0706743718766052.

74 Tiffin, P.A. (2005). Social mobility over the lifecourse and self reported mental health at age 50: prospective cohort study. *Journal of Epidemiology & Community Health*, *59*(10). doi: https://doi.org/10.1136/jech.2005.035246

75 Remes, O., Lafortune, L., Wainwright, N., Surtees, P., Khaw, K., & Brayne, C. (2019). Association between area deprivation and major depressive disorder in British men and women: a cohort study. *BMJ Open*, *9*(11). doi: https://doi.org/10.1136/bmjopen-2018-027530

76 Robinson, M., Keating, F., & Robertson, S. (2018). Ethnicity, gender and mental health. Diversity in Health and Care. *Diversity in Health and Care*, *8*(2). doi: ISSN 1759-1422

77 King, M., McKeown, E., Warner, J., Ramsay, R., Johnson, K., Cort, C., … Davidson, O. (2003). Mental health and quality of life of gay men and lesbians in England and Wales. *British Journal of Psychiatry*, *183*(6). doi: https://doi.org/10.1192/03-207

78 Canetto, S.S., & Sakinofsky, I. (1998). The gender paradox in suicide. . *Suicide and Life-Threatening Behavior*, *28*(1). doi: https://pubmed.ncbi.nlm.nih.gov/9560163/

79 McManus, S., Gunnell, D., Cooper, C., Bebbington, P.E., Howard, L.M., Brugha, T., … Appleby, L. (2019). Prevalence of non-suicidal self-harm and service contact in England, 2000–14: repeated cross-sectional surveys of the general population. *The Lancet Psychiatry*, *6*(7). doi: https://doi.org/10.1016/s2215-0366(19)30188-9

80 O'Conno, R., & Kirtley, O.J. (2018). The integrated motivational–volitional model of suicidal behaviour. *Philosophical Transactions of the Royal Society B: Biological Sciences*, *373*(1754). doi: https://doi.org/10.1098/rstb.2017.0268

81 GBD 2021 Suicide Collaborators, . (2025). Global, regional, and national burden of suicide, 1990–2021: a systematic analysis for the Global Burden of Disease Study 2021. *The Lancet Public Health*. doi: https://doi.org/10.1016/S2468-2667(25)00006-4

82 GBD 2021 Suicide Collaborators, . (2025). Global, regional, and national burden of suicide, 1990–2021: a systematic analysis for the Global Burden of Disease Study 2021. *The Lancet Public Health*. doi: https://doi.org/10.1016/S2468-2667(25)00006-4

83 Slade, A., Reily, N.M., Fujimoto, H., Seidler, Z.E., Christensen, H., Shand, F., … Tang, S. (2025). Men's mental health and suicide prevention service landscape in Australia: a scoping review.. *MC Public Health*, *25*(1). doi: https://doi.org/10.1186/s12889-025-22676-6

84 Aaltonen, K., Isometsä, E., Sund, R., & Pirkola, S. (2018). Risk factors for suicide in depression in Finland: first - hospitalized patients followed up to 24 years. *Acta Psychiatrica Scandinavica*, *139*(2). doi: https://doi.org/10.1111/acps.12990

85 Freeman, A., Mergl, R., Kohls, E., ..., ., & Rummel-Kluge, C. (2017). A cross-national study on gender differences in suicide intent. *BMC Psychiatry*, *17*(1). doi: https://doi.org/10.1186/s12888-017-1398-8

86 Hee Ahn, M., Park, P., Ha, K., Choi, S., & Hong, J.P. (2012). Gender ratio comparisons of the suicide rates and methods in Korea, Japan, Australia, and the United States. *Journal of Affective Disorders*, *142*(1). doi: https://doi.org/10.1016/j.jad.2012.05.008

87 Varnik, A., Kolves, K., van der Feltz-Cornelis, C., ..., ., & Hegerl, U. (2008). Suicide methods in Europe: a gender-specific analysis of countries participating in the "European Alliance Against Depression." . *ournal of Epidemiology & Community Health*, *62*(6). doi: https://doi.org/10.1136/jech.2007.065391

88 Kanchan, T., Menon, A., & Menezes, R.G. (2009). Methods of Choice in Completed Suicides: Gender Differences and Review of Literature. *Journal of Forensic Sciences*, *54*(4). doi: https://doi.org/10.1111/j.1556-4029.2009.01054.x

89 Miranda-Mendizabal, A., Castellví, P., Parés-Badell, O., ..., ., & Alonso, J. (2019). Gender differences in suicidal behavior in adolescents and young adults: systematic review and meta-analysis of longitudinal studies. *International Journal of Public Health*, *64*(2). doi: https://doi.org/10.1007/s00038-018-1196-1.

90 Qin, P., Agerbo, E., Westergård-Nielsen, N., Eriksson, T., & Mortensen, P.B. (2000). Gender differences in risk factors for suicide in Denmark. *British Journal of Psychiatry*, *177*(6). doi: https://doi.org/10.1192/bjp.177.6.546.

91 Sörberg Wallin, A., Sjöqvist, H., Dehara, M., Wells, M.B., Dykxhoorn, J., Kosidou, K., … Dalman, C. (2022). Parenthood and lower risk of suicide in women and men: the total Swedish population followed across adulthood. *Social Psychiatry and Psychiatric Epidemiology*, *57*. doi: https://doi.org/10.1007/s00127-022-02321-y

92 Samaritans. (2020). Out of sight, out of mind: Why less well-off, middle-aged men don't get the support they need. Retrieved from https://media.samaritans.org/documents/Samaritans_-_out_of_sight_out_of_mind_2020.pdf

93 Brent, D. (2011). Nonsuicidal Self-Injury as a Predictor of Suicidal Behavior in Depressed Adolescents. *American Journal of Psychiatry*, *168*(5). doi: https://doi.org/10.1176/appi.ajp.2011.11020215.

94 Duarte, T.A., Paulino, S., Almeida, C., Gomes, H.S., Santos, N., & Gouveia-Pereira, M. (2019). Self-harm as a predisposition for suicide attempts: A study of adolescents' deliberate self-harm, suicidal ideation, and suicide attempts. *Psychiatry Research*, *287*. doi: https://doi.org/10.1016/j.psychres.2019.112553.

95 Whitlock, J., & Knox, K.L. (2007). The Relationship Between Self-injurious Behavior and Suicide in a Young Adult Population. *rchives of Pediatrics & Adolescent Medicine*, *161*(7). doi: https://doi.org/10.1001/archpedi.161.7.634

96 Diggins, E., Heuvelman, H., Pujades-Rodriguez, M., House, A., Cottrell, D., & Brennan, C. (2024). Exploring gender differences in risk factors for self-harm in adolescents using data from the Millennium Cohort Study. *Journal of Affective Disorders*, *345*. doi: https://doi.org/10.1016/j.jad.2023.10.106.

97 Claes, L., Vandereycken, W., & Vertommen, H. (2007). Self-injury in female versus male psychiatric patients: A comparison of characteristics, psychopathology and aggression regulation. *Personality and Individual Differences*, *42*(4). doi: https://doi.org/10.1016/j.paid.2006.07.021.

98 Demuth, A., & Demuthova, S. (2022). Gender differences in adolescent self-harming behaviour. *International Journal of Health Sciences*. doi: https://doi.org/10.53730/ijhs.v6ns3.9026

99 Tsirigotis, K., Gruszczynski, W., & Lewik-Tsirigotis, M. (2012). Manifestations of Indirect Self-destructiveness and Methods of Suicide Attempts. *Psychiatric Quarterly*, *84*(2). doi: https://doi.org/10.1007/s11126-012-9239-x

100 Tang, S., Hoye, A., Slade, A., ..., ., & Calear, A.L. (2025). Motivations for Self-Harm in Young People and Their Correlates: A Systematic Review. *Clinical Child and Family Psychology Review*. doi: https://doi.org/10.1007/s10567-024-00511-5

101 Laye-Gindhu, A., & Schonert-Reichl, K.A. (2005). Nonsuicidal Self-Harm Among Community Adolescents: Understanding the “Whats” and “Whys” of Self-Harm. *Journal of Youth and Adolescence*, *34*(5). doi: https://doi.org/10.1007/s10964-005-7262-z

102 Xavier, A., Cunha, M., & Pinto-Gouveia, J. (2017). Daily Peer Hassles and Non-Suicidal Self-Injury in Adolescence: Gender Differences in Avoidance-Focused Emotion Regulation Processes. *Journal of Child and Family Studies*, *27*(1). doi: https://doi.org/10.1007/s10826-017-0871-9

103 Marzano, L., Adler, R., & Ciclitira, K. (2013). Responding to repetitive, non-suicidal self-harm in an English male prison: Staff experiences, reactions, and concerns. *Legal and Criminological Psychology*, *20*(2). doi: https://doi.org/10.1111/lcrp.12025

104 Tofthagen, R., Gabrielsson, S., Fagerström, L., Haugerud, L., & Lindgren, B. (2021). Men who self - harm—A scoping review of a complex phenomenon. *Journal of Advanced Nursing*, *78*(5). doi: https://doi.org/10.1111/jan.15132

105 Adamson, V., & Braham, L. (2011). Pathways to episodes of deliberate self - harm experienced by mentally ill men in a high - secure hospital over the course of their lives: an exploratory study. *The British Journal of Forensic Practice*, *13*(3). doi: https://doi.org/10.1108/14636641111157814.

106 Ramluggun, C.S. (2013). A Critical Exploration of the Management of Self-Harm in a Male Custodial Setting. *Journal of Forensic Nursing*, *9*(1). doi: https://doi.org/10.1097/jfn.0b013e31827a5984

107 Russell, G., Moss, D., & Miller, J. (2010). Appalling and appealing: A qualitative study of the character of men’s self-harm. *Psychology and Psychotherapy: Theory, Research and Practice*, *83*(1). doi: https://doi.org/10.1348/147608309x466826.

108 Fox, K.R., Millner, A.J., Mukerji, C.E., & Nock, M.K. (2018). Examining the role of sex in self-injurious thoughts and behaviors. *Clinical Psychology Review*, *66*. doi: https://doi.org/10.1016/j.cpr.2017.09.009

109 Oliffe, J.L., Ogrodniczuk, J.S., Gordon, S.J., Creighton, G., Kelly, M.T., Black, N., … Mackenzie, C. (2016). Stigma in Male Depression and Suicide: A Canadian Sex Comparison Study. *Community Mental Health Journal*, *52*(3). doi: https://doi.org/10.1007/s10597-015-9986-x

110 Stillion, J.M., White, H., Edwards, P.J., & McDowell, E.E. (1989). Ageism and sexism in suicide attitudes. *Death Studies*, *13*(3). doi: https://doi.org/10.1080/07481188908252302

111 Mackenzie, C.S., Visperas, A., Ogrodniczuk, J.S., Oliffe, J.L., & Nurmi, M.A. (2019). Age and sex differences in self-stigma and public stigma concerning depression and suicide in men. *Stigma and Health*, *4*(2). doi: https://doi.org/10.1037/sah0000138.

112 Marzano, L., Adler, J.R., & Ciclitira, K. (2013). Responding to repetitive, non-suicidal self-harm in an English male prison: Staff experiences, reactions, and concerns. *Legal and Criminological Psychology*, *20*(2). doi: https://doi.org/10.1111/lcrp.12025

113 Cacioppo, J., & Patrick, W. (2008). Loneliness: human nature and the need for social connection. *Choice Reviews Online*, *46*(3). doi: https://doi.org/10.5860/choice.46-1765

114 Lauder, W., Sharkey, S., & Mummery, K. (2004). A community survey of loneliness. *Journal of Advanced Nursing*, *46*(1). doi: https://doi.org/10.1111/j.1365-2648.2003.02968.x

115 Ekwall, A.K., Sivberg, B., & Hallberg, I.R. (2005). Loneliness as a predictor of quality of life among older caregivers. *Journal of Advanced Nursing*, *49*(1). doi: https://doi.org/10.1111/j.1365-2648.2004.03260.x

116 Weiss, R.S. (1973). Loneliness: The experience of emotional and social isolation. *Cambridge, MA: MIT Press.*.

117 van Tilburg, T.G. (2021). Social, Emotional, and Existential Loneliness: A Test of the Multidimensional Concept. [No description]. doi: https://doi.org/10.1093/geront/gnaa082

118 Coyle, C.E., & Dugan, E. (2012). Social Isolation, Loneliness and Health Among Older Adults. *Journal of Aging and Health*, *24*(8). doi: https://doi.org/10.1177/0898264312460275

119 Peterson, N.A., Farmer, A.Y., Wang, Y., Borys, S., & Hallcom, D.K. (2017). Social isolation profiles and older adult substance use: A latent profile analysis. *The Journals of Gerontology: Series B*, *77*(5). doi: https://doi.org/10.1093/geronb/gbab078

120 Holt-Lunstad, J., Smith, T.B., & Layton, J.B. (2010). Social Relationships and Mortality Risk: a Meta-analytic Review. *PLoS Medicine,*, *7*(7). doi: https://doi.org/10.1371/journal.pmed.1000316.

121 Valtorta, N.K., Kanaan, M., Gilbody, S., Ronzi, S., & Hanratty, B. (2016). Loneliness and Social Isolation as Risk Factors for Coronary Heart Disease and stroke: Systematic Review and meta-analysis of Longitudinal Observational Studies. *Heart*, *102*(13). doi: https://doi.org/10.1136/heartjnl-2015-308790.

122 Cacioppo, J.T., Hawkley, L.C., Crawford, E., ..., ., & Berntson, G.G. (2002). Loneliness and health: Potential mechanisms. *Psychosomatic Medicine*, *64*(3). doi: https://doi.org/10.1097/00006842-200205000-00005

123 Cacioppo, J.T., Hughes, M.E., Waite, L.J., Hawkley, L.C., & Thisted, R.A. (2006). Loneliness as a specific risk factor for depressive symptoms: Cross-sectional and longitudinal analyses. *Psychology and Aging*, *21*(1). doi: https://doi.org/10.1037/0882-7974.21.1.140.

124 Pai, N., & Vella, S.L. (2022). The physical and mental health consequences of social isolation and loneliness in the context of COVID-19. *Current Opinion in Psychiatry*, *35*(5). doi: https://doi.org/10.1097/YCO.0000000000000806

125 Wei, M., Shaffer, P.A., Young, S.K., & Zakalik, R.A. (2005). Adult attachment, shame, depression, and loneliness: The mediation role of basic psychological needs satisfaction. *Journal of Counseling Psychology*, *52*(4). doi: https://doi.org/10.1037/0022-0167.52.4.591

126 Holt-Lunstad, J., Smith, T.B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: A meta-analytic review. *Perspectives on Psychological Science*, *10*(2). doi: https://doi.org/10.1177/1745691614568352.

127 Steptoe, A., Shankar, A., Demakakos, P., & Wardle, J. (2013). Social isolation, loneliness, and all-cause mortality in older men and women. *Proceedings of the National Academy of Sciences*, *110*(115). doi: https://doi.org/10.1073/pnas.1219686110

128 Office for National Statistics (ONS). (2025). Public opinions and social trends, Great Britain: January 2025. *https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/publicopinionsandsocialtrendsgreatbritain/january2025*.

129 Department for Culture, Media and Sport (DCMS). (2023). Community Life Survey 2021/22. Retrieved from https://www.gov.uk/government/statistics/community-life-survey-202122

130 Scottish Government. (2023). Scottish Household Survey 2022: Key Findings. Retrieved from https://www.gov.scot/publications/scottish-household-survey-2022-key-findings/

131 Teuton, J. (2018). Social isolation and loneliness in Scotland: A review of prevalence and trends. *NHS Health Scotland*. doi: https://consult.gov.scot/equality-unit/connected-scotland/user_uploads/a-connected-scotland---tackling-social-isolation-and-loneliness-3.pdf

132 Ratcliffe, J., Galdas, P., & Kanaan, M. (2020). Men and loneliness in the 'west': A critical interpretive synthesis. *Research Square*. doi: https://doi.org/10.21203/rs.3.rs-17584/v1.

133 Gierveld, J., Tilburg, T.G., & Dykstra, P.A. (2018). New Ways of Theorizing and Conducting Research in the Field of Loneliness and Social Isolation. *The Cambridge Handbook of Personal Relationships*. doi: https://doi.org/10.1017/9781316417867.031.

134 Rokach, A. (2018). The Effect of Gender and Culture on Loneliness: A Mini Review. *Emerging Science Journal*, *2*(2). doi: https://doi.org/10.28991/esj-2018-01128.

135 Cleary, A. (2012). Men, masculinities and suicidal behaviour. *Social Science & Medicine*, *74*(4). doi: https://doi.org/10.1016/j.socscimed.2010.04.011

136 Cramer, K.M., & Neyedley, K.A. (1998). Sex differences in loneliness: The role of masculinity and femininity. *Sex Roles*, *38*(7). doi: https://doi.org/10.1023/A:1018850711372

137 Jylhä, A. (2004). Old Age and Loneliness: Cross-sectional and Longitudinal Analyses in the Tampere Longitudinal Study on Aging. *Canadian Journal on Aging / La Revue canadienne du vieillissement,*, *23*(2). doi: https://doi.org/10.1353/cja.2004.0023.

138 De Jong Gierveld, J., & Van Tilburg , T.G. (2006). A six-item scale for overall, emotional and social loneliness: confirmative tests on new survey data. *Res Aging*, *28*. doi: 10.1177/0164027506289723

139 Russell, D., Peplau, L., & Ferguson, M.L. (1978). UCLA Loneliness Scale. *PsycTESTS Dataset*. doi: https://doi.org/10.1037/t05974-000.

140 Oshagan, H., & Allen, R.L. (1992). Three Loneliness Scales: An Assessment of Thier Measurement Properties. *Journal of Personality Assessment*, *59*(2). doi: https://doi.org/10.1207/s15327752jpa5902_13.

141 Liebler, C.A., & Sandefur, G.D. (2002). Gender differences in the exchange of social support with friends, neighbors, and co-workers at midlife. *Social Science Research*, *31*(3). doi: https://doi.org/10.1016/S0049-089X(02)00006-6

142 Umberston, D., Lin, Z., & Cha, H. (2022). Gender and social isolation across the life course. *Journal of Health and Social Behavior*, *63*(3). doi: https://doi.org/10.1177/00221465221109634

143 Stokes, J.P., & Levin, I. (1986). Gender differences in predicting loneliness from social network characteristics. *Journal of Personality and Social Psychology*, *51*(5). doi: https://doi.org/10.1037//0022-3514.51.5.1069.

144 Bell, R.A., & Gonzalez, M.C. (1988). Loneliness, negative life events, and the provisions of social relationships. *Communication Quarterly*, *36*(1). doi: https://doi.org/10.1080/01463378809369703.

145 Patulny, R., & Wong, M. (2012). Poor Mothers and Lonely Single Males: The 'Essentially' Excluded Women and Men of Australia. Social Policy and Society. *Social Policy and Society*, *12*(2). doi: https://doi.org/10.1017/s1474746412000449.

146 Junttila, N., Kainulainen, S., & Saari, J. (2015). Mapping the Lonely Landscape - Assessing Loneliness and Its Consequences. *The Open Psychology Journal*, *8*(1). doi: https://doi.org/10.2174/1874350101508010089.

147 Tornstram, L. (1992). Loneliness in Marriage. *Journal of Social and Personal Relationships*, *9*(2). doi: https://doi.org/10.1177/0265407592092003

148 Dykstra, P.A. (1995). Loneliness among the never and formerly married: The importance of supportive friendships and a desire for independence. *The Journals of Gerontology: Series B: Psychological Sciences and Social Sciences*, *50*(5). doi: https://psycnet.apa.org/record/1996-08006-001

149 Dykstra, P.A., & Fokkema, T. (2007). Social and emotional loneliness among divorced and married men and women: Comparing the deficit and cognitive perspectives. *Basic and Applied Social Psychology*, *29*(1). doi: https://doi.org/10.1080/01973530701330843

150 Nurmi, M.A., Mackenzie, C.S., Roger, K., Reynolds, K., & Urquhart, J. (2018). Older men's perceptions of the need for and access to male-focused community programmes such as Men's Sheds. *Ageing and Society*, *38*(4). doi: https://doi.org/10.1017/S0144686X16001331.

151 Davidson, K. (2004). 'Why Can't a Man Be More Like a Woman?': Marital Status and Social Networking of Older Men. *The Journal of Men's Studies*, *13*(1). doi: https://doi.org/10.3149/jms.1301.25.

152 Collins, T. (2018). The personal communities of men experiencing later life widowhood. *Health & Social Care in the Community*, *26*(3). doi: https://doi.org/10.1111/hsc.12542.

153 Peters, A., & Liefbroer, A.C. (1997). Beyond Marital Status: Partner History and Well-Being in Old Age. *Journal of Marriage and the Family*, *59*(3). doi: https://doi.org/10.2307/353954.

154 Knox, D., Vail-Smith, K., & Zusman, M. (2007). The Lonely College Male. *International Journal of Men's Health*, *6*(3). doi: https://doi.org/10.3149/jmh.0603.273.

155 Stevens, N., & Westerhof, G.H. (2006). Marriage, Social Integration, and Loneliness in the Second Half of Life. *Research on Aging*, *28*(6). doi: https://doi.org/10.1177/0164027506291747.

156 Eckhard, J. (2020). Gender Differences in the Social Consequences of Unemployment: How Job Loss Affects the Risk of Becoming Socially Isolated. *Work, Employment and Society*, *36*(1). doi: doi:https://doi.org/10.1177/0950017020967903.

157 Paul, K.I., & Moser, K. (2009). Unemployment Impairs Mental health: Meta-analyses. *Journal of Vocational Behavior*, *74*(3). doi: doi:https://doi.org/10.1016/j.jvb.2009.01.001.

158 Leana, C.R., & Feldman, D.C. (1991). Gender differences in responses to unemployment. *Journal of Vocational Behavior*, *38*(1). doi: doi:https://doi.org/10.1016/0001-8791(91)90018-h.

159 Pfau-Effinger, B. (2004). Socio-historical paths of the male breadwinner model - an explanation of cross-national differences. *The British Journal of Sociology*, *55*(3). doi: https://doi.org/10.1111/j.1468-4446.2004.00025.x.

160 Fathers Network Scotland. (2023). Dads' Survey Results 2023. Retrieved from https://www.fathersnetwork.org.uk/dads_survey_2023.

161 Fisher, S.D., Cobo, J., Figueiredo, B., ..., ., & Singley, D.B. (2021). Expanding the international conversation with fathers' mental health: toward an era of inclusion in perinatal research and practice. *Archives of Women's Mental Health*, *24*(5). doi: https://doi.org/10.1007/s00737-021-01171-y.

162 Hambidge, S., Cowell, A., Arden-Close, E., & Mayers, A. (2021). "What kind of man gets depressed after having a baby?" Fathers' experiences of mental health during the perinatal period. *BMC Pregnancy and Childbirth*, *21*. doi: https://doi.org/10.1186/s12884-021-03947-7

163 Darwin, Z. (2017). Fathers' views and experiences of their own mental health during pregnancy and the first postnatal year: a qualitative interview study of men participating in the UK Born and Bred in Yorkshire (BaBY) cohort. *BMC Pregnancy and Childbirth*, *17*(1). doi: https://doi.org/10.1186/s12884-017-1229-4.

164 Scottish Government . (2024). Paternal perinatal mental health: evidence review. Retrieved from https://www.gov.scot/binaries/content/documents/govscot/publications/research-and-analysis/2024/01/paternal-perinatal-mental-health-evidence-review/documents/paternal-perinatal-mental-health-evidence-review/paternal-perinatal-mental-health-evidence-review/govscot%3Adocument/paternal-perinatal-mental-health-evidence-review.pdf

165 Scottish Intercollegiate Guidelines Network (SIGN). (2012). Management of perinatal mood disorders. Retrieved from https://www.sign.ac.uk/assets/sign127_update.pdf

166 Bauer, A., Parsonage, M., Knapp, M., Lemmi, V., & Adelaja, B. (2014). The costs of perinatal mental health problems. *Centre for Mental Health & London School of Economics*. doi: https://www.centreformentalhealth.org.uk/publications/costs-perinatal-mental-health-problems

167 Field, T., & et al., , . (2004). Early interactions between infants and their depressed fathers. *Infant Behavior and Development*, *27*(1). doi: https://doi.org/10.1016/j.infbeh.2003.05.001

168 Fletcher, R., & et al., . (2011). Engaging fathers: Evidence review.. *Research Alliance for Children and Youth (ARACY)*.

169 Giallo, R., & et al., . (2013). Father mental health during the early parenting period: Results of an Australian population-based longitudinal study. *Social Psychiatry and Psychiatric Epidemiology*, *48*. doi: https://doi.org/10.1007/s00127-012-0618-4

170 Rominov, H., Pilkington, P.D., Giallo, R., & Whelan, T.A. (2016). A systematic review of interventions targeting paternal mental health in the perinatal period. *Infant Mental Health Journal*, *37*(3). doi: https://doi.org/10.1002/imhj.21560.

171 Dhanpal, H.N., & Shil, R. (2023). Prevalence of Postnatal Depression in Fathers: A Systematic Review and Meta-Analysis. *Journal of Health and Allied Sciences*. doi: https://doi.org/10.1055/s-0043-1777701.

172 Cameron, E.E., Sedov, I.D., & Tomfohr-Madsen, L.M. (2016). Prevalence of paternal depression in pregnancy and the postpartum: An updated meta-analysis. *Journal of Affective Disorders*, *206*. doi: https://doi.org/10.1016/j.jad.2016.07.044

173 Da Costa, D., Zelkowitz, P., Dasgupta, K., ..., ., & Khalifé, S. (2017). Dads get sad too: Depressive symptoms and associated factors in expectant first-time fathers. *American Journal of Men's Health*, *11*(5). doi: https://doi.org/10.1177/1557988315606963

174 Spry, E., & et al., . (2018). Preconception prediction of expectant fathers' mental health: 20-year cohort study from adolescence. *Journal of Affective Disorders*, *230*. doi: https://doi.org/10.1016/j.jad.2018.01.004

175 Paulson, J.F., & Bazemore, S.D. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression: A meta-analysis. *JAMA*, *303*(19). doi: https://doi.org/10.1001/jama.2010.605

176 Craig, F., Duncan, G., Rutsohn, J., ..., ., & Chase-Lansdale, P.L. (2014). A longitudinal study of paternal mental health during transition to fatherhood as young adults. *Pediatrics*, *133*(5). doi: https://doi.org/10.1542/peds.2013-3262

177 Gettler, L.T., & Oka, R.C. (2016). Endocrine and behavioral correlates of fatherhood across cultures. *Hormones and Behavior*, *84*. doi: https://doi.org/10.1016/j.yhbeh.2016.06.004

178 Mangialavori, S., & et al., . (2021). Perinatal depression in mothers and fathers: Differences in symptom presentation and assessment challenges. *Journal of Affective Disorders*, *282*. doi: https://doi.org/10.1016/j.jad.2020.12.045

179 Mangialavori, S., & et al., . (2021). Perinatal depression in mothers and fathers: Differences in symptom presentation and assessment challenges. *Journal of Affective Disorders*, *282*. doi: https://doi.org/10.1016/j.jad.2020.12.045

180 Gawlik, S., & et al., . (2014). Prevalence and risk factors of paternal perinatal depression in Germany. *Archives of Women's Mental Health*, *17*(6). doi: https://doi.org/10.1007/s00737-014-0426-1

181 Fisher, J., & et al., . (2012). Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: A systematic review. *Bulletin of the World Health Organization*, *90*. doi: https://doi.org/10.2471/BLT.11.091850

182 Ramchandani, P., & Psychogiou, L. (2009). Paternal psychiatric disorders and children's psychosocial development. *The Lancet*, *374*. doi: https://doi.org/10.1016/S0140-6736(09)60238-5

183 Pedersen, S.C., Maindal, H.T., & Ryom, K. (2021). “I Wanted to Be There as a Father, but I Couldn’t”: A Qualitative Study of Fathers’ Experiences of Postpartum Depression and Their Help-Seeking Behavior. *American Journal of Men's Health*, *15*(3). doi: https://doi.org/10.1177/15579883211024375

184 Hammer, J.H., Vogel, D.L., & Heimerdinger-Edwards, S.R. (2013). Men’s help seeking: Examination of differences across community size, education, and income. *Psychology of Men & Masculinity*, *14*(1). doi: https://doi.org/10.1037/a0026813.

185 Addis, M.E., & Mahalik, J.R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologis*, *58*(1). doi: https://pubmed.ncbi.nlm.nih.gov/12674814/

186 Berger, J.L., Addis, M.E., Green, J.D., Mackowiak, C., & Goldberg, V. (2013). Men’s help seeking: Examination of differences across community size, education, and income. *Psychology of Men & Masculinity*, *14*(1). doi: :https://doi.org/10.1037/a0026813.

187 Mayers, A., Hambidge, S., Bryant, O., & Arden-Close, E. (2020). Supporting women who develop poor postnatal mental health: what support do fathers receive to support their partner and their own mental health? . *BMC Pregnancy and Childbirth*, *20*(1). doi: https://doi.org/10.1186/s12884-020-03043-2.

188 Felder, J.N., Lemon, E., Shea, K., Kripke, C., & Dimidjian, S. (2017). Role of stigma and health literacy in men's help-seeking for perinatal depression. *Archives of Women's Mental Health*, *20*(4).

189 Musser, A.K., Ahmed, A.H., Foli, K.J., & Coddington, J.A. (2013). Paternal postpartum depression: What health care providers should know. *Journal of Pediatric Health Care*, *27*(6). doi: https://doi.org/10.1016/j.pedhc.2012.10.001

190 Singley, D.B., & Edwards, L.M. (2017). Men's perinatal mental health in the transition to fatherhood. *Professional Psychology: Research and Practice*, *48*(5). doi: https://doi.org/10.1037/pro0000143

191 Schöch, P., Hölzle, L., Lampe, A., ..., ., & Paul, J.L. (2024). Towards effective screening for paternal perinatal mental illness: a meta-review of instruments and research gaps. *Frontiers in Public Health*, *12*. doi: https://doi.org/10.3389/fpubh.2024.1393729.

192 O’Leary, J.L., & Thorwick, C. (2006). Fathers’ Perspectives During Pregnancy, Postperinatal Loss. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *35*(1). doi: https://doi.org/10.1111/j.1552-6909.2006.00017.x.

193 Bergstrom, M., Kieler, H., & Waldenstrom, U. (2009). Effects of natural childbirth preparation versus standard antenatal education on epidural rates, experience of childbirth and parental stress in mothers and fathers: a randomised controlled multicentre trial. *BJOG: An International Journal of Obstetrics & Gynaecology*, *116*(9). doi: https://doi.org/10.1111/j.1471-0528.2009.02144.x.

194 Nash, M. (2017). ‘It’s just good to get a bit of man-talk out in the open’: Men’s experiences of father-only antenatal preparation classes in Tasmania, Australia. *Psychology of Men & Masculinity*, *19*(2). doi: https://doi.org/10.1037/men0000102.

195 National Institute for Health and Care Excellence (NICE). (2014). Antenatal and postnatal mental health: clinical management and service guidance. Retrieved from https://www.nice.org.uk/guidance/cg192

196 Campbell, A., Forbes, T., McLaughlin, A., ..., ., & McKeaveney, C. (2019). Rapid evidence review: The relationship between alcohol and mental health problems. *Alcohol Change UK*. doi: https://alcoholchange.org.uk/publication/rapid-evidence-review-the-relationship-between-alcohol-and-mental-health-problems

197 Marel, C., Mills, K., Kingston, R., ..., ., & Kay-Lambkin, F. (2016). Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings. *Sydney: Centre of Research Excellence in Mental Health and Substance Use, National Drug and Alcohol Research Centre.* .

198 Ross, K., & Peselow, E. (2012). Co-Occurring psychotic and addictive disorders. *Clinical Neuropharmacology*, *35*(5). doi: https://doi.org/10.1097/wnf.0b013e318261e193.

199 Kelly, T.M., & Daley, D.C. (2013). Integrated treatment of substance use and psychiatric disorders. *Social Work in Public Health*, *28*(3). doi: https://doi.org/10.1080/19371918.2013.774673.

200 O'Connor, R., & et al., . (2020). Alcohol dependence and mental health. *UK Health Security Agency*. doi: https://ukhsa.blog.gov.uk/2020/11/17/alcohol-dependence-and-mental-health/

201 Weaver, T., Madden, P., Charles, V., ..., ., & Ford, C. (2003). Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. *British Journal of Psychiatry*, *183*(4). doi: https://doi.org/10.1192/bjp.183.4.304.

202 World Health Organization. (2024). Alcohol. Retrieved from https://www.who.int/news-room/fact-sheets/detail/alcohol

203 Wilsnack, S.C., Vogeltanz, N.D., Klassen, A.D., & Harris, T.R. (2000). Childhood sexual abuse and women's substance abuse. *Addiction*, *95*(6).

204 Wilsnack, R.W., Kristjanson, A.F., Wilsnack, S.C., & Crosby, R.D. (2006). Are U.S. women drinking less (or more)?. *Addiction*, *101*(9).

205 Wilsnack, R.W., & et al., . (2009). Gender differences in alcohol consumption and adverse drinking consequences. *Addiction*, *104*(9).

206 Wilsnack, R.W., & et al., . (2009). Gender differences in alcohol consumption and adverse drinking consequences. *Addiction*, *104*(9).

207 Erol, A., & Karpyak, V.M. (2015). Sex and gender-related differences in alcohol use and its consequences.. *Alcohol Research*, *35*(2).

208 World Health Organization. (2018). Global status report on alcohol and health 2018. Retrieved from https://www.who.int/publications/i/item/9789241565639

209 World Health Organization . (2024). Global status report on alcohol and health and treatment of substance use disorders. Retrieved from https://www.who.int/publications/i/item/9789240096745

210 Darke, S., & Hall, W. (2003). Heroin overdose: Research and evidence-based intervention. *Journal of Urban Health*, *80*(2).

211 Tweed, E.J., Miller, R.G., Schofield, J., Barnsdale, L., & Matheson, C. (2022). Why are drug-related deaths among women increasing in Scotland? A mixed-methods analysis of possible explanations. *Drugs (Abingdon, England)*, *29*(1). doi: https://doi.org/10.1080/09687637.2020.1856786

212 Scottish Government. (2024). Scottish Health Survey 2023 – Volume 1: Main Report. Retrieved from https://www.gov.scot/publications/scottish-health-survey-2023-volume-1-main-report/pages/7/.

213 Public Health Scotland. (2024). Drug-related deaths increase in Scotland. Retrieved from https://publichealthscotland.scot/news/2024/august/drug-related-deaths-increase-in-scotland/

214 National Records of Scotland. (2024). Alcohol-specific deaths 2023.. Retrieved from https://www.nrscotland.gov.uk/publications/alcohol-specific-deaths-2023/

215 Public Health Scotland. (2025). Public health alert: Xylazine – newly detected drug. Rapid Action Drug Alerts and Response (RADAR) Alert: Xylazine, version 1.1 . Retrieved from https://publichealthscotland.scot/publications/rapid-action-drug-alerts-and-response-radar-alert-xylazine/rapid-action-drug-alerts-and-response-radar-alert-xylazine-version-11/public-health-alert-xylazine-newly-detected-drug/

216 Allik, M., Brown, D., Dundas, R., & Leyland, A.H. (2020). Deaths of despair: cause-specific mortality and socioeconomic inequalities in cause-specific mortality among young men in Scotland. . *International Journal for Equity in Health*, *19*(1). doi: https://doi.org/10.1186/s12939-020-01329-7.

217 National Records of Scotland. (2025). Drug-related deaths in Scotland, 2024. Retrieved from https://www.nrscotland.gov.uk/publications/drug-related-deaths-in-scotland-2024/

218 Brown, D., Allik, M., Dundas, R., & Leyland, A.H. (2019). 'All-cause and cause-specific mortality in Scotland 1981–2011 by age, sex and deprivation: a population-based study'. *European Journal of Public Health*. doi: https://doi.org/10.1093/eurpub/ckz010

219 Whittle, E.L., Fogarty, A.S., Tugendrajch, S., ..., ., & Proudfoot, J. (2015). Men, depression, and coping: Are we on the right path?. *Psychology of Men & Masculinity*, *16*(4). doi: doi:https://doi.org/10.1037/a0039024.

220 Spendelow, S. (2015). Men's self-reported coping strategies for depression: A systematic review of qualitative studies. *Psychology of Men & Masculinity*, *16*(4). doi: :https://doi.org/10.1037/a0038626.

221 Emslie, C., Ridge, D., Ziebland, S., & Hunt, K. (2013). Men's accounts of depression: Reconstructing or resisting hegemonic masculinity?. *Social Science & Medicine*, *62*(9).

222 de Visser, R.O., Smith, J.A., & McDonnell, E.J. (2007). 'That's not masculine': Masculine capital and health-related behaviour.. *Journal of Health Psychology*, *12*(2).

223 Scottish Health Action on Alcohol Problems (SHAAP). (2022). Alcohol sponsorship of football: Examining the nature of sponsorship relations for professional football teams across countries with varied restrictions on alcohol marketing. Retrieved from https://www.shaap.org.uk/publication/alcohol-sponsorship-of-football-examining-the-nature-of-sponsorship-relations-for-professional-football-teams-across-countries-with-varied-restrictions-on-alcohol-marketing/

224 World Health Organization . (2024). Gambling. Retrieved from https://www.who.int/news-room/fact-sheets/detail/gambling.

225 Gambling Commission . (2024). Statistics on gambling participation – Year 2 (2024), wave 1: Official statistics. Retrieved from https://www.gamblingcommission.gov.uk/statistics-and-research/publication/statistics-on-gambling-participation-year-2-2024-wave-1-official-statistics

226 Royal College of Psychiatrists. (2021). Gambling disorder. Retrieved from https://www.rcpsych.ac.uk/mental-health/mental-illnesses-and-mental-health-problems/gambling-disorder.

227 Office for Health Improvement and Disparities. (2023). Gambling-related harms evidence review: summary. Retrieved from https://www.gov.uk/government/publications/gambling-related-harms-evidence-review/gambling-related-harms-evidence-review-summary--2

228 Kristensen, J., Pallesen, S., Bauer, J., ..., ., & Erevik, E.K. (2023). Suicidality among individuals with gambling problems: A meta-analytic literature review. *Psychological Bulletin*, *150*(1). doi: https://doi.org/10.1037/bul0000411.

229 Rintoul, A., Dwyer, J., Millar, C., Bugeja, L., & Nguyễn Văn Huy, . (2023). Gambling-related suicide in Victoria, Australia: a population-based cross-sectional study. *The Lancet Regional Health - Western Pacific*. doi: https://doi.org/10.1016/j.lanwpc.2023.100903.

230 Karlsson, A., & Håkansson, A. (2018). Gambling disorder, increased mortality, suicidality, and associated comorbidity: A longitudinal nationwide register study. *Journal of Behavioral Addictions*, *7*(4). doi: https://doi.org/10.1556/2006.7.2018.112.

231 McCormick, J., Delfabbro, P., & Denson, L. (2014). Gender and gambling behaviour: An analysis of electronic gaming machine expenditure patterns.. *Journal of Gambling StudieS*, *30*(2).

232 Griffiths, M.D., Wardle, H., Orford, ., Sproston, J., & Erens, B. (2009). Internet gambling and problem gambling in the UK: A prevalence survey.. *Journal of Gambling Studies,* .

233 Wood, R.T.A., & Williams, J.R. (2009). Internet gambling: Prevalence, patterns, problems, and policy options. *Addiction*, *104*(9).

234 Wardle, H., Sproston, K., Orford, J., ..., ., & Pigott, S. (2007). The British Gambling Prevalence Survey 2007. *National Centre for Social Research.*.

235 Wardle, H., Moody, A., Griffiths, M., Orford, J., & Volberg, R. (2011). British Gambling Prevalence Survey 2010. *National Centre for Social Research.* .

236 Baggio, S., Starling, S., Studer, J., & Gmel, G. (2018). Gender differences in gambling preferences. *Journal of Gambling Studies*, *34*(3).

237 Stark, S., Saunders, P., & Whelan, J. (2012). Risky gambling behaviours among young adults. *Addiction Research & Theory*, *20*(6).

238 Ladd, G.T., & Petry, N.M. (2002). Gender differences among pathological gamblers seeking treatment. . *Experimental and Clinical Psychopharmacology*, *10*(3).

239 Potenza, N.M., Steinberg, M.A., McLaughlin, S.D., ..., ., & O'Malley, S.S. (2001). Gender-Related Differences in the Characteristics of Problem Gamblers Using a Gambling Helpline. *merican Journal of Psychiatry*, *158*(9). doi: https://doi.org/10.1176/appi.ajp.158.9.1500.

240 Wenzel, H.G., & Dahl, A.A. (2008). Female pathological gamblers – A critical review of the clinical findings. . *International Journal of Mental Health and Addiction*, *6*(2).

241 Volberg, R.A., & et al., . (2010). An international perspective on youth gambling prevalence studies. *International Journal of Adolescent Medicine and Health*, *22*(1).

242 Griffiths, M.D., & Barnes, A. (2008). Internet gambling: A literature review of the psychological impact of online gambling. *International Journal of Mental Health and Addiction*, *6*(2).

243 Griffiths, M.D., Wardle, H., Orford, ., Sproston, J., & Erens, B. (2009). Internet gambling and problem gambling in the UK: A prevalence survey.. *Journal of Gambling Studies,* .

244 Wardle, H., & et al., . (2011). Measuring gambling-related harms: A framework for action. *Gambling Commission Report*.

245 Wood, R.T.A., & et al., . (2007). Why do internet gamblers prefer online versus land-based venues? Some preliminary findings and implications.. *Journal of Gambling Issues*, *20*.

246 Wardle, H., & et al., . (2024). The Lancet Public Health Commission on gambling.. *The Lancet Public Health*, *9*(11). doi: https://doi.org/10.1016/s2468-2667(24)00167-1.

247 Cyders, M.A., & Smith, G.T. (2008). Emotion-based dispositions to rash action: Positive and negative urgency.. *Psychological Bulletin*, *134*(6).

248 O'Connor, J., Dickerson, M., & Phillips, J. (2009). Rumination, impulsivity, and gambling: Testing a pathways model. *Addiction Research & Theory*, *17*(6).

249 Zermatten, A., & et al., . (2005). Impulsivity and decision making. *Journal of Nervous and Mental Disease*, *193*(10).

250 Scottish Government . (2023). Mental Health and Wellbeing Strategy 2023–2025. Retrieved from https://www.gov.scot/publications/mental-health-wellbeing-delivery-plan-2023-2025/

251 Scottish Government. (2022). Creating Hope Together: Suicide Prevention Strategy 2022 to 2032. Retrieved from https://www.gov.scot/publications/creating-hope-together-scotlands-suicide-prevention-strategy-2022-2032/

252 Scottish Government. (2024). Update to the Scottish Parliament on the implementation of the Suicide Prevention Strategy. Retrieved from https://www.parliament.scot/-/media/files/committees/equalities-human-rights-and-civil-justice-committee/correspondence/2025/suicide-prevention-in-scotland-notification-of-key-publications-15-august-2025.pdf

253 Scottish Government. (2018). A Connected Scotland: Strategy for tackling social isolation and loneliness and building stronger social connections. . Retrieved from https://www.gov.scot/publications/connected-scotland-strategy-tackling-social-isolation-loneliness-building-stronger-social-connections/

254 Scottish Government. (2023). Social isolation and loneliness: Recovering our Connections 2023 to 2026. . Retrieved from https://www.gov.scot/publications/recovering-connections-2023-2026/

255 Scottish Government. (2018). Alcohol Framework 2018: Preventing Harm. . Retrieved from Alcohol Framework 2018: Preventing Harm.

256 Scottish Government. (2018). Rights, Respect and Recovery: Scotland's strategy to improve health by preventing alcohol and drug harms. . Retrieved from https://www.gov.scot/publications/rights-respect-recovery/

257 Scottish Government. (2019). Drug Deaths Taskforce: establishment and remit. . Retrieved from https://www.gov.scot/publications/drug-deaths-taskforce-response-cross-government-approach/pages/2/

258 Scottish Government. (2021). National Mission on Drug Deaths. . Retrieved from https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2022/08/national-drugs-mission-plan-2022-2026/documents/national-mission-drug-deaths-plan-2022-2026/national-mission-drug-deaths-plan-2022-2026/govscot%3Adocument/national-mission-drug-deaths-plan-2022-2026.pdf

259 Fathers Network Scotland. (2016). Year of the Dad. Retrieved from https://www.fathersnetwork.org.uk/year_of_the_dad_campaign

260 Scottish Government. (2012). National Parenting Strategy.. Retrieved from https://www.gov.scot/publications/national-parenting-strategy-making-positive-difference-children-young-people-through/

261 Scottish Government. (2023). Update on perinatal and infant mental health services. . Retrieved from https://www.gov.scot/publications/perinatal-infant-mental-health-services-update/

262 Scottish Government. (2021). Communities Mental Health and Wellbeing Fund for Adults. . Retrieved from https://www.gov.scot/publications/communities-mental-health-wellbeing-fund-adults-year-3-monitoring-reporting-summary/

263 Scottish Association for Mental Health (SAMH). (2024). The Changing Room: Extra Time, in partnership with the SPFL Trust. . Retrieved from https://www.samh.org.uk/get-involved/physical-activity-and-sport/our-projects/the-changing-room

264 UK Department of Health and Social Care. . (2025). 12-week call for evidence on the Men's Health Strategy. . Retrieved from https://www.gov.uk/government/calls-for-evidence/mens-health-strategy-for-england-call-for-evidence

265 World Health Organization Regional Office for Europe. (2016). Strategy on Women's Health and Wellbeing. . Retrieved from https://www.who.int/europe/publications/i/item/WHO-EURO-2016-4173-43932-61910

266 World Health Organization Regional Office for Europe. (2018). Strategy on Men's Health and Wellbeing. . Retrieved from https://www.who.int/europe/publications/i/item/WHO-EURO-2018-4209-43968-61973

267 Department of Health and Children. (2008). National Men's Health Policy 2008–2013. Dublin: Government of Ireland. . Retrieved from https://www.mhfi.org/menshealthpolicy.pdf

268 Department of Health (DoH)/Health Service Executive (HSE). (2014). Review of Ireland's National Men's Health Policy. . Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.hse.ie/eng/services/publications/health-and-wellbeing/national-men-s-health-action-plan-2024-2028.pdf

269 Baker, P. (2015). Review of the National Men's Health Policy and Action Plan 2008–2013: Final Report for the Health Service Executive.. *https://gamh.org/wp-content/uploads/2015/07/Ireland-Mens-Health-Policy-Review.Final-Full-Report.2015.pdf*.

270 Araújo, J., & et al., . (2014). Evaluation of Brazil's National Policy for Comprehensive Men's Health Care (PNAISH). . Retrieved from https://eanjournal.org/article/10.5935/1414-8145.20140097/pdf/ean-18-4-682.pdf

271 Brandão, A., & et al., . (2025). National Policy for Comprehensive Men's Health Care: 15 years of important advances and persistent challenges.. *Interface - Comunicação Saúde Educação*, *29*(1). doi: https://doi.org/10.1590/interface.250311.

272 Araújo, J., & et al., . (2014). Evaluation of Brazil's National Policy for Comprehensive Men's Health Care (PNAISH). . Retrieved from https://eanjournal.org/article/10.5935/1414-8145.20140097/pdf/ean-18-4-682.pdf

273 Brandão, A., & et al., . (2025). National Policy for Comprehensive Men's Health Care: 15 years of important advances and persistent challenges.. *Interface - Comunicação Saúde Educação*, *29*(1). doi: https://doi.org/10.1590/interface.250311.

274 Australian Government Department of Health. (2010). National Male Health Policy. . Retrieved from https://www.health.gov.au/sites/default/files/documents/2021/05/national-men-s-health-policy-2010.pdf

275 Australian Government Department of Health. (2020). National Men's Health Strategy 2020–2030. Canberra: Commonwealth of Australia. . Retrieved from https://www.health.gov.au/sites/default/files/documents/2021/05/national-men-s-health-strategy-2020-2030_0.pdf

276 World Health Organisation. (2016). 'Healthy Man, Happy Family': International Scientific Conference Discusses Men's Health.. Retrieved from https://www.who.int/mongolia/news/detail/19-08-2016--healthy-man-happy-family-international-scientific-conference-discusses-men-s-health

277 Esmailzade, H., & et al., . (2016). Devising a national men's health policy document: The current challenges to men's health in Iran.. *International Journal of Men's Health*, *15*(2). doi: https://www.researchgate.net/publication/308618448_Devising_a_National_Men%27s_Health_Policy_Document_The_Current_Challenges_to_Men%27s_Health_in_Iran

278 Ministry of Health Malaysia. . (2018). National Men's Health Plan of Action Malaysia 2018–2023. Putrajaya: Family Health Development Division, Ministry of Health Malaysia.. Retrieved from https://hq.moh.gov.my/bpkk/images/3.Penerbitan/2.Orang_Awam/5.Kesihatan_Dewasa/2.PDF/5Mens_Health_Plan_of_Action_Malaysia.pdf

279 Munoz, S., & et al., . (2015). The social enterprise as a space of well-being: an exploratory case study.. *Social Enterprise Journal*. doi: https://doi.org/10.1108/sej-11-2014-0041.

280 Ballinger, M.L., & et al., . (2009). More than a place to do woodwork: a case study of a community-based Men's Shed.. *Journal of Men's Health*, *6*(1). doi: https://doi.org/10.1016/j.jomh.2008.09.006.

281 Lowry, R., & et al., . (2022). Step By Step Project Evaluation Report. . *University of Chichester.* .

282 Wilson, N.J., & Cordier, R. (2013). A narrative review of Men's Sheds literature: reducing social isolation and promoting men's health and well-being.. *Health & Social Care in the Community*. doi: https://doi.org/10.1111/hsc.12019.

283 Foster, E.J., & et al., . (2018). The personal and community impact of a Scottish Men's Shed.. *Health & Social Care in the Community*. doi: :https://doi.org/10.1111/hsc.12560.

284 Kelly, D. (2021). Men's Sheds in Scotland: the potential for improving the health of men.. *Journal of Public Health Policy,*. doi: https://doi.org/10.1057/s41271-020-00268-5.

285 Lowry, R., & et al., . (2022). Step By Step Project Evaluation Report. . *University of Chichester.* .

286 Glasgow Clyde College. (2025). SCQF Level 5: Conversations for Male Mental Health. . Retrieved from https://scqf.org.uk/news-and-blog/breaking-the-stigma-scqf-level-5-qualification-tackles-male-mental-health/

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