Social cost

Economic cost

Pressing issues
  - Containment and prevention
  - Anti-depressive policy
  - Follow-up care

Summary

Social cost

A mentally ill person is often not the best of friends for anybody. Rather than being able to help others, they need help. By the time anyone realises that a man needs outside help he has probably stopped being much of an asset to friends, neighbours and even his family. This has an effect upon all those who need his help, guidance, and support. Yet it is very often being needed for help, guidance and support that drives a man and gives him a mentally fulfilling life. The longer he goes untreated, the worse it is for everyone around him.

Many cases of untreated mental ill-health end up in prison. There, they usually get entirely the wrong kind of treatment and may finish a custodial sentence far worse than they started it.

Economic cost

Businesses suffer from absence and loss of efficiency. They may have to go through the expensive process of firing a man and rehiring his replacement. Some businesses prefer to keep a check on the mental health of all employees and offer counselling at the earliest possible stage of ill health; this is better economically and socially but carries its own costs.

Often, someone with severe ill-health is unable to work and becomes reliant on social welfare. The length of time they will remain on welfare broadly equates to the length of time they are not treated.

Even if someone with mental health problems manages to hold down a job, it is unlikely to be the best job they could do. Illness has a direct negative impact upon the financial economy. Productivity is lower and there is either lower taxable income, or no income tax at all from the person suffering.

Pressing issues

The most urgent issue on mental health is the containment and prevention of suicide. Nobody’s health can improve if they are not at least alive.

The most important issue on mental health is the cessation of policies that lead to depression.

The most financially tasking issue on mental health is the provision of pre-primary care.
**Containment and prevention**

Somebody in the middle of a suicidal episode (contemplating imminent death) might – if we are lucky – reach out to one person or organisation; if they make contact of any kind, they will rarely reach out to anyone else.

It is impossible to control the quality of the contact they make for every individual. They may phone the Samaritans, for example, and find themselves speaking to someone with a distinctive regional accent. If we are lucky, that accent will represent calmness and sanity; if we are unlucky, the accent will represent oppression, rage or disgust for the individual. There is no way to control for this.

Given the impossibility of getting the first contact perfect, it is even more vital that all first-contact people are well-trained. This training needs to be planned by – and possibly even undertaken by – men with a record of social and political care of other men, to stand the greatest chance of success. First contact training must not be given by those with little understanding of masculinity or the male experience.

**Anti-depressive policy**

Government policies, including law and regulation, need to start focusing on men’s needs. Men’s lives have been made worse by policies that – whatever their intent – marginalise them from family and society.

Men have always had a precarious relationship with their own family and children. It has been men’s strong paternal instinct that has held them to suffer hardship and early death on behalf of their family. Far too many fathers, forcibly divorced despite not breaking their marital vows and despite doing all they can for their children, find themselves kicked out of home and family. Being wrenched away from their children is devastating to most men, a trauma that has only lately been professionally measured. Given the notable statistical harm to children of being fatherless, there should be policies to strengthen, not further weaken, the family.

Men and boys are continually given the message that they are privileged, even to the extent that university students are forced to make such a statement against their judgement and conscience if they wish to study at the university they have just started at. Yet males know they have worse educations, higher unemployment, are punished more harshly throughout school and by the judiciary, will start off by earning less per hour on average than women, and after a lifetime of hard work and lower health care, should expect to spend only a fraction of time in retirement compared to women. In short, boys and men are being indoctrinated with a message that, even if they believe it on one level, does not accord with observed reality. Colloquially, believing something that is not true is called madness. We have to stop driving boys, and men, mad.

**Follow-up care**

Many NHS Trusts have designated members of their mental health team who will attend to people contemplating imminent suicide. These teams are saving lives. Most patients are not ‘sectioned’ and it would be impossible, as well as inadvisable, to section most people. Once the person is considered safe, they are left to continue with their life. They are left.

Most suicidal people are suffering from acute depression, anxiety or other disabling conditions.

It is almost useless to have more suicide emergency teams around the country to see to people who are suicidal, if the suicidal person is then left without follow-up attention. This attention must be proactive but not invasive. A suicidal person usually cannot seek help, they often cannot keep a doctor’s appointment (and fining them for this is detrimental to their health), and may not even be aware of the existence of an appointment made two days before. In short, they are a hard bunch to treat, until they are at a point where they are able to take an active role in their own healing.
Close care is required if a person with mental issues is to ever be able to take an active role in their own healing and move into primary care. The length (and therefore cost) of that close care is generally dependent upon how long they are left uncared for. It is almost a definition of mental illness that the longer a person gets no care, the more care they need.

Rapid intervention to deal with emergencies is necessary and is already being improved. Moving someone who has needed such care into long-term treatment is poorly done and might take several applications from a GP, even though the person is known to have mental health problems. Earlier intervention in deteriorating mental health, leads to quicker recovery and a lower financial and social cost to society.

**Summary**

The poor health of men and boys has a large social and economic cost. The social or economic justification for putting effort into solving it is clear.

Government can not avoid making some decisions which will have a negative impact on people. Nevertheless, there should be legislative and policy oversight to ensure that nothing unnecessarily or disproportionately impacts upon boys and men to worsen their mental health. A ministry for men would be the most obvious way to provide this guidance.

Putting people into prison effectively because they are suffering from mental ill-health is neither socially nor economically sound. We need to be a society that cares about people with poor health, not a society that just locks them away. What we are doing currently is like ancient societies once did with sufferers from epilepsy or leprosy: lock them away from us and hope not to be contaminated. It didn’t work then and it isn’t working now.

Services are needed to care for those who are closed off from society – often by their own ill-health. These need to be aimed at bringing sufferers into primary mental health care. This needs to be combined with greater social and legal support for men and boys.

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