Centre for Policy Research on
Men and Boys

Evaluating and Scaling Male Community-Based Programmes

Interim Report

Dr Dimitrios Panayotopoulos-Tsiros, Dr Gary Shepherd,
James Fildes, and Professor John Tomaney

June 2026

Contents

Centre for Policy Research on Men and Boys

The Centre for Policy Research on Men and Boys (CPRMB) is a research organisation and think tank dedicated to understanding and addressing issues that uniquely affect men and boys in the UK. Its vision is a world where men and boys of all backgrounds thrive in their families and communities, one where the sexes can rise together by supporting each other.

It will do this by supporting the development of new research, thinking and insight into policy affecting men and boys. This is by focusing on critical areas where they face unique challenges, promoting policy change, and fostering public awareness and understanding. These are in seven core areas: Economy, Employment and Skills; Education; Health; Fatherhood and Family; Criminal Justice; Male Identity; and Portrayal of Men in Media and Culture.

Randal Foundation

About the Randal Charitable Foundation

Founded by Dr Nik & Moni Kotecha, The Randal Foundation has a clear unwavering vision, which is to directly save, and significantly improve the lives of 1 million people globally.

Supporting issues connected to healthcare for the most vulnerable, tackling mental ill-health, alleviating poverty, and providing education for the most disadvantaged are the areas of focus for the Foundation. It works at scale and with pace with aligned partner organisations, to deliver its goals.

For more information about the Randal Foundation visit: https://www.randalfoundation.org.uk/

Centre for Policy Research on Men and Boys

Randal
Charitable Foundation

Report Authors

This report was authored by:

Dr Dimitrios Panayotopoulos-Tsiros (Research Fellow, University College London): Dr Panayotopoulos-Tsiros is a Research Associate and Honorary Research Fellow at the Bartlett School of Planning, UCL, and an Affiliated Researcher at the Bennett Institute for Public Policy, University of Cambridge. His academic focus combines community, place and social infrastructure. He is the lead researcher on this project.

Dr Gary Shepherd (Senior Lecturer in Counselling and Mental Health, York St John University): After graduation Dr Shepherd began working as a counsellor within the charity sector and developed and ran a male-focused anger management intervention. His research focus is on male suicide prevention and how male centric community groups can reduce suicide rates through challenging hegemonic masculinity.

James Fildes is the Founder of Space North East, an award-winning organisation that delivers community-led support to men in the North East of England 6 days per week. Space also delivers an extensive outreach programme, travelling the North East with its mobile coffee van, targeting professions such as construction and manufacturing, which experience the highest rates of suicide, to encourage men to seek help and challenge long-held stigmas about mental health. James is also a guest lecturer at the University of Sunderland on their Male Psychology module

Professor John Tomaney of Pro-Provost (Regional Communities) and Professor of Urban and Regional Planning at UCL, where he leads on developing UCL's relationships with communities outside London. His recent work has focused on the importance of social infrastructure in local development. He is a co-author of Social Infrastructure and Left-behind Places (Taylor and Francis, 2024).

Acknowledgements

We would like to thank Dr Nik Kotecha OBE DL, Founder and Chairman of the Randal Foundation for the generous grant to enable this major research project.

We would also like to thank Andy Man's Club, Dope Black Dads, Dad La Soul , MAN v FAT, Samaritans, Space North East and UK Men's Sheds Association for their participation in the initial round table.

In addition, thank you to the CPRMB Research Fellow, Richard Miller for his work on producing the sector database and mapping.

Foreword

We are now all too familiar with the story. Too many men, too many partners, families and communities are being scarred by male (and female) suicide. The numbers have been growing. The biggest cause of death in men under the age of 50. More men dying through suicide than people killed in car accidents. The rates of suicide in the North East are over twice those in the South East. Suicide statistics hide a world of pain, despair and overwhelming loneliness. And too often hopelessness.

This is one of the many reasons why men's community groups play such an important role in helping men at risk of harm, of depression and simply loneliness. However, the challenge is not simply that there are too few groups. It is also that many existing organisations are under- resourced, unevenly supported and operating without the frameworks that would help them sustain and develop their work. In some places, more provision may be needed; in others, the priority may be to strengthen what already exists. Simply put, we do not know in sufficient detail how they operate, how they can be better supported and how they can be scaled.

That is the work the Centre for Policy Research on Men and Boys (CPRMB) with the generous support and partnership of the Randal Foundation has set out to do with this project. As this report argues the Men's Health Strategy offers a wonderful opportunity to get it right when it comes to supporting and reducing harms men face in their lives, homes and communities. The strategy explicitly frames future reform through three broad shifts:

1. from sickness to prevention
2. from hospital to community
3. from analogue to digital.

The work we are undertaking intersects with these three shifts. It will answer the question of how services and systems can engage men earlier, how there can be more of those services and how those services can reach more men wherever they live in the UK.

Understanding what works, how to scale and how not to intervene are all factors that need to be better understood by the health system, local authorities, the Department of Health and Social Care (DHSC) and organisations themselves. Men such as Marvyn Harrison of Dope Black Dads or James Fildes of Space North East are social entrepreneurs, difficult to clone, unique in their approaches. The alchemy of what they have done and achieved can however be distilled and disseminated. Monies available can be directed well rather than wasted. Audit and value for money systems managed by the state need to be light touch so they do not overwhelm or crush the entities they seek to support. All of this is in scope for this project.

However, the overarching goal is to reduce the rate of male suicide. And to reduce it by at least 10% over the next five years. We believe this is an attainable goal. But more than that it MUST be an attainable goal. For we need to do far more to help men to lead healthy lives, get seen earlier when they fall ill and support them far more in their moments of direst need.

As Marcus Aurelius said, 'men exist for the sake of one another.'

Executive Summary

Across England, boys and men experience disproportionately high levels of poor mental health, social isolation and suicide risk. This burden, however, is not evenly distributed. It is shaped by deprivation, regional inequality, weakened social infrastructure, uneven access to services, and patterns of help-seeking that often leave men outside formal provision until distress has intensified. Many of the organisations considered in this report have emerged from the ground up rather than being designed as formal services. They are often created by and for men, beginning at a very local level in response to the lived experience, loss, frustration or concern of founders who have seen men around them struggle to find support that feels accessible or trustworthy. Examples include organisations such as Space North East, Menfulness and Dope Black Dads, which differ in form and geography but share a common starting point: they create familiar, non- clinical spaces where men can connect through activity, conversation and mutual support. Some may work alongside social prescribing pathways or receive referrals from statutory services, but they should not be understood simply as social prescribing programmes. Their value often lies precisely in the fact that men encounter them as community spaces first, rather than as extensions of the health system.

In that context, this project asks what role community-led, non-clinical programmes can play in supporting boys and men before crisis point, and what would be required to strengthen, sustain and scale the most effective forms of provision?

This work sits at an important policy moment. England now has its first Men's Health Strategy, with a stated shift towards prevention and community. The strategy explicitly recognises that evidence gaps remain around men's access to support, health literacy, engagement with services, and the role of community-based approaches. This project speaks directly to those gaps by asking what kinds of community-led, non-clinical provision exist, who they reach, how men come to trust and use them, and what forms of support, funding and evaluation would allow them to be strengthened without losing their distinctive character. It therefore has a strong opportunity to shape an emerging policy agenda to inform commissioning, funding, partnership and implementation.

The project also builds on earlier UCL and York St John University research, which showed that community-led, non-clinical interventions matter profoundly for men's wellbeing, especially in places ‘left-behind’. That earlier work suggested that what makes these initiatives effective is a constellation of conditions: purpose, familiarity, mutual respect and trust, ownership, consistency, and a strong fit with place and local culture.

The current phase extends that work in two directions. First, it is building a broader map and typology of community-led provision across England. Second, it is using meetings, roundtables.

and related project materials to sharpen the conceptual and policy questions that should guide the next stage. The mapping already suggests that England has a messy and uncoordinated geography of community support. Provision appears uneven, patchy and locally contingent but this should not be read simply as a deficiency. In part, it reflects the fact that effective community-led support emerges from local conditions: the presence of trusted founders, voluntary-sector capacity, local histories, cultural fit, and the ways men in different places recognise support as legitimate. The emerging policy question is therefore less about whether provision exists in the abstract, and more about how national support can enable stronger local action by identifying where visible support ecosystems are thin relative to need, where stronger local ecologies have emerged, and what kinds of provision appear to be working for whom and why.

At the same time, through policy and practitioner engagement, it is becoming increasingly clear that the central challenge is to understand the conditions under which non-clinical initiatives become effective, sustainable and supportable. A central tension running through first roundtable organised by the Centre for Policy Research on Men and Boys in April 2026 was that these organisations may need public, NHS or philanthropic support to become more sustainable, but the form of that support matters. Overly clinical language, visible institutional branding, referral requirements or narrow outcome measures could weaken the low-pressure, trusted character that makes men willing to attend in the first place. The roundtable concluded that effective support needs to be nationally legible but locally grounded and pointed to a series of recurring concerns:

- fragile and opaque funding routes
- the risk of imposing inappropriate evaluation frameworks too early
- the need to co-produce outcomes with organisations rather than impose them from above
- the importance of leadership development and governance support
- the danger of treating all men as a single category
- the need to recognise that a core reason men attend is because they are not a statutory service
- the need to think about men's distress not only as a mental health issue in the narrow clinical sense, but also as a problem of purpose, identity, social connection and life pressures such as debt, relationship breakdown, gambling, work or substance use.

The evidence gathered so far supports five interim conclusions:

1. community-led, non-clinical initiatives should be understood as part of a wider ecosystem of care
2. what makes them valuable is the intangible and relational modus operandi which is difficult to measure through conventional performance frameworks
3. scaling should not be understood only as making existing organisations bigger; in some places it may mean strengthening organisations on their own terms, building leadership capacity, or enabling more trusted local actors to develop analogous forms of support
4. the strongest policy frame may be the health system and prevention agenda, rather than exclusively a local authority focus
5. the next phaseoftheproject will need to balance rigour with realism: building a stronger evidence basewhilerecognising that much of the value of these organisations lies in accepting menastheyare, meeting them where they are, and offering support that fits their lives, placesandrelationships.

The next phase aims at building a stronger evidence base without flattening the relational and place-based qualities of these initiatives. It will focus on completing and refining the national mapping, selecting and undertaking deeper qualitative work with a small number of organisations, developing baco-produced and proportionate outcomes framework, and translating the findings into decision-ready insights for government, commissioners, regional actors and funders. All aimed at helping these organisations to grow in scale and for more to coming into being – with the collective aim of helping to reduce male suicide.

Introduction

A generous grant from the Randal Foundation is enabling a major research project by the Centre for Policy Research on Men and Boys (CPRMB) to assess the value of male community-based programmes in benefitting adult male mental health. More than 80 men per week take their own lives in England.That is three times the number of peope killed on the country's roads. Suicide remains the biggest killer of men under 50.

The aim of the research is to help inform and shape national and regional policies with the goal of cutting those numbers. This research also aligns with the delivery of the Men's Health Strategy for England and is also aimed at making an effective contribution to its delivery.

Men traditionally are reluctant to access clinical services and it's hoped male community health organisations and their programmes (for example, Men's Sheds, Andy's Man Clubs, Talk Clubs) may be shown to provide support in an effective and scalable way. If that proves to be the case, the aim is that local authorities, national/local health departments, mental health services, and funders (including philanthropic and corporate) will support and incorporate such groups into broader strategies.

The research is being led and conducted by John Tomaney, Professor of Urban and Regional Planning in the Bartlett School of Planning at University College London and his team which has already carried out encouraging work into non-clinical interventions into men's mental health in the north-east of England.

He is being supported by Dr Dimitrios Panayotopoulos-Tsiros (University College London), Dr Gary Shepherd (York St John University) and James Fildes (Space North East).

The research team will aim to map the various organisations around the country and to interview the people who run them and those who attend. It will look at how and why various groups were founded and the benefits their members feel they get from them. It will examine any problems they may have in terms of funding, capacity and meeting spaces, for example, and consider ways in which they might be supported by GPs, health trusts, employers, local authorities et al. It will also look at the image and promotion of such groups online, offline and in the media and social media as there is already evidence that men are more likely to seek help when struggling if engaged by such campaigns.

This interim report provides a staging post before fuller research is undertaken, which will be published in Spring 2027.

Policy and Research Context

Policy and Research Context

The Men’s Health Strategy (DHSC, 2025) presents men's health as a major and long-neglected public issue. It links poor outcomes to deprivation, social inequality, unhealthy behaviours, barriers to access, and social norms that shape how men interpret distress and whether they seek help. It also explicitly frames future reform through three broad shifts:

1. from sickness to prevention
2. from hospital to community
3. from analogue to digital.

The present project sits directly at the intersection of those priorities. It is concerned with prevention, with community-based support, and with the question of how services and systems can engage men earlier, more effectively and in forms they are willing to use.

The Men’s Health Strategy emphasises inequalities between regions and across cohorts, recognising that risk accumulates differently depending on place, deprivation, work, ethnicity, sexuality, disability and life stage. It also acknowledges important evidence gaps, particularly around men’s engagement with services, health literacy, and the practical design of interventions that men will use. These gaps are precisely where this project aims to contribute by improving the evidence base on community-led, non-clinical provision, identifying the mechanisms through which it may work, and translating that knowledge into policy and commissioning terms. The Strategy also marks a shift in how policy engages with community-based mental health support by committing new investment to programmes designed to reach men most at risk and least likely to engage with traditional services. The task, therefore, is to understand what kinds of support exist or are emerging, how they work, who they reach, and how policy can strengthen this ecology without undermining the trust, local fit and relational qualities that often make it effective.

Research to date points in the same direction. Previous UCL work in North East England (Panayotopoulos-Tsiros et al., 2025) examined three community initiatives – Space North East in Sunderland, Woodshed Workshop in Sacriston, and Chopwell Regeneration Group in Chopwell – and situated men's mental health and suicide risk within wider patterns of regional inequality, deindustrialisation, weakened social infrastructure, loneliness and loss of role or purpose. It argued that clinical services remain vital, but that they cannot, on their own, address the social and cultural conditions through which distress is produced and experienced. That work identified several recurring ingredients. The first is purpose: men have a reason to leave the house, turn up, take part and do something with others. The second is familiarity: activities recur and become part of a routine. The third is mutual respect and trust: men can talk in settings where they feel understood and not judged. The fourth is ownership: participants can become contributors, helpers and co-producers of the support they initially received. The fifth is consistency: support is reliable over time, not just available as a one-off intervention. These ingredients work together through place, routine, activity and belonging.

York St John University's work (Shepherd et al., 2024) supported this line of inquiry highlighting that community-led, non-clinical initiatives matter because they can create routes into support that formal systems often struggle to provide. It assessed “Menfulness” a York-based men's suicide prevention and wellbeing charity and found that activity-based provision, clear communication, welcoming first contact, frequent sessions and meaningful relationships over time can all support engagement. It also showed that different activities can create different levels of emotional intensity: some men may want a direct talking space, while others may first need a lighter route into connection. It cautions against assuming that achievement, goal-setting or visibly therapeutic framing will always be helpful. Although this project focuses primarily on adult men, related evidence with younger male cohorts points to a similar design lesson: support is more likely to be usable when it is co-created, practical and socially engaging. Recent work with 12-to-16-year-olds from Black and mixed ethnic groups in London found that co-created mental health and life-skills workshops were most useful when they combined practical coping strategies with enjoyment, social connection, self-reflection and space to talk about emotions (Pomfret & Wong, 2026).

This view is increasingly reflected in policy and practice literature, which frames suicide prevention as a whole-system public-health task rather than a matter for clinical services alone. National suicide prevention policy identifies middle-aged men, people who have self-harmed, people in contact with mental health services, and groups exposed to financial difficulty, alcohol and drug misuse, loneliness and social isolation as priorities for prevention (Department of Health and Social Care, 2023). It also places emphasis on earlier intervention, crisis support, bereavement support, improved data, and cross-sector action across government, the NHS, local authorities, employers and the voluntary and community sector (Department of Health and Social Care, 2023; Garratt & Kirk-Wade, 2024). This is reinforced by local suicide prevention guidance, which presents suicide prevention as a whole-system public-health task requiring local partnerships, suicide audits, community engagement and action on wider determinants such as debt, unemployment, substance use and social isolation (Public Health England & National Suicide Prevention Alliance, 2020). Recent suicide statistics further underline the gendered nature of the issue, with suicide in England and Wales remaining around three times more common among men than women and rates varying by place, age and deprivation (Danechi, 2026).

These policy priorities sit within a wider structural literature on place, inequality and mortality. Academic work on “deaths of despair” and related mortality trends provides an important backdrop. Studies have linked suicide, drug-related deaths and alcohol-related mortality to economic insecurity, income inequality, low social mobility and place-based disadvantage (Knapp et al., 2019; Kuo & Kawachi, 2023). While much of this literature has developed from US evidence, recent UK work points to similar concerns about the relationship between place, long- term economic decline and despair-related mortality. Saville’s analysis of former coalfield communities, for example, found higher levels of suicide, alcohol-related deaths and drug poisoning in areas with a mining history, with some differences persisting even after deprivation was taken into account (Saville, 2026). Comparative work across the US, UK and Canada also cautions against treating these causes as a single uniform phenomenon, since suicide, alcohol- specific mortality and drug-related deaths may follow different patterns across countries, regions and cohorts (Dowd et al., 2022). This suggests that community-led men’s mental health interventions should not be understood only as downstream responses to individual distress, but also as attempts to rebuild connection, trust and help-seeking routes in contexts where formal ces may be experienced as inaccessible, stigmatising or poorly aligned with men’s everyday lives.

If the structural literature explains why place, connection and social infrastructure matter, programme evaluations begin to show how some community organisations may respond in practice. The It’s a Goal! programme used football metaphors and non-clinical language to engage men who might not otherwise access mental health support (Broadbent, 2009; Smith & Pringle, 2010). More recent work by Panayotopoulos-Tsiros et al. (2025), together with the evaluation of Menfulness by Shepherd et al. (2024), suggest that activity-based, male-only and peer-led spaces can create trusted, non-clinical routes into conversation, belonging, help- seeking and more positive mental health. These examples align with service-design principles that emphasise activities as routes into conversation, welcoming and accessible entry points, clear communication, relationships built over time and opportunities for men to experience connection without immediately entering formal therapeutic settings (Samaritans, 2021, as cited in Shepherd et al., 2024).

At the same time, the evidence base remains incomplete. Existing research and evaluation provide strong hypotheses about mechanisms but less robust evidence on reach, effectiveness, sustainability, costs, governance, safeguarding, and the conditions under which different models can be supported or scaled. There remains a need for more systematic understanding of what provision exists, which men it reaches, which mechanisms appear to matter, and how policy and commissioning can support this ecology without over-formalising the qualities that make it trusted and usable. The current project is designed to close part of that gap.

Current Phase of Work and Evidence Base

Current Phase of Work and Evidence Base

This project's first phase is an evidence-building and framing exercise bringing together three streams of evidence:

1. an England-wide mapping of visible community-led, non-clinical provision for boys and men
2. synthesis of earlier research and evaluation on the mechanisms through which this kind of support may work
3. structured engagement with practitioners, policymakers, funders and researchers to test what the mapping means and what the next phase should investigate.

2.1 Mapping

The mapping was designed as a first attempt to make visible a scattered and only partly documented landscape of community-led, non-clinical support for men across England. Working at the local authority level, the mapping included grassroots groups that were set up by men for men, had an explicit or implicit focus on mental health and wellbeing, or used shared activities such as sport, walking, making or social connection to reach men who may not otherwise engage with formal support.

The emerging database was built with the intention of going beyond counting and supporting typology-building. The inclusion criteria deliberately excluded referral-only services, structured short courses, and most institutionally created provision, while allowing groups that were either free to attend or charged membership or participation fees. Relevant fields include geography, organisational type, branch structure, core activity, intended audience, website presence and social media activity.

The resulting mapping uncovered 2082 community-led non-clinical interventions and should be treated as a useful picture of visible provision, rather than a comprehensive register. It captures the unevenness, informality and local contingency of this field (See Figure 5), while also highlighting the methodological difficulty of mapping groups that may have little online presence, uncertain activity status, or sit between grassroots and institutional forms of support.

2.2 Qualitative Research and Stakeholder Engagement

As part of the wider engagement with professionals, policymakers and academics, the Centre for Policy Research on Men and Boys in partnership with the Randal Foundation held a roundtable in April 2026 to discuss the findings from the mapping and gather lived-experience evidence. The roundtable allowed the project to test its rationale and assumptions against the realities of delivery, funding, governance and policy use, while also bringing to the surface the ambiguities and tensions currently existing in practice (see Section 3.3).

The next phase of the research will build on this engagement through fieldwork with a selected group of community-led organisations working with men across England. The purpose is to understand, in practical terms, how these organisations work: how they are built, how they earn trust, who they reach, what kinds of support they provide, and what enables or constrains their sustainability. This will allow the project to move beyond a map of provision towards a clearer account of how community-led support operates in practice, and what policy or funding conditions may help strengthen it without undermining the qualities that make it effective.

This approach is designed to capture both the organisational conditions and the lived experience of community-led support. It will also inform the project’s thinking on outcomes. Many organisations in this field do not describe themselves primarily as mental health services, even where their work may contribute to wellbeing, help-seeking, reduced isolation or suicide prevention. The research will therefore explore what success looks like from the perspective of organisations and participants themselves, while also considering what evidence policymakers, funders and commissioners reasonably need. The aim is to develop an account of outcomes that is credible for policy use, but proportionate to the realities of small, community-led organisations and sensitive to the trust on which their work depends.

Interim Findings

3. Interim Findings

3.1 The‘problem’

The project is responding to a layered problem. At one level, boys and men experience a disproportionate burden of poor mental health, social isolation and suicide risk. At another level, that burden is shaped by geography, and a range of socio-economic conditions such as deprivation, ethnicity, family life, age, etc. Recent ONS data indicate that suicide remains a persistent and worsening public health concern in England. Although age-standardised suicide rates are lower than they were at the beginning of the ONS time series in 1981, the longer-term trend has shifted. Since the mid-2000s, suicide rates have shown a gradual upward movement for both men and women, marking a notable departure from the earlier decline (Figure 1).

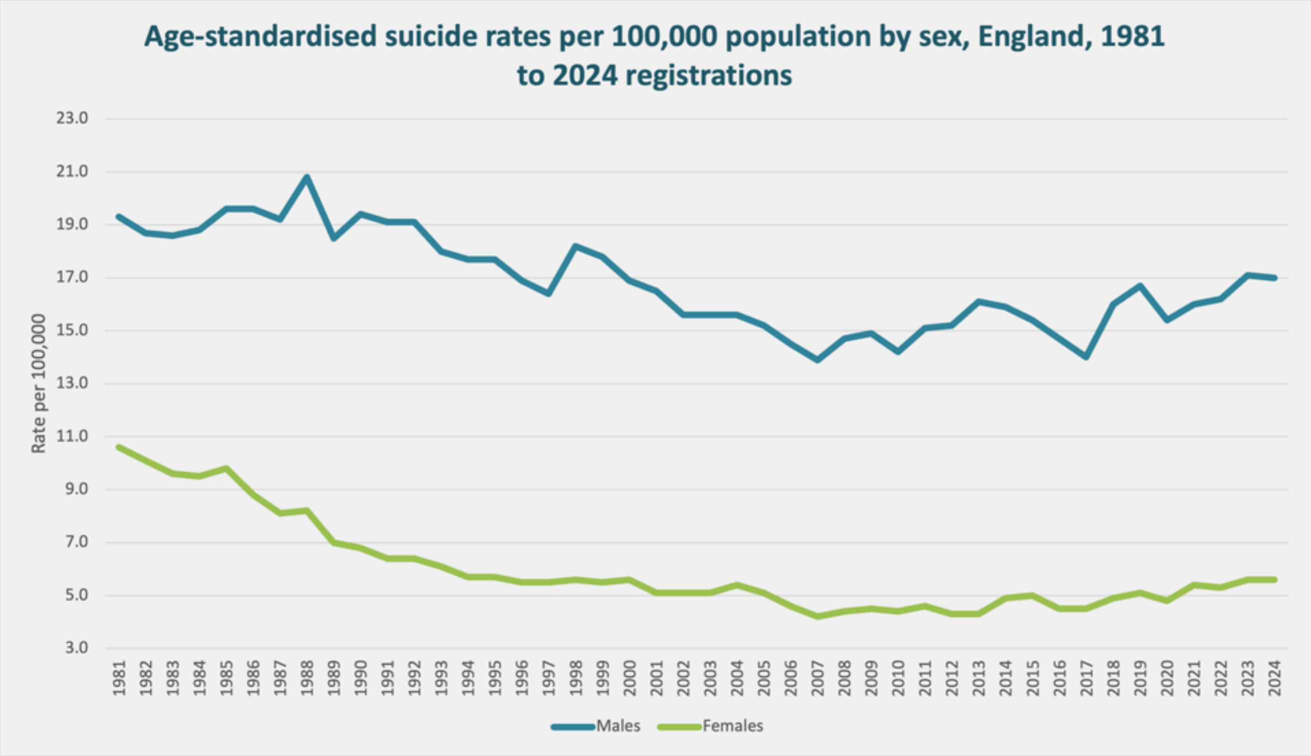

Figure 1: Suicide by sex in England, 1981 to 2024. Source: ONS, Suicides in England and Wales dataset, 3 October 2025, Table1

In England, the lowest male suicide rate this century was recorded in 2007, at 13.9 deaths per 100,000, corresponding to 3,048 male deaths (Figure 2). By 2024, the male suicide rate had risen to 17.0 per 100,000, corresponding to 4,231 deaths. This is equivalent to an increase from around 8.4 male suicide deaths per day in 2007 to around 11.6 per day in 2024, or just over three additional male deaths per day. The male suicide rate in 2023 was the highest recorded this century, at 17.1 per 100,000, with 2024 the second highest at 17.0 per 100,000. This points to a sustained worsening in the wider mental health landscape that forms the backdrop to this project.

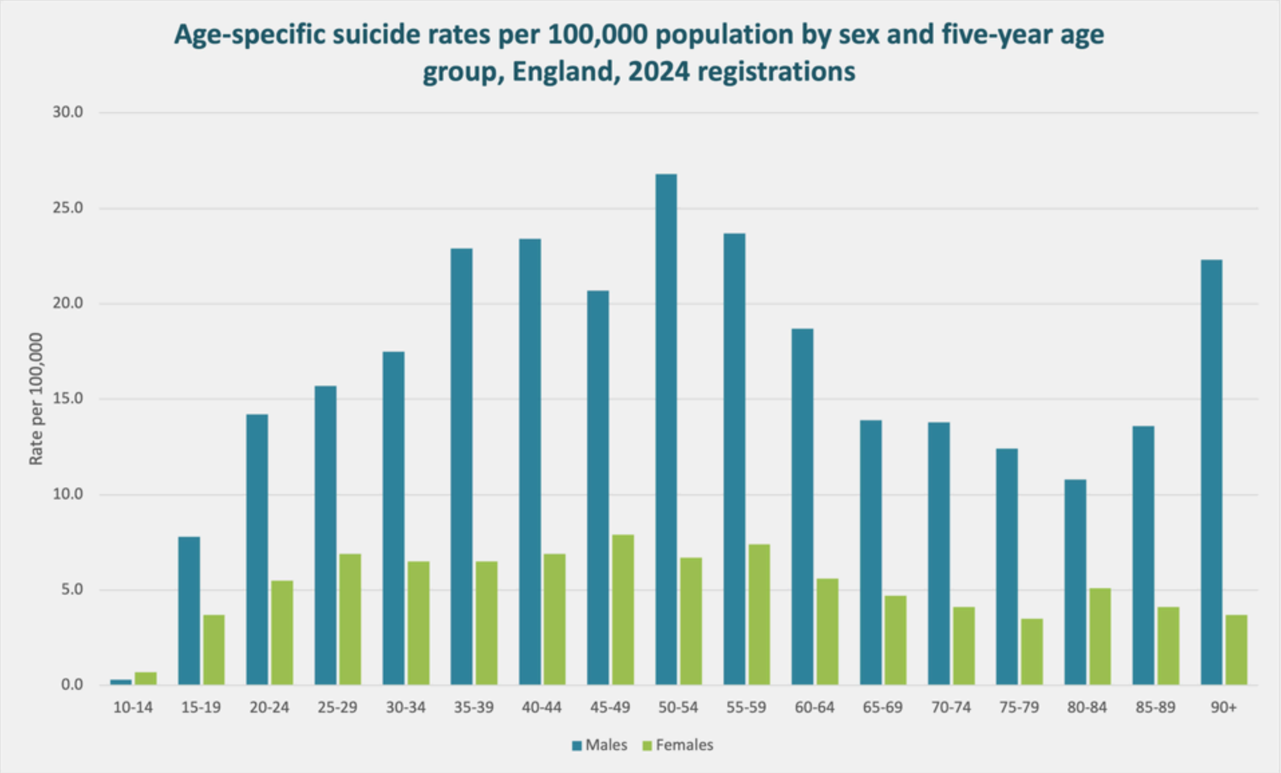

Figure 2: Suicide by sex and age group in England. Source: ONS, Suicides in England and Wales dataset, 3 October 2025, Table 5.

The issue is therefore not just that distress exists, but that it is unevenly experienced and unevenly supported. Recent evidence (see Shepherd et al., 2023) repeatedly points to the limits of formal mental health routes. Some men do not seek help until distress has intensified. Some do not recognise formal services as spaces designed for them. Others face waiting lists, diagnostic thresholds, practical barriers or a lack of cultural fit. These barriers and challenges highlight that a prevention strategy such as that proposed by the Men's Health Strategy must pay attention to the earlier, more informal and more relational forms of support through which men may first reconnect, talk, return and ask for help (see Shepherd et al., 2025).

The challenge is also social and place-based. Previous UCL work situates men's distress in relation to a wider set of structural social conditions. These include deindustrialisation, the decline of social infrastructure, loss of role or purpose, loneliness, weakened community structures, and reduced opportunities for meaningful connection. The CPRMB roundtable discussion added further emphasis on life pressures such as debt, relationship breakdown, gambling, substance use and moments of acute crisis. These issues are not all mental health problems in the narrow clinical sense, but they can shape the pathways through which men become isolated, overwhelmed or at risk.

This has important implications for policy, as early or effective support may often be located outside formal clinical settings. Where men's distress is shaped by social, relational or practical pressures, support may begin with actions such as a walk, a workshop, a football session, a shared meal, or a peer group in a familiar environment. These forms of support matter not only because of what they provide, but because of how they are experienced: as accessible, trusted, and rooted in environments where men may already feel some sense of belonging.

The current project is therefore asking how these forms of support operate, which men they reach, and how they can be strengthened without turning them into something men no longer recognise or trust. This question is particularly important because the evidence base remains uneven. Community-led organisations are increasingly visible, but they are not yet well understood as a field. As the mapping exercise highlights, some are sophisticated and well governed; others are informal, founder-led, or fragile. The project is therefore addressing a double gap: a service and support gap for men, and an evidence and policy gap about the community organisations attempting to respond.

3.2 Geography of suicide, distress and non-clinical support

The ongoing mapping exercise is positioned within this context. The initial maps suggest that suicide rates among men are geographically widespread but unevenly distributed across England, while community-led, non-clinical support appears to follow a separate and more clustered geography. These figures should be interpreted with care. Official suicide data are essential for identifying broad regional and local authority patterns, but they cannot fully capture the finer-grained geography of risk within places. Even within the same region or local authority, suicide risk, deprivation, service access, social infrastructure and community provision are likely to vary significantly between neighbourhoods and population groups.

First, suicide risk is geographically uneven but not confined to a small number of places. Age-standardised suicide rates between 2022 and 2024 vary by region, with higher rates in parts of the North East, North West, South West and Wales, while London records substantially lower rates (Figure 4). Change over time is also spatially varied: some areas with high rates have seen further increases, while some areas with lower rates have also experienced sharp rises. This reinforces the importance of place-based analysis. National strategy can set direction, but it cannot by itself determine what effective support should look like in every place. The task is therefore not to roll out a single model of provision, but to enable local authorities, Integrated Care Boards, NHS partners and community organisations to understand their own patterns of risk, identify gaps in local support, and strengthen the forms of community-led provision that fit local conditions[1].

---

[1] England already has a national suicide prevention strategy and a local planning architecture for suicide prevention. The 2023–2028 Suicide Prevention Strategy identifies middle-aged men as one of the groups requiring specific attention and states that all areas of the country now have local suicide prevention plans. Public Health England's local suicide prevention planning guidance similarly emphasises the role of local authorities, NHS partners, health and wellbeing boards, the voluntary sector and wider local networks in developing and implementing local plans.

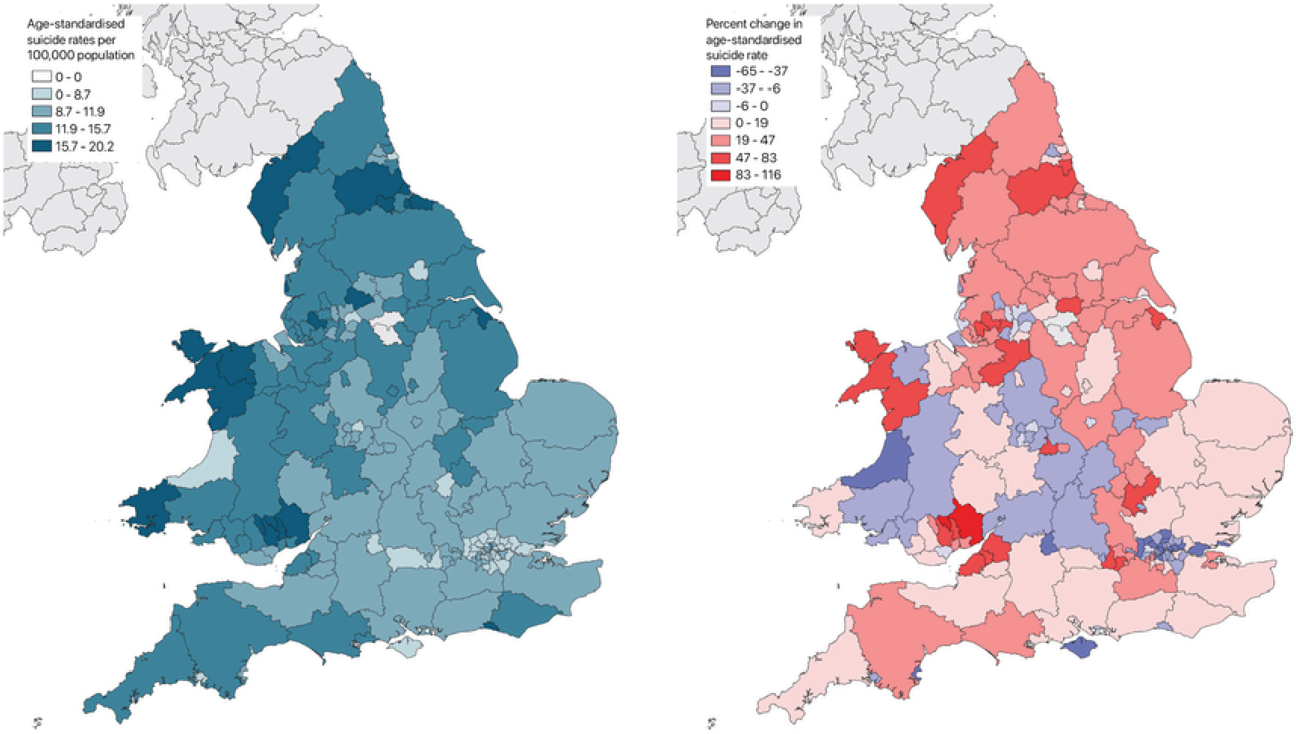

Figure 3: Age-standardised suicide rates (2022-2024) and Percent change in age-standardised suicide rates, 2001-2003 to 2022-2024. Source: Office for National Statistics (ONS), released 3 October 2025, ONS website, statistical bulletin, Suicides in England and Wales: 1981 to 2024.

Second, community-led provision is also uneven (Figure 5). Mapping organisations by local authority provides a useful starting point, but absolute counts can be misleading because they do not account for differences in population size. Organisation density per 100,000 people therefore provides a more meaningful basis for comparison with suicide data. On this measure, provision remains highly uneven: some local authorities have no visible organisations of this kind, while others have more than ten per 100,000 people. London appears distinctive in the current mapping, although this may partly reflect the limits of identifying provision in dense metropolitan areas, where services may operate across borough boundaries, be less explicitly male-specific, or be harder to identify through current search methods.

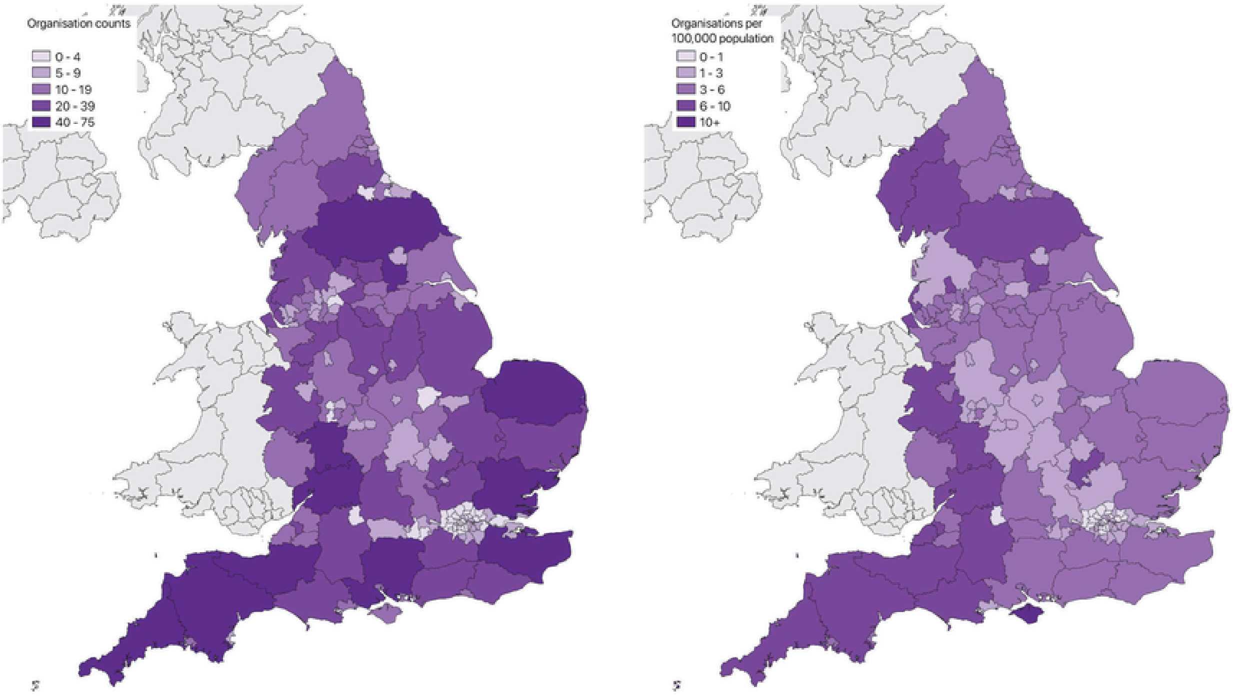

Figure 4: Community-led, non-clinical interventions for men’s mental health across England, shown as absolute counts and per 100,000 population. Source: Centre for Policy Research on Men and Boys, 2026.

Read alongside suicide rates, the emerging picture is one of partial overlap rather than clear alignment (Figure 6). There is no obvious pattern suggesting that higher organisation density is associated with lower suicide rates. Some places with relatively high organisation density still sit in middling or higher suicide-rate bands, while some places with lower visible provision are not among the most acute suicide hotspots. Parts of the North East and South West appear relatively high on both maps, suggesting that in some areas a stronger community response may have emerged alongside higher apparent need. However, the pattern is not consistent enough to support a causal claim.

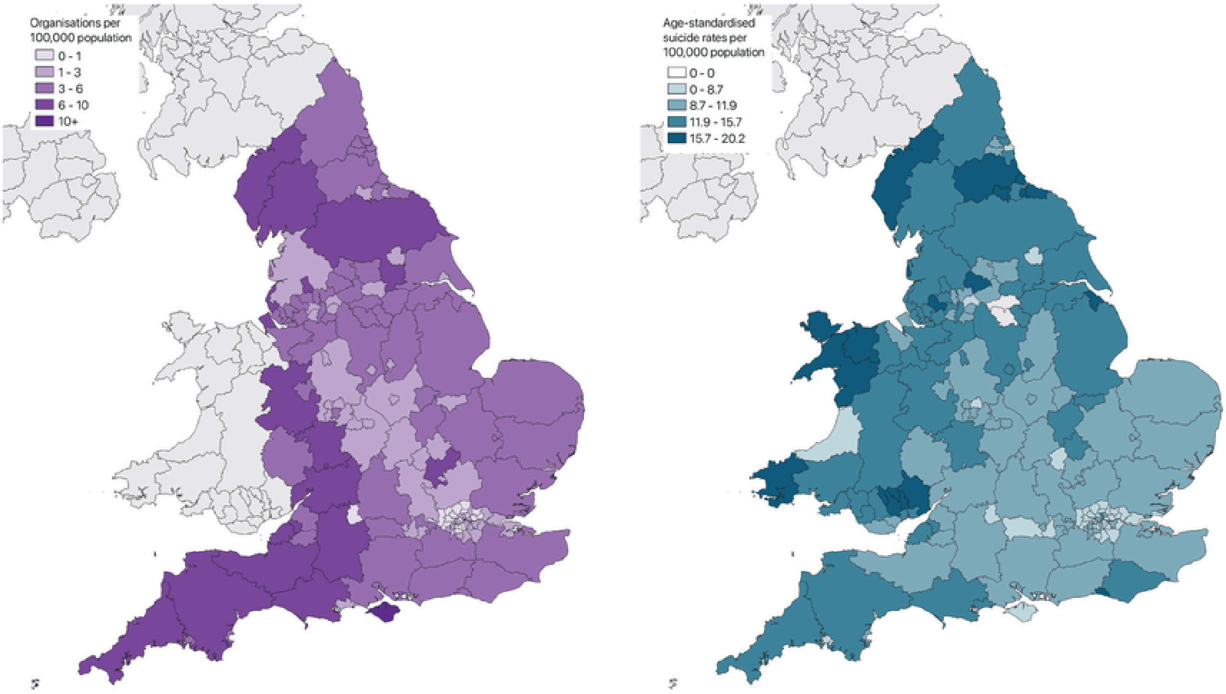

Figure 5: Community-led, non-clinical interventions per 100,000 population and age-standardised suicide rates, 2022–2024, by local authority. Sources: Centre for Policy Research on Men and Boys, 2026; Office for National Statistics (ONS), released 3 October 2025, ONS website, statistical bulletin, Suicides in England and Wales: 1981 to 2024.

This suggests that the presence of organisations alone cannot explain the geography of suicide. The policy task is therefore to identify where support ecosystems appear thin relative to apparent need, where stronger local support ecosystems already exist, and what kinds of organisations are operating in those places. The emerging picture is that suicide risk appears broad and structural, while the geography of community-led provision appears more contingent, patchy and place- specific.

The comparison with deprivation adds a further layer (Figure 7). The emerging analysis suggests some overlap between deprivation and organisation density, particularly in parts of the North East, where structurally disadvantaged places also appear to have denser community-led provision. However, deprivation does not reliably predict where provision is most visible. Some deprived urban authorities do not appear especially well provided in per-capita terms. This may indicate a genuine coverage gap, but it may also reflect the limits of the mapping method in dense metropolitan contexts, where support may operate across local authority boundaries, be less explicitly male-specific, or be harder to identify through current search methods.

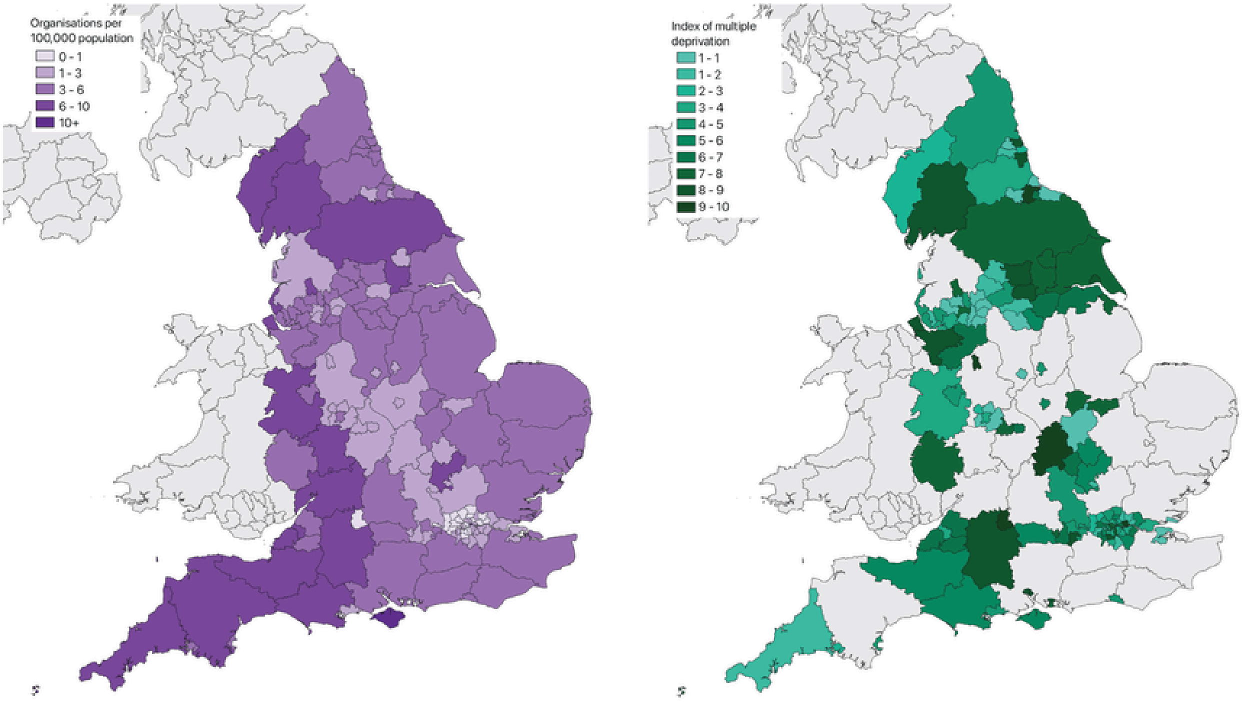

Figure 6: Community-led, non-clinical interventions per 100,000 population and Index of Multiple Deprivation 2025, by local authority. Sources: Centre for Policy Research on Men and Boys, 2026; Office for National Statistics (ONS), released 30 October 2025, ONS website, English indices of deprivation 2025.

The emerging interpretation, then, is that England has a geography of structural need and a separate, less predictable geography of community response in relation to male suicide(?). Sometimes these overlap; often, they do not. Areas where these patterns do not overlap raise important questions for policy and further research. Why do some places generate visible community-led support while others do not? Is provision shaped by deprivation, by local civic capacity, by local leadership, by voluntary-sector history, by regional culture, or by place-based identities that make this kind of support more likely to emerge and endure?

So far, the England-wide mapping suggests that provision is visible, varied and policy-relevant, but not evenly distributed. It points to potential coverage gaps, possible local strengths, and a set of places where deeper qualitative work may be especially valuable.

3.3 Practitioner and Policy Engagement

The CPRMB and Randal Foundation roundtable provided an opportunity to test these emerging mapping findings against the experience of people working close to affected communities. It helped to clarify a central implementation challenge: need appears to be increasing faster than services and community support systems are able to respond. Participants linked this not only to pressure on formal services, but also to the weakening of informal forms of support that may previously have helped to absorb, delay, or soften distress before it reached the point of clinical crisis. This reflects a wider theme in the academic and policy literature: that community, social connection and trusted local spaces can play an important role in earlier-stage support. In this account, the thinning of that supportive social layer leaves statutory services under greater pressure and some men with fewer places to turn before problems escalate.

Funding emerged as a central concern. Participants described a landscape in which accessible local funding is limited, routes into funding and commissioning are opaque, and governance requirements can exclude some of the organisations most in need of support. The issue is not simply the availability of funding, but also the transparency of routes, the capacity required to navigate them, the length of funding cycles, and the mismatch between short-term grants and the time required to build trust.

Evaluation was another major theme. Many organisations do not define themselves primarily as mental health services, even where their work may contribute to wellbeing or suicide prevention. Some may collect quantitative data; others may fear that formalised data collection will be counterproductive and incompatible with their ethos. The roundtable also sharpened the question of institutional identity. Some organisations appear to work precisely because they do not look or feel like statutory services. Men can attend without formal disclosure, diagnosis or a help-seeking identity. This creates a policy tension. Government and NHS support may be necessary for sustainability and scale, but visible institutional branding, referral requirements or clinical outcome measures may undermine the low-pressure character that makes engagement possible. Participants highlighted that funders often prefer highly tangible outcomes, such as weight-loss targets, whereas in suicide prevention and men's wellbeing, the outcomes are more relational, less immediate and much harder to reduce to simple metrics. This project will, thus, explore how outcomes can be co-produced, proportionate and sensitive to the stage of organisational development.

Leadership and governance were repeatedly identified as practical priorities. Many founders and volunteers bring commitment, credibility and lived experience, but may lack the operational skills, compliance knowledge or governance structures (including legal structures) needed to sustain or grow an organisation. Support for leaders, trustees, volunteers and organisational systems may therefore be as important as programme funding. As organisations grow or work with more vulnerable men, safeguarding, peer support boundaries, data handling and referral pathways become more important.

The roundtable also surfaced a crucial equality lens. Men differ by ethnicity, disability, sexuality, age, class, faith, geography, neurodiversity and levels of social anxiety. A local group may feel accessible to some men and intimidating to others. Some may be attracted by explicitly male spaces; others may need different routes in. More broadly, suicide prevention and men's mental health support often depend on creating social contexts in which men can recognise their own distress and be recognised by others without stigma. This is consistent with previous research and helps explain why many organisations work through activity, shared endeavour and community. However, a major unresolved concern is that a large cohort of men may remain invisible and not engage at all. An important question, therefore, is why men do not come forward even where community-led services appear to exist, and why uptake remains uneven in more diverse areas. The key challenge is to reach men who are not entering any service system and who may frame their problems not as mental health, but as life-related hardships (debt, gambling, relationship breakdown or other). If men do not understand suicidal distress through a mental health frame, then improving mental health help-seeking may be only part of the answer. The more relevant question may be: where do men go when they are trying to fix the problem that is making life unmanageable?

Finally, several contributors suggested that the strongest strategic frame may sit within the health system and the wider prevention agenda. If community-led provision can help men access earlier support, improve connection and prevent escalation, it should be understood as part of a broader health-system response, while remaining rooted in local voluntary and community infrastructure.

3.4 Rethinking Outcomes

A further emerging issue revolves around how outcomes should be understood in the context of suicide prevention and wellbeing. The key challenge is that the most important intended outcome – deaths that do not occur – is extremely difficult if not impossible to measure directly. Suicide prevention often depends on identifying changes in risk, protection, connection and help- seeking, rather than attributing a prevented death to a single intervention.

In suicide prevention and men’s wellbeing, the most important outcomes are often indirect, relational and preventative. They may include improved connection, reduced isolation, greater willingness to seek help, renewed purpose, more trusted peer relationships, better routes into further support, or strengthened organisational capacity. As past research and current empirical evidence show, these outcomes matter because they may reduce exposure to risk or increase protective factors, but they are not always immediate, easily attributable or well captured by conventional performance metrics.

The risk in creating standardised metrics, KPIs and targets, is that outcomes can become too narrow or too externally imposed. If funders or commissioners require simple, tangible indicators too early, organisations may be pushed towards measuring what is easiest to count rather than what matters most. Furthermore, a most immediate risk is that inappropriate reporting requirements may undermine trust, especially where men attend precisely because a group does not feel clinical, bureaucratic or officially branded. This means that outcomes need to be proportionate, co-produced and sensitive to the stage, ethos and capacity of different organisations.

A useful way forward could be to treat outcomes as a learning framework, not only as a reporting framework. In this view, processes of support should be seen not simply as a route towards the desired outcome, but as part of the outcome. The quality of engagement, the inclusion of different voices, the ability to identify vulnerabilities, the strength of local knowledge, and the presence of trusted relationships all shape whether an intervention is likely to work and endure. For community-led men’s wellbeing work, it is therefore not enough to ask only what changed. Policy, commissioning and evaluation also need to ask who was reached, who was missed, what forms of trust were built, what risks became visible, and what capacities were strengthened for the future.

These findings have important implications for the next phase of the project. Rather than seeking to impose a single metric across a diverse field, the analysis points towards a more proportionate approach to understanding outcomes. The next phase will therefore involve targeted engagement with community-led initiatives of different sizes, including small, medium and larger organisations, through interviews, focus groups and observation. This will help to understand how organisations and participants perceive and define success in practice, what kinds of evidence they already collect, where measurement creates burden or risk, and how outcome domains might be developed in ways that are credible to both organisations and policy audiences. Such an approach would help to build a common language for policy, commissioning and evaluation, while preserving the local, relational and low-pressure qualities that make community-led initiatives valuable.

Implications for Policy, Commissioning and Research

Implications for Policy, Commissioning and Research

The interim evidence points to several implications.

First, community-led, non-clinical initiatives should be framed as part of a wider ecosystem of care. Their value lies in doing something that formal services often cannot do alone: creating low- pressure, repeated, familiar opportunities for men to reconnect, build trust and move towards help on their own terms. Policy should therefore recognise this complementarity.

Second, commissioning and funding should be proportionate to the scale and stage of organisations. For small groups, immediate demands for sophisticated evaluation, complex governance paperwork or clinical reporting may be counterproductive. A better approach would combine accessible funding routes, transparency about local opportunities, support for governance and safeguarding, and patient investment in the relationships that make these groups work. Scaling should be understood more broadly than growth. Some organisations may be able to expand geographically or increase participation. Others may be most valuable when they remain small, local and culturally specific. Scaling may therefore mean strengthening local leadership, sharing practice between founders, supporting new trusted local actors, developing common safeguarding resources, or enabling analogous models to emerge elsewhere rather than replicating a single branded programme.

Third, outcomes frameworks need to measure what matters without distorting practice. Conventional mental health metrics may capture some relevant changes, but they are unlikely to capture the full value of purpose, familiarity, trust, belonging, ownership, consistency and peer connection.

Fourth, the evidence strategy should be contribution-based. It would be misleading to claim that community-led organisations alone can directly reduce suicide rates by a specified amount. Instead, the more credible route could be to model how community support may reduce risk factors, strengthen protective factors, increase help-seeking, reduce isolation and improve connection within a wider prevention system. This is also more realistic for small organisations to measure.

Finally, the notion of place is of particular importance. The mapping already suggests that need, provision and deprivation do not align in a simple way. Place affects not only the level of distress, but also the cultural conditions under which support becomes legitimate. Policy, therefore, needs nationally legible categories and locally grounded interpretation. The policy opportunity is therefore to make this field more visible, more sustainable and more transparent without making it less trusted. That will require an evidence strategy that is rigorous and attentive to outcomes. It will also require a different approach to scale, one that strengthens organisations, leaders and local ecosystems rather than assuming that bigger is always better.

References

References

Bloodworth, J. (2026, April 15). What nobody told me about the male midlife crisis (until I hit 40). *The Times*.

Broadbent, R. (2009, November 25). Freeing the shackles set by stigma of owning up to a mental illness. *The Times,* 97.

Danechi, B. S. (2026). Suicide statistics (Research Briefing No. 07749) (Issue January).

Department of Health and Social Care. (2025). Men's health: A strategic vision for England (Issue November).

Department of Health and Social Care. (2023). Suicide prevention in England: 5-year cross-sector strategy.

Dowd, J. B., Angus, C., Zajacova, A., & Tilstra, A. M. (2022). Midlife "deaths of despair" trends in the US, Canada, and UK, 2001–2019: Is the US an anomaly? MedRxiv.

Garratt, K., & Kirk-Wade, E. (2024). Suicide prevention policy (Research Briefing No. CBP-10090) (Issue September).

Knapp, E. A., Bilal, U., Dean, L. T., Lazo, M., & Celentano, D. D. (2019). Economic insecurity and deaths of despair in US counties. American Journal of Epidemiology, 188(12), 2131–2139.

Kuo, C., & Kawachi, I. (2023). County-level income inequality, social mobility, and deaths of despair in the US, 2000–2019. JAMA Network Open, 6(7).

Panayotopoulos-Tsiros, D., Morris, S., Fildes, J., & Tomaney, J. (2025). Community-Led Non-Clinical Interventions in Men's Wellbeing in North East England.

Pomfret, I., & Wong, K. K.-Y. (2026). Impact of co-created mental health and life-skill workshops with 12-to-16-year-olds from black and mixed ethnic groups during COVID-19 in the UK: A qualitative study. BMJ Open, 16(e107310).

Public Health England, & National Suicide Prevention Alliance. (2020). Local suicide prevention planning (Issue September).

Sandeman, G. (2026, June 5). Gareth Southgate: We need to teach boys differently to girls to get best out of them. BBC.

Saville, C. (2026). Why 'deaths of despair' are higher in former coal mining communities. In The Conversation.

Shepherd, G., Murphy, H., Woodhams, J., & Watling, S. (2024). Menfulness evaluation of service report: Men's suicide prevention impact and evaluation project.

Published by the Centre for Policy Research on Men and Boys (CPRMB), June 2026

E: contact@menandboys.org.uk
W: https://www.menandboys.org.uk
LinkedIn: centre-policy-research-menboys
Instagram: cprmenandboys
X: CPRMenBoys

Centre for Policy Research on
Men and Boys

Randal
Charitable Foundation

Address: Centre for Policy Research on Men and Boys
c/o 2 Dean Trench Street, Westminster, SW1P 3HE

Publication Number: 03/26