Cumberland Council

Man up?

Understanding men's health and identity in Cumberland, and why it matters for everyone

Cumberland Public Health Annual Report 2026

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Foreword

This Public Health Annual Report was initially inspired by a complex mix of feelings. As Chair of the Cumberland Community Safety Partnership, one of my roles is to receive reports from Domestic Abuse Related Death Review (DARDR) panels, which consider the circumstances surrounding every death – whether by murder, neglect or suicide – in which domestic abuse is thought to be a factor. These are always tragic, frequently harrowing accounts of the experience of a (usually, but not exclusively) female victim of domestic abuse and a (usually, but not exclusively) male perpetrator – or sequence of perpetrators. In Cumberland we have an unusually high number of such reviews underway compared to other parts of the country, and there are only so many of them that you can read before patterns of appalling male behaviour and attitudes towards women become obvious. And of course, situations that lead to a death are very much the tip of the iceberg when it comes to domestic abuse; while reliable data are difficult to come by, the sheer number of women in Cumberland suffering abuse by men is distressing. Alongside this there appears to be at least a sub-culture, exemplified by the online influencers known as the "manosphere", that is promoting misogyny, contempt of, and exploitation of, women – so-called "toxic masculinity". So on the one hand, this report was inspired by the furious question – just what is wrong with men?!

On the other hand, it is also clear that men are suffering too. As shown in this report, men have much higher rates than women for deaths related to suicide, drug and alcohol use; many are significantly struggling with mental health challenges; they appear to be falling behind women in education; and for many, employment opportunities are not what they were, leading to a wider economic and social malaise. These outcomes are concentrated in men experiencing higher levels of deprivation, cumulative adversity and limited access to support structures. All of which prompts the same, though this time sympathetic, question – just what is wrong with men?

So that is the underlying question behind this report. Inevitably, the answers are complex. Disadvantage begins early, with boys experiencing lower levels of school readiness and higher levels of exclusion and contact with the justice system. These early experiences impact on work, place and identity, interacting further with cultural factors and economically disadvantaged communities affected by deindustrialisation.

Men's health inequalities are further shaped by social norms around masculinity, including expectations of strength, self-reliance and emotional control. While these norms can help provide a sense of identity and bring with them some very positive implications, they can also discourage help-seeking and contribute to risk-taking, silence and late presentation to services; taken to an extreme they can indeed be toxic.

The report also finds that existing systems do not consistently meet men's needs. Men are less likely to engage with preventative services and often present at crisis point. Service design, access barriers and cultural expectations all play a role in reinforcing these patterns.

The evidence highlights the need for a more targeted, gender-transformative and preventative approach to men's health in Cumberland. By addressing the social conditions that shape risk, intervening earlier in the life course, designing services that better work for men, and helping to create healthier concepts of masculinity that are fit for the 21st Century, it is possible to reduce health inequalities and improve outcomes for men, women and children alike.

Colin Cox
Director of Public Health, Customer and Community Wellbeing

Introduction – why are we focusing on men, and why does this matter for everyone?

According to the Oxford English Dictionary, 'to man up' means to "To demonstrate **manliness, toughness, or courage** when faced with a difficult situation", and to be masculine is described as "having a character befitting or regarded as appropriate to the male sex; **vigorous, powerful**" (Oxford English Dictionary, n.d.). In contrast, to be feminine is to be "soft", "tender", "gentleness and pliability" and "grace". When femininity is used in reference to a man it is described as "**Chiefly disparaging**. Of a man's qualities, actions, or appearance: regarded as (stereotypically) appropriate for or characteristic of a woman, generally in a way considered to be **inappropriate for or undesirable in a man**"(Oxford English Dictionary, n.d.). While some of these definitions date back to the 1300s, the values they represent: strength, stoicism, toughness in men; softness and caregiving in women, remain deeply embedded across societies today. And while the positive side of these values is clear, when taken to extremes or applied stereotypically or inflexibly they can bring significant challenges that are exacerbated by our changing society.

This report focuses on exploring the worsening health outcomes experienced by many men in Cumberland, and on the impact that male attitudes and behaviours can have on society as a whole. We have a declining life expectancy in our most deprived groups of men in Cumberland, while the less deprived men and female life expectancies remain relatively stable. There are rising suicide rates, drug and alcohol misuse rates, worsening mental health, unequal educational attainment and restricted employment opportunities. The report will provide an analysis of the underlying drivers of these trends and highlight the gaps, challenges and opportunities across our communities, services and systems.

The health and wellbeing of men, women and children are deeply interconnected. The impacts of male health and emotional wellbeing shape women's safety, children's emotional development, family stability, and community structures. Equally, strong and healthy relationships, families and workplaces provide far reaching benefit. In highlighting the unique challenges and need to tailor approaches to improve men's health, we aim to produce action that works for men but ultimately benefits all.

The Big Question

Alongside the quantitative evidence presented in this report, findings from The Big Question, a mixed-methods study commissioned by Cumberland Council and undertaken by Liverpool John Moores University to explore why suicide risk remains high locally (Ashworth, E. et al, 2026), reinforce the case for action. Residents described the impact of suicide, mental distress and isolation not only on individual men, but on families and communities. While conversations about mental health are increasing, stigma and delayed help-seeking remain significant barriers. Participants consistently called for earlier intervention, more accessible community-based support and stronger postvention for those affected by suicide.

Together, the data and lived experience highlight that improving men's health and wellbeing is essential to reducing avoidable harm across the whole population. This report responds to that clear local mandate for change.

November 2025 saw the publication of the first Men's Health Strategy in England: a 10 Year Plan to reduce health inequalities through a targeted approach (Department of Health and Social Care, n.d.). This report aligns with the national strategy's three overarching aims:

- Ensuring health services engage men and boys and are responsive to their needs.
- Building structures which empower men and boys to maximise their own health and wellbeing.
- Creating the conditions in which men and boys' health and wellbeing can thrive.

Cumberland's Annual Public Health Report applies these aims to our local context. It sets out our unique local picture, what is driving local inequalities, and what action is needed to create healthier futures for our population.

The aims of this year's Annual Public Health Report are to:

- **Describe the current pattern of men's health in Cumberland**, including the social, economic and environmental factors that shape outcomes from childhood to older age.
- **Highlight the ways in which men's health interacts with the wellbeing of women and children**, recognising these as relational, interconnected and mutually reinforcing.
- **Identify the unique cultural, structural and service-level factors** that contribute to men's poorer engagement with health services and prevention opportunities.
- **Highlight existing good practice across Cumberland.**
- **Propose clear, actionable recommendations** for local systems, services and partners to improve men's health and narrow inequalities.
- **Promote an evidence-informed conversation about masculinity, the male identity and men's wellbeing** in Cumberland.

Sex and Gender

Throughout this report, the terms men and women are used to describe patterns of health and wellbeing. In doing so, it is important to acknowledge that sex and gender are related but distinct concepts. Sex refers to biological characteristics, while gender describes the socially shaped roles, expectations and identities associated with being a man, woman, or another gender identity. Most population-level data, health systems and policy frameworks remain structured around binary sex categories, which, along with the aim to explore male gender-based determinants and outcomes, shapes the analysis presented here. However, this report recognises that gender is complex, and that some people identify as transgender, non-binary or gender diverse. The intention throughout is to use available data pragmatically while remaining mindful of this diversity and of the ways in which gendered expectations and experiences influence health outcomes.

Chapter 1: How we understand men's health

Health outcomes are shaped by wider determinants of health (Figure 1): the social norms that we inherit, the socioeconomic conditions we live in, the relationships and expectations that surround us and the cultural norms that shape communities over generations. These factors interact with the local infrastructure, service accessibility, influencing what kinds of help they seek, what kind of actions they take and what sort of opportunities and futures feel visible and possible.

Gendered expectations describe the societal norms and stereotypes around how individuals should act, present and behave based on their sex. Commonly cited and investigated domains on gendered stereotypes include personality traits, role behaviours, occupational and emotional.

Frequently, men's health is described through a language of personal actions or failing of action; men 'don't talk' or 'won't seek help' or are 'risk takers'. Similarly to expressions such as 'man-up' or 'grow some balls', the language used to describe masculine health seems to assume that poor health is driven by personal failings and individual actions. While individual actions matter, this framing does not sufficiently recognise the influence of the social norms of what it means, or does not mean, to be a man, and how this shapes our communities and individuals. In Cumberland, these norms are shaped by a history of industrial work, de-industrialisation, tight-knit communities and a longstanding local culture towards stoicism and emotional self-reliance.

This chapter provides the conceptual grounding for understand the patterns of men's health outcomes seen across Cumberland. It aims to situate male health inequalities in sociological context, to explore how masculinities develop and result in differential health outcomes.

Figure 1: The building blocks to health by the Health Foundation

How Men's, Women's and Children's Health Interconnect

The phrase 'health is not a zero-sum game' is often used in relation to health. This phrase addresses the concept that one person's health gain is another person's health loss. 'Positive sum', are health investments that have wider impacts beyond the primary aim, such as improved physical health leading to improved economic productivity or social connection, simultaneously benefiting others in immediate and wider circles.

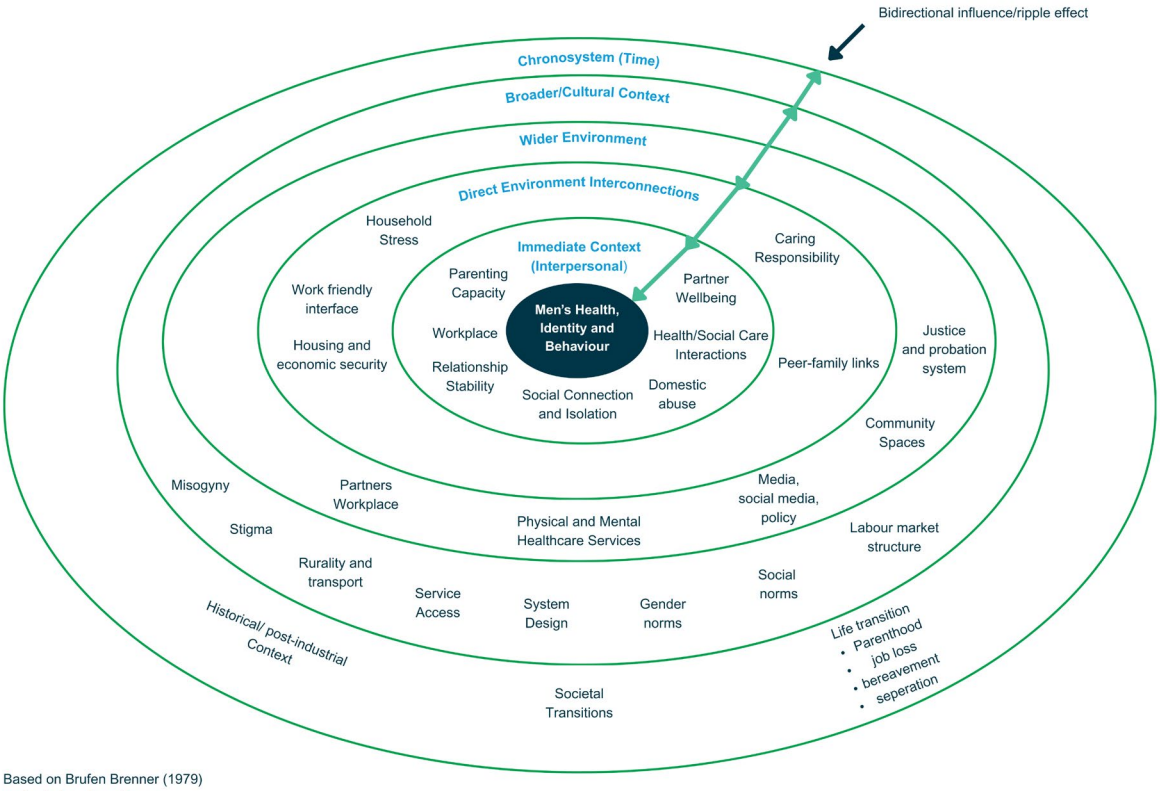
Men and women's health are interdependent. Individual, partnership, societal and systemic interactions between genders influence physical, mental and social health.

Poor male health, whether through chronic illness, addiction, or mental ill-health, has consequences for women and children. Women may carry increased caring responsibilities, face financial strain, or encounter emotional and physical risks within relationships. Children exposed to instability, conflict or trauma may have poorer health and emotional wellbeing outcomes, which in turn can shape the outcomes of the next generation of men.

Parental wellbeing directly affects children's emotional security, educational attainment and health development, influencing how children grow and behave. Household stressors such as poverty, grief, insecure work and poor-quality housing are experienced collectively.

From a sociological perspective, gender operates as a social system: a set of rules, expectations and practices that shape how people behave and how society responds to them. We adopt a gender-relational lens: the health of one group cannot be understood or improved without analysing gender differences, dynamics and social norms, allowing us to identify systematic drivers and design targeted solutions.

Figure 2: The bi-directional interactions between men's health and identity, and relationships, environment and cultural. Adapted) ecological systems theory (Bronfenbrenner, 1979).



Based on Brufen Brenner (1979) ecological systems theory

Masculinities - "being a man"

Masculinity is a socially constructed set of behaviours, traits, roles, and practices associated with men and boys, which are learned and practiced through life. Most men do not consciously choose to learn these norms; they are inherited from families, peers, communities, media and workplaces.

Because masculinity is learned rather than inherent, it exists in multiple forms. These forms are shaped by social position, including class, ethnicity, age, sexuality, body and ability. Importantly, different expressions of masculinity are associated with different health risks, behaviours and outcomes, and can vary between cultures and evolve over time.

Sociologist Raewyn Connell's framework helps to explain the social construct of 'ideal' masculinity in relation to femininity and other forms of masculinity. It explains patterns through which different individuals relate differently to masculinity, and how this shapes exposure to risk, vulnerability and health outcomes.

Table 1: Summary of Raewyn's Connell masculinities framework and how they may shape harmful health and relationship outcomes (Connell, 2020).

Definition	Potential health Impacts for men	Potential impacts for women and children
Hegemonic masculinity is the culturally dominant ideal of manhood, which is typically characterised by strength, emotional control, self-reliance, heterosexuality and authority. This form establishes social expectations against which other men are measured and reinforces men's power over women and other men.	Reluctance to seek help or disclose distress Late presentation to health services Risk-taking behaviours, including substance use and dangerous driving Emotional suppression, which increases risk of depression, suicide and relationship breakdown	Reinforces unequal power dynamics in relationships, increasing women's exposure to emotional labour, caregiving burdens, and, in some cases, coercive control or violence. Limits children's exposure to emotional modelling, communication and help-seeking behaviours. Provides harmful role modelling for children regarding how men should act and relationship's function. Contributes to cultures in which women's safety concerns or emotional needs may be minimised or dismissed.

Definition	Potential health Impacts for men	Potential impacts for women and children
Complicit masculinity describes men who do not fully meet hegemonic ideals but still benefit from the wider system of male privilege. These men may not actively promote dominant norms, but neither do they challenge them.	Adopting silence or emotional distance as a default coping strategy Accepting harmful norms around drinking, work or stress as "just how things are" Benefiting from male privilege in some settings while remaining vulnerable to poor health outcomes	Increased strain within families as women act as mediators or carers Reinforces silence around men's distress, delaying support and increasing the likelihood of crises that affect whole households.
Subordinated masculinities are masculinities that are devalued or stigmatised in relation to the dominant ideal, including gay men, emotionally expressive men, or those who challenge gender norms.	Higher exposure to stigma, discrimination and harassment Increased rates of anxiety, depression and self-harm Barriers to accessing safe and affirming services Heightened social isolation	Stress and marginalisation can affect relationships
Marginalised masculinities refer to men whose intersecting social positions, shaped by class, ethnicity, disability, care experience or poverty, limits access to power, status and resources. These men may be expected to meet dominant masculine ideals but lack the material conditions to do so.	Chronic stress linked to economic insecurity Higher exposure to trauma, bereavement and adverse childhood experiences Increased risk of substance dependence, poor mental health and early mortality Limited access to timely, appropriate services	Economic insecurity and exclusion can increase financial strain on households Accumulated trauma and stress may contribute to relationship conflict, instability, or intergenerational transmission of adversity to children.

This framework is included to illustrate how masculinity interacts with inequality to shape health outcomes. It helps explain why:

- Some men avoid help until crisis.
- Some men experience disproportionate harm from structural disadvantage.
- One-size-fits-all approaches to men's health fail to reach those most at risk.

Positive masculinities

While Connell's framework helps explain how certain dominant forms of masculinity can generate risk and inequality, masculinity itself is not inherently harmful. Many traditionally masculine traits: loyalty, courage, responsibility, and pride in providing for others, can be protective and health-promoting when expressed in flexible and relational ways.

The aim of this report is to examine how masculinities can become harmful when combined with deprivation, trauma and structural change, and to promote healthier expressions of masculinity that support men, women and children alike.

Local expressions of masculinity

The Big Question explored local male experiences through in-depth, qualitative methods (Ashworth, E. et al, 2026). The industrial heritage and relatively isolated geography of West Cumbria have shaped a form of masculinity centred on hard work, close loyal workforces, and resilience. These strengths are sources of pride. However, when work becomes unstable, the same norms can produce silence, shame, or withdrawal. Men may avoid asking for help because it feels incompatible with family and cultural norms.

These socially learned norms can become health-harming when combined with poverty, trauma, grief, discrimination or limited opportunities. They help explain why men sometimes present late to services, respond to distress through anger, or turn to substances as coping mechanisms.

Inequalities: why some men are more affected than others

The poorer health outcomes observed among men in Cumberland do not affect all men equally. Their experience depends on intersecting factors such as socioeconomic situation, place, ethnicity, disability and sexuality, which can generate cumulative disadvantage.

Boys and men who have grown up in care, live with disability, are neurodivergent, identify as LGBTQ+, or come from ethnic minority backgrounds often encounter additional barriers in education, employment, relationships and access to support. These experiences influence not only opportunities, but also whether men feel safe in expressing their identity, asking for help, or being vulnerable.

Gender norms do not affect all men in the same way. Some men socially benefit from dominant expectations of masculinity, while others find themselves constrained or harmed by them. Men who face social or economic disadvantage often experience the sharpest consequences, as expectations of self-reliance and toughness meet with limited resources, discrimination or trauma. These patterns reflect structural conditions rather than personal failure.

Place and employment

Despite employment data that appears consistent with national averages, West Cumbrian communities face long term challenges due to deindustrialisation of coal and steel production. Recent generations have experienced the effects of unemployment, abrupt changes in work identity. The local economy remains dependent on major employers like Sellafield, which offers well-paid jobs but create economic disparity. Masculine norms shaped around traditionally male roles and breadwinning can be challenging when employment is unstable or income is disparate. This is further explored in Chapter 4: Work, place and identity in adult men's lives.

Adversity and grief

Individuals in communities with unstable work, low income, or limited opportunities often carry high cumulative grief loads, multiple bereavements, sudden losses, or traumatic events. Without the tools to express vulnerability or seek support, grief can become internalised and have long lasting psychological and/or physical impacts. The Big Question report highlighted grief as a major factor in suicide in Cumberland (Ashworth, E. et al, 2026).

Approach and frameworks

This report draws on several established public health perspectives to guide the analysis.

Life-course approach.

Health inequalities accumulate across time. Early childhood experiences, school environments, work pathways, relationships and community settings all shape men's wellbeing in adulthood.

Determinants of health framework (Dahlgren & Whitehead, 2021).

The report considers how wider systems, such as housing, employment, social security, education, justice, and service design influence health. These structural determinants explain why individuals facing similar stresses have different outcomes.

Diderichsen's inequalities framework (Diderichsen et al., 2019)

We employ Diderichsen's framework on how inequalities emerge through differential exposure, vulnerability, consequences, and responses.

Evidence and engagement

This report was informed by engagement with a wide range of local practitioners, service leads and community organisations working with men, boys and families across Cumberland. Contributors included representatives from Cumberland Council, Cumbria Constabulary, community and voluntary organisations and sports and wellbeing organisations.

A survey was undertaken to capture professional insight into the needs of boys and young men in Cumberland. The survey was completed by 53 practitioners working across education, youth justice, family support, wellbeing and voluntary sector services. The survey captured practitioner perspectives on needs, barriers to engagement and effective approaches.
The survey does not represent the views of boys and young men themselves. Findings are used throughout this report to contextualise and corroborate population-level data.

Chapter 2: The state of men's health in Cumberland

Introduction

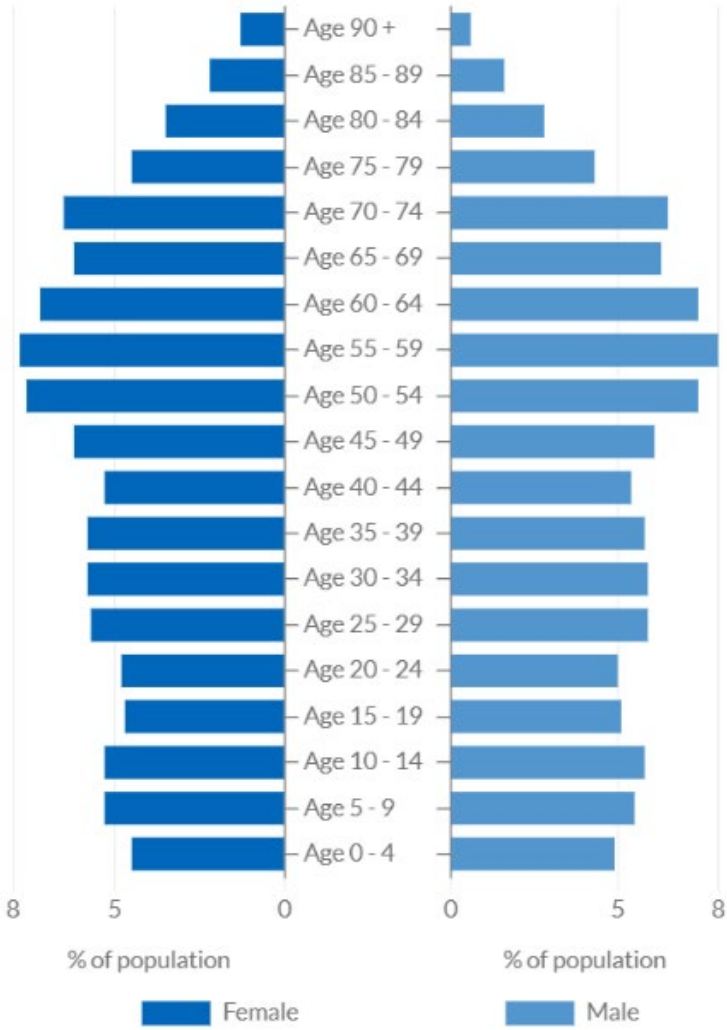
This chapter lays out the picture of men's health in Cumberland.

As is typical in other areas, **nationally and internationally**, health outcomes of men in Cumberland are not equal across the population. Certain groups face persistently worse health, earlier deaths, less years of life in good health and higher levels of unmet need. Patterns in health outcomes can be seen in deprivation, geography, ethnicity, education and other socioeconomic factors. When people face multiple forms of disadvantage, these patterns of poor health outcomes are amplified.

Demographics and Life Expectancy

Cumberland has a population of 280,495 (2024), 49.2% of whom are male. There are nearly double the number of females aged 90 and over compared with males (1,961 females, compared with 1,009 males). The population pyramid for Cumberland in 2021 (Figure 3) shows markedly higher proportions of females emerging aged 75 years, while higher proportions of males are seen from birth to 34 years.

Figure 3: Percentage of population by age and sex, Cumberland, 2021



In 2022-24 men born in Cumberland had a **life expectancy** of 77.8 years, while men aged 65 had a life expectancy of 83.6 years. This is respectively 1.7 years and 0.3 years less than the average male in England (source: ONS). A boy born in Cumberland today can expect to live for 3.9 years less than a girl, and a man aged 65 currently can expect to live on average 2 years less than a woman.

Out of the 380 areas across the United Kingdom, Cumberland had the 84th lowest life expectancy for boys at birth in 2022-24, matching life expectancies of boys born in County Durham and Fenland in Cambridgeshire. While Cumberland sits in the fourth most **deprived** decile of local authorities, both Country Durham and Fenland are in the second most deprived deciles in England (source: gov.uk). This indicates that in terms of life expectancy Cumberland is doing worse than would be expected given our level of deprivation, prompting the question of what is causing this discrepancy.

Life Expectancy and Depivation

Figure 4 and Figure 5 show life expectancy for males and females between 2011-13 and 2021-23. While women's life expectancy has plateaued, life expectancy in the most deprived groups of men in Cumberland has dropped. This widens both the gap in life expectancy between the most and least deprived individuals in Cumberland, and between men and women.

Figure 4: Male life expectancy at birth in Cumberland by deprivation decile, 2011-13 to 2021-23, OHID

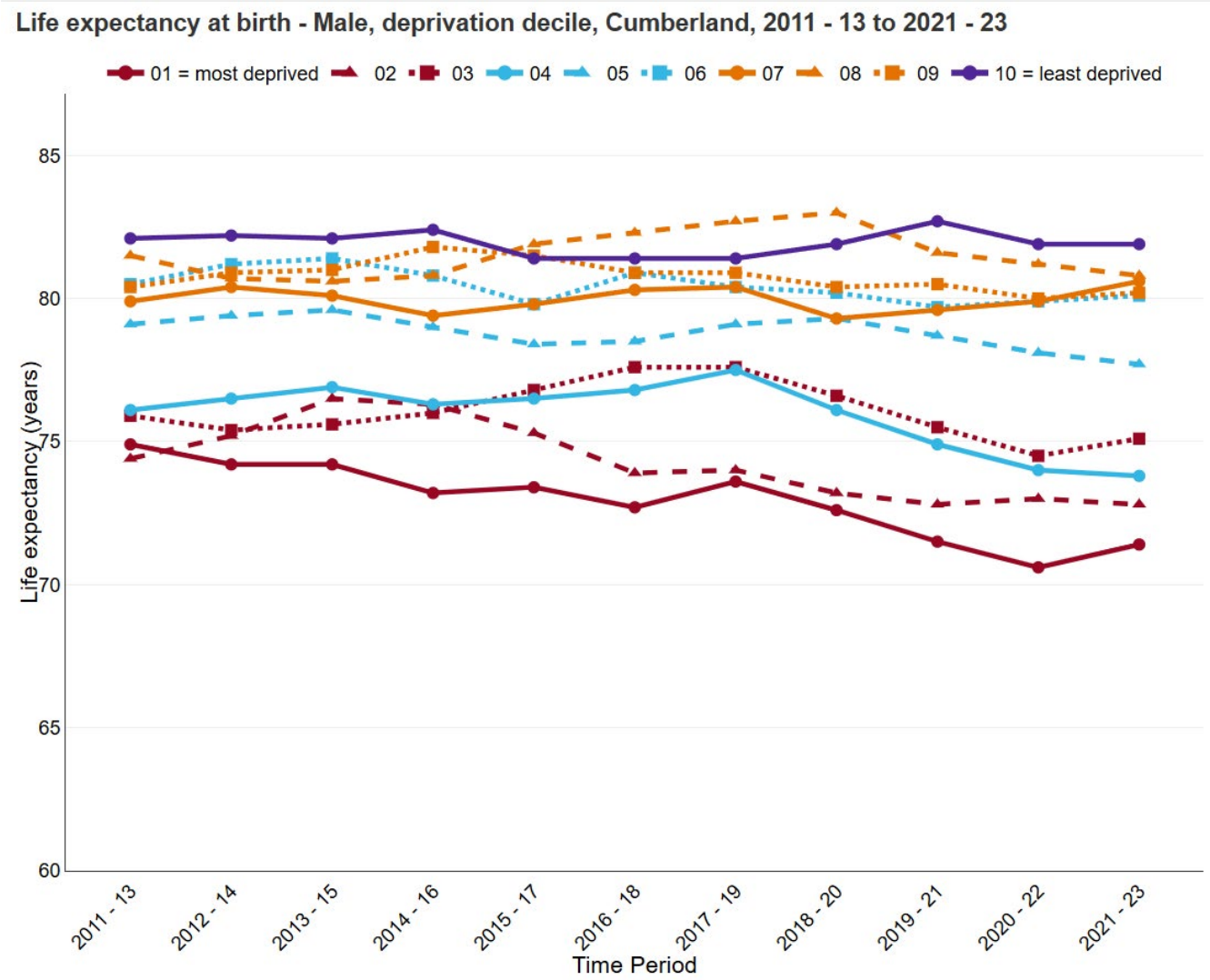
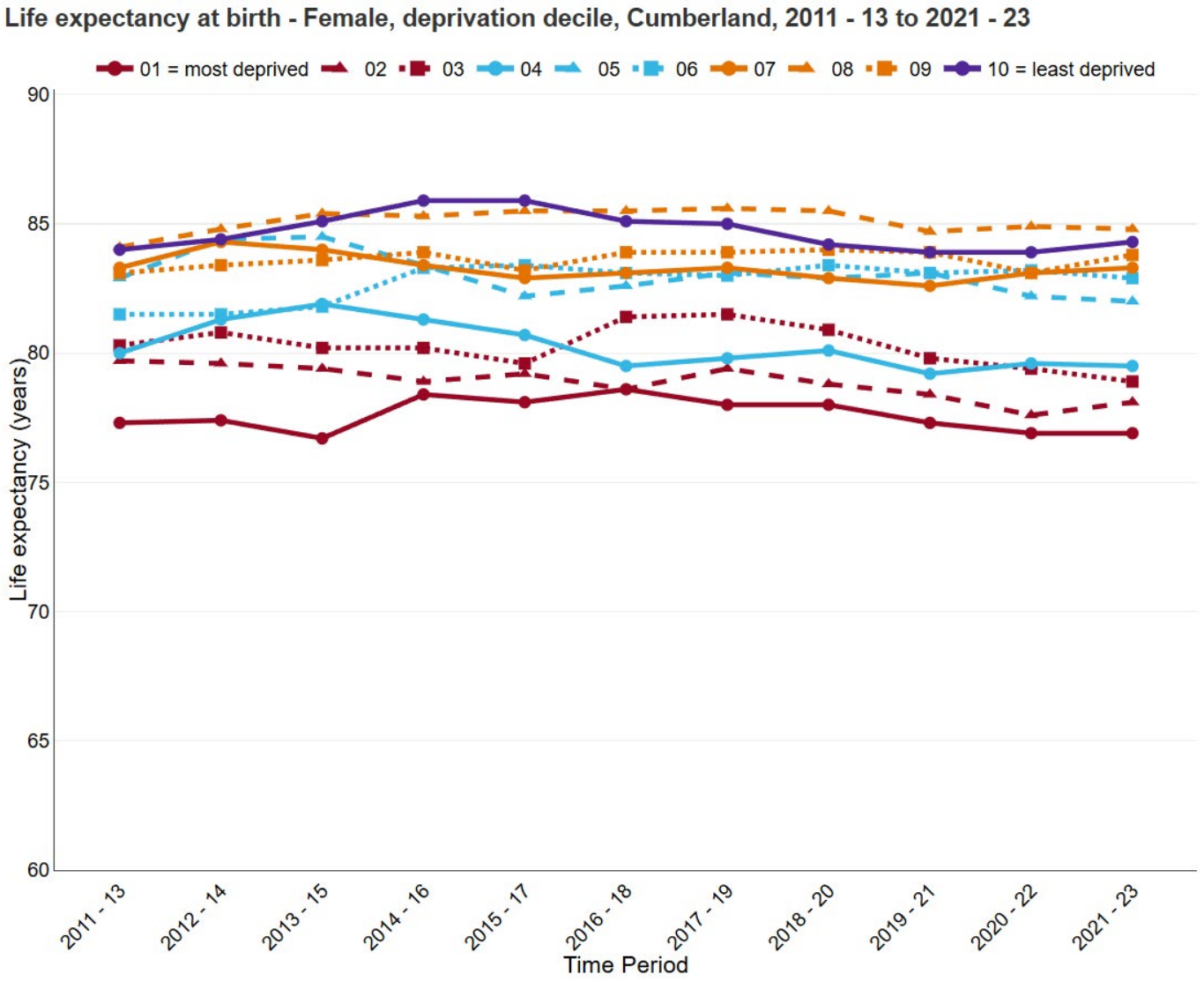
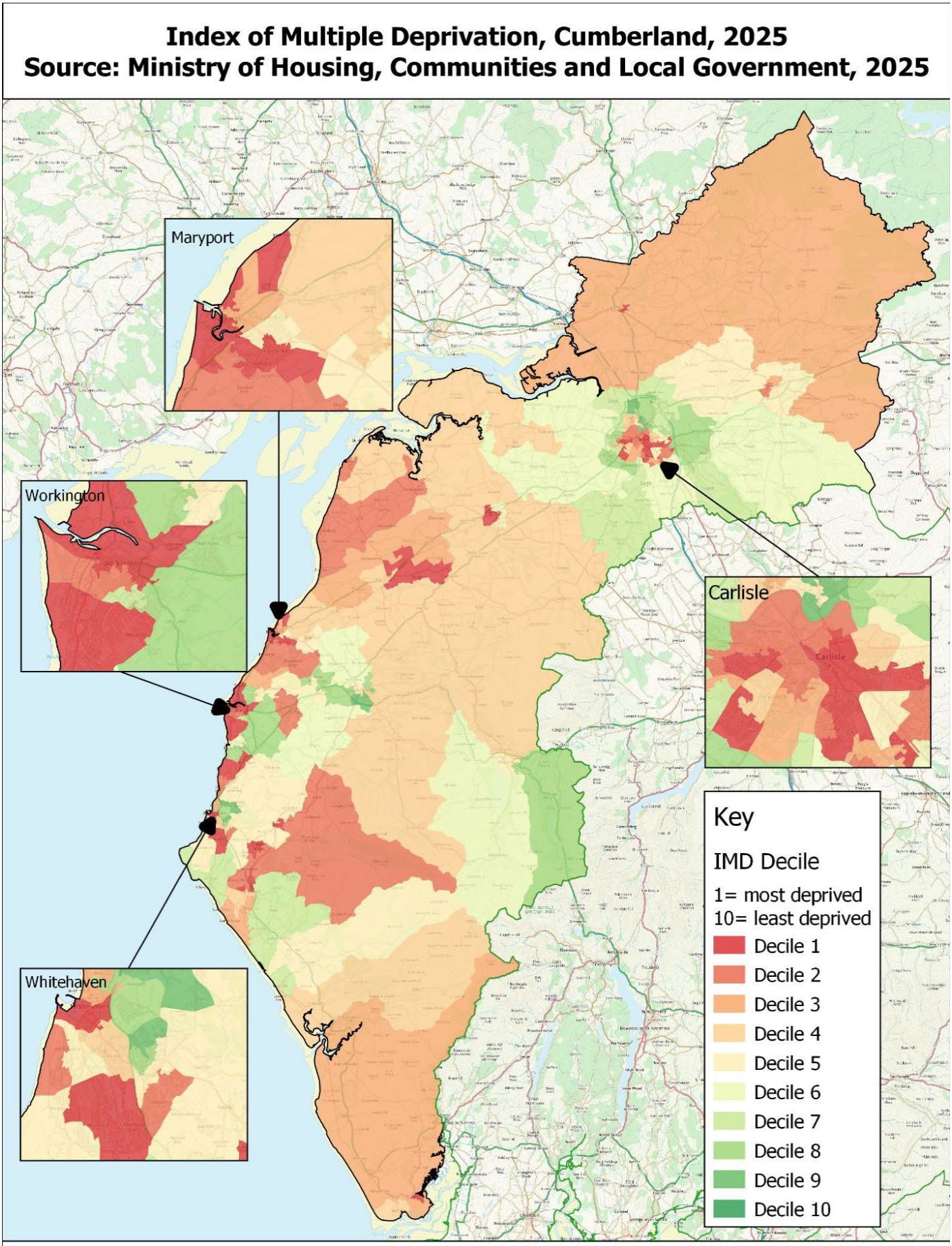


Figure 5: Female life expectancy at birth in Cumberland by deprivation decile, 2011-13 to 2021-23, OHID



Deprivation is not equally distributed throughout Cumberland. In Figure 6 we can see clusters of deprivation in Carlisle and the coastal areas of Maryport, Workington and Whitehaven. Throughout England it is recognised that coastal areas have some of the poorest health outcomes, with geographical barriers to services, more limited transport and communities historically more likely to have been created around single industries, resulting in less resilience to changing tourism and employment patterns (source: **CMO report 2021, gov.uk**).

Figure 6: Cumberland Index of Multiple Deprivation 2025 at lower super output area level (geographical areas consisting of around 1000 to 3000 people)



Causes of differences in male life expectancy in Cumberland

The gap in average life expectancy between men in Cumberland and England has increased, mostly due to cancer, respiratory and external causes (Figure 7). The biggest contributor to the life expectancy gap at 54.8% is external causes. External causes consist of deaths from injury, poisoning and suicide, while the mental and behavioural category covers deaths due to dementia and Alzheimer's disease. This chart highlights the importance of preventing deaths due to suicide, injury and poisoning as key in reducing the inequalities in Cumberland.

The gap in life expectancy between the most and least deprived groups of men in Cumberland increased during the COVID-19 pandemic to 9.7 years and then decreased afterwards, to 8.6 years in 2022-23, how this remains higher than the pre-pandemic gap of 7.3 years. Between 2017-19 and 2022-23 the lead contributing cause has shifted from circulatory causes to external causes from suicide, poisoning and injury, explaining 31.1% of the gap. Circulatory causes remain a leading cause of the gap at 20.4%.

Figure 7: Gap figure showing causes of difference in life expectancy between men in Cumberland and England, 2017-19 to 2022-23 (source: OHID).

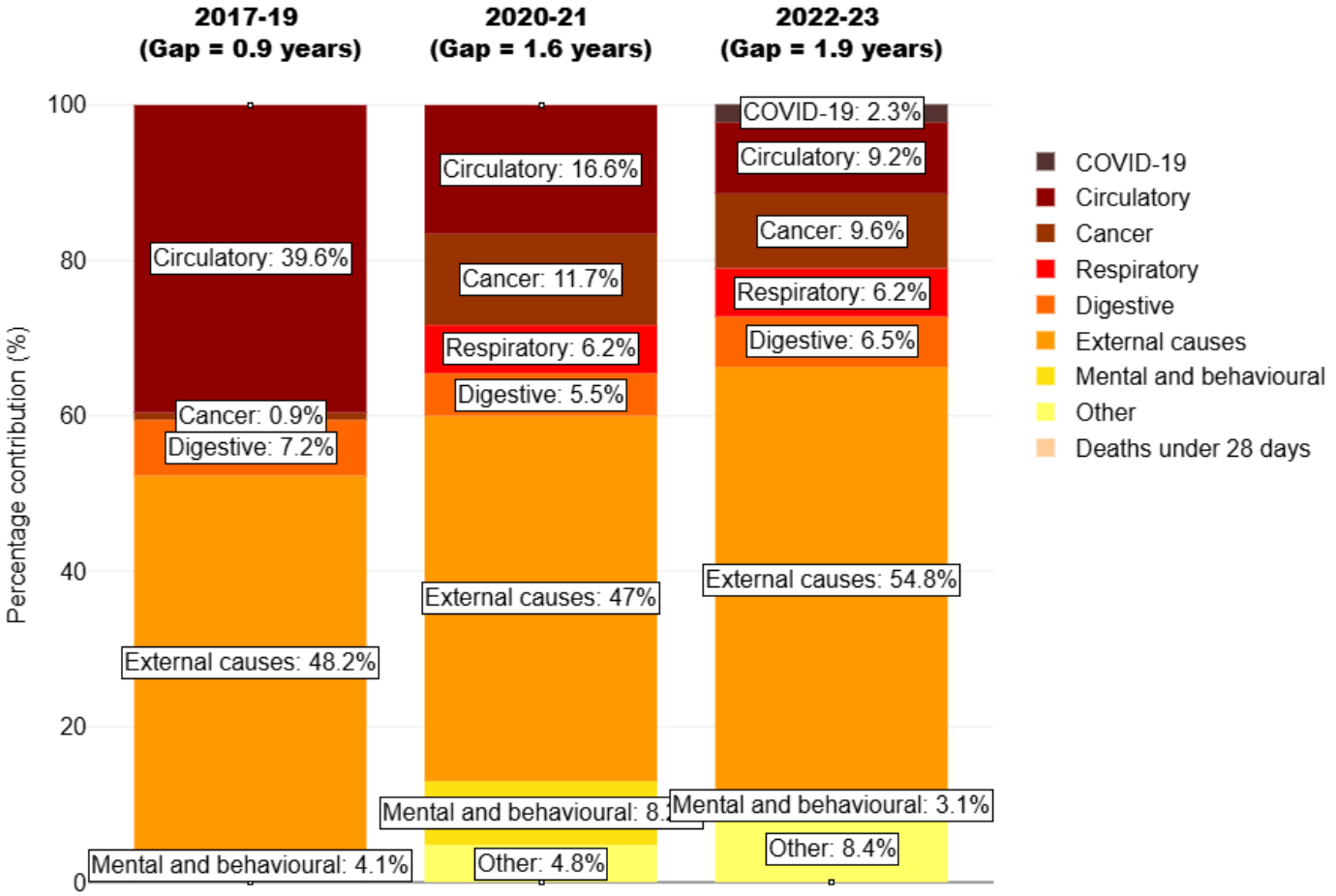
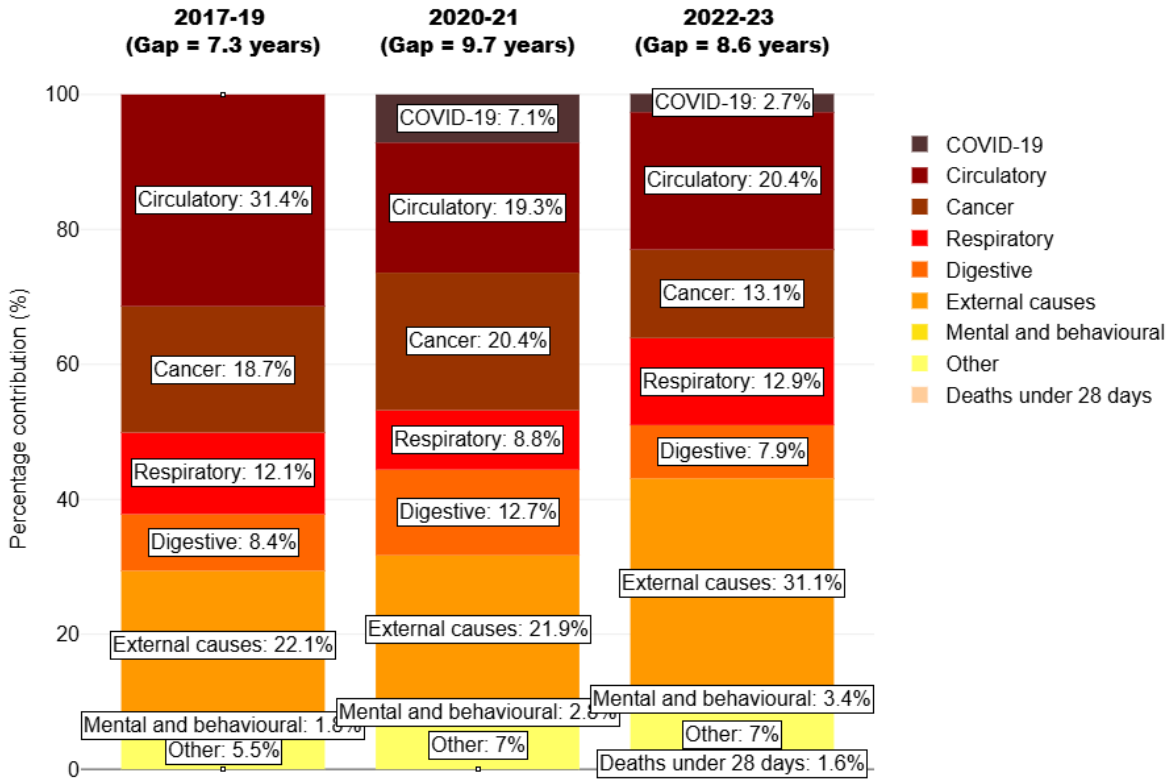


Figure 8: Gap figure showing causes of difference in life expectancy between the most and least deprived groups of men in Cumberland, 2017-19 to 2022-23 (source: OHID).



Healthy life expectancy

Healthy life expectancy has been declining for both men and women in Cumberland since 2018. While a drop has also been seen on a national level, the decrease in healthy life expectancy is dropping more steeply in Cumberland. In the most recent data, 2021 to 2023, women in Cumberland lived around one year extra in good health than men.

Figure 9: Healthy life expectancy of males born in Cumberland, 2011-2023 (Source: ONS)

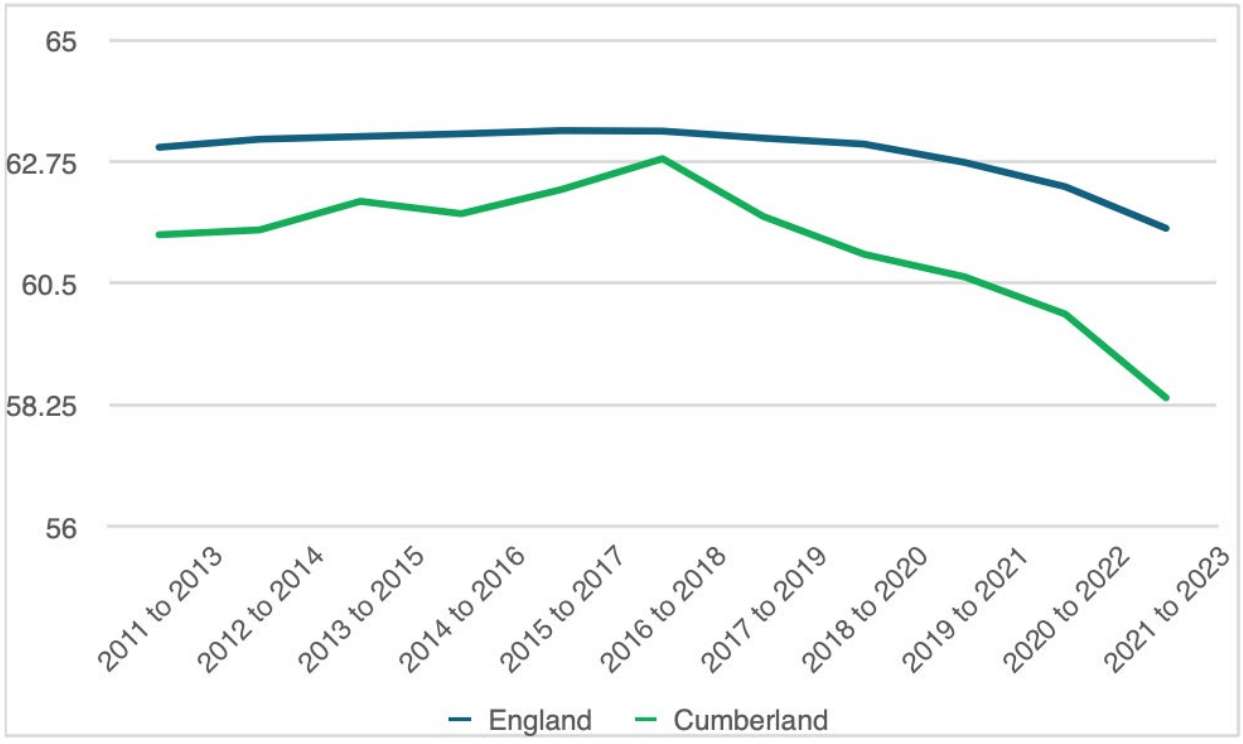
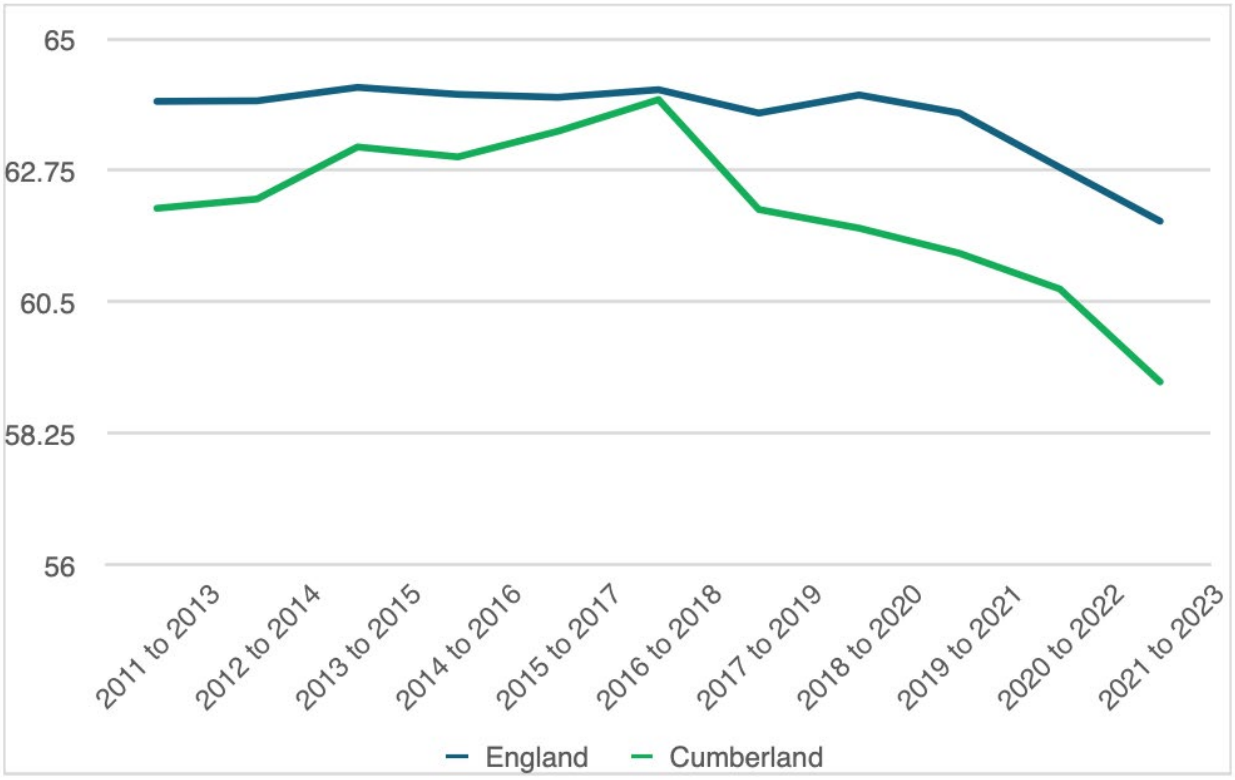


Figure 10: Healthy life expectancy of females born in Cumberland, 2011-2023 (Source: ONS)



Physical health and late presentation to services

The **men's health strategic vision for England**, published in November 2025, highlights key foci for physical health of men, including:

- High levels of frailty in 'young old' populations who are sleeping homeless and 30 year earlier death compared with the general population. It is mainly men who are homeless and rough sleeping.
- Rates of cancer, circulatory and respiratory conditions drive much of the difference in life expectancy between the most and least deprived men nationally. Risk factors for these conditions, such as smoking and obesity, are higher in the most deprived areas of the country.
- Men develop cardiovascular disease around six years earlier than women.
- There is a higher prevalence of type two diabetes in men.
- Cancer incidence and mortality is higher in men than women above the age of 60 years.
- Cancer incidence rates are 19% higher for men in the most deprived quintile compared with the least deprived quintile.
- Men carry the greatest burden of respiratory disease, particularly those who smoke, are former industrial workers and live in the most deprived communities.
- Two thirds of live disease is in men, linked with alcohol consumption, obesity and viral hepatitis.

The strategy includes a plan, formed around meeting men where they are. Major commitments include:

- The investment of £3 million over three years from April 2026 into community-based men's health programmes, targeting areas at highest risk.
- Men's health training for healthcare professionals via new e-learning modules.
- Workplace health pilots in male-dominated industries through the Keep Britain Working Vanguard Programme.
- Enhanced lung disease support for former miners via the Respiratory Pathways Transformation Fund.
- Home PSA testing for prostate cancer patients from 2027 via the NHS App (subject to clinical approval).
- £200,000 trial of interventions to tackle rising cocaine and alcohol-related cardiovascular deaths.

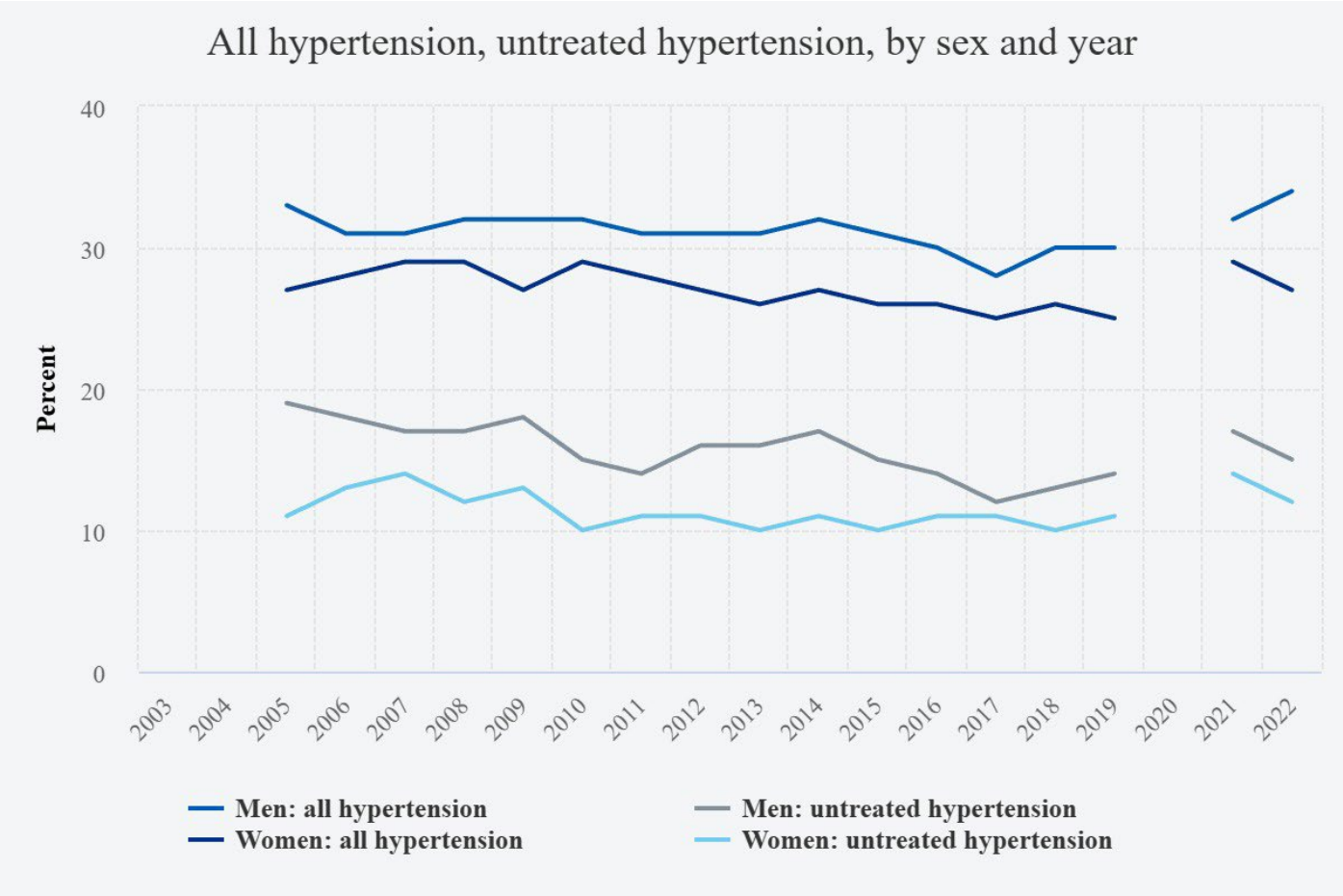
An additional major investment from national government has been the Premier League's Together Against Suicide initiative with the Samaritans, embedding match day messages and support at stadiums. While positive, this strategy fails to recognise the lack of premier league teams in the areas with the highest suicide rates, including Cumberland, Westmorland and Furness, Blackpool, and Darlington. While the strategy is welcomed, it must be ensured that interventions do not neglect those most at risk.

In the **2022 health survey for England**, men were slightly more likely to self-report good health compared with women (76% vs 74%), and less likely to report acute sickness. Women more commonly reported musculoskeletal conditions, mental, behavioural and neurodevelopmental conditions and conditions of the digestive system, while men more commonly reported heart and circulatory conditions.

Hypertension and cardiovascular health

Deaths due to circulatory causes is one of the leading causes of health inequalities both within and outwith men in Cumberland (Figure 7 and Figure 8). Men are more likely to have hypertension 'all' and untreated hypertension than women. Modifiable risks factors for cardiovascular disease accumulate over a lifetime (obesity from childhood, poor diet, lack of exercise, alcohol consumption, obesity), while early intervention for cardiovascular health has the potential to be highly effective, if utilised. Psychological trauma and chronic stress are increasingly being recognised as increasing risk of cardiovascular disease (Song et al., 2019).

Figure 11: Prevalence of hypertension in adults in England, all and untreated, by sex and year, 2003-2022.



NHS Health checks are important appointments offered free to adults age 40-74 years, five yearly, to assess for signs of chronic conditions including cardiovascular disease. Uptake of checks in Cumberland was 27.4% in 2024/25, below the national average of 37.5% (source: **fingertips**). There is a stark gap in publicly available data for NHS health check uptake by gender. The last national figures on 2017/18 data showed women were more likely to attend than men (44% vs 38%) (source: **healthwatch**). Locally acquired data for 2024-25 reflects this pattern, with 3,951 females attending for health checks, compared with 3,222 males.

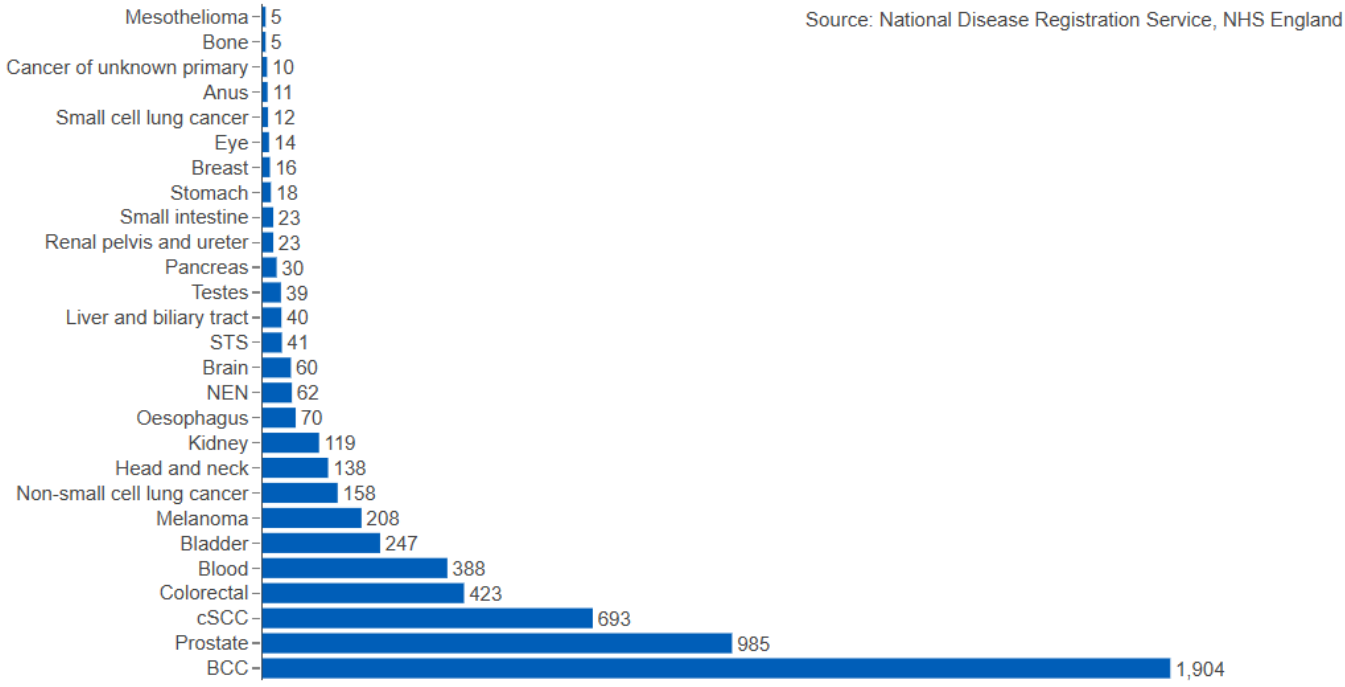
Fingertips data indicates that men in Cumberland have higher levels of certain risk factors: smoking (three percentage points higher) and overweight and obesity (10 percentage points higher), although women have higher levels of physical inactivity (three percentage points higher).

Preventative pathways such as routine health checks rely on proactive help-seeking, yet men are less likely to engage with these services, increasing the likelihood that cardiovascular disease is first identified at either a more advanced stage, or at the point of fatal consequence. As with other health conditions, this pattern reflects not a lack of concern for health, but the interaction between masculine norms, work pressures and service design.

Prostate Cancer

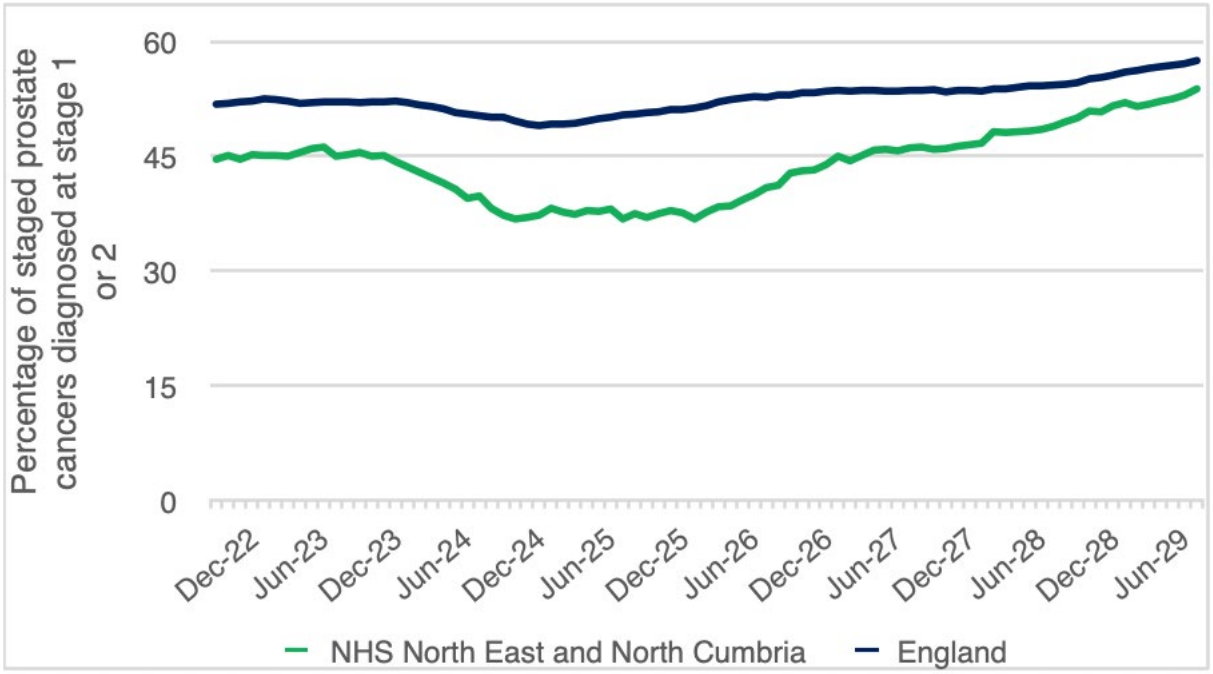
Other than skin cancer, prostate cancer is the most common cancer in men both nationally and in Cumberland, with risk increasing with age (Figure 12). However, lung cancer is the leading cause of cancer death nationally.

Figure 12: Number of men living with and beyond cancer in Cumberland, 2022, by cancer site. Abbreviations: Soft Tissue Sarcoma (STS), Neuroendocrine Neoplasm (NEN), Cutaneous Squamous Cell Carcinoma (cSCC), Basal Cell Carcinoma (BCC). (Source: National disease registration service)



For the 12 months ending October 2025, lower proportions of people were diagnosed with prostate cancer during the early stages, one to two, in Cumberland compared with England (53.8 vs 57.5%) The difference between local and national early stage diagnoses has been reducing since 2022 (Figure 13).

Figure 13: Prostate cancer 12 month rolling early stage at diagnosis proportion (stages 1 and 2), Jan 2019 to Oct 2025, NHS North East and North Cumbria Integrated Care Board Cancer Alliance and England. (Source: National disease registration service)



There is currently no national screening programme for prostate cancer. While this remains a contested decision, the conclusion of the UK National Screening Committee remains that the current available screening tests are not fully reliable at picking up cancers that actually need treatment, and some of the investigations and treatments are invasive and harmful, not balancing the need for a screening programme to do more good than harm. However,

a targeted approach to screening based on risk is currently being considered.

Instead, diagnosis with prostate cancer relies on individuals presenting to medical services with symptoms such as frequent nighttime urination, weak stream of urine or difficultly passing urine. The pattern of high proportions of later stages of diagnosis of prostate cancer in Cumberland may represent later presentation and delayed engagement with diagnostic pathways, consistent with wider evidence on men's health-seeking behaviour locally, including lower uptake of preventative care and a higher tendency to seek help only at crisis point.

Mental health and wellbeing

For many men in Cumberland, psychological distress is closely linked to experiences of redundancy, insecure employment, declining physical capacity or perceived failure to meet provider roles (Ashworth, E. et al, 2026). Contact with the justice system factor is also associated with poor mental health, with half of the boys and men in contact with the justice system reporting anxiety or depression, compared with 15% of the general population. Cultural norms that value stoicism and "getting on with it" can discourage early disclosure, leading men to internalise distress and delay seeking support. As a result, mental health difficulties frequently come to attention only once they have escalated, often alongside physical illness, financial strain or crisis events, with consequences that extend beyond individual men to families, workplaces and communities.

Available data on mental health and wellbeing is generally scarce and not available split by sex. Where data is available, the ratio of higher suicide rates in men compared with women does not tend to correlate with diagnosis of mental health conditions. NHS England population **survey data** conducted every seven years since 1993 show that women have a higher prevalence of diagnosed common mental health conditions than men across all age groups at all time points, including anxiety disorders, depression and phobias.

A local survey in the Cumberland, conducted by The Big Question study (explored further in the next section) found that a higher proportion of men reported thoughts of self-harm compared with women (52% vs 47%), however women were slightly more likely to have previously ever self-harmed (28% vs 25%), and slightly more likely to seek help (57& vs 51%) (Ashworth, E. et al, 2026). Participants reported varying quality of help received; while some were supported by healthcare organisations, there was report of private therapy, third-sector organisations (e.g. Andy's Man Club and Samaritans) and organisations outside of Cumberland.

Key challenges in seeking help were varied and somewhat echoed those in surveyed professionals supporting children and young people. Some Big Question respondents reported self-reliance and management, stigma, previous negative experiences, difficulty in asking for help, accessibility, lack of long term support for men and feeling they had to reach crisis point before being eligible for support.

These findings echo wider knowledge that men are less likely to report symptoms or engage with services at an early stage, and are more likely to present later, with more severe or complex manifestations of distress. This helps explain why men in Cumberland experience disproportionate rates of mental health-related economic inactivity, substance use and suicide, despite lower diagnosed prevalence of common mental health conditions.

Debt and gambling harms

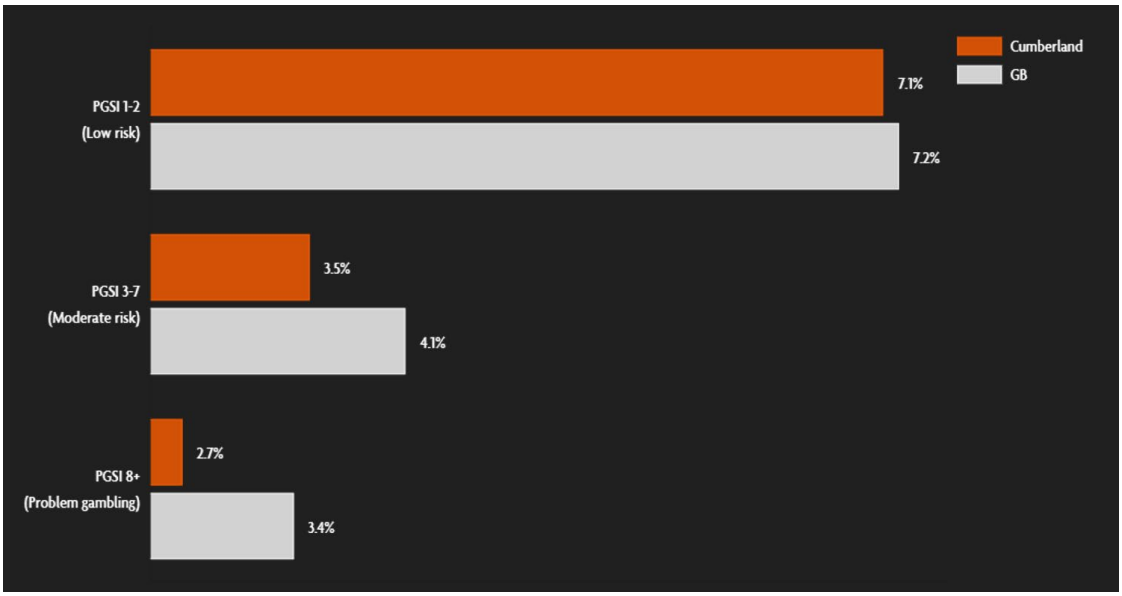
Gambling is widely known to be a harmful commodity, impacting on psychological and physical health. While overall gambling levels are highest in people with better psychological health and life satisfaction, at-risk and problem gambling prevalence is higher in those with poor health, low life satisfaction and wellbeing (source: **NHS England**). Being male and having poor mental health are strong predictors of at-risk gambling.

In understanding patterns of gambling, one challenge is the reliability of data. Much of what is available, and quoted below, comes from **GambleAware**; this is an organisation funded primarily by voluntary donations from the UK gambling industry and has previously faced scrutiny over conflicts of interest regarding ties to the industry and lack of independence concerns, including in a case raised by the **Good Law Project** which was later closed by the Charity Commission. The data that follow should therefore be seen in this context.

In 2020 data collated by **GambleAware**, around 7% of the population of Great Britain were negatively affected by someone else's gambling. In 2020, Of the 7%, affected others were more likely to be a women, 25% were a spouse or partner, 21% were a mother or father, while 9% were a son or daughter. Impacts were felt most severely by partners, parents or children of problem gamblers.

In further data collated by **GambleAware**, through the Annual GB Treatment and Support Survey 2024, Cumberland appears to have gambling problems below the national average. It is important to note the **limitations** of the Problem Gambling Severity Index (PGSI), the screening tool used to assess problem gambling. The tool assesses for presence of harms at that moment only, not severity of harms, wider impacts or ongoing to harms to people who have previously had gambling. However, this still generated an estimated fiscal cost of £5,542,704 of harms associated with gambling, predominantly though welfare costs and hospital inpatient stays.

Figure 14: Prevalence of gambling problems, Cumberland and Great Britian, 2024 (Source: GambleAware)



Direct harms to gamblers were financial harms, relationship harms, mental and physical harms (those with a gambling disorder have an increased risk of all cause mortality), employment and education harms, criminal harms and cultural harm (source: OHID, PHE). These are echoed in harms felt by those impacted by harm, with 75% reporting feelings of anger, anxiety, depression, sadness, or distress and 60% reporting negative financial impacts (source: **GambleAware**).

Men and women demonstrate differing patterns of gambling behaviour and associated harms. Research consistently finds that men are more likely to engage in higher-risk, competitive and rapid-cycle forms of gambling such as sports betting, poker, online betting and casino gambling, whereas women are more likely to participate in chance-based formats such as gambling machines (Baggio et al., 2018). Males gamble proportionately more than females, except regarding scratch cards. Harmful gambling among men has been more strongly associated with sports betting and substance use, whereas among women it appears less associated with substance-use networks (Baggio et al., 2018).

The structure of gambling activities also differs in ways that may influence harm. High-intensity formats such as online sports betting and casino games are characterised by rapid cycles of staking and reward, and greater opportunities for escalation and solitary play, whereas other formats are more socially embedded. Recent research indicates that for both men and women, gambling motivated by coping is strongly associated with severity of harm, with maladaptive emotion regulation emerging the key predictor (Theodorou et al., 2025).

The National Men's health strategy highlights gambling as key concern in men's health. Men were highlighted as more likely to experience gambling rating harms, to gamble online and engage in online gambling, increasing exposure to gambling-like content. A new national gambling tax law was announced in the 2025 budget and provides protected funding for gambling harms prevention (30% of levy funding), treatment (50% of levy funding), and research (20% of levy funding). The Government has committed to developing a coordinated approach to gambling prevention, including a new voluntary sector grant, delivering a research programme and increasing treatment and support services. It is imperative that **Cumberland advocates for shared receipt of these resources and that statutory organisations support voluntary sectors in doing so.**

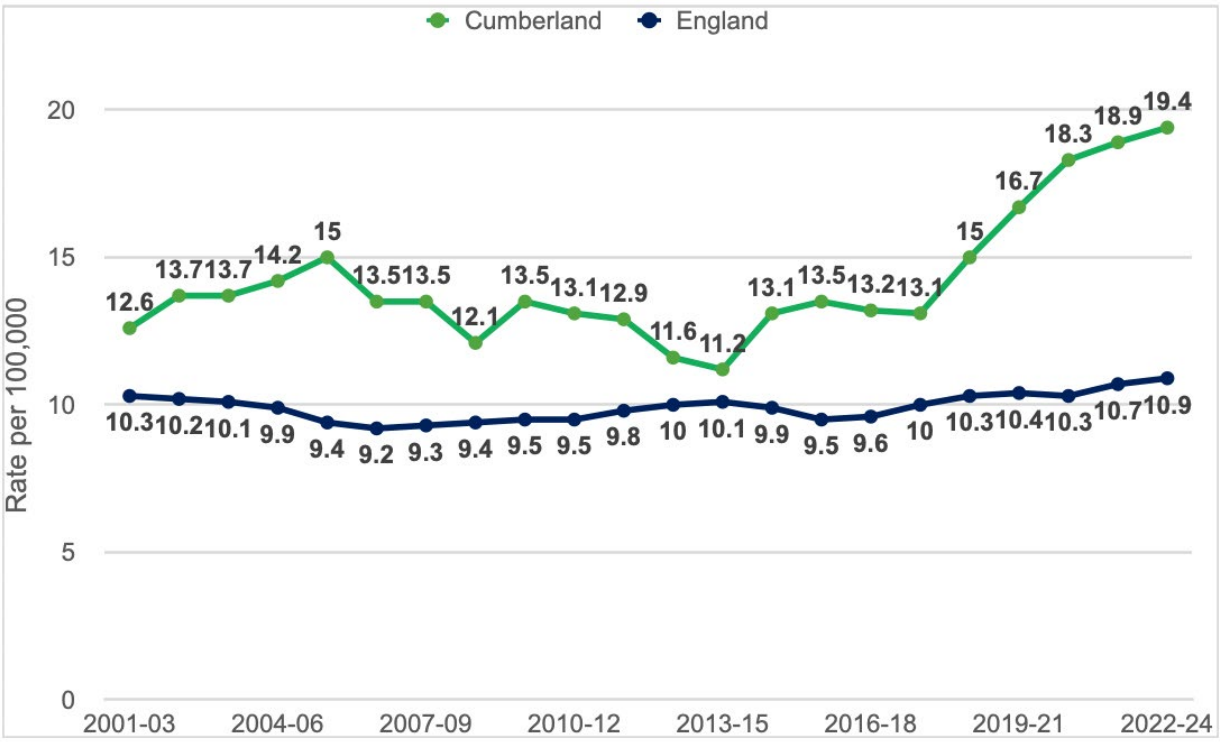
Suicide rates

Across the UK, suicide and injury or poisoning of undetermined intent is the leading cause of death for both males and females aged 20 to 34 years. Men were more than three times as likely to die by suicide compared with women in this age group. Since 2001, the leading cause of death in men aged 35 to 49 years has changed from ischaemic heart disease to suicide in 2011-2015 and accidental poisoning more recently (source: ONS).

In 2022-24, there were 137 suicides in men and women in Cumberland, the third highest out of 153 upper tier local authorities in England and a rate of 19.4 per 100,000 population (source: ONS). Suicides rates in Cumberland are increasing, and at a higher rate compared with England.

In 2022-24, men in Cumberland had the 7th highest rate of suicide deaths nationally. Of the 137 suicide deaths in Cumberland, 98 were in men. This is a rate of 28.2 per 100,000, significantly above the national rate of 16.8. In the same period, women in Cumberland had the highest rate of suicide related deaths, with a rate of 11.2 per 100,000 compared to 5.5 per 100,000 nationally. This is further explored in Chapter 4: Work, place and identity in adult men's lives.

Figure 15: Suicides: Cumberland and England; 2001 to 2024 Age-standardised Rates per 100,000 population (Source: ONS)



Suicide: The Big Question Report

Suicide rates in Cumberland show a persistently high burden, particularly among men. This fact prompted The Big Question, a mixed-methods study commissioned by Cumberland Council and undertaken by Liverpool John Moores University, to explore why suicide risk remains high and how it is experienced locally (Ashworth, E. et al, 2026).

Men and women were similarly likely to report suicidal thoughts (57% of men compared with 55% of women), and men were slightly more likely to report having received support. Of the 40 men who reported a previous suicide attempt, 27 (67.5%) reported receiving support after (although only 30 gave responses). Of 99 reporting suicide attempts, 52 received support (52.5%), with 94 out of 99 responding to this question. These findings suggest that high male suicide mortality in Cumberland is not by total disengagement from services, but by more complex factors. However, it may also be that those responding to the survey are a selection of people more likely to engage with health services than the general population.

Respondents were asked to comment on mental health challenges and contributing factors to the high suicide rates in Cumberland. Responses included mental health conditions, chronic pain and other long-term illness, neurodivergence (often diagnosed late), intergenerational trauma and adverse childhood experiences. Drugs and alcohol were described as coping mechanisms, and the long-term impact of suicide bereavement was prominent, with over half of respondents reporting being affected by the death of someone who died by suicide. Of the 781 respondents, 52% reported havening been bereaved or affected by the death of someone who died by suicide. This was lower in men than women (44.6% vs 55.2%). Common relationships were friend, family and work colleague, with many participants citing knowing more than one person who died by suicide.

Acute triggers reported to precede crisis included relationship breakdown, abusive relationships, interpersonal conflict and bullying. Environmental and socioeconomic stressors were also prominent, including isolation, rurality and transport barriers, financial strain, seasonal factors (poor winter weather), limited recreational opportunities and a labour market shaped by a small number of dominant employers. Some respondents highlighted access to firearms within agricultural settings as a specific risk factor, while social media was described as increasing isolation and undermining communication.

Attitudes and assumptions are known to shape help-seeking. Suicide was perceived as taboo for many, with suicidal thoughts often minimised or normalised. A "Cumbrian tendency" towards stoicism and emotional restraint among men was frequently cited, alongside shame and concerns about confidentiality in close-knit communities. Attitudes to mental health were reported to be shifting across generations to become less conservative and more liberal. Frustration with the availability and continuity of support was common.

Taken together, these findings reinforce and evidence that suicide in Cumberland reflects the interaction of identity-based pressures, place, constrained opportunity and delayed help-seeking. Men may articulate distress and access support at points, but remain vulnerable where help is fragmented, short-term or poorly aligned with lived realities. Addressing suicide risk therefore requires approaches that recognise identity and place as determinants of health, alongside timely, sustained and culturally aware support.

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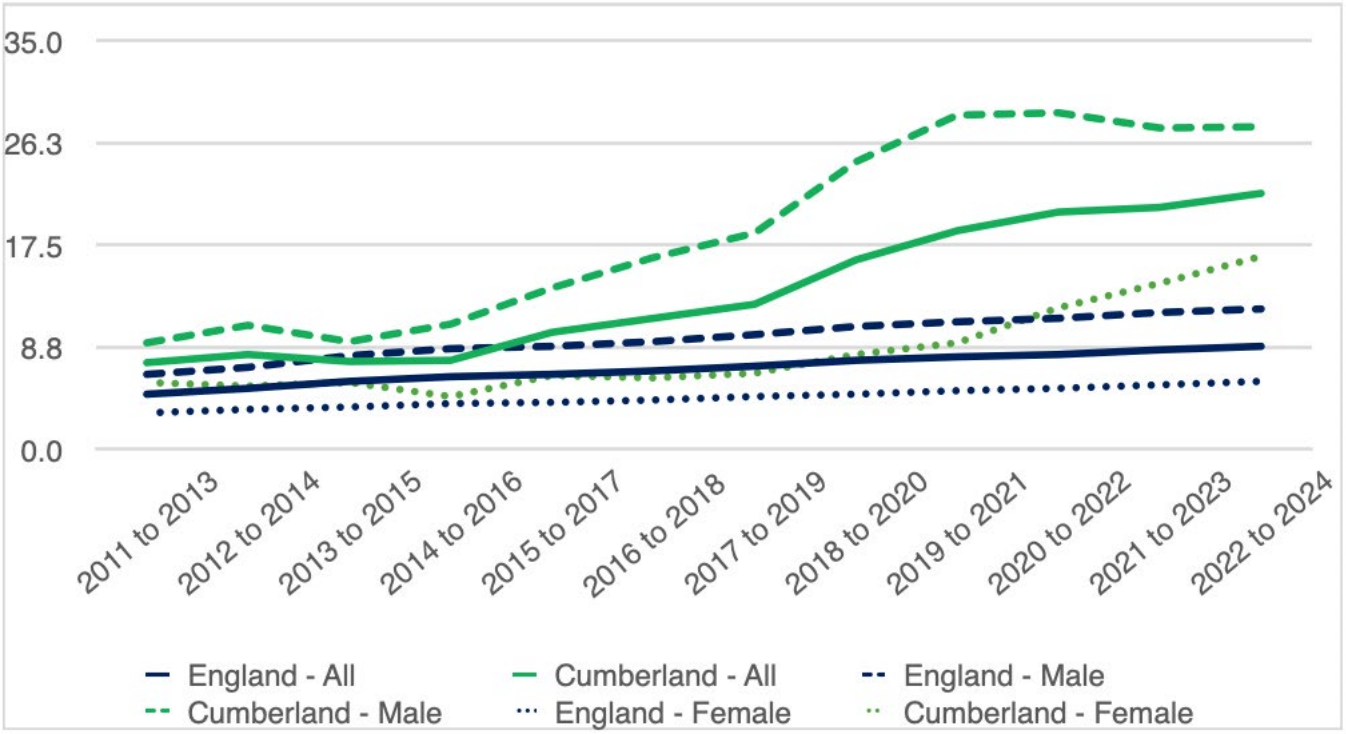
Substance misuse rates

Substance use is a significant public health concern in Cumberland, contributing to mortality, hospital admissions, crime and unmet support needs. In 2022-24 there were 164 drug-related deaths in Cumberland, an age-standardised morality rate of 21.9 per 100,000 which is around double the national average. Cumberland had the third highest rate of local authorities nationally, with only Blackpool and Middlesborough having higher. Drug related deaths are around double in men compared to women, at 27.6 (7th highest) and 6.9 (14th highest) per 100,000 respectively, and are rising in recent years in both men and women (Figure 16) (Sources: **ONS, 2024** and **Cumberland statistical summary, 2025**).

Figure 16: Drug related deaths (drug poisoning & misuse) All persons; Age-standardised Rate per 100,000), ONS



Local assessment data for **Cumbria** indicate that there were approximately 2,400 individuals using opiates and crack, with opiate prevalence higher than regional and national averages, and around 5,594 adults estimated to be dependent on alcohol at similar rates to England overall.

In 2024/5 there were 1,940 people in treatment for drug and alcohol use (source: **NDTMS**), 1290 (66.5%) of whom were male, 1145 (59.0%) in the 30-49 year age group. People with opiate dependence formed the largest treatment group (875/1940, 45.1%) with the next largest treatment group being people with alcohol misuse (685/1940, 35.3%).

Co-occurring mental health needs are common among those entering treatment, while unmet need for treatment among dependent people persists at similar or higher levels than national benchmarks. These patterns occur alongside rising levels of drug-related crime and a growing proportion of treatment clients who are parents, underlining both the personal and social impact of substance use in the area.

Regarding children and young people, in 2023 the youth substance team received around 100 referrals for young people across both Cumberland and Westmorland and Furness. Most of these referrals were young men, with over half of referrals for drug use and around a third for alcohol use. In 2023/24, there was a rate of 44.7 per 100,000 alcohol specific admissions for under-18s in Cumberland, around double the national rate and the highest rate in the Northwest of England (source: **Fingertips**).

National data 2023/24 collated by the Office for Health Improvement & Disparities found that 21% of people started treatment in substance services had no home of their own, higher in people starting treatment for opiate problems. Almost three quarters of adults had a mental health need. Table 2 shows the national breakdown by sex of adults in contact with drug and alcohol treatment services. The age group with the highest number of people in contact is 40 to 44 years, at 53,747 individuals.

Table 2: Adults in contact with drug and alcohol treatment services between 1 April 2023 and 31 March 2024, England, by Sex

Substance group	Men	Women	Total
Opiate	100,359 (72.7%)	37,606 (27.3%)	137,965 (44%)
Non-opiate only	24,982 (68.4%)	11,545 (31.6%)	36,527 (12%)
Non-opiate and alcohol	30,101 (71.3%)	12,097 (28.7%)	42,198 (14%)
Alcohol only	56,429 (59.9%)	37,744 (40.1%)	94,173 (30%)
Total	211,871 (68.2%)	98,992 (31.8%)	310,863 (100%)

Cumberland is experiencing a crisis in drug related deaths in men and women, at 27.5 and 14.2 deaths per 100,000 population respectively. The rates of deaths have tripled for men and nearly tripled for women over the last ten years.

Safer Drug Consumption Facilities (SDCFs) are a relatively novel intervention: settings where people can consume drugs procured elsewhere while in the presence of health care professionals to reduce and respond to overdoses and offer access to healthcare and social services. Globally, many countries including Scotland have introduced SDCFs. Evaluation of existing SDCFs found they were cost-effective, reduced drug related deaths and injecting harms, associate with increased uptake of addiction care, reduced publicly discarded syringes around the facilities and can provide links to housing and mental health services. Despite the evidence in favour of SDCFs, the Misuse of Drugs Act prohibits the legal operation of SDCFs, and the UK parliament has announced their intention to keep this legislation in place, even if Scottish pilot evaluations demonstrate benefit, precluding the opening of SDCFs in England. In the face of high and up-trending drug related deaths and harms, it is important that due consideration is given to novel, potentially revolutionary drug treatment service models such as SDCFs, and **that local authorities most impacted by drug related deaths advocate for these approaches.**

Interpretation

While cardiovascular and respiratory disease remain important contributors to mortality among men in Cumberland, it is deaths from external causes, particularly suicide, drug poisoning and injury, that most sharply contribute to differences in men's outcomes from both women locally and men nationally. These deaths tend to occur earlier in the life course, disproportionately affecting men of working age, and therefore contribute heavily to the gap in life expectancy. Perspectives from local practitioners and professions regarding the root causes of these patterns are explored in Box 1.

Box 1: Local professional and practitioner perspectives regarding the underlying factors in Cumberland leading to high rate of deaths due to 'external causes' (suicide, poisoning and injury).

Practitioners working with men and boys consistently described these deaths not as isolated events, but as the culmination of cumulative distress: unresolved trauma, economic insecurity, relationship breakdown and delayed engagement with support. This aligns with professional survey findings, where emotional suppression, trauma and low aspiration were among the most commonly observed challenges, and where the majority of practitioners reported that boys and young men often or almost always hold back from seeking help. These patterns raise the need to explore when these inequalities begin, if they can be prevented earlier and how this prevention might take shape.

Deaths of despair

The combined mortality arising from suicide, drug poisoning and alcohol-related causes is often described as "deaths of despair" (DoD). The term was originally used by economists Anne Case and Angus Deaton to describe rising mortality in the United States, particularly among White men without higher education, linked to long-term economic and social dislocation (Case & Deaton, 2022).

Subsequent research in England, including analysis by the University of Manchester, has shown a similar pattern, with deaths of despair disproportionately concentrated in the North of England and in coastal areas. This research characterises deaths of despair as an "avoidable human cost of inequitable resource deprivation" (Camacho et al., 2024). Key factors associations with DoD were living in the North, unemployment, White British ethnicity, living alone, economic inactivity, employment in elementary occupations, and living in urban areas (Camacho et al., 2024).

Many communities in Cumberland experience a clustering of these risk factors. Rising mortality due to suicide, drug-related deaths and alcohol-related harm locally reflects a pattern consistent with deaths of despair, highlighting the cumulative impact of economic insecurity, social isolation and limited access to early support. This framing reinforces the need to address upstream determinants and underlying causes of cycles of deprivation.

Chapter 3: How inequalities begin: boys, education and early challenges

Introduction

This chapter examines how inequalities begin. It focuses on the earlier points at which outcomes diverge for boys. The data demonstrating high suicide rates, poor mental health and violence in men represents a slow accumulation of disadvantages and missed points of intervention in early life and pre-conception.

This chapter aims to highlight that poor outcomes are not inevitable, and explore points of preventable divergence at which earlier, targeted support could reduce later harm.

Pre-conception and early years

The first 1001 days of life, from conception to age two, are crucial to building the physical health and emotional wellbeing of an individual. Positive parent-child interactions are associated with good early development, school readiness and long-term emotional adjustment ability (Source: **OHID**).

Though confidence intervals are wide and often sometimes overlapping, given the relatively small population, **fingertips data** indicates that health in Cumberland differs from national averages in ways that have long-term implications for child development and later health outcomes.

While overall fertility rates are broadly comparable with England, Cumberland has higher rates of under-18 conception, birth and delivery, alongside a lower proportion of women giving birth aged 35 and over. There is a significantly lower proportion of women taking folic acid supplements pre-pregnancy, which are recommended for at least three months prior to conception to reduce the risk of neural tube defects. There are slightly lower rates of smoking in early pregnancy and statistically significantly higher rates of obesity.

The proportion of babies first feed being breastmilk appears to be significantly lower than national rates, at 55.8% compared with 71.9%, although this data is not fully comparable due to differences in data collection methods. **Breastfeeding** is associated with both physical health benefits and early bonding, and lower initiation rates may reflect wider pressures on parents during the perinatal period, including socioeconomic stress (Modak et al., 2023; Oakley et al., 2013).

These early indicators matter not only for physical health, but for the development of secure attachment relationships in infancy. Attachment theory highlights the importance of consistent, responsive caregiving in the first years of life for the development of emotional regulation, stress management and the capacity to seek support (Behrens et al., 2025). Where families experience socioeconomic stress, parental mental ill-health, young parenthood or limited access to support, opportunities to establish secure attachment may be constrained. At a population level, these pressures are more common in areas of deprivation and coastal communities.

Family structure forms part of this context. The former Districts of Carlisle, Copeland and Allerdale each have 6.2% to 6.4% of households made up of **single family households** of a lone parent with dependent children. This proportion varies, and is increased in Whitehaven, Workington, Flimby and Ellenborough and Carlisle to 10-12%. Nationally, only 16.7% of lone parent families with dependents are families headed by a lone father. Feedback from surveyed professionals in Cumberland consistently highlighted lack of positive male role models as an in issue impacting the wellbeing of boys in Cumberland.

Nationally, boys have **higher infant mortality than girls** (rate of deaths in the first year after birth), and that infant mortality **increases with deprivation** (local sex-specific infant mortality data are not available for Cumberland). There are higher rates of A&E attendances in 0-4 years for boys compared with girls, seen in both **national and local data**. Boys are also more likely to have **dental caries at age 5**, an indicator of nutrition, dental neglect, a leading cause of hospital admissions for young children, and a predictor of future chronic disease.

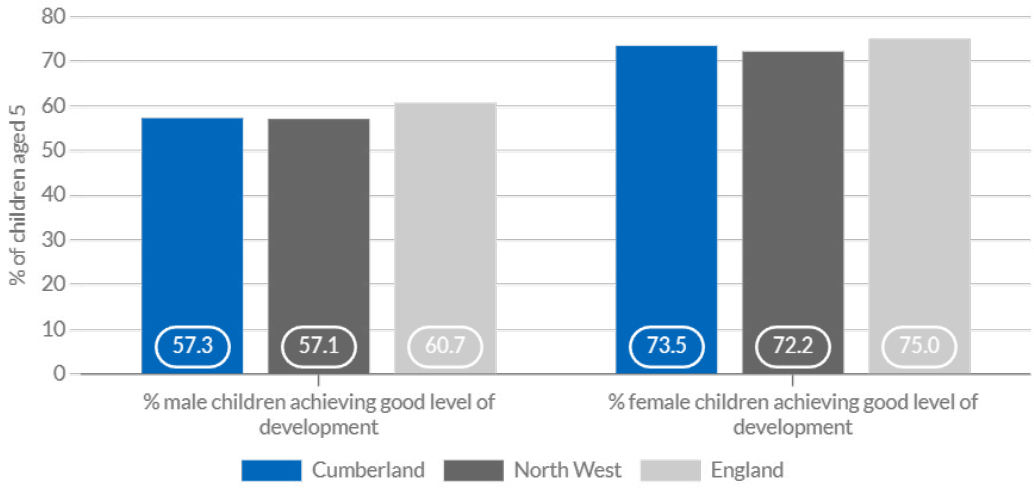
These early life patterns point to early differences in illness and injury acquisition between boys and girls. Attachment theory helps explain how early adversity can translate into later difficulties with emotional regulation, school engagement and behaviour. These early differences shape trajectories, making timely, relational and family-centred support in the earliest years a critical point for preventing later inequalities in boys' mental health, educational engagement and wellbeing.

Educational attainment

End of reception

Gendered differences in outcomes appear early, seen in data at the end of reception, where a good level of development[1] is achieved by fewer boys (57.3%) than girls (75.3%) in Cumberland, broadly mirroring national inequities (Figure 17). The group of children with the lowest rates are boys who receive free school meals (42.6%, noting wide confidence intervals). This is in line with the national rate of 43.2%.

Figure 17: Percentage of children achieving a good level of development at the end of reception (2024)



1 A good level of development at this point is achieved if the child has reached the expected goals in personal, social and emotional development; physical development; and communication and language learning areas, as well as maths and literacy.

Of black and minority ethnic children in Cumberland, 56.2%, achieve a good level of development at reception; lower than all other children in Cumberland (65.9%), and with other black and ethnic minority children across the northwest (61.6%) and nationally (66.1%). This likely represents cumulatively poorer outcomes in boys of black and minority ethnicities, though this data breakdown is not available.

Key stage two

At the end of the academic year 2024/25, 791/1506 (52.5%) of boys in Cumberland finished key stage two meeting the expected standard in reading, writing and maths combined, compared with 889/1513 (58.8%) of girls. These gender gaps are compounded by disadvantage; children receiving free school meals are far less likely to achieve the expected standard, with boys lower than girls (116/354 (32.8%) vs 153/388 (39.4%) respectively).

This patterning repeats in girls and boys with special educational needs (SEN). Out of 405 boys with SEN, 68 met the expected standard (16.8%), and 45 out of 246 (18.3%) of girls met the expected standard. It is important to note here the higher number of boys with SEN compared to girls, however systematic differences in diagnosis patterns in boys and girls likely misrepresents the true figures.

Key stage four attainment

Educational inequalities evident by the end of primary school persist into adolescence. At the end of Key Stage 4 in 2024/25, boys in Cumberland achieved lower average Attainment 8 scores than girls (40.2 compared with 44.5), and were less likely to achieve grades 5 or above in both English and Maths (34.9% of boys compared with 38.1% of girls). Pupils eligible for free school meals have substantially lower attainment, though the gap between genders is narrower, at fewer than one in six boys (16.4%) achieving attainment score 8, slightly less than girls at 17.8%.

This indicates that early educational disadvantage is not corrected by secondary schooling but becomes embedded by the point at which qualifications most strongly shape post-16 pathways, employment prospects and future health outcomes.

Table 3: All state-funded pupil characteristics and geography data' for Boys and Girls in Cumberland for 2024/25

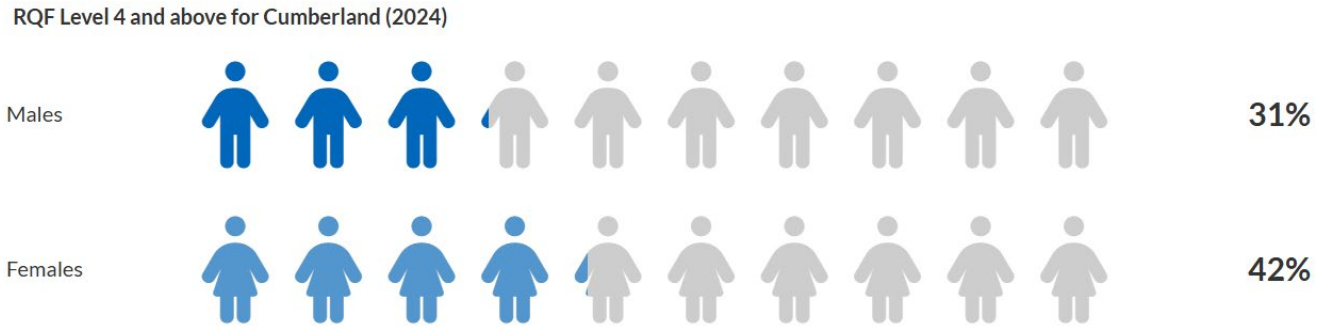
		Number of pupils at the end of KS4	Average Attainment 8 score	Percentage of pupils achieving grades 5 or above in English and maths GCSEs
Boys	Total	1,538	40.2	34.9%
	FSM eligible	348	30.2	16.4%
Girls	Total	1,343	44.5	38.1%
	FSM eligible	303	33.0	17.8%

Post compulsory education

RQF Level 4[2] represents a key progression point beyond compulsory education. Qualifications at this level demonstrate advanced subject knowledge and analytical skills and often provide access to professional and technical roles.

In Cumberland, progression to RQF Level 4 and above shows a clear gender divide. In 2024, 31% of men had achieved qualifications at this level or higher, compared with 42% of women. This gap reflects the cumulative effects of earlier educational divergence observed at primary and secondary school stages. Lower progression to higher-level qualifications limits access to secure, well-paid and less physically demanding employment, increasing long-term vulnerability to economic insecurity and poorer health outcomes. These patterns underline how early educational inequalities translate into constrained opportunities in early adulthood, reinforcing the importance of earlier intervention and more inclusive progression pathways for boys and young men.

Figure 18: Regulated Qualifications Framework Level 4 and above, Cumberland, 2024



Not in education, employment or training

Local data indicate that a small but significant minority of young people in Cumberland are not in education, employment or training (NEET) at ages 16–17, with boys more likely than girls to be NEET (Table 4). Although overall NEET proportions in Cumberland are relatively low, the range of alternative post-16 opportunities for those young people are more limited than in many other local authorities. This means that even small increases in disengagement have the potential for disproportionate impact due to fewer accessible pathways back into learning or work, increasing the risk of longer-term economic and social exclusion.

Table 4: Proportion of young adults who are not in educational, employment or training in Cumberland, 2024 (Source: gov.uk)

Sex	NEET proportion	Number NEET	Activity not known proportion
Female	2.4%	69	0.7%
Male	2.9%	91	0.9%

2 RFQ4: a UK qualification level equivalent to the first year of a Bachelor's degree or a Higher National Certificate (HNC), demonstrating detailed knowledge and analytical skills in a subject, often leading to professional roles in education, IT, or finance, with pathways to higher qualifications like RQF Level 5 or degree programs.

School suspensions and permanent exclusions

The following sub-section uses Department for Education data from autumn school term 2023/24 to autumn school term 2024/25 inclusive, for state funded secondary schools. Secondary schools are focused on, as there are much few suspensions and exclusions in primary schools.

Across the four terms combined, Cumberland has lower rates of suspension than England but higher rates of permanent exclusion. The largest difference is a 1.61 times increased rate of exclusions for children eligible for free school meals in Cumberland compared with England (Table 5).

Table 5: Rates and rate ratios for permanent exclusions and suspensions state funded secondary schools, Cumberland vs England, Autumn 2023/24 to Autum 2024/25, Department for Education

Group	England rate per 100 pupils (95% confidence intervals)	Cumberland rate per 100 pupils (95% confidence intervals)	Rate ratio (95% confidence intervals)
Permanent exclusions			
Total	0.085 (0.084–0.087)	0.115 (0.094–0.140)	**1.35 (1.10–1.66)**
Female	0.055 (0.053–0.056)	0.084 (0.058–0.118)	**1.52 (1.06–2.19)**
Male	0.115 (0.113–0.118)	0.147 (0.116–0.185)	**1.28 (1.01–1.62)**
Free school meal eligible	0.225 (0.222–0.229)	0.362 (0.305–0.430)	**1.61 (1.34–1.93)**
Suspensions			
Total	7.62 (7.59–7.66)	6.25 (6.00–6.52)	**0.82 (0.79–0.86)**
Female	6.16 (6.12–6.20)	4.74 (4.46–5.05)	**0.77 (0.72–0.82)**
Male	9.06 (9.01–9.11)	7.72 (7.38–8.08)	**0.85 (0.81–0.89)**
Free school meal eligible	18.38 (18.31–18.45)	15.68 (15.04–16.34)	**0.85 (0.81–0.89)**

Suspension rates in Cumberland are consistently below national averages. However, permanent exclusion rates are 35% higher overall and 61% higher among pupils eligible for free school meals (FSM). Pupils eligible for FSM in Cumberland experience permanent exclusion at over three times the overall rate (Table 6). The social gradient in exclusion is stronger locally than nationally (2.5 times the rate nationally).

Table 6: Rates and rate ratios for permanent exclusions and suspensions in children eligible for free school meals in state funded secondary schools, Cumberland vs England, Autumn 2023/24 to Autum 2024/25, Department for Education

Outcome	Area	Total rate (per 100 pupils)	FSM rate (per 100 pupils)	Rate ratio
Permanent exclusions	England	0.085	0.225	**2.65 (2.61–2.70)**
	Cumberland	0.115	0.362	**3.15 2.57–3.87)**
Suspensions	England	7.62	18.38	**2.41 (2.39–2.43)**
	Cumberland	6.25	15.68	**2.51 (2.35–2.69)**

Across state-funded secondary schools, suspensions and permanent exclusions are strongly concentrated in mid-secondary years (Years 8–10), peaking in Year 9 for suspensions and Year 9–10 for permanent exclusions. This pattern is consistent nationally and locally, but Cumberland shows higher permanent exclusion rates in these key years. Given the elevated rates among FSM pupils and boys, the intersection of FSM status and mid-secondary years likely represents the highest-risk group.

Reasons for suspensions

Nationally, persistent disruptive behaviour accounts for just over half of all suspensions (approximately 55%). The next most common reasons are verbal abuse or threatening behaviour towards an adult (around 16–17%) and physical assault against a pupil (around 11–12%). Drug and alcohol-related incidents account for a smaller proportion nationally (approximately 2–3%).

Cumberland shows a similar overall picture to national suspensions, with persistent disruptive behaviour accounting for around half of suspensions. However, verbal abuse towards adults represents a consistently higher share locally in several terms (ranging from approximately 18% to over 20%). Drug and alcohol-related suspensions also account for a larger share locally in some terms (around 4–7%). Physical assault against pupils remains one of the top three causes, although slightly lower proportionally than national averages in some terms.

Reasons for exclusions

Permanent exclusions follow a similar pattern but are more concentrated in high-severity behavioural categories.

Nationally, persistent disruptive behaviour accounts for around 40–42% of permanent exclusions. The next most common reasons are physical assault against a pupil (around 16–17%) and verbal abuse or threatening behaviour against an adult (around 11–12%). Drug and alcohol-related incidents account for approximately 6–7% of permanent exclusions nationally.

In Cumberland, persistent disruptive behaviour accounts for a larger share of permanent exclusions in several terms (ranging from the mid-40% range to over 50%).

Physical assault against a pupil and verbal abuse towards adults also consistently appear among the leading causes (11 to 21% and 11 to 16% respectively). While numbers are small and therefore proportions fluctuate more locally, the dominant pathway to permanent exclusion remains persistent behavioural escalation.

Exclusions and suspensions summary

Exclusion is concentrated in mid-secondary years, a period associated with early adolescence, social identity development and increasing academic pressure. This suggests that Years 8–10 and the time immediately preceding **represent a critical intervention window**.

Second, inequality is pronounced. **FSM pupils experience more than three times higher permanent exclusion rates**, and the gradient is stronger locally than nationally. Exclusion therefore reflects and potentially reinforces wider socioeconomic disadvantage.

Third, the dominant drivers are **persistent disruptive behaviour**. Cumberland's lower suspension rates combined with higher permanent exclusion rates suggest that when behavioural difficulties persist, **escalation to permanent removal may be more likely locally.**

Exclusion should be understood as an indicator of cumulative vulnerability intersecting with deprivation, adolescent development and emerging mental and emotional wellbeing health needs. **Preventative, early intervention approaches in early and mid-secondary years, particularly for disadvantaged pupils, are therefore central to reducing long-term harm.**

Adversity in childhood and gendered responses

Adversity in childhood is a key driver of health inequality, with strong evidence linking early life stress, trauma and disrupted attachment to poorer mental health, educational outcomes and increased risk of substance use and suicide in adulthood. Ten of these have been defined, referred to as adverse childhood experiences (ACEs), though these do not capture all adversities, such as living in a community experiencing poverty, poor employment, bereavement and isolation (Figure 19). The ACE pyramid (Figure 20) is a conceptual framework, demonstrating how adverse childhood experiences influence health and wellbeing.

Figure 19: Adverse childhood experiences, taken from Liverpool CAMHs website

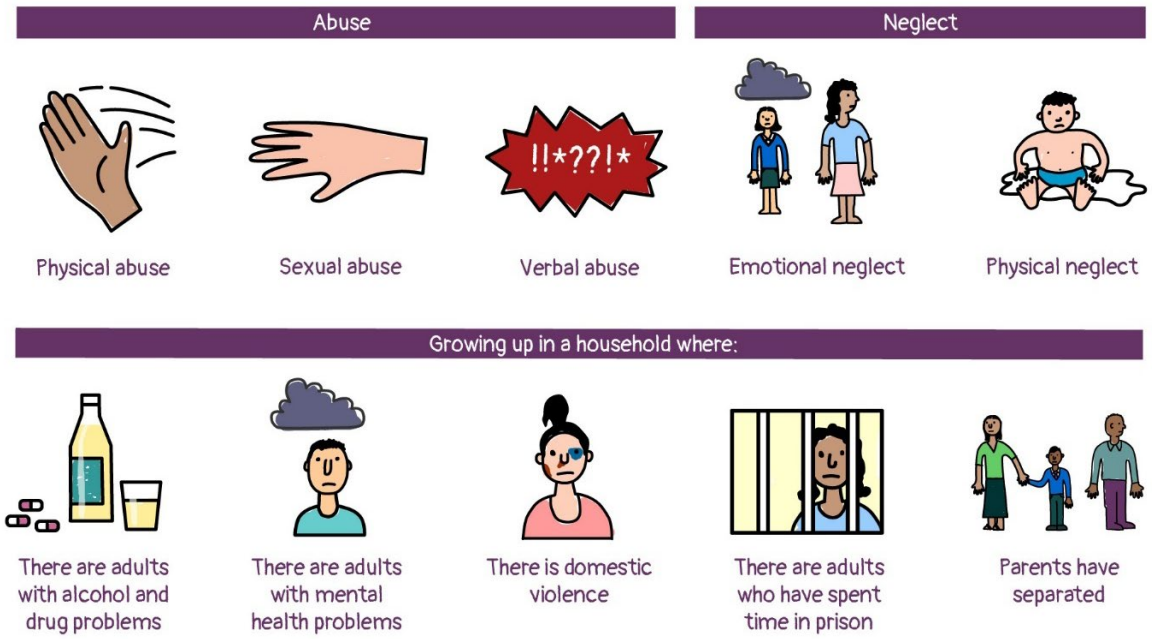
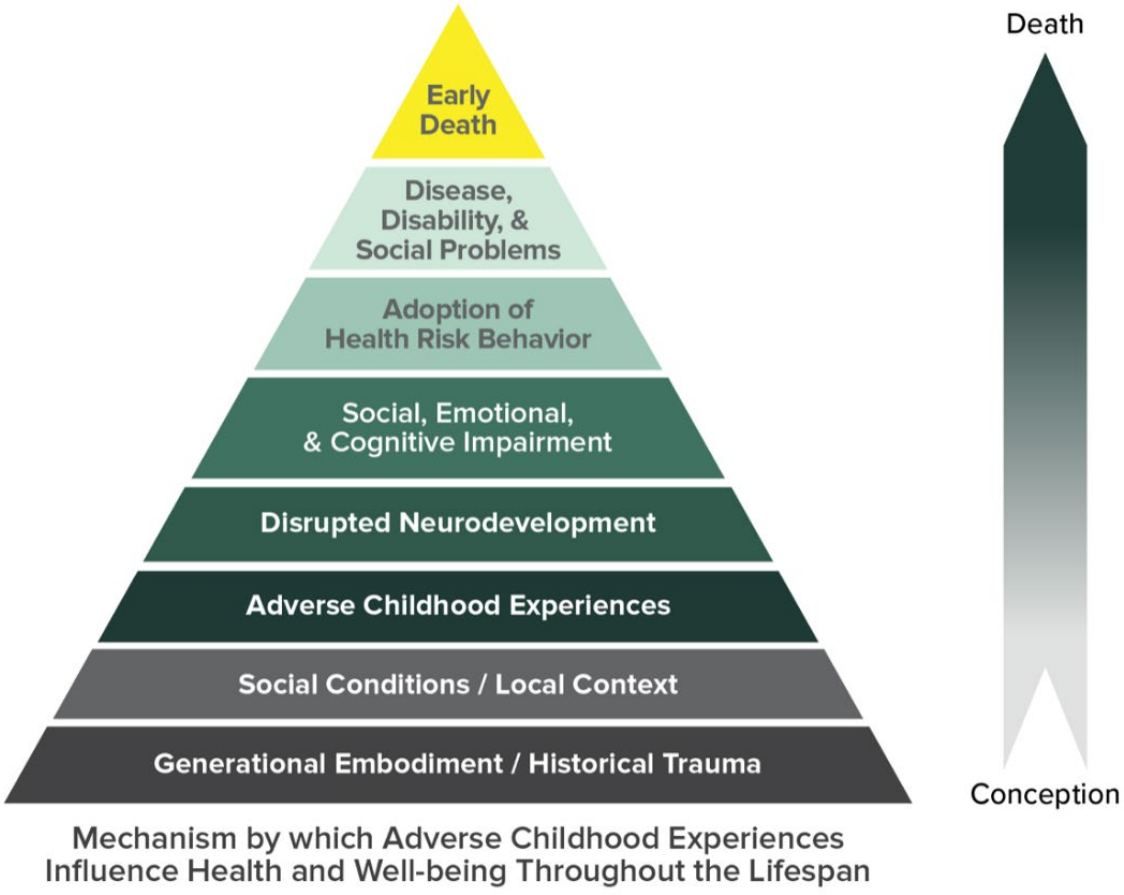


Figure 20: The ACE pyramid, taken from the US Centers for Disease Control and Prevention (CDC, 2025)



Evidence suggests that girls are more likely than boys to report ACEs overall, and that ACEs experienced differ by sex, with boys more likely to experience physical abuse and girls more likely to experience sexual abuse(Jones et al., 2022). Boys and girls respond to adversity in different ways: boys are more likely to exhibit externalising responses, such as anger, behavioural disruption or withdrawal, while girls are more likely to exhibit internalising responses, such as anxiety or low mood. Gendered responses to behaviours are learned through and beyond childhood, including in schools. Both biological and social factors influence the emergence of gendered behaviours, with theoretical models of development summarised from Chaplin in Table 7.

Table 7: Theoretical models of emergence of gendered behaviour, extracted from Chaplin (Chaplin, 2015).

Theoretical Model	Explanation
Biological	Innate differences are related to biological factors, such as the influence of testosterone and sex differences in gene expression.
Social developmental	Children learn gender-role consistent behaviours over time based on observing their environments and proceed to select activities and environments that reproduce the roles.
Social constructionist	Behaviours emerge from interactions between a person, environment and larger culture and are constantly developing according to the situation.
Bio-psychosocial model	"Gender differences in emotion expression emerge through a combination of innate biological differences, socialization, and through the influence of in the-moment social context and societal expectations within a culture."

In practice, externalising responses are more likely to be interpreted as behavioural or disciplinary problems, particularly within school settings. This increases the likelihood that boys experiencing adversity are sanctioned or excluded. Over time, this contributes to disengagement from education, increased contact with the care and youth justice systems, and reduced access to protective factors.

The **2018 Annual Public Health Report** for Cumbria highlighted the importance of recognising and responding to adverse childhood experiences through whole-system, trauma-informed approaches. Understanding how adversity is experienced, expressed and responded to differently in boys is critical to preventing the escalation of risk across the life course.

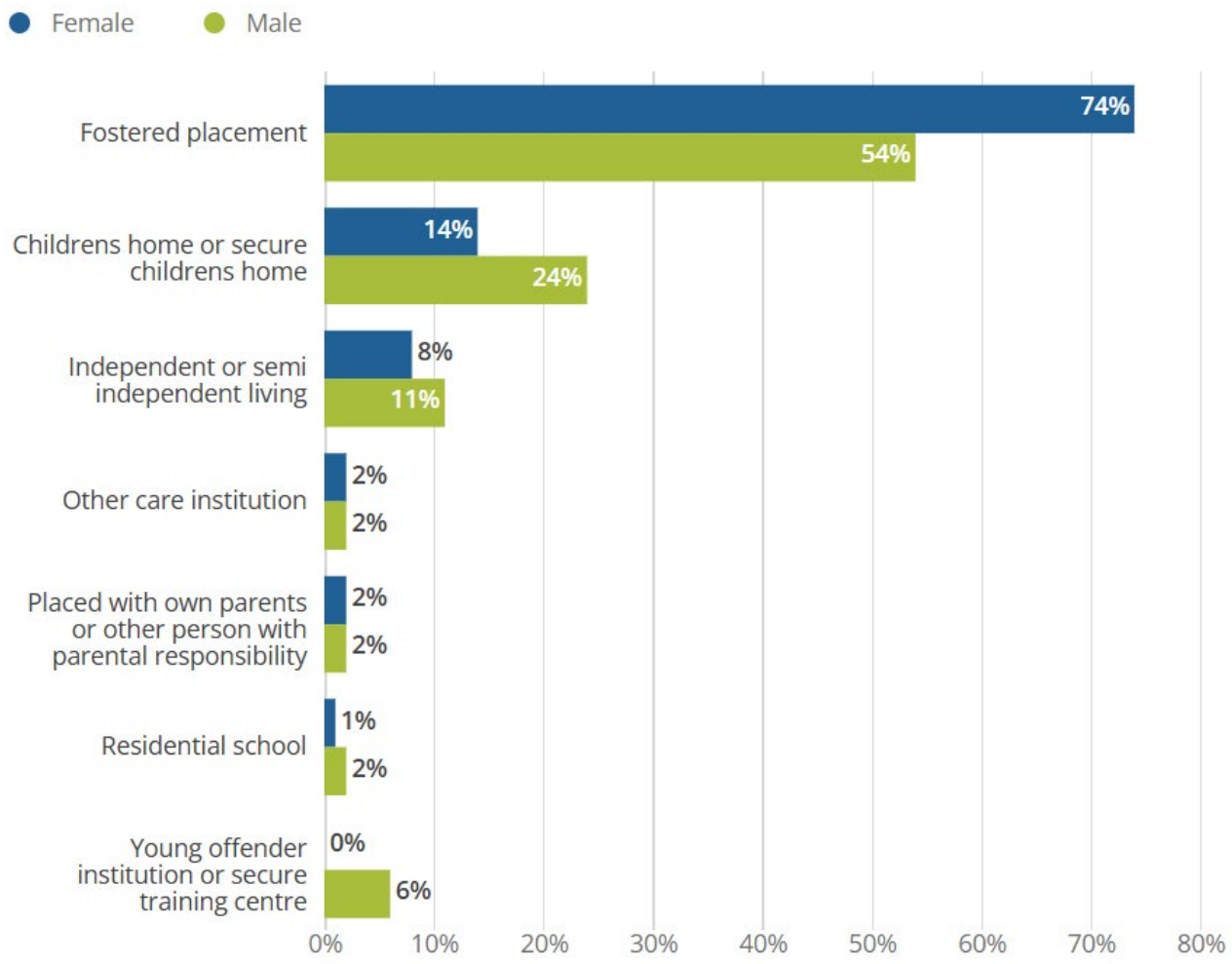
Boys growing up in deprived and coastal communities are more likely to experience multiple, overlapping stressors, including economic insecurity, bereavement, parental ill-health or substance use, and limited access to services. These experiences often accumulate rather than occur in isolation. Where adversity coincides with care experience, placement instability or school exclusion, its impact on emotional development and wellbeing is amplified.

The care system

When considering ACEs, it is important to consider the care system as by definition, children in the care system will have been exposed to ACEs. Cumberland has higher rates of children in need, on a protection plan and children cared for (94.4 vs 71.3 per 10,000) compared to the national average and statistical neighbours. Over half (51.5%) of children cared for are placed outside the Cumberland boundary, but are less likely to be moved through multiple placements. However, Cumberland has shorter adoption waiting times, and higher rates on onwards employment and care experienced adults in higher education that the England average (source: **Cumberland HDRC**).

National data from 2011-2015 shows that across England, boys were less likely to be placed into foster care than girls, and more like to be placed into children's homes, secure children's home or young offender institutes (Figure 21).

Figure 21: Distribution of placement type by sex, unweighted, England, 2011 to 2015 (source: ONS)



Identity formation in boys and young men

Identity formation is a central developmental task of adolescence and early adulthood. Through family relationships, school experiences, peer interactions and community context, boys learn who they are, what is expected of them and how they are valued. Identity is not a fixed personal characteristic, but a socially shaped process that reflects opportunity, context and lived experience.

Erikson's psychosocial model conceptualises identity development as a lifelong process, structured around a series of developmental stages, each involving a central psychosocial challenge. Figure 22 presents Erikson's eight stages of psychosocial development, the associated core challenges and the psychological strengths, or "virtues", that emerge when these challenges are successfully navigated.

Figure 22: Erik Erikson's Stages of Psychosocial Development, image taken from Psychology today

Erikson's Psychosocial Stages

Stage	Basic Conflict	Virtue	Description
Infancy 0–1 year	Trust vs. mistrust	Hope	Trust (or mistrust) that basic needs, such as nourishment and affection, will be met
Early childhood 1–3 years	Autonomy vs. shame/doubt	Will	Develop a sense of independence in many tasks
Play age 3–6 years	Initiative vs. guilt	Purpose	Take initiative on some activities—may develop guilt when unsuccessful or boundaries overstepped
School age 7–11 years	Industry vs. inferiority	Competence	Develop self-confidence in abilities when competent or sense of inferiority when not
Adolescence 12–18 years	Identity vs. confusion	Fidelity	Experiment with and develop identity and roles
Early adulthood 19–29 years	Intimacy vs. isolation	Love	Establish intimacy and relationships with others
Middle age 30–64 years	Generativity vs. stagnation	Care	Contribute to society and be part of a family
Old age 65 onward	Integrity vs. despair	Wisdom	Assess and make sense of life and meaning of contributions

Early childhood and school-age experiences are key periods in shaping sense of competence and self-worth. Repeated experiences of difficulty, sanction or low expectation can undermine the development of competence and purpose. Boys in Cumberland are disproportionately exposed to cumulative stressors, including poverty, bereavement, substance use and involvement with the care system. Where such experiences coincide with limited opportunities to express vulnerability or access trusted adult support, identity may become organised around emotional self-reliance, withdrawal or risk-taking. These patterns reflect adaptation to context and are reinforced by social expectations around masculinity.

As boys move into adolescence and early adulthood, these identity pathways influence how they relate to work, relationships and support. For those whose early experiences have disrupted the development of competence, belonging or role identity, transitions into employment or training may be particularly challenging, especially in areas with limited local labour market opportunities. This helps explain why early disadvantage in Cumberland is closely linked to later patterns of insecure work, social isolation and poor mental health among men. Where a sense of future role, belonging or purpose is weakened, feelings of hopelessness may emerge, a factor consistently associated with suicide risk. Consistent relationships, access to meaningful work or training, community connection and responsive services can support the re-development of identity, even where early experiences have been adverse.

Youth justice and escalation pathways

Between April 2023 and September 2025 there were a total of 626 children referred to the youth justice service, 512 (81.8%) of whom were boys. The first six months of 2025/26 have seen a lower number of referrals into the service. Though the reasons for this drop cannot be specifically attributed to a cause, the Pol-Ed resource was introduced on June 2nd 2025. This is a police resource for use in schools designed to help teachers deliver lesson around relationships and consent, the law, keeping safe and wellbeing.

Local Youth Justice Service referral patterns show that most contact occurs before statutory court involvement. Over a third of referrals (35.8%) relate to prevention activity, with a further 13.5% involving early assessment to understand risk or suitability for diversion. Around one third of referrals (32.5%) are managed through out-of-court resolutions, indicating a strong emphasis on diversion where offending does occur. Statutory youth justice supervision accounts for fewer than one in five referrals (18.3%), representing a smaller but higher-need group. This distribution highlights the importance of effective early intervention to prevent escalation into formal justice pathways.

Of 101 children involved with Cumberland Youth Justice Service in December 2025, 27 (26.7%) were receiving support for drug use, three (3.0%) for alcohol and ten (9.9%) support for both drugs and alcohol. During March 2025 to September 2025 the most common criminal charges associated with children referred for intervention were 'theft/robbery/burglary', 'assault/ABH/violence' and 'threatening/harassment/stalking'.

Online influences

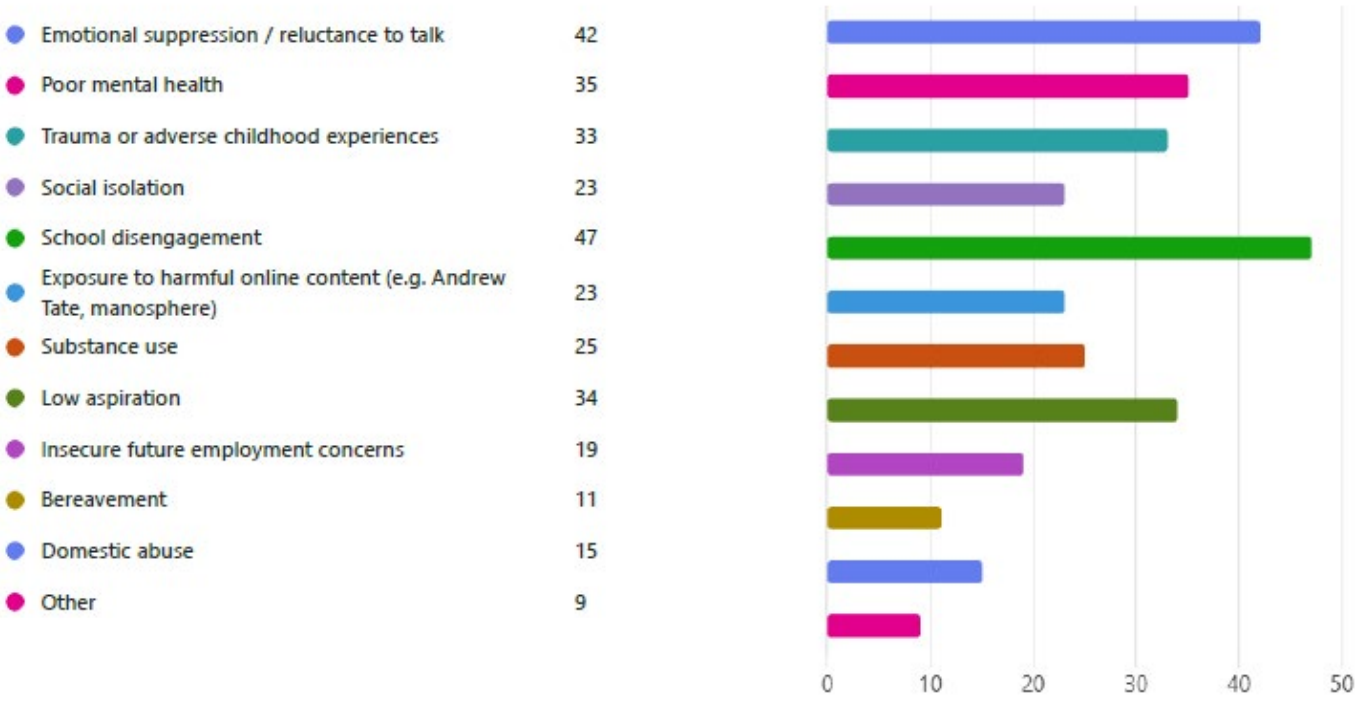
In recent years, there has been growing concern about the influence of online content that promotes rigid or harmful models of masculinity, often referred to as the "manosphere". High-profile online figures have been associated with messages that emphasise dominance, emotional suppression, entitlement and misogyny, raising concerns about their potential impact on boys' attitudes, relationships and behaviour.

Around half of professionals working with boys and young men surveyed at the end of 2025 identified exposure to harmful online influencers as a driver of need. Trauma, emotional suppression, school disengagement, low aspiration and poor mental health were more frequently cited. When asked specifically about the impacts of online influencers, 8/53 professionals answered 'a lot' or 'very significantly'.

This suggests that while digital environments warrant ongoing attention, focus should lie on preventing the underlying factors that leave young children open to influence from online sources that result in susceptibility, such as early abandonment, family dysfunction and psychological vulnerabilities (Campelo et al., 2018).

Figure 23: Responses of surveyed individuals relating to online influencers, collated for the purpose of the report

4. Which issues do you most commonly see among boys/young men you work with? *(Tick all that apply)*



8. Have you observed online influencers (e.g. Andrew Tate) affecting the attitudes or behaviours of boys/young men you work with?

Place of birth: the coastal disadvantage

The social and economic conditions children grow up in have a lasting influence on their mental health, educational engagement and life chances. Young adults in coastal communities have disproportionality poor mental health. National longitudinal research following adolescents in England found that young adults living in the most deprived coastal areas experienced around three times the risk of undiagnosed mental distress compared with young adults in inland areas with similar levels of deprivation. The key driver of this difference was household socioeconomic circumstances (Murray et al., 2025).

The authors of this research emphasise that reducing mental health inequalities in coastal communities requires both improved access to timely support and sustained action on underlying socioeconomic drivers. Recommended national actions include reducing waiting times for mental health treatment in deprived coastal areas, increasing investment in preventative programmes for young people, and prioritising the development of Young Futures Hubs in communities with the highest burden of need. At a local level, the research highlights the importance of setting clear improvement targets for young people's mental health and committing to long-term investment in education, employment, housing and transport, recognising that mental health outcomes are shaped as much by opportunity and infrastructure as by clinical provision.

In Cumberland, many children grow up in coastal, post-industrial communities where deprivation, limited access to services and economic insecurity are more prevalent. These conditions shape health from the very earliest stages of life. Indicators such as infant mortality, early childhood emergency department attendances, and developmental outcomes consistently show social gradients.

Professional insights regarding the needs of boys and young men in Cumberland

Predominate themes around the needs of boys and young men in Cumberland gathered from surveyed professionals can be seen in Figure 23. Within the free text 'other' options, unmet neurodiversity needs were highlighted three times. One professional highlighted feelings of inadequacy amongst boys who 'are not enough' for major local employers, with one further professional citing financial concerns as an issue, particularly for the oldest child. These, together with high levels of reported needs around low aspiration and future insecure employment concerns highlights an early awareness of opportunities, and lack of, impacting the wellbeing of young men.

The majority of respondents reported that boys and young men often or almost always hold back from seeking help when they need it. Stigma around emotions, fear of looking weak and distrust of services were the three leading reported reasons for boys and young men not engaging with support when needed. The vast majority (93%) of respondents reported that local cultural norms around stoicism had a medium to very high impact. Box 2 presents an example of local work being completed to support the development of health masculinities by The Little Blackbird, founded by Adrian and Claire Dakers.

Where support is effective, professional insight points strongly towards relational and practical approaches. Boys and young men were reported to respond best to activities-based engagement, one-to-one relational support, and trusted adults or positive male role models. Digital-only provision and crisis-led responses were identified as less effective.

These findings reinforce the importance of preventative, community-embedded approaches that build relationships before crisis point, rather than relying on self-referral into clinical or online pathways.

Box 2: The Little Blackbird

Founded by Ade & Claire Dakers, Little Blackbird are a well-being focused organisation that offers impactful Training, Workshops and Social Value projects, across Education, Business & Community settings. Specialising in masculinity and well-being, their mission is to positively challenge cultures and beliefs by delivering programmes that improve communication, strengthen emotional intelligence and explore the power of vulnerability.

Little Blackbird created one of their core projects, "The Man I Want To Become" in 2022 following the tragic loss of a friend to suicide. Built on lived experience, it is an early-intervention, film-led initiative that supports young people to explore healthy masculinity, improve communication, strengthen emotional resilience and understand accountability. It can be delivered in schools, grassroots sport, community projects and adapted for adult groups within the same settings. Little Blackbird strives to challenge cultures and stereotypes related to old age perceptions of masculinity which are no longer fit for purpose, instead creating new ideas around what it means to be a boy/man, and promoting a better understanding of what positive expressions of masculinity look like.

In November 2025, Little Blackbird delivered "**The Man I Want To Become**" project with the U16 team at Workington Zebras RFC, in collaboration with Morgan Sindall Construction as a Social Value Partner. The project was a resounding success, with exceptional feedback;

Quotes from some of lads who participated in the project;

"I've learnt that it's okay to show your emotions and to know how to be brave. To really check on each other and to share how you feel, and to look at being a man not as being powerful, but being brave to share what you feel"

"Lads talking is something we need to be encouraging in this area. Times are changing and us in Cumbria are stuck in the past where men weren't allowed to talk about their feelings"

Parents feedback;

"It's made my lads understand that it's ok to not be ok and we all need to vent about things that are getting us down and to understand that there's always an answer"

Ade's vision to create a safe space for men to have real conversations saw the introduction of the Little Blackbird podcast, "Tackling it Together" in 2024. A true labour of love, **Tackling it Together** has already had immeasurable impact and is now a core part of Little Blackbird's Social Value offering. With a wide range of themes covered, Ade promotes honest and vulnerable connections and powerful conversations, demonstrating that two fellas can sit down and have an open and authentic chat without a pint.

Contact: **adrian@littleblackbird.uk**

Summary

This chapter has demonstrated that many of the inequalities observed in men's health in Cumberland begin early in life. Differences in development, emotional wellbeing, educational engagement and system contact emerge in childhood and adolescence, particularly among boys growing up in deprived and coastal communities and those experiencing cumulative adversity.

For boys, adversity is more likely to be expressed through behavioural change, disengagement or externalising distress. When these responses are met primarily through disciplinary or fragmented systems rather than early, coordinated support, disadvantage is more likely to escalate than resolve. Over time, this reduces protective factors, narrows opportunities and increases exposure to further risk.

These experiences shape how men relate to employment, identity and support in later life, and set the scene for poor mental health, substance use and premature mortality observed among men in Cumberland.

The following chapter examines how these early disadvantages interact with work, place and identity in adulthood, and how economic structure and labour market conditions can either compound or mitigate the risks established earlier in the life course.

Chapter 4: Work, place and identity in adult men's lives

Introduction

Work plays a central role in shaping a person's health and wellbeing. Beyond income, employment provides structure, social connection, identity and a sense of purpose. For many men, particularly in communities with a strong industrial heritage, work is closely tied to masculine identity and self-worth. Where employment is insecure, inaccessible, or perceived as unattainable, this can generate shame, withdrawal and psychological distress. These dynamics are visible in Cumberland, where patterns of work, place and identity have been shaped by deindustrialisation, rurality and the presence of a small number of dominant employers.

This chapter explores how labour market conditions, economic inactivity and local employment structures shape masculine identity in Cumberland, and how this, in turn, influences men's wellbeing, aspiration and engagement with support in adulthood.

Employment and the Cumberland labour market

Nationally and locally, significant policy effort has been directed towards increasing female participation in STEM (science, technology, engineering and mathematics) fields, addressing long-standing gender imbalances in traditionally male-dominated sectors. By contrast, comparatively less strategic focus has been placed on encouraging boys and young men to enter HEAL (health, education, administration and literacy) professions, a term coined by social scientist Richard Reeves to describe sectors in which men are underrepresented (Reeves, 2022). These sectors represent a growing proportion of employment opportunities. In areas such as Cumberland, where employment pathways are already relatively concentrated, this asymmetry may further narrow perceived occupational identities for young men, particularly those who do not access high-status technical roles. Broadening aspiration must therefore operate in both directions: supporting girls into STEM and supporting boys into expanding care, education and health-based professions.

The December 2025 labour market briefing recorded 224,935 payrolled employees in Cumbria. Occupations with the highest demand were care workers, sales roles, cleaners and domestic staff, teaching assistants, and kitchen and catering assistants, roles that largely fall within the HEAL categories. These fields tend to be more caregiving, people-facing and often offer stable, accessible careers with significant worker shortages, and some not requiring university-level qualifications. Reeves argues that increasing male participation in the HEAL professions is key to widening access to stable employment, particularly in contexts where traditionally male-dominated fields are relatively more susceptible to changing industries and instability (Reeves, 2022). In addition to economic benefits, entering more men into people-focused employment will provide more diverse role models for younger generations.

In Cumberland, the relevance of the HEAL framework is particularly stark. Figure 24 shows that the highest volume of active job postings in 2025 were concentrated in care work, although large volumes of adverts were also present for engineers and large goods vehicle drivers, roles more closely aligned with traditional masculine identities. For men whose identities have been shaped by industrial, technical or physically demanding work, HEAL roles may be perceived as poorly aligned with masculine norms, despite offering stability and long-term employment. In this context, labour-market mismatch is not simply a skills issue, but an identity issue, helping to explain why economic inactivity and mental health-related benefit claims can persist even where vacancies are high.

Figure 24: Leading 20 active job postings by occupation, Cumberland, 2025, Source: Lightcast™

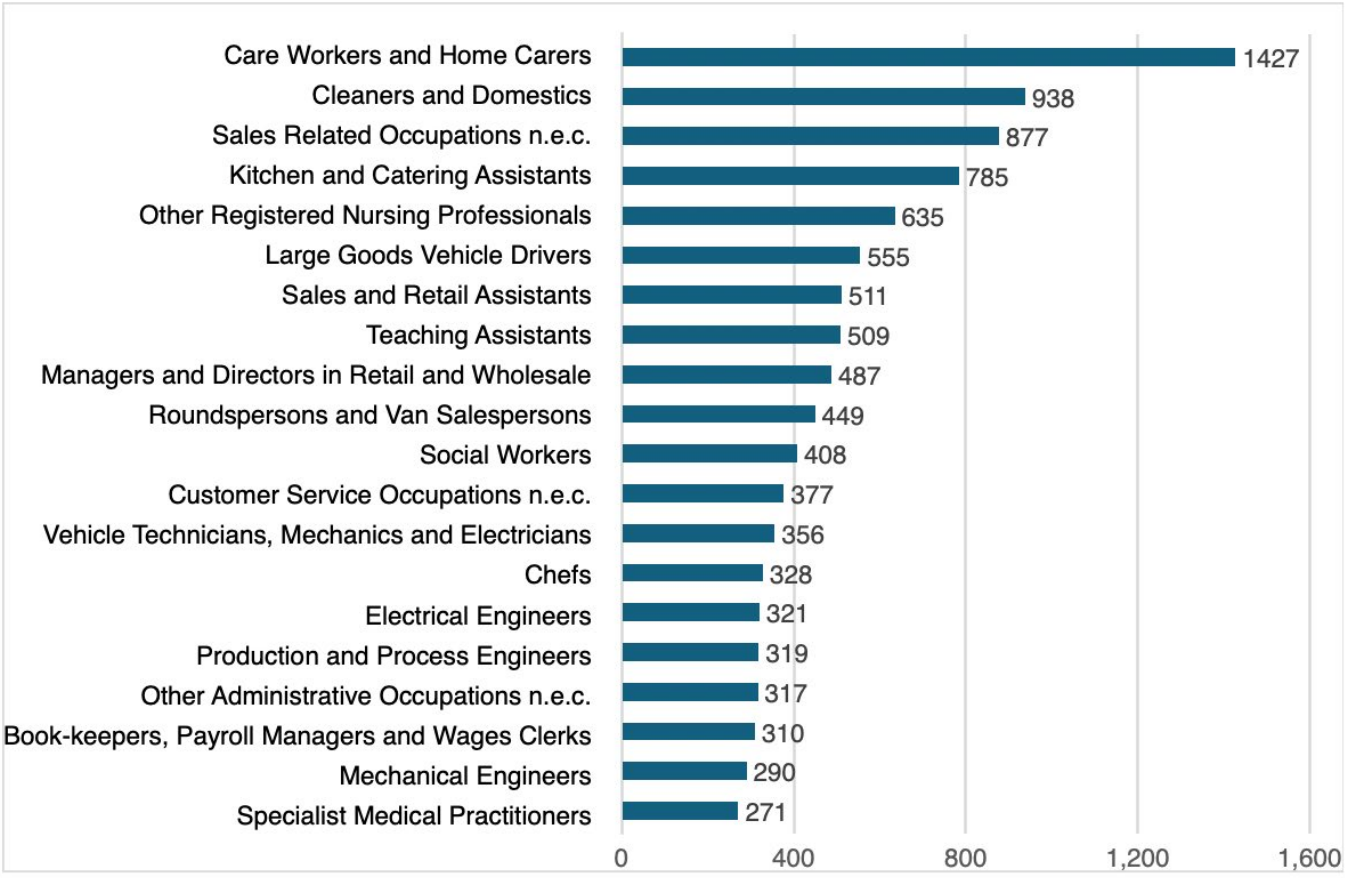
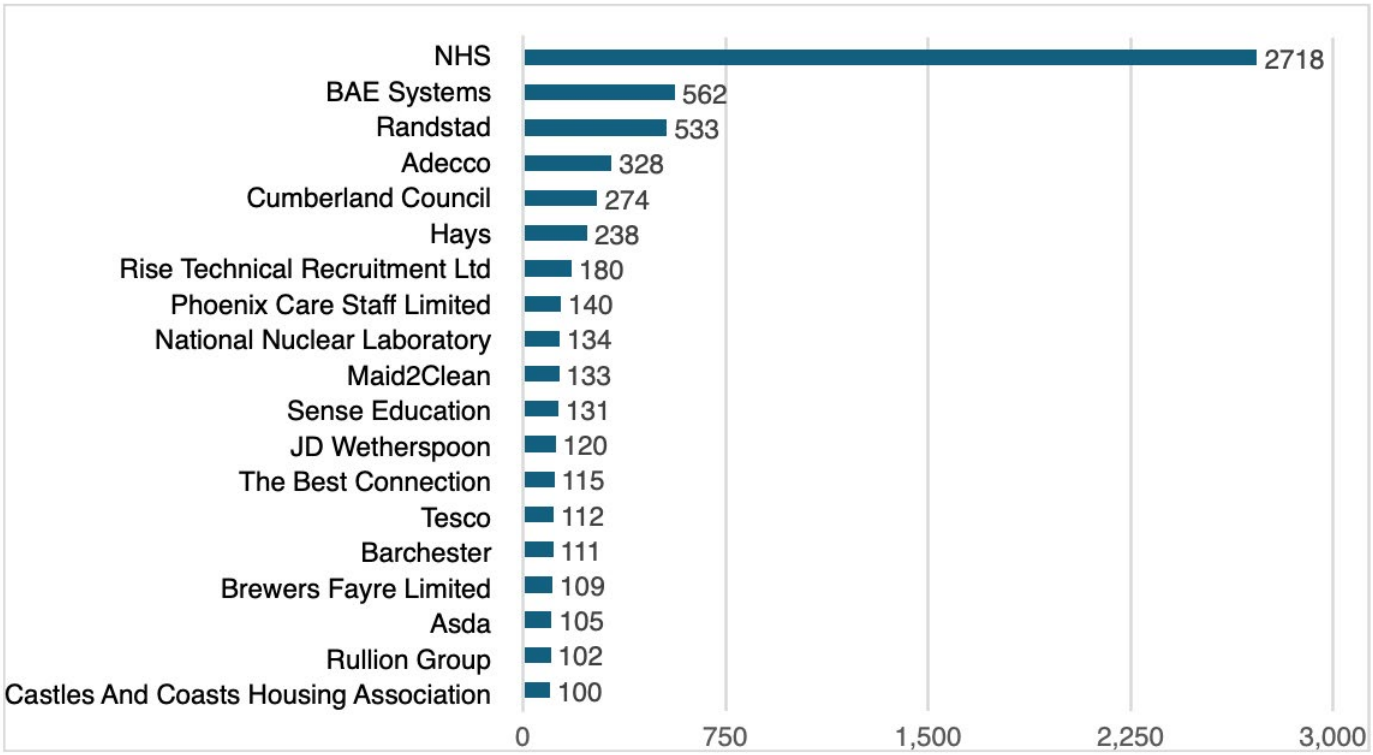


Figure 25: Leading recruiters according to number of active job postings (all with > 100 postings)*, Cumberland, 2025, Lightcast™



* Sellafield generally recruits via agencies so does not appear explicitly named in Figure 25, although the company is a major recruiter. The number of NHS roles may be inflated due to roles being left open (e.g. bank roles), or inaccurately allocated geographical areas due to vague advert listings.

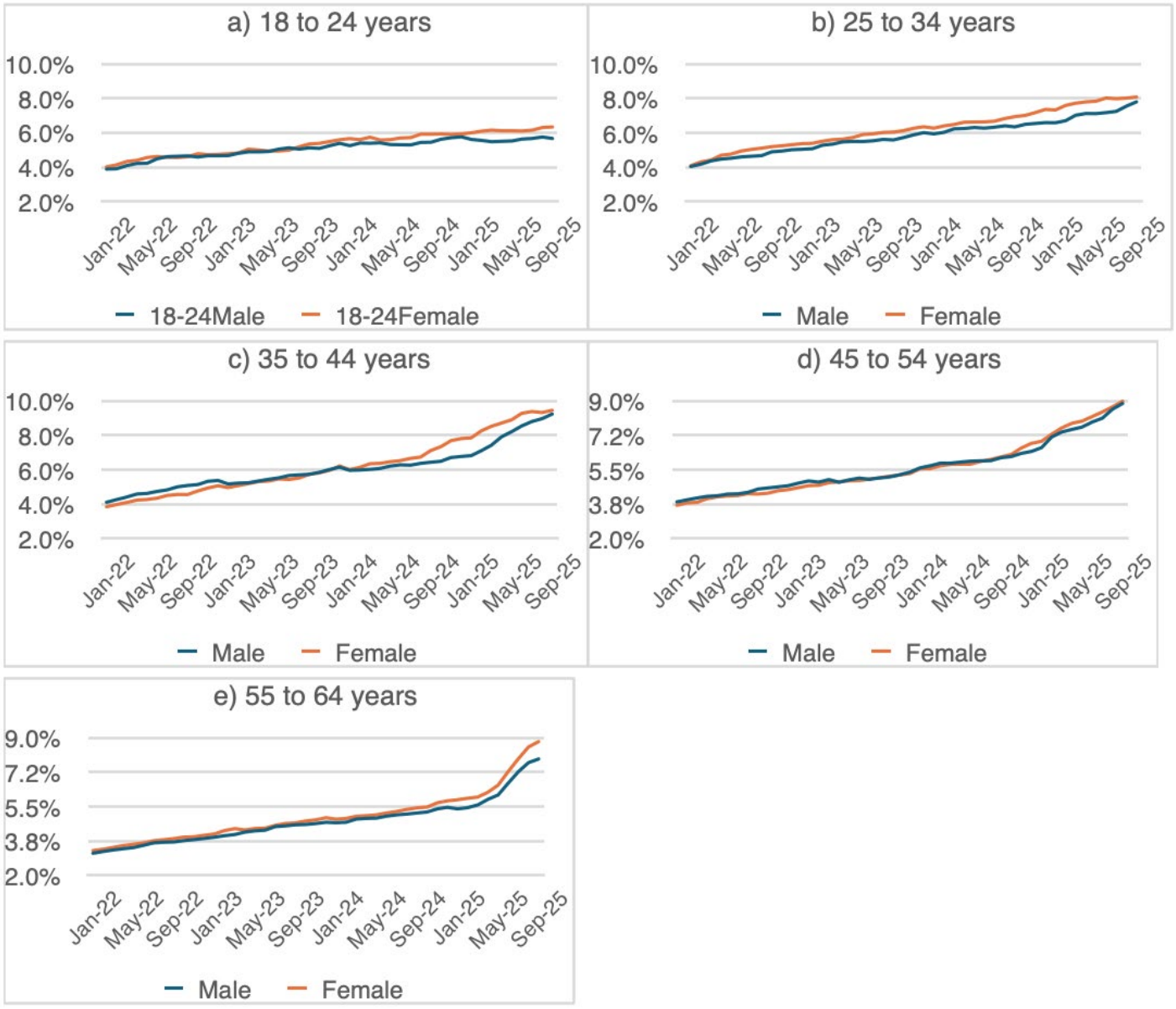
The organisations with the most active job listings were the NHS, BAE systems and Randstad (a recruitment agency specialising locally in social care and construction roles (Figure 25). The dominance of a small number of large employers has created a tiered local economy. Secure, well-paid employment is available to some and come with a high level of social desirability. This dynamic creates a sharp divide between men who access secure, high-status employment and those who do not, which appears before children enter the labour market. One surveyed professional reflected that an issue for boys and young men locally was "feeling inadequate if they are not enough for Sellafield or Innovia".

For men excluded from these opportunities, repeated rejection or perceived unsuitability can reinforce feelings of failure and reduce confidence. These experiences interact with masculine norms that discourage vulnerability, amplifying distress while limiting routes to support.

Unemployment and economic inactivity

Headline unemployment rates in Cumberland remain relatively low. In November 2025, the unemployment standard claimant rate was 2.8% for men and 2.1% for women, both below national averages (4.4% and 3.4% respectively) (Source: ONS via **Cumberland Council Labour Market Briefing**). However, these figures obscure a more complex picture of economic inactivity, ill health and labour-market disengagement. Women are more likely to claim Universal Credit (UC) overall (20.6% compared with 15.6% of men). Figure 26a-e shows that patterns of UC for health reasons show similar trends in both males and females, with a rising proportion of the population claiming in all groups, but most steeply in the older age groups. These patterns suggest long-term health conditions, ageing workforce patterns and structural barriers to participation may be key contributors to economic inactivity in Cumberland.

Figure 26a-e: People aged 16-64 on Universal Credit with a health condition or disability restricting their ability to work, Cumberland, by sex, January 2022 – September 2025. (Source: DWP StatXplore / ONS Mid-Year Population Estimates)



Workforce projections and replacement demand

Looking ahead, workforce projections reinforce the importance of occupational transition. Replacement demand to 2034 is broad-based, with the largest share in mixed/structurally gendered occupations (44,200; 36.1%), followed by HEAL roles (38,200; 31.2%), non-STEM male-dominated roles (28,000; 22.8%) and STEM roles (12,000; 9.8%). This suggests that traditional male employment routes remain significant, but that a substantial share of future vacancies will arise in HEAL occupations. A balanced workforce response is therefore needed: improving health and female participation in male-dominated sectors while also widening pathways for men into HEAL roles, particularly as physical capacity declines with age and long-term health conditions contribute to economic inactivity.

Transitions between traditionally gender-dominated roles are constrained by differences in status, qualification requirements, working conditions and cultural norms. Without changes to training pathways, job design and employer practice, replacement demand alone is unlikely to encourage gender diversity in HEAL sectors. Workforce strategies must therefore focus not only on meeting demand, but on enabling sustainable and acceptable transitions across sectors over the life course.

Figure 27: Ten Year Replacement Demand Analysis 2024-2034, Cumbria, (Source: Cumberland Council projections developed with the aid of CE/IER LEFM software)

Occupation	STEM / male-dominated / HEAL / mixed	Net Requirement
Caring Personal Service Occs	HEAL	16,500
Managers and Proprietors	Mixed	9,900
Science/Tech Professionals	STEM	8,500
Sales Occupations	Mixed	8,100
Business/Public service Prof.	Mixed	7,100
Corporate Managers	Mixed	7,000
Health Professionals	HEAL	6,200
Process Plant & Mach Ops	non-STEM / male-dominated	6,200
Admin & Clerical Occupations	HEAL	6,100
Transport Drivers and Ops	non-STEM / male-dominated	5,200
Bus/Public Serv. Assoc Prof.	Mixed	5,100
Skilled Construct. Trades	non-STEM / male-dominated	5,100
Skilled Agricultural Trades	non-STEM / male-dominated	5,000
Teaching/Research Prof.	HEAL	4,500
Skilled Metal/Elec Trades	non-STEM / male-dominated	4,200
Leisure/Oth Pers Serv Occs	Mixed	4,200
Science Associate Prof.	STEM	3,500
Elementary: Clerical/Service	HEAL	3,200
Culture/Media/Sport Occs	Mixed	2,800
Customer Service Occupations	HEAL	2,000
Protective Service Occs	non-STEM / male-dominated	1,800
Elementary: Trades/Plant/Mach	non-STEM / male-dominated	300
Other Skilled Trades	non-STEM / male-dominated	200
Health Associate Prof.	HEAL	-100
Secretarial & Related Occs	HEAL	-200
Totals	**Mixed**	**44,200 (36.1%)**
	STEM	**12,000 (9.8%)**
	HEAL	**38,200 (31.2%)**
	Non-STEM / male-dominated	**28,000 (22.9%)**
	Total	**122,400**

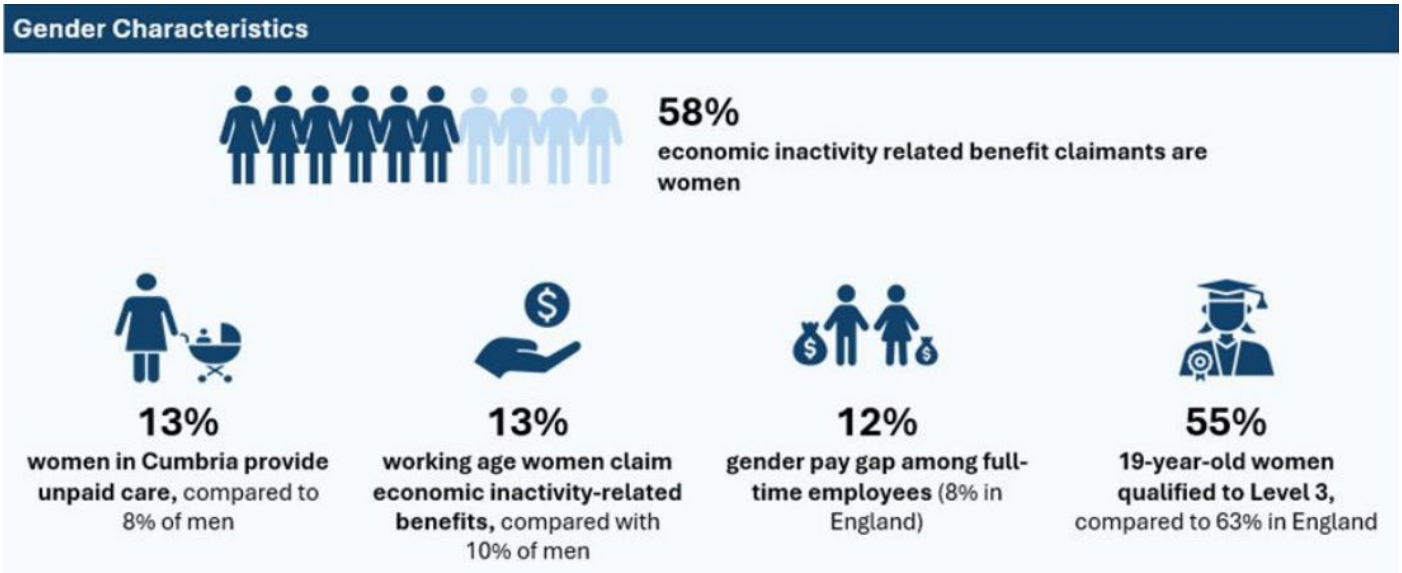
Compounded disadvantage in the labour market

Intersecting forms of disadvantage related to gender, health, age, ethnicity, caring responsibilities and prior life experience are seen within Cumberland's labour market. Understanding these overlapping factors is essential to explaining why some men are more likely to disengage from work and experience poor health outcomes, even where job vacancies remain high. These dynamics also have wider implications for household stability and local economic resilience.

According to the 2021 Census, around 8,000 people aged 16–64 from ethnic minority backgrounds live in Cumbria, representing approximately 3% of the working-age population, compared with around 20% nationally. People from ethnic minority backgrounds in Cumbria are more likely than White residents to be unemployed (5% compared with 3%) or economically inactive (26% compared with 22%), despite being more highly qualified and less likely to report disability or unpaid caring responsibilities. This pattern indicates the presence of structural barriers to labour market participation, including discrimination or a mismatch between qualifications and available roles.

These ethnic inequalities sit alongside other recognised barriers to employment in Cumberland, including long-term sickness or disability, older age, young people not in education, employment or training (NEET), caring responsibilities, and experiences of multiple disadvantage such as substance dependence, homelessness, justice involvement or experiences of domestic abuse. Economic inactivity in Cumbria is most commonly driven by long-term sickness or health conditions, accounting for 43% of all economically inactive people, followed by retirement or early retirement (22%). Caring responsibilities also remain a significant factor, with over 31,800 working-age people providing unpaid care, around half of whom provide 35 or more hours per week and are economically inactive.

Figure 28: Gender characteristics and other disadvantaged groups, Cumbria wide, taken from the Economic Inactivity in Cumbria Presentation Dec 25.



These drivers of economic inactivity are gendered in different ways. Women are disproportionately affected by caring-related inactivity and lower earning potential, while men are more likely to disengage from work due to health conditions, industrial change and disrupted employment pathways. These patterns are not independent: where men experience unemployment or health-related withdrawal from work, women often absorb increased caring, emotional responsibilities within households, and are more likely to be victims of domestic abuse. This can constrain women's own labour market participation, reinforce gendered divisions of labour and increase economic pressure within families.

Justice system involvement

Labour-market exclusion, poor mental health and justice system involvement are closely intertwined for many men. For some, contact with the justice system represents the culmination of cumulative disadvantage, including disrupted education, unstable employment, substance use and limited engagement with support. Justice involvement should be understood as part of a broader pathway of social and economic marginalisation.

The health needs of people in prison and under probation supervision are set out in detail in the **Chief Medical Officer's (CMO's) annual report**, published in November 2025. National evidence shows that people in contact with the justice system experience substantially higher burdens of physical ill health, mental health conditions, substance misuse and neurodiversity, alongside markedly lower life expectancy. Men make up the overwhelming majority of the prison population (96% in 2022/23) meaning these inequalities disproportionately affect men and contribute to wider patterns of male premature mortality and morbidity (source: **Ministry of Justice**).

For some, justice involvement follows periods of employment instability, insecure housing, poor mental health or untreated trauma. Contact with the prison and probation services are an important intervention point. Many individuals entering custody or supervision have had limited or inconsistent engagement with health services in the community. Periods of custody or probation can therefore provide rare opportunities for sustained assessment, treatment and structured rehabilitation.

This framing is relevant to Cumberland. Poor mental health, substance misuse and late presentation to services can culminate in justice involvement, particularly for men. Without effective health and rehabilitation support, justice contact risks reinforcing cycles of disadvantage, further restricting employment opportunities and worsening health outcomes on release. Well-designed prison healthcare, skills development and linked probation services

have the potential to interrupt these trajectories, supporting recovery, reducing reoffending and improving long-term employability and reintegration into the workforce.

HMP Haverigg is the only prison located within Cumberland, a Category D open prison, holding just under 500 inmates, primarily convicted of sexual offences. Following concerning inspections and riots historically, recent **inspections** have highlighted improvements in the rehabilitation programmes, including employment programmes and offending plans resulting in a relatively low proportion of recalls (6%). However, inspection findings also identified long waiting times for trauma therapy, an important part of rehabilitation.

It's important to note that men from Cumberland who are remanded or sentenced to Category A–C custody are placed outside the local area. This displacement can disrupt family contact, continuity of healthcare and coordination with local probation and employment services and reducing the opportunities to support successful rehabilitation following release.

The CMO's report emphasises the importance of continuity of care, trauma-informed practice and integration between prison healthcare, probation services and community provision. Rehabilitation involves rebuilding identity, confidence and credible pathways into employment. Addressing substance misuse as a coping response to distress, supporting mental health and neurodiversity needs, managing long-term physical conditions, and building skills and confidence for reintegration into work. Approaches that focus solely on compliance or punishment, without addressing underlying health drivers, are unlikely to prevent reoffending or support sustainable workforce participation.

Justice-based health interventions should be understood as part of a wider workforce and prevention strategy. Improving health and rehabilitation within prisons and probation services, and access to stable accommodation post-release, can reduce repeat justice contact, support transitions into stable employment, and mitigate the downstream impacts on families and communities. In this context, justice involvement is both a marker of accumulated disadvantage and a critical opportunity to reshape adult identity and life trajectory.

Loneliness and community life

Data from the Health Foundation's Local Authority Dashboard, drawing on the Community Life Survey 2023/24, provide an important insight into the social fabric of Cumberland. Nationally, Cumberland ranks amongst the highest for measures of neighbourhood belonging, speaking to neighbours and reporting that people would be there if needed, ranking 7th, 10th and 8th respectively out of 151 upper tier local authorities. However, Cumberland ranks substantially lower for loneliness, placing 66th out of 151 authorities (Health Foundation, 2024).

This apparent paradox suggests that while Cumberland benefits from strong place-based identity and visible community connection, this does not necessarily translate into protection from emotional isolation. It may reflect a distinction between social contact and emotional disclosure. In communities where norms of stoicism and self-reliance are strong, individuals may experience connection without vulnerability, belonging without necessarily sharing distress. This dynamic is particularly relevant when considering men's mental health and patterns of delayed help-seeking.

Place, identity and aspiration

The preceding sections describe structural labour-market patterns. This section returns to the question of identity.

Chapter 3 described how identity formation in boys and young men is shaped by belonging, recognition and perceived competence within family, peer and community settings. Using Erik Erikson's model of identity development (Figure 22) as a guide, we can understand continued identity development into adult as the navigation of intimacy and relationships in early adulthood, then contribution to society and operating as part of a family in later adulthood. This section explores the functioning of male identity through contribution to and functioning in society, through employment, unemployment, addition and physical health outcomes. For many men in Cumberland, identity and aspiration are closely tied to local labour markets, community norms and historically valued forms of work, shaping both what futures feel possible and which pathways feel socially successful.

Cumberland's industrial history, rural geography and the presence of a small number of high-status employers have created narrow and highly visible definitions of success. Secure, skilled employment in some large employers carry strong social value, while other forms of work are often perceived as lower status. Where men do not access these roles, aspiration may narrow rather than expand, with disengagement from work experienced as personal failure rather than as a response to structural constraint.

Stakeholder feedback highlighted limited perceived alternatives among men who do not follow dominant local employment pathways. Rather than reflecting a lack of ambition, this pattern suggests constrained aspiration. In this context, staying local can be both a source of belonging and a barrier to opportunity.

These dynamics intersect with health and help-seeking behaviour. Where identity and worth are tightly bound to work, illness, redundancy or declining physical capacity can threaten a man's sense of self, increasing shame and reluctance to seek support. This contributes to patterns of late presentation, economic inactivity and disengagement described earlier in the chapter. Over time, limited aspiration and repeated experiences of exclusion can reinforce cycles of withdrawal, risk-taking or reliance on coping strategies such as substance use or gambling.

Importantly, place also represents a potential protective factor. Strong community identity, attachment to locality and pride in place can be harnessed to support positive transitions, provided alternative pathways are made visible and credible. Creating opportunities for men to develop valued roles within their communities, including in caring, mentoring, education, health and public service settings, can broaden definitions of success. Interventions that build aspiration through locally rooted role models, skills development and supported transitions into new forms of work were championed by stakeholders.

Understanding the relationship between place, identity and aspiration is therefore central to addressing men's health inequalities in Cumberland. Without expanding what futures f eel achievable and socially valued, efforts to improve employment outcomes, health behaviours and service engagement are likely to remain limited. This reinforces the need for place-based strategies that recognise identity as a determinant of health, not merely an individual characteristic.

Chapter 5: Family and relationships wellbeing

‘No man is an island’

This report explores men’s health and wellbeing not only as outcomes for men themselves, but through its wider impacts on partners, children, families and communities. As illustrated in Figure 2, men’s health, identity and behaviour sit within a broader social, cultural and economic context and can generate ripple effects across households, services and places. Health and wellbeing do not exist in isolation. Individual experiences are shaped by relationships, work, place and social norms, and in turn influence the wellbeing of others.

Men’s health impacts family functioning, women’s wellbeing and children’s outcomes across the life course. Where men experience poor physical or mental health, unstable employment or untreated substance use, the effects are rarely confined to the individual. Partners may experience increased emotional labour, financial insecurity or exposure to harm; children may experience instability, disrupted attachment or reduced access to protective relationships. Men also provide important role models for children, in how a man should act, what behaviour is acceptable and in how relationships should function. These impacts accumulate over time, contributing to intergenerational patterns of disadvantage.

Evidence presented this far highlights upstream drivers of family and population-level harm:

- **Work strain and insecure employment**, which undermine identity, increase stress and reduce capacity for family participation
- **Mental ill-health**, particularly where stigma and norms of self-reliance delay help-seeking
- **Substance misuse**, frequently used as a coping mechanism for distress, trauma or economic insecurity
- **Justice system involvement**, which disrupts family relationships, limits employment opportunities and increases long-term disadvantage

Improving men’s health is therefore not a zero-sum exercise, nor does it detract from addressing persistent inequalities faced by women. Rather, it is a population health intervention. By addressing the root causes of poor health and wellbeing in men, including economic insecurity, social isolation, stigma and barriers to support, there is potential to improve outcomes for women, reduce pressures on families and services, and support healthier developmental environments for children.

This chapter highlights the impact that poor wellbeing in men can have on partners and children.

Domestic abuse: prevalence, and who is affected

Domestic abuse includes emotional, economic, sexual and physical abuse, as well as coercive and controlling behaviour. Interpreting domestic abuse data requires caution; it is a hidden harm, and reporting varies by severity, abuse type, stigma and service access. Official statistics are therefore likely to underestimate prevalence and need.

National survey data from the Crime Survey for England and Wales, (source: **ONS**) a household-based survey, for the year ending March 2025 show that domestic abuse is both common and strongly gendered. **Nearly one in three women (29.6%) and over one in five men (21.8%) report experiencing domestic abuse since the age of 16**. In the last year alone, **9.1% of women and 6.5% of men experienced domestic abuse**.

The gender gap is most pronounced for the most severe forms of abuse. Sexual violence within domestic settings is reported at **approximately four times the rate among women compared with men**. Domestic Abuse Safe Accommodation data for Cumberland indicate that four out of five clients in 2024/25 (82.7%; 206) identified as female; 11.6% (29) identified as male. Gender is unknown for 4.8% (12). Physical violence and threats by a partner are around twice as common among women. Emotional abuse affects large numbers of both men and women, but remains more prevalent among women.

Patterns of sexual assault and stalking reinforce this divergence. Nationally, **25.6% of women have experienced sexual assault since the age of 16 compared with 5.9% of men**. Rape or assault by penetration is reported by 8.2% of women compared with 0.7% of men. Nearly one in five women report experiencing stalking since age 16.

Risk varies according to demographic characteristics:

- **Age: Young men aged 16–19** report higher prevalence than young women (20.3% vs 15.7%), but from age 20 onwards women report consistently higher rates, peaking in women aged 20–24 (19.4% vs 6.7%).
- **Relationship status:** Separated individuals face the highest risk of domestic abuse, particularly women (26.3% of **separated women compared with 16.3% of separated men).** Prevalence is also elevated among **divorced individuals** (17.1% of women and 14.8% of men). This is compared with 4.4% of married individuals.
- **Disability and ill health:** Higher prevalence among disabled adults (14.5% women; 11.7% men) and among those long-term sick/ill (16.2% women; 12.6% men).
- **Care experience:** Very high prevalence among care-experienced adults (29.1% women; 20.9% men), underlining **intergenerational vulnerability.**
- **Homelessness:** Markedly higher prevalence among those who have ever experienced homelessness (25.0% women; 18.9% men).
- **Ethnicity:** Higher reported prevalence among Black or Black British adults (12.8% women; 10.1% men) than White adults (9.1% women; 6.5% men), These differences may reflect intersecting structural inequalities and require culturally responsive support.
- **Sexual orientation and gender identity:** Higher prevalence among LGBTQ+ groups, particularly bisexual women (23.4%), and among people whose gender identity differs from sex registered at birth (19.3% overall), highlighting intersectional vulnerability.

Police-recorded domestic abuse and sexual offences

The **ONS** Domestic Abuse prevalence and victim characteristics publication (year ending March 2025) provides police-recorded data. Cumbria Constabulary covers both Cumberland and Westmorland and Furness; local police-recorded domestic abuse statistics are therefore available at Cumbria level. In Cumbria in April 2024 to March 2025 there were 6,417 domestic abuse related crimes, 17.3% of all crimes, similar to the regional proportion at 17.7%.
This data is not available split by gender.

Table 8, Table 9 and Figure 29 present gender-patterns of police-recorded domestic abuse-related crimes. This data is only available nationally.

Table 8 shows that victims of domestic abuse-related crimes are predominantly female (72.1%), and this is most pronounced for sexual offences (90.0%).

Table 8: Proportion of domestic abuse-related crimes recorded by the police by sex of victim, selected offence groups, April 2024 to March 2025, nationally (source: ONS, domestic abuse prevalence.)

Offence	Number of offences	Female victims (%)	Male victims (%)
All offences	816,493	72.1	27.9
Violence against the person	635,394	71.1	28.9
Sexual offences	44,785	90.9	9.1
Miscellaneous crimes	29,552	78.0	22.0
Public order offences	46,786	73.7	26.3
Criminal damage and arson	45,261	72.8	27.2
Other offences	635,394	62.9	37.1

Table 9 demonstrates that the context in which sexual offences occur differs markedly by gender. For women aged 16 years and over, rape is predominantly a domestic abuse-related crime. Over half (53.2%) of recorded rapes of adult women occur in a domestic context, meaning they are linked to intimate partners or family members. In contrast, sexual assault (excluding rape) against women is far more likely to occur outside domestic settings (85.6% non-domestic).

For men, the pattern is structurally different. A relative minority of 13.7% of rapes of adult men and 12.5% of sexual assaults against men are recorded as domestic abuse related. The vast majority of male sexual victimisation occurs in non-domestic contexts (over 85% across both rape and sexual assault).

These patterns suggest three important distinctions:

- **Domestic abuse is a defining feature of female rape victimisation.** Sexual violence against women is linked to intimate partner violence and coercive control.
- **Male sexual victimisation is distributed differently.** While male domestic sexual abuse certainly exists, the data suggests it represents a minority of recorded cases.
  Male victims are more likely to experience sexual assault in non-domestic contexts, including acquaintance, peer, institutional or public settings.
- **Non-domestic contexts dominate sexual assault (non-rape) offences for both sexes.**

Table 9: Number of rape and sexual assault offences recorded by the police by sex of victim, April 2024 to March 2025, nationally, (source: ONS)

Offence	Domestic abuse-related (% of offences of this type)	Non-domestic abuse-related (% of offences of this type)	Total by offence (% of all recorded offences)
Rape of a female aged 16y +	26,070 (53.2)	22,928 (46.8)	48,998 (42.9)
Sexual assault on a female aged 13y+	7,411 (14.4)	44,161 (85.6)	51,572 (45.2)
Rape of a male aged 16y+	505 (13.7)	3,185 (86.3)	3,690 (3.23)
Sexual assault on a male aged 13y+	1,234 (12.5)	8,615 (87.5)	9,849 (8.63)
Total	35,220 (30.9)	78,889 (69.1)	114,109 (100)

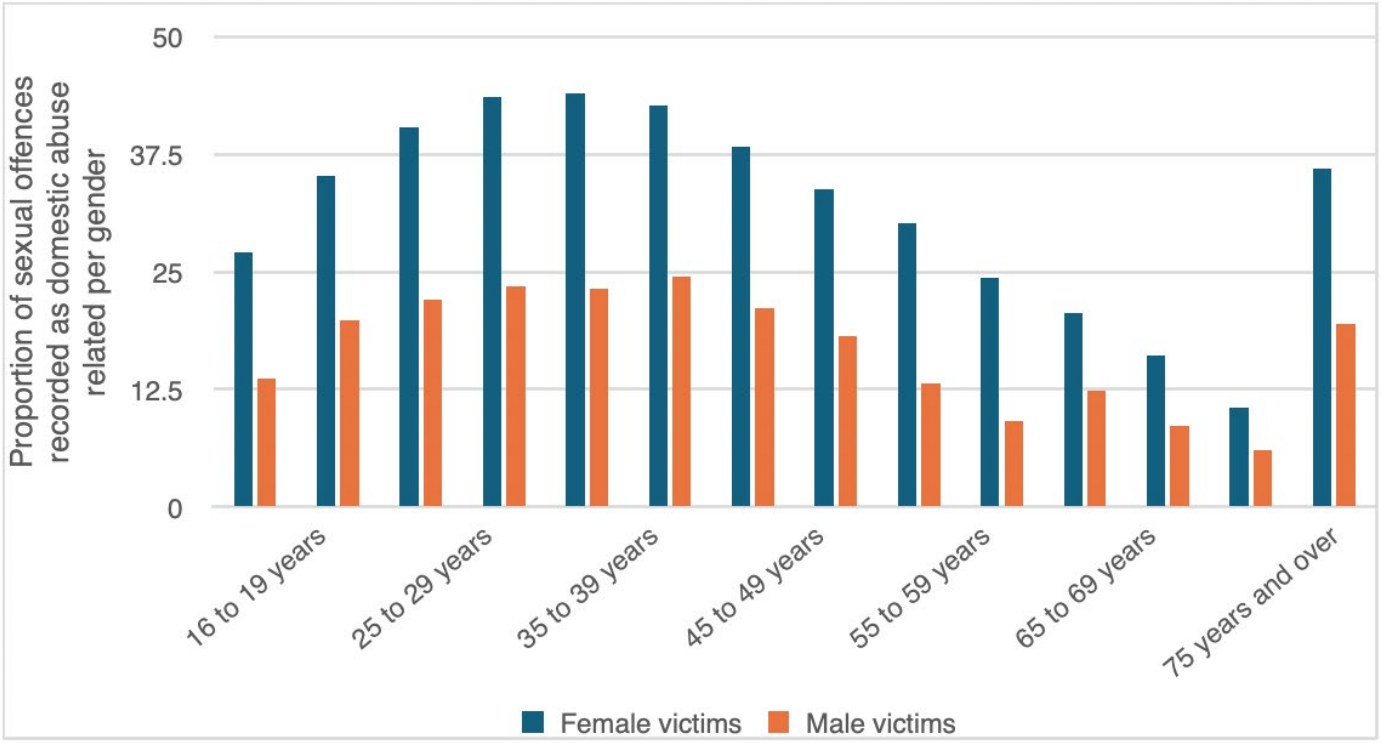
These structural differences have important implications for prevention and service design. Interventions addressing violence against women must continue to focus on coercive control, partner abuse and safeguarding within relationships. At the same time, prevention of sexual violence against men requires attention to institutional, peer and community contexts, including stigma and barriers to disclosure.

Figure 29 shows the proportion of sexual offences which were recorded as domestic abuse related by age group and gender. Age patterns further illustrate the gendered nature of domestic sexual violence. Among women, the proportion of sexual offences recorded as domestic abuse-related increases from adolescence into early adulthood, peaking at over 40% in the 30–44 age range before gradually declining in later life. This period corresponds to peak partnering and child-raising years, reinforcing the link between domestic sexual violence and intimate partner relationships.

For men, the domestic proportion is consistently lower and flatter, supporting the above indication that male sexual offences are less concentrated within domestic partnerships and more likely to occur outside intimate contexts across the life course.

These age-specific patterns highlight the importance of safeguarding within intimate relationships, particularly during early and mid-adulthood (under 16 data was not included in this dataset), and reinforce the need for prevention strategies that address coercive control and relationship dynamics alongside broader community-based sexual violence prevention.

Figure 29: Proportion of sexual offences recorded by the police which were identified as domestic abuse-related, April 2024 to March 2025, nationally (source: ONS)



Domestic homicide and severe harm

Homicide data illustrate starkly gendered patterns in lethal violence. Between year ending March 2022 and year ending March 2024, there were 1,831 homicide victims in England and Wales. Men accounted for 1,313 victims (72%) of all homicides; however, only a small proportion of male homicides were domestic (107 cases, under 10% of all male homicide victims). Women accounted for 518 victims (28%) of all homicides; in contrast to men, nearly half of female homicides were domestic in nature (245 cases), meaning women were far more likely than men to be killed in a domestic setting.

The Domestic Homicides and Suspected Victim Suicides 2020-2024 Report highlights the most severe consequences of domestic abuse. In 2023/24, there were 98 suspected victim suicides following domestic abuse, 80 intimate partner homicides, 39 adult family homicides and 11 child deaths. The majority of victims were females aged 25-54 years, and the majority of perpetrators were male and of the same age bracket.

Domestic abuse-related death reviews and local learning

Domestic abuse-related death reviews (DARDRs), also known as Domestic Homicide Reviews (DHRs), are statutory processes under the Domestic Violence, Crime and Victims Act 2004, undertaken following the death of a person aged 16 or over resulting from violence, abuse, neglect or suicide linked to domestic abuse. There are 20 DARDRs currently open and under review in Cumberland Council; all of which should be considered as preventable deaths of individuals. At the time of writing, there were **ten published Cumberland DARDRs**, detailing the deaths of nine women and one man. There are a further sixteen ongoing DARDRs at various stages, all of which relate to female victims, and in 14 of these cases the alleged perpetrator is male.

Common themes identified across the Cumberland DARDRs include:

- A history of involvement with the criminal justice system.
- Misuse of alcohol and other substances, including methadone and novel psychoactive substances.
- Previous incidents of domestic abuse or violence.
- Missed opportunities for professional curiosity across services.
- Concerns raised by social housing providers.
- Removal of children into care.

These local findings closely mirror national learning. National reviews of DHRs and DARDRs show that vulnerability is common among both victims and perpetrators. Around 70% of victims and 77% of perpetrators had at least one identified vulnerability, most frequently mental ill-health, problem alcohol use and illicit drug use. Forty per cent of perpetrators were known to mental health services and nearly one-third were managed by probation. Aggravating factors such as coercive control, financial abuse, stalking and digital abuse were present in the majority of cases, particularly among victims who died by suicide.

Participants also raised concerns about the invisibility of male victims of domestic abuse, reporting experiences of dismissal or minimisation by services, which may increase isolation and elevate suicide risk. Qualitative findings from The Big Question survey further highlight community concern about domestic abuse in Cumberland. Respondents described a reluctance to confront domestic abuse, noting that emotional neglect and harsh language were demonstrated by parents in front of children, normalising these behaviours and passing the patterns down generationally. The interviews also highlighted the invisibility of male domestic abuse victims as a cause for concern, with reports of services minimising or dismissing male victims, increasing isolation and heightening risk of suicide.

National and local evidence demonstrates that domestic abuse is not an isolated phenomenon, nor solely a matter of individual behaviour. Childhood abuse is associated with perpetrating abuse as an adult, and perpetrators often go on to repeat patterns with new partners (Huecker et al., 2025). Females who witness domestic violence are more likely to be in abusive relationships as victims in adulthood.

From a public health perspective, preventing domestic abuse requires earlier identification of risk, improved coordination across mental health, substance misuse, housing and justice services, and approaches that address the upstream drivers of harm while maintaining clear safeguarding and accountability.

Child victimisation

In the Crime Survey for England and Wales (CSEW), "victimisation" refers to a child reporting that they have experienced one or more crimes in the previous year. For children aged 10–15, this includes violence against the person (with or without injury), theft, criminal damage and other personal crimes, whether or not these were reported to the police. It captures children's direct experiences of crime and harm, rather than exposure to domestic abuse between adults.

National Crime Survey data show that boys aged 10–15 are more likely than girls to have experienced victimisation in the year prior to the survey (14.5% compared with 9.1%). Disabled children are also at increased risk (14.1% compared with 11.7% among non-disabled children). Rates peak at key transitional points in schooling, including the end of primary school (Year 6) and at the end of secondary school (Year 11), suggesting heightened vulnerability during periods of social and developmental transition.

These findings are important in the context of this report. While women are disproportionately affected by domestic and sexual violence in adulthood, boys are more likely to experience general victimisation during childhood. This reflects different exposure patterns across the life course and reinforces the need for age- and gender-responsive prevention strategies.

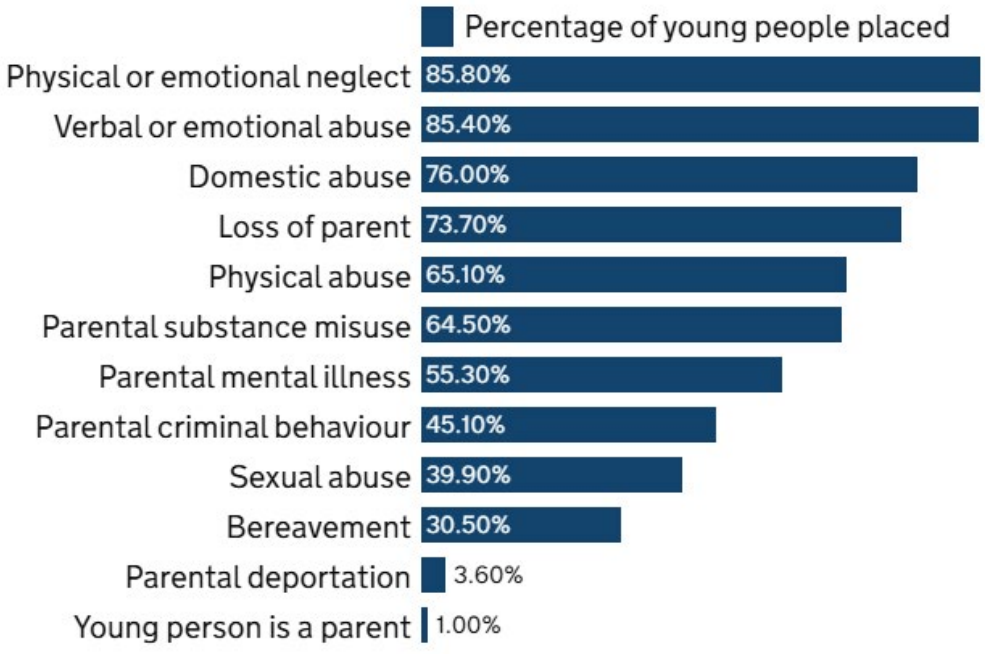
Childhood adversity and intergenerational harm

Parenting capacity as defined by Conley is "the ability to parent in a 'good enough' manner long term" (Conley, 2003). Parental capacity is shaped not only by parenting skills, but by parents' physical and mental health, economic security and ability to engage consistently with children. Men's health and wellbeing therefore play a critical role in shaping father–child relationships and wider family functioning.

Children's development and life chances are shaped by both individual parenting behaviours, and the wider conditions within which families operate (source: **UCL Institute of Health Equity**). Men's physical and mental health, economic stability and ability to engage consistently in family life play a critical role in shaping these conditions. Where men experience poor health, insecure employment, substance misuse or involvement with the justice system, the effects often extend beyond the individual, altering household environments in ways that increase risk for children.

Adverse childhood experiences (ACEs) provide a framework for understanding these pathways. Exposure to domestic abuse, parental mental ill-health, substance misuse, family conflict or parental absence are all recognised ACEs and are associated with increased risk of poor mental health, substance misuse, bullying and school belonging, involvement with the justice system and an increased risk of multi-morbidity, continuing to increase with higher numbers of ACEs experienced (Gu et al., 2022; Hughes et al., 2025; Senaratne et al., 2024). Figure 30 shows the occurrence of ACEs in children placed into secure estates for welfare reason.
By definition, there is an extremely high prevalence of ACEs, including neglect, abuse, parental loss, parent mental illness and bereavement.

Figure 30: Adverse childhood experiences of young people placed into secure estates for welfare reasons (for their own protection or for the safety of others) in England between 2021 to 2024 (Source: DHSC, Ministry of Justice)



Exposure to domestic abuse, parental mental ill-health, substance misuse, family conflict or parental absence are all recognised ACEs. As outlined in Chapter 2, Cumberland has higher-than-average levels of several adult risk factors associated with ACEs, including substance misuse, suicide and justice contact, indicating increased population-level vulnerability for children.

Children learn how to understand and respond to stress by observing adult behaviour. Where coping is characterised by emotional suppression, anger, withdrawal or substance use, these responses may be normalised and reproduced across generations. Evidence demonstrates significant links between high levels of father involvement and more adaptive emotional regulation(Puglisi et al., 2024). Research from Public Health Wales and Bangor University, studying Welsh male prisoners, found that paternal ACE exposure increased risk of children experiencing multiple ACEs and recommended the need for interventions to break intergenerational continuity of ACEs, supporting both incarcerated individuals and their families (Ford et al., 2024).

Improving men's health and wellbeing has important knock-on impacts to child health and wellbeing. Addressing upstream drivers of male distress has the potential to improve family environments, reduce childhood adversity and interrupt intergenerational cycles of harm. This reinforces the need for early, gender-aware and family-focused approaches that support men as parents and caregivers.

Community safety and emerging crime in Cumbria

Crime and community safety are a key part of "family and relationship wellbeing" because they shape fear, trauma exposure, neighbourhood cohesion and the lived experience of place. They also represent an important wider impact of the upstream drivers described throughout this report, including alcohol and drug harm, distress, exclusion and disrupted identity pathways.

Cumberland has consistently higher rates of overall crime compared with the North West region (source: **Cumbria Observatory**) Figure 31. However, this is not consistent for all crime types (Figure 32). Cumberland has lower levels of antisocial behaviour, vehicle crime and robbery rates that the region, and equal rates of burglaries, theft and theft from the person. Where Cumberland has higher rates of crime is most markedly **violence and sexual offences** (Figure 33) (the most common crime committed in Cumberland), **public order offences, possession of weapons, and criminal damage and arson, followed by shoplifting, bicycle theft and drug offences.**

Figure 31: All crime, monthly rate, Cumberland vs North West, Jan 24 to Dec 25. (source: Cumbria Observatory).

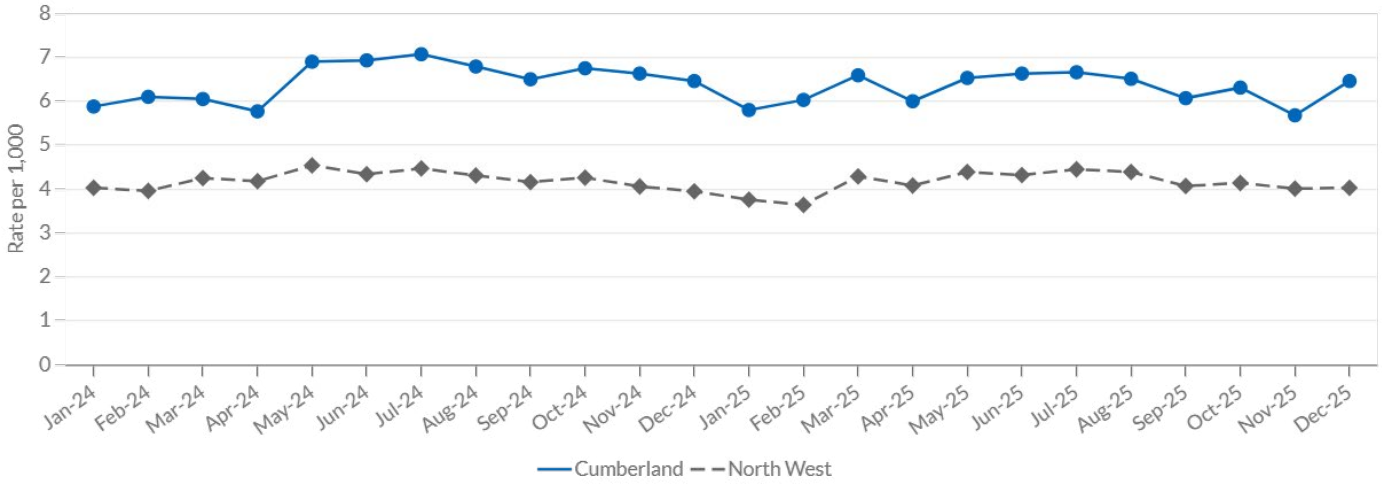


Figure 32: Crime count by type for Cumberland, Jan 25 to Dec 25. (source: Cumbria Observatory).

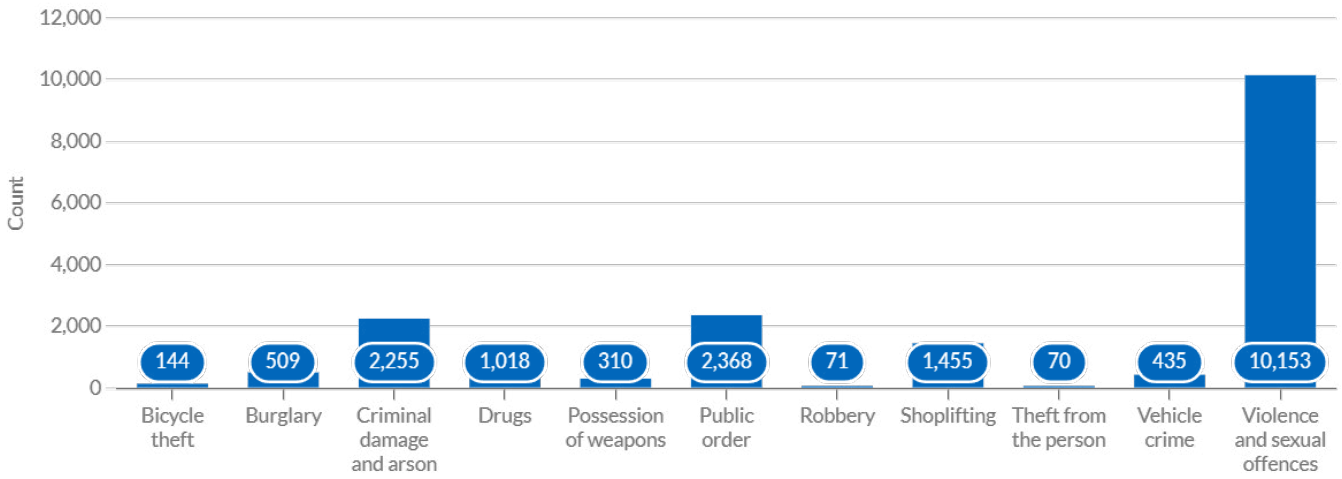
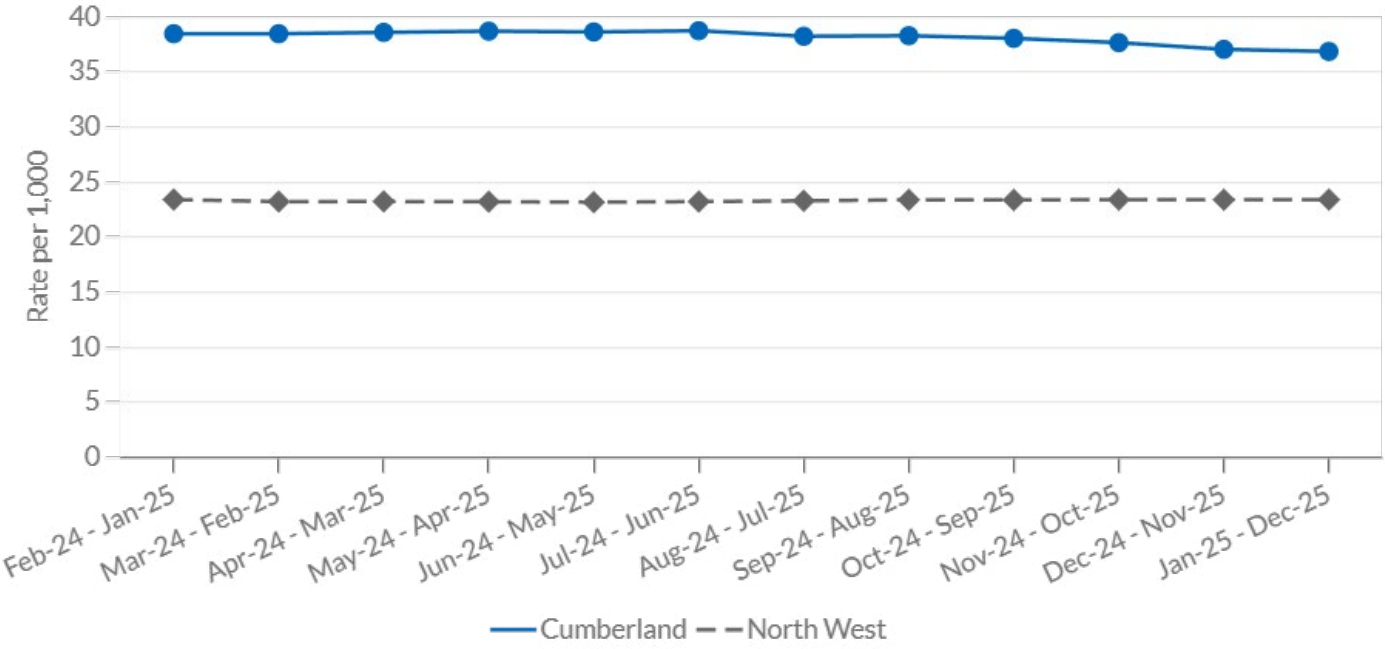


Figure 33: 12 month rolling rates for violent and sexual offences, Feb-24 – Jan 25 to Jan 25-Dec-25, Cumberland vs North West. (source: Cumbria Observatory).



Emerging trends in crime and community safety in Cumbria, 2022-23
(source: **Cumbria Observatory)**

Violence against the person accounts for almost 17,000 recorded offences across Cumbria (2022–23), with rates highest in **Carlisle** and Furness. These two localities account for over half of hospital admissions due to violence in the county.

Alcohol is a significant driver of harm. **Alcohol-related crime accounts for one in seven offences** in Cumberland (14.7%). Patterns of heavy drinking, particularly when combined with economic strain and social norms around masculinity, increase risk of both self-harm and violence.

While rates for **drug related offences** (trafficking and possession) are lower than the regional and national average, they are increasing. Drug-related deaths in Cumbria are approximately double the national average.

Economic pressures are also reflected in crime trends. S**hoplifting and residential burglary have increased in line with inflation**, with rates in Carlisle exceeding regional and national levels. Fraud has risen by 11.5% since 2020–21.

The multi-agency, proactive and collaborative approach by Local Focus Hubs across Cumbria has also contributed to a reduction in antisocial behaviour in recent years. **Although antisocial behaviour has reduced locally (-28.2% across Cumbria), it remains one of the top concerns for residents**, alongside fear of burglary. Perception of safety influences community cohesion and wellbeing, shaping how people live and engage within neighbourhoods.

Geographical concentration of crime and harm

Crime within Cumberland is not evenly distributed (Figure 37). Analysis from the **Crime and Community Safety Strategic Assessment** shows clear geographical clustering of harm, closely aligned with deprivation.

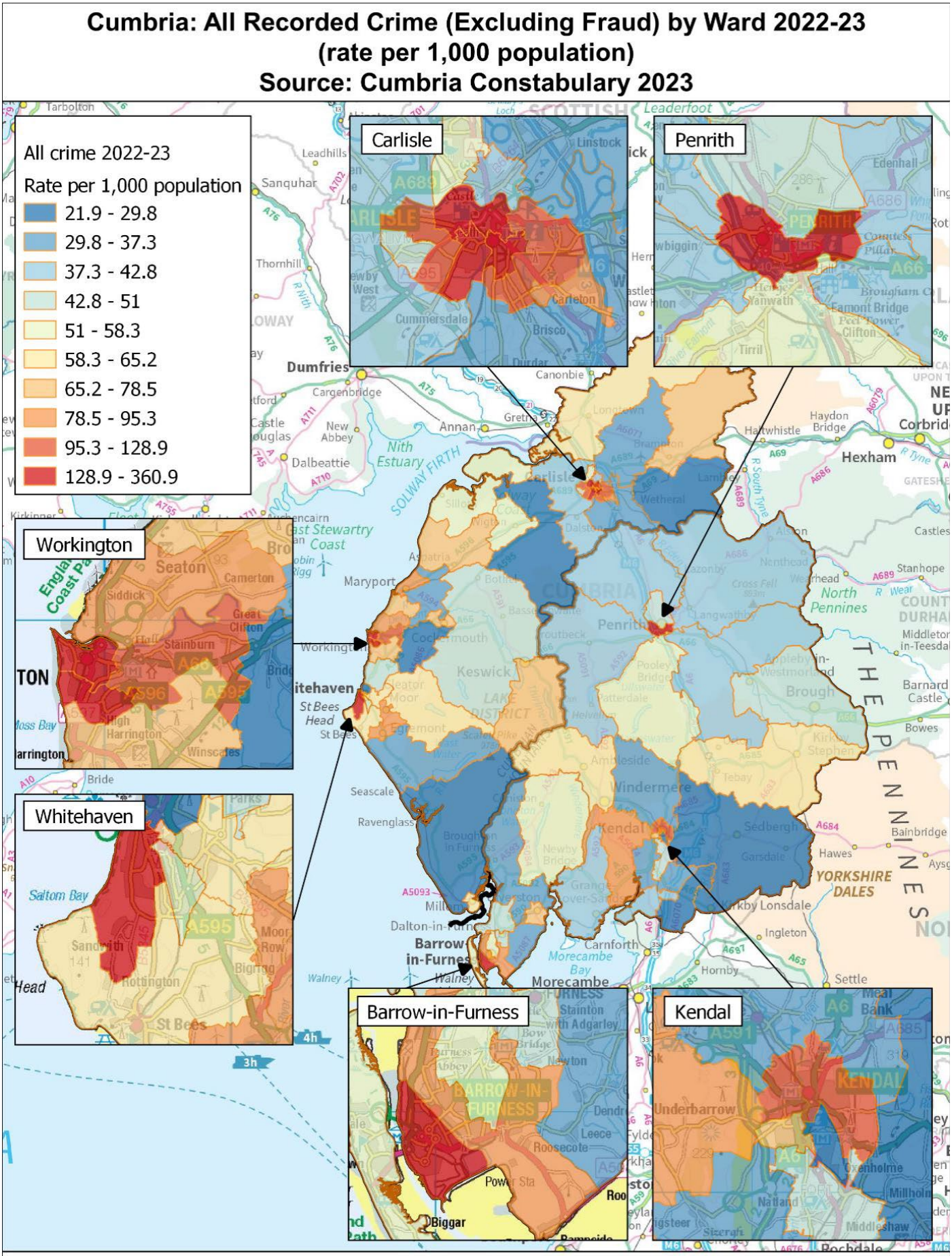
In 2023, across Cumberland, 36 Lower Super Output Areas (LSOAs) fell within the 20% most deprived nationally. Crime rates are highest within the Carlisle locality area. Within Cumberland, the wards identified as least safe, including Castle, Currock, Moss Bay and Moorclose, and Kells and Sandwith, together contain one third of all of Cumberland's most deprived LSOAs.

The community panel areas with the highest crime rates, Petteril, Carlisle West and Workington Together, account for nearly three fifths (58%) of all Cumberland's most deprived neighbourhoods.

This pattern reinforces the well-established relationship between deprivation and crime. Exposure to violence, antisocial behaviour and domestic abuse is spatially concentrated, meaning that some communities experience cumulative disadvantage: economic strain, poorer health outcomes, and higher exposure to crime.

For a report focused on men's health, this matters. Many of the same areas facing higher crime rates also experience higher unemployment, substance misuse, poorer mental health and justice involvement. Improving men's wellbeing in these communities is therefore both an individual health intervention and a place-based strategy to reduce violence and narrow inequalities.

Figure 37 All Recorded Crime Map (excluding fraud) by Ward, Cumbria, 2022-23



Crime in Cumberland is not solely a justice issue; it is a population health issue. Patterns of violent crime, domestic abuse, alcohol-related offending and sexual offences are closely intertwined with the upstream drivers explored throughout this report: economic insecurity, mental ill-health, substance misuse, trauma and social isolation. Where male distress manifests in harmful coping, aggression or disengagement, the impacts extend beyond the individual to partners, children and neighbourhoods.

The burden of crime is experienced directly by victims through injury, fear and trauma, and indirectly through its effects on communities. High-crime environments shape perceptions of safety, restrict the use of public space, increase pressure on policing and emergency care, and generate sustained demand across mental health, substance misuse, housing and safeguarding services. Concentrated crime in areas of deprivation compounds existing inequalities, reinforcing cycles of disadvantage.

Addressing men's mental health, substance misuse and economic exclusion is therefore relevant not only to men's individual outcomes, but to community safety and family wellbeing. Strengthening early support, improving access to help before crisis, and challenging harmful norms that contribute to violence are central components of prevention.

Chapter summary

The evidence in this chapter reinforces a clear message: men's health is inseparable from the wellbeing of women, children and communities. Women are disproportionately affected by domestic and sexual violence. Children experience harm both directly, through victimisation, and indirectly, through exposure to instability, conflict and trauma. Crime patterns further shape the lived experience of place, particularly in deprived neighbourhoods.

Improving men's health, particularly mental wellbeing, substance use support, economic inclusion and access to early intervention, must therefore be aligned with safeguarding, tackling violence against women and girls (VAWG), and community safety priorities. Strengthening upstream prevention in men is key to fewer individuals and families experiencing harm downstream.

Chapter 6: Local systems and services

Introduction

This chapter examines how well local systems and services in Cumberland align with the needs of boys and men across the life course. Drawing on professional survey responses, service mapping and interviews, it highlights a consistent pattern: while provision exists across statutory and voluntary sectors, many services are not designed in ways that reflect how boys and men access support or build trust.

Barriers to engagement are about not just awareness and motivation, but also service design, accessibility, cultural fit and continuity. Understanding this misalignment is essential to improving outcomes and preventing escalation to crisis.

What boys and men report needing from services

A central theme revealed was the importance of **relationship**s. Respondents repeatedly emphasised that trust, familiarity and continuity are prerequisites for disclosure and meaningful engagement. Many men do not present with explicit emotional language or self-identify as needing mental health support; instead, distress is often expressed through physical symptoms, behaviour, substance use, anger, withdrawal or practical problems. Engagement tends to occur gradually, once a relationship feels safe and non-judgemental.

Activity-based and informal approaches were widely described **as more effective entry points** than clinic-based or verbally led services. Outdoor activity, sport, practical tasks, shared interests, group settings were seen as lowering the perceived threat of engagement and reducing stigma. This pattern was reflected in feedback for both boys and for adult men.

Relatable role models and lived experience were consistently valued. Men were more likely to engage when support was delivered by people they perceived as credible and able to understand their experiences, whether through shared background, gender, life experience or recovery journeys. Visible role models were also consistently reported as a vital component of creating aspiration for boys and young men. Seeing men in employed in a diverse range of roles is important in promoting the social acceptability of HEAL employment opportunities.

Neurodiversity, particularly patterns associated with **ADHD and autism**, emerged as a significant cross-cutting issue. Delays in assessment, limited understanding among professionals and underlying neurodivergence were reported to affect boys and men at multiple life stages. For some, unmet neurodiverse needs contribute to educational disengagement, employment difficulties, mental ill-health and contact with the justice system.

Rurality, transport limitations and limited evening or community-based provision were identified as major barriers to access. These constraints affect boys and men of all ages, particularly those without private transport, those in coastal or isolated communities, and those whose working patterns do not align with standard service hours.

How the current system is organised

The landscape of services in Cumberland is set-up of universal services (primary care, schools), council-commissioned (housing, sexual health services), NHS (mental health, addiction), and a large and vital network of voluntary/community sector offers. Some of these services, such as Andy's Man Club, are male-specific initiatives, while some services, such as addiction services provide support for all but deliver interventions in an area of importance for male health outcomes. Some available services are listed in Appendix 1: Overview of current services, but this list is not exhaustive.

Statutory services are largely organised around referrals and episodes of care. Support is frequently time-limited, condition-specific or crisis-led, with multiple transitions between complementary services. While appropriate for some needs, this structure can be poorly suited to men whose engagement develops slowly or who require long-term relational support.

Outside of the voluntary and community sectors, services are predominantly clinic-based. Success of these services rely more heavily on the ability of individuals to articulate emotional distress, attend appointments and navigate complex pathways. For many men, particularly those experiencing stigma, mistrust of services, neurodivergence or chaotic life circumstances, these expectations act as barriers rather than gateways.

Workforce composition is also relevant. Services supporting emotional wellbeing are often female dominated, which may affect how safe or relatable some men perceive them to be, particularly in early engagement.

Gaps between the Cumberland system and population need

Rather than failures of individual service, the challenges identified indicate a system-level misalignment between need and design.

A **timing gap** was frequently described, with support often becoming available only once problems have escalated to crisis, safeguarding thresholds or acute mental health need. Earlier, informal or preventative engagement was reported to be limited or inconsistently available.

A **mode of delivery gap** was also described. Services that rely on formal appointments, verbal disclosure and clinical framing were perceived as less accessible to many men, particularly those who mask distress or present through behaviour or physical symptoms.

There is a distinct **cultural gap**, with stigma, fear of judgement and concerns about confidentiality, especially in small or close-knit communities, deterring engagement.

A physical **access gap** persists, particularly in rural areas, where transport, cost and service location limit participation. Even well-designed services may be effectively inaccessible to those who cannot physically reach them.

Finally, a **continuity gap** was highlighted. Short-term projects, time-limited interventions and frequent service changes were described as undermining trust and discouraging re-engagement, particularly for men who have previously disengaged or experienced rejection from services.

Services that help in practice

The evidence assembled in this report suggests that boys and men in Cumberland are more likely to engage when services feel accessible, relational and non-judgemental, and when they meet men geographically, emotionally and practically. This aligns strongly with professional feedback that many boys and men will hold back from disclosing distress until trust is established, and that engagement is often more successful when it is informal, consistent and built around shared activity rather than clinical framing.

Local insights from The Big Question (Ashworth, E. et al, 2026) highlight several initiatives and organisations that participants felt are helpful in practice. These include the **Baton of Hope tour** (as a visible, community-level way to acknowledge suicidal distress and suicide bereavement), **Every Life Matters** (a training, campaigning and support offer for those impacted by suicide), and **The Lighthouse (Mind)** (for in-person, same-day crisis appointments). These services share features that are repeatedly valued by men and those supporting them: visibility, credibility, reduced stigma, and routes into support that do not rely solely on formal referral pathways.

A consistent theme was that services work best when they create **multiple entry points.** including community events, peer spaces, informal drop-ins and activity-based engagement. These entry points can act as bridges into more specialist care when required, while also providing ongoing social connection that reduces isolation.

Two local examples illustrate these design principles in practice. Firstly, Andy's Man Club provides free, peer-led groups for men, offering a non-clinical and informal environment where men can attend regularly without referral (Box 3). Andy's Man Club is an important complement to statutory services rather than a replacement, with value as an accessible route into support and onward signposting where needed. However, peer-led groups are not suited to everyone, and it is important to offer range of open access early support services. Secondly, The Hope Haven (Box 4) offers community-based support with an emphasis on referral-free, walk-in accessibility, with multi-agency partnerships.

Box 3: Andy's Man Club

Andys Man Club

"Andy's man club (AMC) is a national volunteer led mental health and suicide prevention charity that opened in mid 2016 following the tragic suicide of Andrew Roberts in early 2016. Starting with just 9 men meeting in a small room there are now 334 physical venues across the UK and online sessions running every Monday (except bank holidays) from 7pm until 9pm where men over the age of 18 can meet in a non-judgement neutral and confidential setting to open up about their mental health struggles and get support from a group of peers in similar situations."

Facts and figures

In Cumberland, there are eight groups. In 2025, there were 6,672 attendees, with 402 of these being new, first-time Andy's Man Club attendees

Brampton: 106 attendees | 20 new (opened Oct 2025)

Carlisle: 1,988 attendees | 142 new

Cockermouth: 671 attendees | 37 new

Maryport: 798 attendees | 25 new

Millom: 362 attendees | 27 new

Whitehaven: 669 attendees | 52 new

Wigton: 261 attendees | 20 new

Workington: 1,818 attendees | 79 new

Box 4: Hope Haven

Hope Haven is a radical new collaborative mental health 24/7 neighbourhood centre and one of only 6 NHS England National Pilot sites, situated in Copeland in West Cumbria.

In this service the concepts of 'referral', 'discharge' and 'criteria' are all removed with access to support as easy as walking through the door, ringing our telephone number or connecting online.

Our partners all work together as a 'Team of the day' each day. This includes 'welcomers' who make sure anyone walking through the door receives a warm welcome and will listen to you to find out how we can help.

What's unique about Hope Haven is that if you need more than one type of support, we'll build that around you – you won't get passed between different services. Our service is built on different organisations in the local community working together and collectively aiming to support a truly community led approach to mental health and wellbeing.

Hope Haven's model is based on partnership working around the person's needs. People will be able to access support for mental health experiences and help to identify what areas may trigger or drive their mental health distress. Support is then arranged across varied levels from providing advice and guidance to complex interventions.

This places the person and their family at the centre of a collective approach to listen and understand their needs and help to support, build strength, value and wellbeing as part of their daily life.

Hope haven has a range of partners offering areas including:

- Together in a Crisis interventions
- Virtual safe haven (4pm-midnight 7 days a week with bookable appointments)
- Support with Housing needs
- Support with addictions
- Physical health support including GP access,
- NHS Mental health interventions for all ages
- Short stay beds for those in crisis

Hope Haven supports a greater understanding of the person, their needs, and also their interests and aspirations, using a multi-disciplinary approach.

Implications for service design and system response

Evidence from The Big Question, local surveys and professional feedback converges on a clear message: improving outcomes for boys and men is about reshaping the system around accessibility, continuity and earlier engagement. Several specific implications emerge:

There is a need to strengthen **crisis access and responsiveness**, while avoiding an overall model where men only receive support once distress has escalated. Crisis support must therefore be visible, rapid and easy to navigate, with clear routes between crisis response and ongoing follow-up.

Cumberland requires a more **geographically distributed offer**, including outreach, evening provision and local "third spaces" that are welcoming and easy to access.

There is a strong case for embedding front-door **early intervention and education** across settings where boys and men already are: schools, colleges, workplaces, community venues and primary care, so that help-seeking is normalised long before crisis.

Services need to be more **relational**, recognising that engagement may be gradual and that many men present with practical, behavioural or physical concerns rather than explicit emotional distress. Models that allow men to engage through shared activity, peer spaces, trusted adults and informal drop-ins are routes to earlier contact and sustained engagement.

Peer-led spaces and public conversation reduce stigma create visible permission for men to speak about distress and suicide bereavement. These approaches work best when they are integrated with clear routes into support, so that awareness translates into access.

There is a need for **stronger collaboration across statutory and third sector partners**, including shared pathways, clearer signposting and smoother transitions. Many of the most acceptable entry points for men sit in community and voluntary settings, but they must be connected to clinical and safeguarding responses when risk is identified.

There must be deliberate attention to **welcoming, psychologically safe spaces**, including spaces that work for neurodivergent people. Across the evidence, neurodiversity, emerged as an important factor shaping behavioural presentation, disengagement from education and services, and later mental health risk.

Finally, the system should treat **postvention**, support after suicide bereavement, as a core component of prevention. Given the high proportion of residents reporting being affected by suicide, bereavement support is a population-level need that has the potential to reduce longer-term trauma, isolation and risk.

The recommendations in the next chapter translate these design implications into priorities for commissioning, workforce development and place-based delivery in Cumberland.

Chapter 7: Conclusion and Recommendations

Through this report, we aim to have demonstrated the need for a gender-focused call to action to improve health and wellbeing for the whole population of Cumberland. We have set out where health and wellbeing outcomes are poorer in men and characterised the wider determinants of these. We have examined the mechanisms of male identity formation through the life course and discussed how these identities interplay with social, economic and cultural factors to result in the picture we see today.

Crucially, we recognise that Cumberland is a changing landscape. There is growing public conversation around men's mental health, reflected in the rapid expansion and high utilisation of voluntary and community sector provisions such as Andy's Man Club, and increasing visibility of local grassroots discussion around masculinity and wellbeing.

With Cumberland experiencing the highest suicide rates among women of any local authority, and a clear link between these suicides and experience domestic abuse, and the third highest suicide rate overall, there is a clear need for coordinated, system-wide action that supports men's health not in isolation, but as part of the health of families, communities and future generations.

The recommendations in this chapter are therefore framed at a system level. They focus on addressing upstream drivers of harm in ways that improve outcomes for men and reduce secondary impacts on partners, children and communities.

Taken together, these recommendations emphasise prevention, earlier engagement, cultural change and coordinated delivery across statutory, voluntary and community partners.

We are at a critical juncture. We have the opportunity to engage with the felt and expressed need of our population and respond to the clear and concerning story told by our mental health data.

Headline recommendations

Recommendation one: Apply a gender-transformative approach and challenge identity, culture and stigma drivers of health inequality

Improving men's health outcomes in Cumberland requires explicit attention to **identity, culture and social norms**, including expectations around masculinity, emotional expression and help-seeking.

Cumberland should adopt a **gender-transformative approach** (Box 5) that:

- Challenges harmful norms without reinforcing stereotypes,
- Promotes diverse and positive models of masculinity,
- Normalises help-seeking across the life course.
- Applies this lens within education systems to address differential attainment and engagement patterns between boys and girls, supporting identity, belonging and aspiration from early years onwards.

- Ensures that work on male identity sits alongside continued commitment to preventing violence against women and girls, safeguarding children and addressing abuse.
- Integrates public-facing initiatives and peer-led activity with accessible service pathways.

Recommendation two: Build a prevention-first, place-based system that aligns with how men engage

Cumberland should move towards a **prevention-first, place-based system of support** that enables boys and men to access help early, informally and without stigma. This includes developing and expanding existing accessible wellbeing hubs or community entry points in key towns.

This requires access to support that is available through multiple entry points, including community venues, wellbeing hubs, and activity-based offers, with capacity to reach rural and coastal communities.

A prevention-first front door should prioritise:

- Early engagement before crisis
- Flexible access routes
- Continuity of contact
- Clear pathways into specialist support when risk escalates
- Embed a coordinated multi-agency postvention approach following suspected suicide, including trauma-informed support for families, schools, workplaces and primary care
- Recognise community and voluntary sector provision as a core part of the system, acting as trusted bridges

Recommendation three: Make men's mental wellbeing a community-based conversation and shared responsibility

Cumberland should treat men's mental wellbeing as a **place-based, community responsibility.** Evidence from The Big Question and professional feedback shows that stigma, silence and lack of visible permission to talk remain major barriers to help-seeking, particularly in rural and close-knit communities. Community-led approaches can reduce these barriers and enable earlier support.

Cumberland should adopt a **community asset-based approach to:**

- **Fund and convene place-based men's mental wellbeing action groups** in priority areas to co-produce local priorities, shape service design and expansion
- Bring together residents with lived experience, community and voluntary organisations, statutory partners and named system leads
- **Support locally designed public campaigns** to normalise help-seeking and challenge harmful norms

This approach requires sustained investment but offers the opportunity to align services with lived experience, reduce stigma at scale and improve early engagement. Making men's mental wellbeing a visible, shared community concern reinforces cultural change, strengthens prevention and supports more effective use of services over time.

Box 5: The Interagency Gender Working Group Gender-transformative approach

Taking a Gender-Transformative Approach

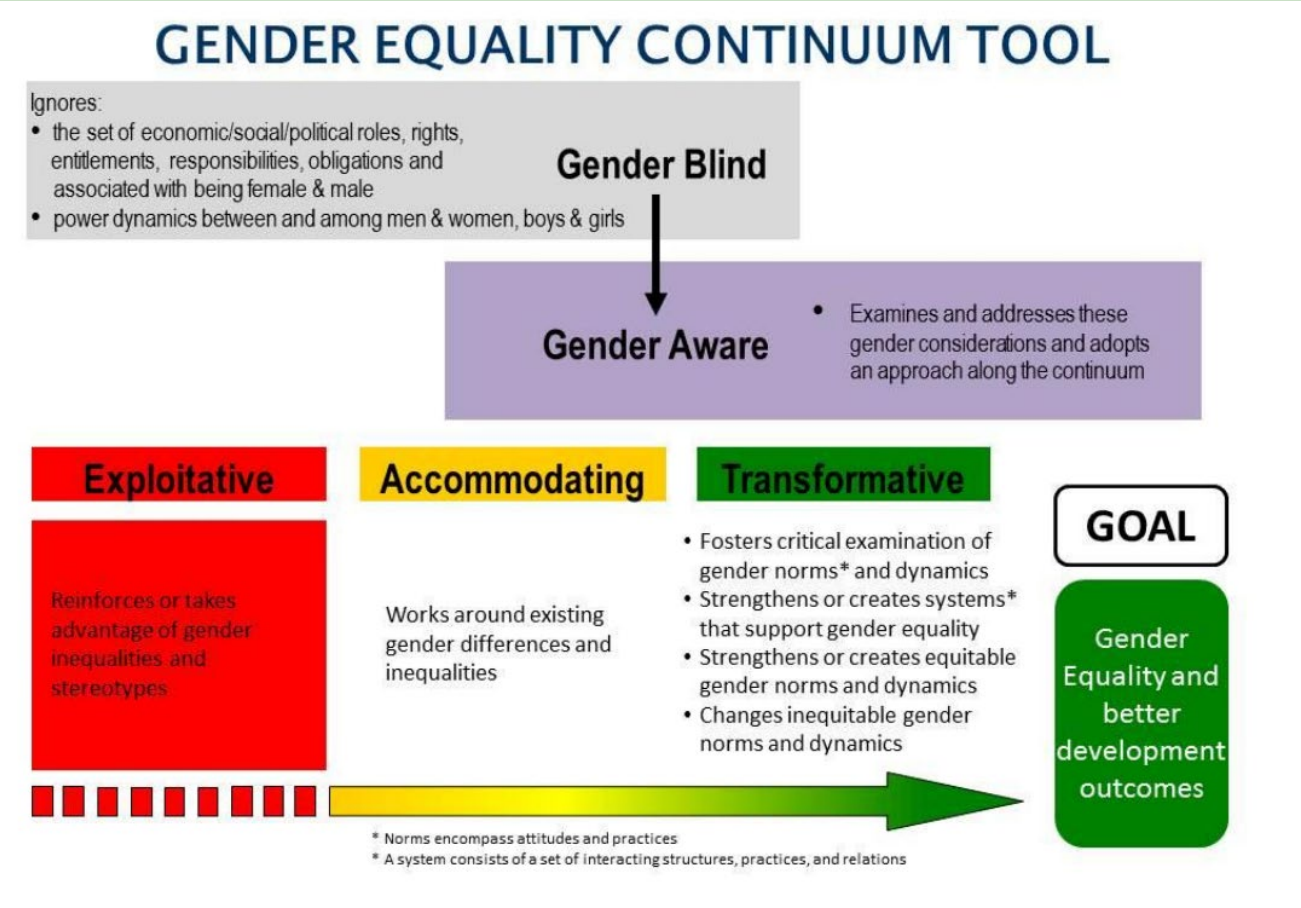
Gender-transformative approaches aim to address the structural and social root causes of gender inequality and thereby promote more equitable outcomes across populations. In the context of men's health, this means examining how gender norms and expectations shape behaviour, identity, help-seeking and exposure to risk.

The Inter-agency Working Group (IGWG) defines a gender-transformative approach as:

A transformative approach promotes gender equality by:

- Fostering **critical examination of inequalities and gender roles**, norms and dynamics
- **Recognizing and strengthening positive norms** that support equality and an enabling environment
- **Promoting the relative position of women, girls and marginalized groups**
- And **transforming the underlying social structures**, policies, systems and broadly held social norms that perpetuate and legitimize gender inequalities

The gender integration continuum (IGWG) provides a framework for assessing whether programmes reinforce, ignore or actively transform gender norms (Source: **IGWG**)



Gender-transformative approaches have been adopted globally, including **MenEngage**, UNICEF. and Victoria Health (VicHealth), which has applied the approach specifically to **masculinities and health** promotion to produce Masculinities and Health: a framework for challenging masculine gender stereotypes in health promotion.

In Cumberland, applying a gender transformative lens to men's health means:

- Challenging restrictive norms around masculinity in both men and women, including expectations of stoicism, self-reliance and economic provision
- Recognising that gender roles are socially constructed and influence boys' educational engagement, men's work identities and patterns of emotional expression across the life course.
- Promoting diverse and positive masculinities that value emotional literacy, caregiving, respect and community contribution.
- Addressing the structural drivers of inequality, including differential attainment, occupational segregation and economic exclusion, that shape men's health outcomes.
- Ensuring that work on men's health strengthens, rather than competes with, efforts to prevent violence against women and girls and safeguard children.
- Recognising that gender is relational, and that improving men's health requires attention to how power, status and inequality operate between women and men and among men.

Recommendations by sector and function

Cumberland Council

1. **Continue the shift towards prevention**, encouraging early help and reducing stigma for boys and men, prioritising life stages and groups at highest risk (including adolescence, early adulthood, working-age men and those affected by unemployment or isolation).
2. **Embed postvention as a core prevention function**, ensuring timely, trauma-informed support for individuals, families, schools, workplaces and communities affected by suicide.
3. **Agree a concise set of important shared outcomes and indicators** for boys' and men's wellbeing, including access, waiting times, continuity, postvention reach and inequalities by place.
4. **Embed proportionate evaluation** within new and existing initiatives, enabling learning, adaptation and scaling of what works.
5. **Report progress publicly**, ensuring transparency and accountability to communities
6. Strengthen **early, relational support within schools**, particularly for boys at risk of exclusion or persistent absence, with a focus on understanding behaviour, supporting neurodiversity and maintaining engagement in education.

NHS health and mental health services

7. **Develop low-threshold, face-to-face access points** (e.g. walk-in or drop-in mental health hubs) in key towns.
8. **Maintain in-person routes alongside digital offers.**
9. **Simplify and increase flexibility of referral pathways**, enabling referrals from GPs, schools, employers, VCSE organisations and families, and reducing repeated re-assessment or "bouncing" between services.
10. **Strengthen crisis response and follow-up**, ensuring empathic first contact, continuity after crisis and proactive re-engagement.
11. **Improve neurodiversity pathways for all genders and ages**, including workforce capacity, earlier identification and practical support for individuals and families across the life course.
12. Improving access to timely assessment and family support, **strengthening links between schools and mental health services.**

Supporting the voluntary and community sector

13. **Formally support and connect peer-led and community-based approaches**, recognising their role as entry points into the wider system rather than standalone solutions.
14. **Strengthen coordination across VCSE providers**, including shared referral routes, and clearer links to statutory services.
15. **Use visible, stigma-breaking community activity** (e.g. public conversations, peer spaces, awareness events) to **normalise help-seeking and reduce isolation.**
16. **Train trusted community figures** to talk about mental health (e.g. barbers, sports leaders, employers, e.g. funding **BarberTalk** training programmes).
17. **Encourage and support community and voluntary sectors to access additional funding opportunities.**

Education and schools

18. **Prioritise early, support for boys at risk of exclusion.**
19. **Reduce reliance on permanent exclusions** by strengthening in-school support, early help links and family engagement.
20. **Embed emotional literacy and help-seeking education** within the curriculum, delivered in age-appropriate, gender-sensitive ways.
21. **Actively raise aspiration and widen horizons**, including exposure to diverse career pathway, and positive male role models from a range of backgrounds.

Employment and workplaces

22. Employers should recognise their workplaces **as key prevention settings**, equipping managers and trusted staff to identify distress, provide early support and signpost effectively.
23. **Employers should support encourage diverse access into employment,** including men into health, education, and administration.
24. Workplaces should lead the way in **recognising and supporting men to be joint-primary caregiver.**

Justice system (including prison and probation)

22. **Strengthen the health–justice interface**, ensuring continuity of mental health, substance misuse and neurodiversity support during custody, probation and transition back into the community.
23. **Integrate family-focused and relational support** into justice pathways to reduce intergenerational harm and repeat cycles of disadvantage.

Conclusion

This report has examined men's health and wellbeing in Cumberland across the life course, showing a pattern of consistently poorer outcomes in some areas, high exposure to risk and later engagement with support. These outcomes are shaped by place, deprivation, rurality, employment patterns, neurodiversity and life transitions, rather than by individual behaviour alone.

A central finding of this report is that many boys and men delay seeking help because support feels inaccessible, stigmatising or poorly aligned with how distress is experienced and expressed. Services that rely on crisis thresholds, short-term interventions or verbal disclosure often engage men too late. In contrast, relational, activity-based and community-embedded approaches support earlier engagement and more sustained connection.

Cumberland has strong foundations to build on, including committed partners, active communities and examples of effective practice. However, improving outcomes will require a shift from fragmented provision towards a coordinated, prevention-first system that addresses identity, culture and aspiration, strengthens education pathways, and aligns services with lived experience.

The recommendations in this report set out a practical framework for action. By acting on this evidence, Cumberland has an opportunity to improve outcomes for boys and men while reducing avoidable harm to families and communities, and to build a healthier, more resilient future.

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Appendix 1: Overview of current services

Prevention and early help

Family Hubs and Early Help (0–19 and families): Cumberland's Family Hubs provide a prevention and early-help front door for families, alongside wider early help support for families and children.

These services are particularly important for boys' and men's outcomes because they provide a route to:

- Earlier family support before escalation (reducing cumulative adversity and household stressors), and
- Practical support around wider determinants (e.g., mental health, smoking support, infant feeding, alcohol and drug support).
- Launch of DadPad in November 2025, offering support for new dads.

Neurodiversity and emotional wellbeing service:

- A pilot service providing online resources and a single point of contact for children, young people, families and professionals relating to neurodiversity and emotional wellbeing.

Youth SAFE (Substance Awareness for Everyone):

- Support for young people and substance use, locally and online.

Mental health services

Children and young people (0–18):

In North Cumbria, specialist Child and Adolescent Mental Health Services (CAMHS) are provided via Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW), supporting children and young people aged 0–18 experiencing significant mental health difficulties.

Digital and low-threshold mental health support for young people: Kooth

Kooth is an online mental health provider for children and young people in Cumberland, commissioned by Cumberland Council. Between Q1 and Q2 of 2045/26 there was an increase seen in proportions of males registering with Kooth. While this is positive, there remains a large difference in male vs female registrations.

Further services include:

- **MyTime** (by Barnados). MyTime is part of the CAMHS service for children and young people aged 5-18 years and a provides short-term, counselling based service.
- **Mental Health Support Teams** (by Barnados), offering support with anxiety and low mood in education settings

Adults Mental Health Support Services:

NHS North Cumbria Talking Therapies: for common mental health problems (including anxiety, depression, panic attacks, post-traumatic stress-disorder),"

Hope Haven (West Cumbria Mental Health Partnership)

Voluntary and community sector services

Every Life Matters:

- Delivers suicide prevention work and provides suicide bereavement support across Cumbria.

Andy's Man Club:

- ANDYSMANCLUB: free-to-attend peer support groups for men (18+) meeting weekly (national model, with local groups including in/near Cumberland).

Support after domestic and sexual abuse

- **Safety Net** (Cumbria): trauma-informed support following domestic and sexual abuse for adults, children and others affected.
- **Cumberland Council** domestic abuse support pages provide pathways and advice, including urgent safety steps and routes to accommodation support where needed.
- **Cumbria Victim Support:** independent support for people affected by crime (including domestic abuse).
- **Gateway 4 Men:** Carlisle men's centre for men experiencing issues such as domestic abuse, social isolation and a need for housing/benefit support, comissoned by Cumberland Community Safety Partnership.

Alcohol and drugs

- **Cumbria Addictions, Advice and Solutions (CADAS):** addiction support (including support for "affected others"/families).
- **Recovery Steps Cumbria (Waythrough):** free, confidential support for people who use drugs and alcohol, with wider links (housing/employment support).

Gambling harms

- **Beacon Counselling Trust:** provides support for gambling-related harms across the North West, including Cumbria, with therapy and practical support delivered face-to-face (where available) and remotely.