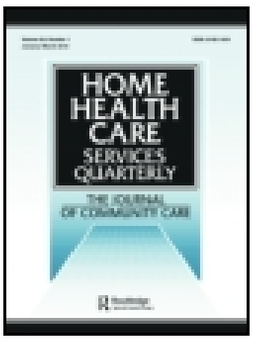

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Community support groups for men living with depression: barriers and facilitators in access and engagement with services

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ABSTRACT

Approximately 10% of the general population will experience depression in adulthood. Concerningly, men with depression are more likely to take their own lives and less likely to seek professional support. Given men's preference for community-based support, this study employed interviews with service providers to explore the barriers and facilitators involved in community support groups for men living with depression. Nine interviews were conducted with service providers across Greater Manchester, UK. Data were analyzed via thematic analysis and revealed four themes: 'Mental Health as a Weakness,' 'Empowering Practice,' 'Trust and Security' and 'Group Support as a Gateway to Treatment.' Men living with depression experience identity conflict, which reduces help-seeking. Community support groups facilitate access and engagement with treatment by providing safe spaces to resolve internal conflicts. Gender-specific group support may facilitate access to support and address long waiting lists of statutory services. Implications for practice, policy and future research are discussed.

KEYWORDS

Men; depression; peer support groups; barriers; facilitators; help-seeking

Introduction

Depression has an estimated lifetime prevalence of 10% in the general population, with main symptoms of the disorder including low mood and loss of pleasure or interest in most activities (National Institute for Health and Care Excellence (NICE), 2009; Tolentino & Schmidt, 2018). Men have been reported to consistently underutilize mental health services for depression, often resulting in depressive states remaining undiagnosed. (Banks & Baker, 2013; Branney & White, 2008; Oliffe, Broom, & Rossnagel, 2020). When men do reach out for help from professionals, this usually relates to physical symptoms rather than emotional challenges or distress induced by depression (Corney, 1990; Möller-Leimkühler, 2002).

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Current evidence suggests that men living with depressive symptoms may prefer to employ dysfunctional coping strategies instead of seeking formal support, mainly due to traditional masculinity norms and the fear of stigmatization (Leimkühler, Heller, & Paulus, 2007; Robertson & Baker, 2017; Vogel et al., 2011) Adherence to social norms of masculinity, such as appearing stoic, can influence men's help-seeking behaviors via the inhibition of emotional expressiveness, which results in significant delays in recognizing and accepting depressive symptoms (Magovcevic & Addis, 2005; Vogel et al., 2014) In recent years, public campaigns have increasingly focused on promoting mental health awareness to facilitate men's help-seeking behaviors (Robertson et al., 2015; Shaw, 2011). Despite significant public activities targeting dysfunctional norms, beliefs and social stigma surrounding mental health (Clement et al., 2015; Gary, 2005; Robertson & Baker, 2017; Whorley & Addis, 2006), men's access to services still remains limited (Banks & Baker, 2013; Oliffe et al., 2020), potentially due to the lack of gender-specific support. (Liddon, Kingerlee, & Barry, 2018; Morison, Trigeorgis, & John, 2014).

Community support groups are becoming increasingly popular due to their informal nature (Liddon et al., 2018) and therapeutic contribution to the management of mental health conditions, such as depression (NICE, 2020; Worrall et al., 2018). Men appear to prefer group support significantly more than women (Liddon et al., 2018), potentially due to their difficulty to discuss intimate or personal emotional experiences with professionals on an individual basis (Clement et al., 2015). Studies have shown that many psychological interventions are unappealing to men because they are mainly emotion-focused and involve discussing personal feelings with a professional who is often of the opposite sex (Blundo, 2010; Kingerlee et al., 2014; Morison et al., 2014). O'Brien, Hunt and Hart (2005) conducted fourteen focus groups with men living with depression to discuss help-seeking behaviors. The findings showed that disclosing emotional problems would challenge men's 'hegemonic' views linked with masculinity which mediated their help-seeking behaviors (O'Brien et al., 2005). In group support, the presence of male peers with similar experiences and facilitation by male practitioners could alleviate those barriers, as men living with depression may find it easier to process sensitive affective states within informal gender-specific group settings (Corrigan et al., 2005; Knight, 2006; Newbold, Hardy, & Byng, 2013).

Given the increasing focus of research-informed policy on the potential benefits of community-based support groups for the management of depression (NICE, 2020), our study aimed to explore what works well and what could be improved in real-life situations. As the majority of previous studies were quantitative or focused on the experiences of service recipients (Möller-Leimkühler, 2002; Vandervoort & Fuhriman, 1991; Whorley & Addis, 2006), we explored service providers' perspectives to identify the

barriers and facilitators involved in access and engagement with community-based group support for men living with depression, and provide recommendations for practice.

Materials and methods

Design

This project was an exploratory qualitative study, utilizing semi-structured interviews. Qualitative data were analyzed using inductive thematic analysis (Braun & Clarke, 2006). Data on participants' socio-demographic characteristics were gathered to provide further context. The study was approved by the Research Ethics Committee of Manchester Metropolitan University (ref. no: 17167).

Participants

Recruitment

An electronic search was conducted to identify third-sector organizations in Greater Manchester, UK, offering community-based group support for men living with depression. Organizations were invited to support the study and facilitate recruitment by advertising the study poster to staff members. Prospective participants could contact the research team directly to receive the participant information sheet, consent form and arrange a date and time for the interview. None of the participants were compensated for participating in the study.

Participant selection

Participants were adult service providers and volunteers, with at least six months of work experience in a third-sector organization or community service providing group support for men living with depression.

Given Braun and Clarke's (Braun & Clarke, 2016, 2021) critique on sample size calculation and data saturation in reflexive thematic analysis, the sample size required for the study was determined during data collection and analysis by assessing whether data were rich and telling a coherent insightful story (Braun & Clarke, 2021). Data collection ceased after nine interviews, confirming Guest et al's. (2006) position that six to twelve interviews suffice for the development of meaningful high-level overarching themes. In total, nine facilitators of peer support groups were recruited via opportunity sampling, including snowball selection.

Table 1. Presentation of participants background and socio-demographic characteristics.

	Mean	Stand. Dev.	Min	Max
Age (years)	48.44	18.521	29	76
Duration of employment (months)	65.67	53.516	14	168
		Frequency	**Percentage (%)**	
Male		5	55.56	
Female		4	44.44	
Received Group Support training		2	22.22	
Received Mental Health training		2	22.22	
Received Group Support and GP Mental Health training		1	11.11	
Received Mental Health and CBT training		1	11.11	
Received CBT training		1	11.11	
Received no specialist training		2	22.22	
Facilitated 'men-only' support group		3	33.33	
Facilitated mixed-gender support group		6	66.66	
Employed at a drop-in group support service		7	77.77	
Employed at a group support service requiring attendance		2	22.22	

Socio-demographic characteristics of participants

The mean age of participants was 48 years, while average time in employment was 66 months. Three participants facilitated 'men-only' support groups and six provided support to mixed-gender groups. Seven groups functioned on a drop-in basis, whereas attendance was required in the remaining two. Data on participants' socio-demographic characteristics are summarized in Table 1.

Data collection

An interview guide was employed to gather rich qualitative data from participants (see Supplemental Material A). The guide was informed by a literature review conducted by the first author, which identified the themes in which the questions were organized: (a) symptom recognition and transitional period to support seeking, (b) factors influencing help-seeking behaviors and initial access to support, and (c) factors affecting engagement with treatment over time. Due to the inductive approach of the study, these thematic areas were covered via broad open-ended questions, to ensure that the study findings were informed by and grounded on participants' views and experiences (Braun & Clarke, 2006, 2016, 2021). Each interview lasted between 30 and 45 minutes. Interviews were conducted from June to July 2020 over the phone or Skype, to minimize health and safety risks resulting from COVID-19. Interviews were audio-recorded and transcribed verbatim.

Each interview commenced with explaining the study to participants. Verbal consent was then acquired and recorded for each statement of the consent form. Participants responded to socio-demographic questions (see Supplemental Material B) before taking part in the semi-structured interview.

Open-ended questions and prompts were employed to acquire insight into the barriers and facilitators involved in (a) men's help-seeking behaviors and access to support groups, and (b) men's engagement with support groups over time. Verbal consent and interview data were recorded separately, to protect participants' confidentiality. All participants were offered a debrief sheet with information on useful sources of support and how to access the study report at the end of the study.

Analysis

Socio-demographic data were analyzed via descriptive statistics in SPSS 26. Interview data were analyzed manually using inductive thematic analysis (Braun & Clarke, 2006). The first author engaged in repeated reading of the data and took notes. During the subsequent coding process, she took reflexive notes and engaged in interactive discussions with the research team to check for potential biases. The code descriptors were then refined and codes were clustered into themes by consensus, based on conceptual similarities. To avoid analytic foreclosure, themes were reviewed and clustered again into richer, more complex themes (Braun & Clarke, 2020). The first author then reviewed the final themes and checked for accurate representation of meanings and coherence within the whole dataset.

Results

Inductive thematic analysis revealed four major themes: 'Mental health as a weakness,' 'Empowering Practice,' 'Trust and Security,' and 'Group support as a gateway to treatment' (see Table 2 and Figure 1).

Mental health as a weakness

Participants referred to men's tendency to experience depression as a weakness. This involved the perception of depressive symptoms as conflicting with stereotypical masculine traits, social challenges associated with stigma attached to depression, and culture-specific influences acting as barriers to accessing support.

Masculine ideal conflicts and changes in familial roles

All participants referred to men's adherence to stereotypical gender norms which acted as a barrier to seeking help and accessing services. "Natasha" reported: "Men don't cry, you know little boys don't cry . . . men are supposed to be the strong person, the hunter-gatherer . . . that's what we've been led to believe." According to participants, depressive symptoms challenged the maintenance of these traits and elicited a sense of belittlement in men's

Table 2. Presentation of the themes and sub-themes identified during analysis of the interview data.

Major Themes	Sub-themes
Mental Health as a Weakness	• Masculine ideal conflicts and changes in familial roles • Social challenges and stigma • Cultural Influences
Trust and Security	• Developing a sense of connectedness • Offering Safe Spaces
Empowering Practice	• Enabling understanding • Support tailored to individual needs
Group support as a gateway to treatment	• Addressing long waiting lists • Lack of funding • Challenges of remote delivery

identity due to changes in familial roles. "Wilber" explained: "They're shifting their dynamic from the traditional sort of breadwinner to the person that is at risk of needing the support, which I think can be a condition within the nest they find uncomfortable occupying." This often led to denial and hesitating to seek or accept help, particularly as men experienced feelings of shame when realizing that they need to be cared for by their family. "Wilber" reported:

> The idea that having a difficult experience like depression, and then sort of disclosing that tothe people closest to them, often isn't what they want . . . it makes them a burden on their family.

This reflects how gender norms and masculinity traits can act as a barrier to help-seeking and prevent men from accepting their symptoms and accessing support.

Social challenges and stigma

Participants emphasized the impact of social influences in men's preparedness to seek help. Stigma attached to depression appeared to be a major barrier. "Lara" reported, "I think it's just the stigma of people talking about it . . . I think they still feel weak. They feel like a failure." Participants referred to strategies employed to tackle the sense of weakness induced by stigma, to facilitate access and engagement with services. This was achieved by focusing on the person and their strengths rather than the condition. "Simon" said:

> I'm conscious sometimes we come across as very 'mental health', in which case people don't come. Whereas, if we come across as activity-based with a slight undercurrent of mental health that tends to work a lot better and it takes away the barriers that some people have with seeking mental health support.

"Simon" further highlighted how campaigns aiming to address gender stereotypes can add pressure to men living with depression: "They're suddenly patronising us with this evil image of masculinity that they created that doesn't actually exist. So, it does a shocking amount of harm." These approaches made

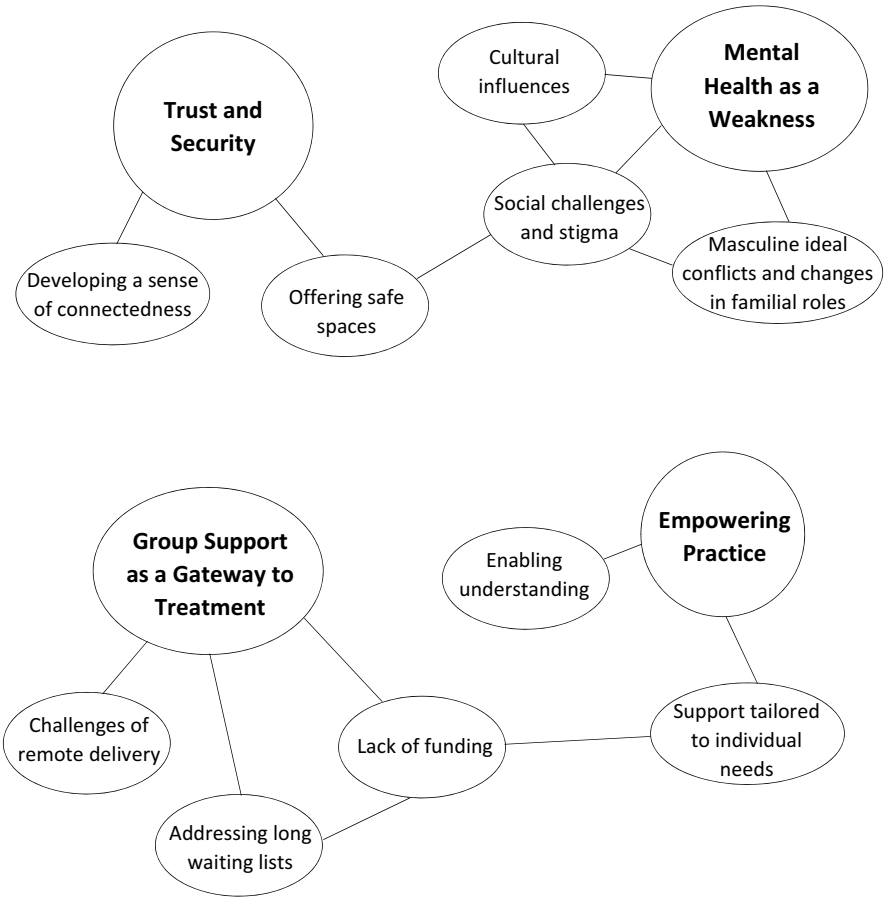

Figure 1. Thematic map of the study findings, presenting the identified themes, sub-themes and their relationships.
(a) The sub-themes within the theme 'Mental Health as a Weakness' were all inter-related due to stigma surrounding mental health difficulties arising in all aspects of men's' personal and social lives (e.g. their roles within their families, communities and cultures).
(b) 'Offering safe spaces,' a sub-theme within the 'Trust and Security' theme, was related with 'Social challenges and stigma,' as accepting judgment-free community support forums enabled addressing the social challenges experienced by men.
(c) The sub-theme 'Lack of funding' was associated with 'Addressing long waiting lists' (theme 'Group Support as a Gateway to Treatment') and 'Support tailored to individuals needs' (theme 'Empowering Practice'). Participants stressed the diversity of activities and approaches needed for needs-based support and underlined the need for financial support to render these sustainable and capable of bridging the gap with formal statutory services.

younger men feel misrepresented or confused about their identity and how to respond, as they were more prepared to seek help compared to their older counterparts. "Rob" described

I think the older ones tend to be . . . stiff upper lip . . . you know we don't do that, we man up and we get on with it . . . whereas the younger ones now there seems to be less stigma, there's more awareness in the public eye.

Such intergenerational differences appeared to play a key role in perceiving depression as a weakness and accessing support, and highlighted gaps in social awareness of the condition among different age groups.

Cultural influences

Participants referred to cultural factors that influenced men's help-seeking behaviors and prevented or delayed access to support. "Bill" reported how men from Black, Asian and Minority Ethnic (BAME) communities viewed depression as a personal challenge to be dealt with within the family rather than through formal support:

> We have been approached by Black, Asian and Minority Ethnic communities to help the younger and older generations of men to access peer-to-peer support … sometimes there's a cultural and religious barrier to recognising you've got a problem … there's a much more in the family way of dealing with problems.

"May" further reflected on the role of common beliefs around health inequities within minority groups, which increased men's sense of social disadvantage and acted as an additional barrier to accessing support:

Perhaps if you are a black man you might not necessarily experience the same treatment in mental health services as you know, your white counterparts … There needs to be a bit more visibility, a bit more funding around those areas.

Trust and security

Participants underscored how the sense of security and connectedness developed within the group setting provided a safe environment for men to discuss intimate experiences related with depression and develop meaningful relationships with peers and professionals.

Developing a sense of connectedness

Participants stressed the significant role of other men with similar experiences within the group. "Wilber" stated: "Having other people around the room who look like them, who talk like them, that experience similar things to them … I think that's a benefit that you don't get with individual therapy." This form of camaraderie appeared to facilitate access and engagement with support as men could identify with peers who understand what it is like to live with depression. Participants also highlighted the importance of informing the public about this aspect of group support, to facilitate men's access. "Natasha" reported: "I think the only barrier is the perception that groups are mainly [for] women … It's quite surprising sometimes how many

men we have in a group." It appears that the sense of connectedness was facilitated by the presence of other men, but did not necessitate a 'men's only' approach.

Men being able to relate or identify with group facilitators was also highlighted as a key factor involved in access and engagement with group support. "Rob" described the role of facilitators' gender in the process: "The male facilitators seem to make people feel a bit more at ease." Although male facilitators appeared to make men feel more comfortable, "May" reported the need to consider additional demographic characteristics of facilitators, to render the support relevant to men from under-represented groups: "Practitioners all tend to be a certain demographic being white, middle-class older women. They might find that quite difficult to speak to somebody who maybe doesn't necessarily understand where they are coming from." These characteristics seem to help men to engage and share their experiences within the group, as they feel they can be heard and understood. Participants further stressed how the external appearance of group facilitators may be important, particularly at first contact with services: "Simon" said:

If you have a suit on and a lanyard and a badge and you're in a clinic, they're going to take away a very different perception than if you're like a mate . . . Our volunteers have that slight air of authority but also approachability.

This highlights the importance of details which may be otherwise perceived as trivial, but can create unfavorable power dynamics and hinder men's access and engagement with support.

Participants highlighted the importance of group facilitators' ability to empathize with men, even if they hadn't "walked in their shoes." There were mixed opinions on how this can be achieved. "May" reported the need for "relevant training" to be provided to female practitioners, while "Bill" described how volunteers with real-life experience with the condition can be helpful. However, "Simon" had an opposing view regarding their ability to provide effective support: "Volunteers have their own issues . . . which can often mean that that person is not necessarily the best person to run a support group." This shows the complex challenges that need to be addressed so that practitioners can empathize and connect with men during the provision of support.

Gender representation in public discussions and campaigns were highlighted as an important factor influencing access to support. "May" described how social media campaigns may lack gender specificity: "I think mental health is predominately promoted in a way that it's kind of indirectly directed at women . . . on social media, there is a lot of Instagram and Facebook groups that are dedicated to mental health led by women." This indicates the need for gender-specific campaigns led by men, which can be

perceived as relevant and facilitate access to support. "Rob" reported how male role models discussing their mental health challenges in the public eye can help to address this issue:

> When there's a 6"4 Australian former rugby player saying 'Look it can happen to me, it can happen to you' . . . Realising there's a big roughty-toughty fella here saying that he had problems. He's admitting it, he's saying if I can do that, you can do it.

Offering safe spaces

Participants emphasized the importance of new members' initial contact with the support group. Providing a warm, safe and judgment-free environment was linked with men's preparedness to open up and maintain engagement with the group. "Rob" reported:

Once they've come in, they're quite frightened you know . . . We can ease them into it and make them feel welcome, settled and straight afterward you can visibly see a difference . . . We see people come in and within the first hour, they open up on some quite heavy issues.

In some cases, men did not feel comfortable walking straight into a group setting and needed a more gradual introduction into the support environment. This was addressed via practitioners' flexible approach who contacted men outside of the group to ease them into the process. "Simon" reported:

> I think we go out of our way to be welcoming to people, I will always generally if someone's nervous I will go phone them up, I'll meet them early, I'll even go for a coffee with some of them in (location).

In other cases, not knowing the group members facilitated entering the group due to the lack of judgment. "May" described: "It's a lot easier to kind of be honest because they don't know you, they don't know anything about you or your background." This indicates the need to consider men's individual needs during their transition to group support.

Empowering practice

Participants described how men's control over depression and its impact was enhanced by the provision of information and knowledge which facilitated understanding the condition, as well as by opportunities to have a voice regarding current and future treatment.

Enabling understanding

The notion that men do not have enough knowledge around depression was repeatedly reported. Group support enabled men to understand their condition, the challenges they faced, and their treatment options. This information

was shared by guest speakers, group facilitators or more experienced members of the group. "Natasha" discussed how sharing information about treatment options instilled feelings of hope and enabled a positive outlook:

While they're coming to our groups, they'll often hear the experience of somebody . . . that had CBT and it worked and how much better they feel, so it gives hope and it gives some understanding of what will happen in a session and what's expected of them.

Participants also described how the group setting allowed recreating and addressing condition-specific challenges, enabling men to understand and resolve more complex issues associated with depression. "Wilber" explained:

Depression manifests itself in their relationships and the people around them . . . I am of the belief that a lot of distress that people experience can, and often at times does, relate itself in relation to other people. So, I think that when supporting someone with the issues that they are facing, it's often good to have an environment where those issues are recreated.

This shows how the group setting can provide a useful space to address the impact of depression on important life aspects, such as social relationships.

Support tailored to individual needs

Professionals referred to the idea that group support was "not for everybody" due to individual differences and challenges experienced by men. "Lily" described the difficulties of tailoring groups to individual needs: "One size doesn't suit everybody. If depression was an illness like having your appendix out, it would be easy. But depression covers masses of issues, that's the problem." Services tended to address this by encouraging access to alternative groups they provide. "Rob" explained: "Some people don't like (group name), they come to it and they think 'Oh it's a bit heavy for me' and I'll say like 'Oh why don't you try a different group on this day?". This shows the importance of service flexibility, particularly at the early stages of support, and the need for different interventions to be available to match men's needs and preparedness for support. "Jeremy" highlighted the importance of "having a multiplicity of activities . . . to get service users included" and facilitate initial engagement with support, while "Lara" reported how informal activities can ease men's transition to support: "What would help was if there were services that men could get involved with that doesn't have to be straight away about mental health, obviously it improves their mental well-being engaging in these activities proactively." This shows the significance of less formal strength-based activities, particularly at the initial stages of support when men may still feel unsure as to the preferred extent of exposure to their mental health difficulties or may not feel prepared to engage with therapeutic work. However, participants emphasized that although these activities may be useful, they are not sufficient to address the challenges imposed by the condition and should only be viewed as

complementary or temporary solutions. "Wilber" reported: "At the other end . . . people do end up in a position where things have got really bad and I think a quiz night or football night isn't going to cut it."

Participants suggested that group support was beneficial when men were treated as equal partners. Services incorporated men's feedback in designing the service and setting the ground rules. "Lara" reported: "Men know themselves, how they feel and what they would benefit from and prefer to have input into their treatment." This shows how men can feel empowered by having a voice and their individual needs informing the support they receive. At "Jeremy's" service, men could also choose their own therapist as "everything is based on the service user's desires," while "Wilber" added how their service works collaboratively with men to form a plan for their support:

What has been important to me is understanding people's experiences as we look to provide a service for those people . . . that idea of if there is a solution, the men themselves are in the best place to define what that is.

Such an approach seems to be important, as it can increase men's perceived sense of control over their lives, the support they receive and how they wish to cope with depression.

An additional aspect that facilitated access was the absence of specific conditions regarding the frequency of attendance; this appeared to be important, particularly at the early stages of support. "May" reported:

> There's no commitment for you to come every week . . . It is probably quite flexible and not as intimidating as attending your first counselling session knowing you've got to be there for a full hour . . . I think that's quite a beautiful thing about drop-in groups because you know there is no expectations.

This shows how the lack of imposed rules and requirements can enhance the informal nature of support groups and balance power relations between men living with depression and service providers.

Group support as a gateway to treatment

Professionals described support groups as a gateway to formal services. They identified the contribution of support groups in addressing the long waiting lists for formal treatment and highlighted organizational and contextual challenges which may act as significant barriers.

Addressing long waiting lists

Participants described group support as a "temporary fix," "supplementary service," and a way to "plug the gap" of waiting for formal treatment, such as CBT or other statutory services. "Natasha" described: "They need CBT . . . there's a 12-week waiting list, at least. We're the kind of plug for the system . . . We

support that person until they see their therapist." The majority of participants identified long waiting lists for access to the above services as a significant challenge and emphasized the usefulness of group support to prevent the deterioration of symptoms. "Simon" said: "You're waiting 8/9 months at which point you're either dead, recovered or in a pretty bad way . . . It was very instant and very easy for service users to get help from us." This shows how support groups can be immediately accessible and ensure the availability of support while men living with depression remain in the waiting lists of formal services.

Lack of funding

Participants stressed the need for appropriate funding schemes, to enable their services to continue providing support and act as a gateway to treatment. Limited funding acted as a barrier in men's access and engagement with support. "Lily" reported: "We had some training from (service name) . . . and then it stopped. No explanation . . . I don't know whether they got difficulty with funding . . . When that ceased, we dropped off the radar as public material." "Natasha" further reported a "financial barrier" which prevented them from starting additional support groups specifically for men and "capturing people who might drop out because they don't feel comfortable in a female environment." "Jeremy" also suggested that drop-out rates could be improved if they were able to provide additional groups at "weekends and early evenings" which at the time was not possible due to financial restrictions. This shows how the lack of financial support can significantly decrease the flexibility and potential usefulness of group support.

Challenges of remote delivery

Participants stressed the impact of Covid-19, with most services choosing to deliver support online following lockdown restrictions. The effect of this change on access and engagement with support varied across groups. "Rob" reported how the new ways of working are gradually being accepted by service recipients: "The Zoom is getting quite popular now . . . a lot of people don't like that but yeah it's getting a bit more popular than when it first started." However, in other cases this posed a significant barrier to the provision of support. "Simon" described: "The lack of face-to-face has been a big thing. With lockdown it's been catastrophic with us . . . Social skills are often not a great strength for some of our people." This indicates that remote support may not be meaningful for all men, particularly those whose social skills have been significantly affected by the condition. Such individual differences can be of particular importance as they can undermine men's engagement with peer support during key transitional stages of their experience with the condition.

Discussion

This study aimed to explore the perspectives of service providers regarding the barriers and facilitators involved in access and engagement with community-based support groups for men living with depression. An inductive thematic analysis identified four major themes: 'Mental health as a weakness,' 'Empowering practice,' 'Trust and security' and 'Group support as a gateway to treatment.'

The theme 'Mental health as a weakness' provides supporting evidence to previous findings suggesting that stereotypical masculinity traits can result in the denial of depressive symptoms and reluctance to seek help (Berger et al., 2013; Magovcevic & Addis, 2005; Vogel et al., 2011). This is consistent with gender socialization theories of men's help-seeking behaviors, which highlight the influential role of social environments in promoting distinct masculine behaviors and attitudes through social norms and gender stereotypes (Mansfield, Addis, & Mahalik, 2003; Pleck, 1995). Our study showed that men experienced identity conflicts resulting from the impact of depression on their capacity to adhere to these norms, which prevented them from accessing services. Wester (2008) describes this specific aspect of gender role conflict as 'restricted emotionality,' which results in men's reluctance to avoid overt expression of emotions and seems to be enhanced by disorders such as depression. Stigma was also highlighted as a common barrier, primarily in older individuals. This is contradictory with previous findings from studies in Canada which suggest that stigma decreases and positive attitudes to help-seeking increase with age (Mackenzie, Gekoski, & Knox, 2006; Mackenzie et al., 2019), indicating potential differences across countries regarding social norms and the way in which stigma is experienced (Wester, 2008). These differences have not been accounted for in the literature and require further investigation. Cultural influences were also highlighted as potential barriers. The National Institute for Health and Care Excellence guidelines (NICE, 2017, 2018) recommend culture-sensitive practice which addresses language barriers, to increase service use for people from BAME communities. Our findings suggest that further actions are required both in terms of public campaigns and real-life practice, particularly given that BAME communities include people from a wide range of cultures, ethnicities and social backgrounds which differ significantly between them (Sewell, 2008).

Our theme 'Trust and Security' identified the importance of providing a safe non-judgmental environment for men to discuss intimate experiences and develop a sense of connectedness with others. Group cohesiveness, interpersonal learning, identification and self-understanding are considered as important factors promoting group change in therapy (Yalom, 1995). In consistence with this view, our findings suggest that promoting a sense of equality and camaraderie among the members of the group and enabling them to learn

from each other played a significant role in access and engagement with support, highlighting the therapeutic potential of informal peer support groups during early stages of treatment.

Our findings show that empowering practice was related with enabling men to understand their diagnosis, how to cope and the available treatment options. Interestingly, Horrell et al. (2014) reported no significant benefits of short-term psychoeducational group workshops for men living with depression. This implies that long-term engagement with group support to address changing needs and circumstances may be more beneficial than ad-hoc service delivery. This remains to be answered by future research focusing on the experiences and reports of service recipients.

Our findings imply that group support may be useful as a gateway to formal mental health services. Though long waiting lists may be of particular concern in the Greater Manchester region where the study took place (Baker, 2019), our findings are consistent with previous research which suggests support groups as an effective bridge to formal mental health support (Worrall et al., 2018). This may be a reasonable approach to address service gaps and facilitate transition to formal support via less intrusive interventions, as suggested by the National Collaborating Center for Mental Health guidelines (NICE, 2018). Cross-sector collaborations would be essential to this end and require additional funding to ensure the effective integration and sustainability of group support services as part of a wider treatment scheme (Bachman et al., 2006).

Strengths and limitations of the study

The study was conducted during the Covid-19 pandemic when lockdown restrictions were in place and services were going through rapid changes to provide remote support. Therefore, the timing provided the opportunity to capture how community-based group support can quickly adapt to external drivers. However, this situation also meant that there were additional time and resource constraints upon services, which reduced the number of organizations that could partake, allowing the possibility of selection bias. Previous research has shown that improving practice and care for service recipients, contributing to the development of the field, and gaining personal knowledge constitute the major drivers for practitioners' participation in research (Poggenburg et al., 2017). Consistent with these findings, our interviews indicate that participants' main motivation for taking part in the study was related with shared interest in promoting positive changes in real-life practice, namely increasing visibility of services, raising awareness in the community, and contributing to new knowledge that will facilitate access and support for men living with depression. Due to time and resource restrictions, it has not been possible to employ an experts' consultation group to inform the content of the interview guide and further confirm the credibility of our findings. However, the interview guide was

informed by a literature review, which enabled identifying key thematic areas of focus, and was employed in consistence with the principles of inductive thematic analysis for the construction and identification of prevalent themes grounded on participants' views and experiences (Braun & Clarke, 2006, 2016, 2021). Furthermore, the brief study report with the study findings was provided to participants who confirmed the coherence, plausibility and relevance of the findings. Our study took place with practitioners from the Greater Manchester region, which may limit the transferability of our findings. Future research in other areas and community settings in England will be useful to confirm and expand on the findings of our study. Our study is the first to explore service providers' perspectives regarding the barriers and facilitators involved in access and engagement with group support for men living with depression and provides new directions for future research in this area. Whilst we do not claim our data may be entirely consistent with service recipients' experiences, it is beneficial to include their perspectives in the literature base to provide balanced insights for wider systemic service developments for community-based support.

Implications for practice, policy and future research

Our study has implications for practice, policy and research. Our findings suggest that mental health campaigns need to target distinct age groups of men living with depression, to tackle age-specific social norms and gender stereotypes and facilitate access to support. Special emphasis needs to be placed on the representation of BAME groups both in public campaigns and practice, to reduce health inequities. Furthermore, specialist training for general practitioners as the first point of contact may be useful to increase awareness and encourage men's help-seeking through signposting to local gender-specific support groups. Flexible supplementary policies are needed to provide funding for local cross-sector collaborative schemes integrating community-based support groups, to address the long waiting lists of statutory services and enable the development of gender-specific group support. Further staff training schemes on gender-specific needs and strengths-based approaches could be beneficial. Further research on the experiences of service recipients with remote delivery of group support during the Covid-19 pandemic is warranted, to acquire insight into what worked well and what could be improved; these insights could inform the design of future remote services. Further studies with families from BAME communities can shed light on culture-specific barriers and facilitators and enable the development of recommendations for inclusive practice in group support. Finally, rigorous randomized controlled trials should investigate the short- and long-term impact of support groups on access to services, depressive symptoms and quality of life for men living with depression and their families.

Conclusions

Social stigma and experiencing depression as a weakness appear to prevent men living with depression from seeking help and accessing services. Community-based support groups provide a safe judgment-free space for men to resolve internal conflicts and feel empowered, and may facilitate bridging the gap with statutory services. Further research into the potential benefits of support groups for men living with depression is warranted.

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Data availability statement

Due to the nature of this research, the data cannot be shared publicly to prevent compromising participants' anonymity and confidentiality.

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