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MEN'S HEALTH RESOURCE KIT

Kit 4: Practitioners' Guide to
Men and Mental Health

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FOREWORD

Professor John Macdonald

This section of the Resource Kit addresses the issue of the mental health of men. The topic of men and mental health has come to public attention in recent years partly on account of the high rate of male suicide, which this document addresses in Chapter Two. This is indeed an important and a rather neglected topic. The study done by the Men's Health Information and Resource Centre on male suicide, also referred to in the text, is part of the literature which draws attention both to the complex nature of mental health, its social as well as biological determinants and to the need to think mental health as well as mental illness. It is hoped that this part of the Resource Kit can help all those interested in the health of men to contribute to environments which foster the positive health of all males across the life course, from young boys to much older men.

INTRODUCTION

WHAT IS MENTAL HEALTH?

Mental health is understood to be “a state of wellbeing in which individuals cope, interact positively with the normal stresses of life, work productively and fruitfully, and are able to make a contribution to their community” [1]. It is not then “simply an absence of mental health problems, but a positive state of being for a person, involving a combination of internal and external factors, that enable the person to function in society, to their own satisfaction and broadly speaking, the satisfaction of others” [2]. Mental illness, then, “describes a situation involving some negative interactions with one’s environment and often with a number of diagnosable disorders that can significantly interfere with a person’s cognitive, emotional or social abilities” [1].

A discussion about mental health needs to take into consideration the determinants of mental health, that is, factors that determine or influence mental health both positively and negatively [3]. These include the biological/ physical, mental, emotional, social, economic, cultural and spiritual dimensions, which have been encompassed by the term *social determinants of health* as defined by the World Health Organisation [4]. The term relates to “factors in the social context of people’s lives which contribute to and are an essential dimension of the creation and maintenance of health in individuals and communities” [5]. The social determinants of health approach to male health is promoted in the Australian National Male Health Policy, ‘Building on the Strengths of Australian Males’, as a useful framework for understanding men’s health [6, 7].

WHO ARE THESE MEN?

TODAY’S BOYS ARE TOMORROW’S MEN

Men can be described, for instance, by age (or within an age range); role in the family (great grandfather, grandfather, husband, partner, father, father-in-law, son, son-in-law, step-son, brother, brother-in-law, uncle, nephew, cousin); by marital status (separated, single, never married or partnered, widowed, divorced); in the workplace (employee, employer); within a social network (friend, confidante, mentor/ee); in the community (leader, neighbour, volunteer); by cultural heritage and ethnicity (indigenous, non-indigenous); employment status (employed full time, part time, casual, self-employed, unemployed, underemployed, retrenched, semi-retired, retired); socio-economic status (poverty, comfort, privilege); housing status (homeless, tenant, mortgagor, owner); citizenship status (resident, immigrant, refugee); by sexual orientation; and physical and mental health status.

Why focus on men? Under current estimates, a boy born today could expect to live 79.7 years while a girl could expect to live 84.2. A male currently aged 65 could expect to live a further 19 years and female a further 22 years [8].

During those years:

- Females are more likely to have affective disorders (7.1% compared to 5.3% for males) whereas males are almost twice as likely as females to have alcohol harmful use disorder (3.8% compared to 2.1%)
- Females are more likely to be suicidal than males, with significantly higher rates of suicidal ideation (2.7% and 1.9%) whereas males are three to four times more likely than females to die by suicide

→ Females are more likely to use health services for mental health problems than males (40.7% compared with 27.5%) [9].

Why focus on men’s mental health? Gender, like other stratifiers, does not operate in isolation. It interacts in an additive or multiplicative way [10] with other determinants and within complex cultural, social and political environments [5]. Men’s mental health affects other men, women and children. By working alongside men towards positive mental health we all are contributing to the wellbeing of whole families and the communities in which we live.

WHO ARE THE PRACTITIONERS?

It is a sad fact that too many people with mental illness cannot identify the health professional they feel is responsible for their care. Too many people are out of sight [11].

The Practitioners are those who provide services to improve or enhance a person’s mental health status or to treat a mental health problem in order to restore them to good health and to assist them to maintain their mental health. The need for a multidisciplinary approach to effective mental health attests to the complexity of the ‘human being’ (or ‘being human’) in various contexts and with changing needs throughout the life course. Table 1 presents a snapshot of practitioners who are generally involved in mental health and by virtue of their roles (informed by training and experience) are aligned with dimensions of ‘the whole complex person’.

Table 1: Practitioners and their role in men's mental health

Practitioner	Role in men's mental health	Dimensions of the whole complex person
General Practitioner	Diagnosis, treatment, referral pathway to other health care practitioners	General health; biological; physical
Psychologist	Mental functions and behaviour, assessment, treatment, therapeutic interventions or techniques such as cognitive behaviour therapy	Psychological; behavioural
Mental health nurse	Assess and support individuals with mental health needs	Mental health; biological; social
Mental health counsellor	Counselling and therapies, treatment of affective disorders, substance abuse	Mental health; psychological; emotional
Social Worker	Intervenes to meet need and to improve context including social support	Social; relational; emotional
Occupational Therapist	Improves functional capacity and ability to engage in occupation; modify working environments and promote participation	Occupational; functional
Psychiatrist	Diagnosis, treatment and prevention of mental disorders; therapeutic intervention	Psychiatric; biological; behavioural
Generalist Men's Health Worker	Practical and emotional support; advocacy, counselling and guidance	General health; physical; social; emotional
Chaplain/Spiritual leader	Pastoral care; engages with belief, faith, meaning	Spiritual

For additional information

Beyondblue: www.beyondblue.org.au/the-facts/who-can-assist

Australian Institute of Health and Welfare: www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129544723^[12]

Practitioners' roles often overlap. For example, many may have the opportunity to actively listen to men, affirm and support them, identify areas of risk, counsel e.g. challenge negative thought patterns, convey positive health messages and guide them towards healthy decision-making. The decisions we and others make today can have implications or consequences for us and others tomorrow.

Male practitioners also need to monitor and manage their own mental health and wellbeing, identify or recognise signs of mental health problems in themselves and in colleagues and to seek, or offer, help when needed.

WHAT IS THE GUIDE?

The Guide takes a mental health promotion, population health and systems approach to men's mental health. Mental health promotion seeks to positively influence determinants of mental health through effective interventions [3]. Population health is 'focused on understanding health and disease in community, and on improving health and well-being through priority health approaches addressing the

disparities in health status between social groups' [13]. A systems approach recognises that each person (a complex system itself) is a part of other interrelated systems or groups (e.g. family) which are part of and interact within a much larger socio-cultural-political system.

This work aims to assist practitioners to:

- detect mental health problems in men
- open up and facilitate conversation with men
- increase men's mental health literacy
- support men in their support of other males to move towards positive health
- create or engender environments which promote men's mental health.

CHAPTER 1:

A MODEL OF DETERMINANTS OF MEN'S MENTAL HEALTH

A determinant of health is a factor or characteristic that brings about a change in health, either for the better or for the worse ^[14].

Determinants of men's mental health include work and family environments, biological/physical health, economic, social, psychological, emotional, housing, educational and spiritual factors. Others include subjective perception of health, health literacy, how the media portrays mental health, health services including practitioners and their practice, and so on, all within a broader socio-cultural-political context or system (Figure 1).

This Model of Determinants emphasises the potential bi-directional positive or negative effect on men's mental health. That is, each determinant can have a positive OR negative effect on men's mental health. For example, a generally positive family environment can buffer against a difficult working environment. However, there is a risk to men's mental health when both environments or systems are relationally strained, particularly over protracted periods of time.

'Work' and 'family' can be viewed as 'allies' ^[15] and a source of 'enrichment'. Greenhaus and Powell ^[15] define 'work-family enrichment as the extent to which experiences in one role improve the quality of life in the other role' (p.72). Men who are proactive in their relationships may be particularly likely to develop skills, receive information and social support, seek flexibility in the time they are expected to commit to role activities, and apply resources generated in one role to another ^[15] [pp.87,88].

Work is the area where many important influences on health are often played out ^[16]. This includes both employment conditions and the nature of work itself ^[17]. Stress and problems at work have been found to have a profound effect on the lives of men who attempt and take their own lives ^[18].

Mental illness can negatively affect work performance in terms of absenteeism or reduced productivity. It can also impact the performance and mental health of co-workers who may experience more stress and have to carry out additional work tasks ^[19]. People who are unemployed or have insecure employment fare worse physically and mentally than those in secure employment. Long periods of job insecurity can become a chronic stressor which can then lead to increased sickness absence and health service use. "Jobs with both high demand and low control carry special risks" ^[4]. Poor job quality (e.g. low pay, long hours, unskilled work, long commuting times) is associated with poorer mental health, so the type of job held may also be important to creating and sustaining mental health ^[20]. Moreover, a systems approach to job stress promotes interventions that 'reduce job demands', 'improve job control', and 'improve social support' ^[21].

Both what the person brings to the job as well as what the job brings to the person are relevant in the job stress process ^[21].

Mental health is most sensitive and more likely to alter in response to changes in job quality over time ^[22]. Being employed in fulfilling work can contribute to the resilience needed to overcome difficulties in life ^[18]. "Returning to work is consistently named as the number one objective for people with mental illnesses, even above health objectives" ^[11].

The Australian National Male Health Policy promotes healthy workplaces. This means not only minimising physical risk at work but encouraging efforts to make the work environment more rewarding of men's input. Relevant literature clearly indicates that the more satisfaction in one's work that a man has and the more control he can exercise over what he does, the healthier he is likely to be. This is one of the basic messages of the famous Whitehall

study which served to launch the social determinants of health research ^[23,24].

The considerable literature on the determinants of health identifies the complex interactions among determinants and across social, environmental, economic and biological dimensions ^[4, 18]. For example, physical problems can limit employment; lower income can result in fewer social engagements which can lead to poor self-esteem. Conversely, physical wellbeing can build confidence and motivation towards actively seeking employment opportunities.

Table 2 sets out these and other Determinants of mental health linked with evidence-based Risk and Protective Factors, as follows:

Figure 1: A Model of Determinants of Mental Health

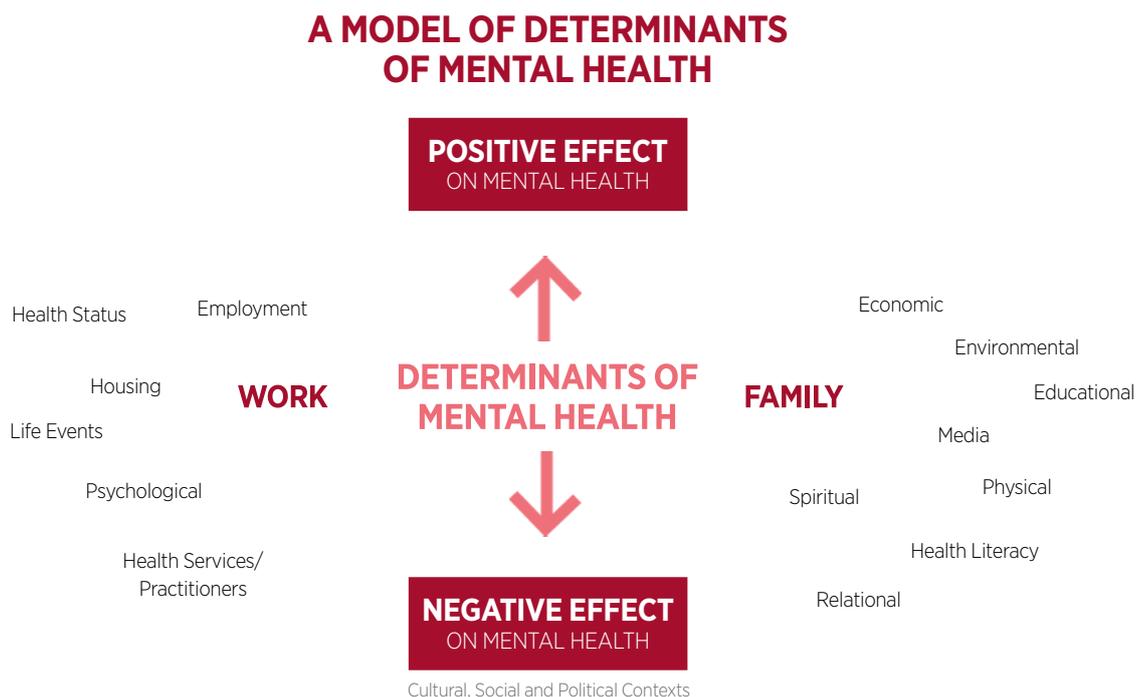


Table 2: Determinants, Protective Factors and Risk Factors

Risk Factors	Determinants	Protective Factors
Genetic predisposition ^[25] ; Adverse childhood events ^[26]	Biological	Early life ^[4] and positive life experiences
Physical health problems ^[27]	Physical	Physical exercise ^[13]
A feeling of helplessness and hopelessness; low self worth, not valued or respected ^[5, 28]	Psychological	Ability to adapt to change; a feeling of control; self-worth, respect from others ^[5, 28]
Lack of quality support/social isolation, Loss of partner/change status ^[4]	Familial/Friendship/Social support	Secure and supportive relationships Social support ^[4]
Stress and problems at work ^[18] ; under-employment; unemployment ^{[29][41]}	Employment	Work as positive influence on mental health ^[16]
Low socio-economic status Economic disadvantage ^[30]	Economic security	Financial stability/income security Economic activity ^[30]
Lack of meaning, purpose ^[31]	Spirituality/Meaning	Meaning, purpose ^[31]
Substandard accommodation; Food insecurity ^[32]	Housing/Environmental	Stable accommodation; Food security ^[32]
Stereotyping; health compromising messages ^[32]	Community Attitudes	Health promoting messages ^[32]

Other determinants influenced by Cultural, Social and Political contexts

Table 2 emphasises that the same determinant can be both a Protective Factor and a Risk Factor.

PROTECTIVE FACTORS

Protective Factors are internal and external resources that can have a positive effect on men's mental health. They create and sustain health, build resilience and capacity for men to cope with adversity and psychological and emotional distress.

Internal resources include optimism, resilience, psychological well-being, spiritual well-being, positive perception of mental health, self-esteem, sense of worth and value, meaning and purpose in life. *External resources* include familial, social, emotional, and workplace support, positive life events, cultural engagement, economic and job security, educational level and accessible health services. External resources, like social support, feed the internal capacity to deal with life and the internal resources bolster the capacity to engage with the wider world.

The Model (Figure 1) and Determinants (Table 2) call for an expanded concept of mental health which encompasses multiple determinants (as protective or risk factors) on mental health.

Health services and health practitioners have the potential to maximise protective factors and minimise risk factors which affect men's mental health.

RISK FACTORS

Risk Factors are determinants which negatively affect men's mental health. The interaction between determinants can have a cumulative effect that can be the impetus for men coming into contact with practitioners and health services. The cumulative effect of negative life events can weaken a person's capacity to cope and can lead to adopting unsafe coping mechanisms such as the use of drugs, drug abuse or addiction ^[18].

Strong relational ties including social participation, supportive relationships, involvement in group and community activity and networks are recognized as protective factors in maintaining good mental health while social exclusion and isolation are risk factors ^[11].

CHAPTER 2:

IDENTIFYING SIGNS OF DEPRESSION IN MEN

Rare is the family that will be free from an encounter with mental disorders. ^{[33][25]}

PREVALENCE AND INCIDENCE OF ANXIETY, AFFECTIVE AND SUBSTANCE USE DISORDERS AND SUICIDE

Prevalence usually measures the proportion of a population with a particular condition over a 12-month period or over the lifetime of an individual. Incidence measures the number of new cases diagnosed each year. According to the 2007 National Survey of Mental Health and Wellbeing (a national study based on a survey of 8,800 participants), mental health problems affected an estimated 3.2 million Australians in the 12 months prior to the survey. The highest prevalence was in the age range of 16-24 years (26%), followed by the prime child rearing years of 25-34 years (25%) and 35-44 years (23%) ^[34].

On account of anxiety, affective and substance disorders, it has been estimated that 45.5% of those aged 16-85 years (7.3 million people) experienced a mental disorder over their lifetime, while 20% (3.2 million people) experienced symptoms of a mental disorder over the 12 months prior to the survey ^[34]. These disorders, together with suicide, are of particular interest in terms of men's mental health.

Anxiety Disorders

Anxiety is defined as a 'feeling of worry: nervousness or agitation, often about something that is going to happen' or, of course, about something that has happened. Anxiety disorders were experienced by one in seven Australians (14.4%) in the 12 months prior to the 2007 National Survey, with posttraumatic stress disorder (6.4%) and social phobia (4.7%) being the most common types of anxiety disorders ^[34]. Prevalence rates of anxiety disorders were reported at rates of 5.7% to 15.4%

in children aged from 7 to 11 years old, and rates of 8.7% to 17.7% in adolescents aged 12 to 18 years old. The onset of anxiety disorders generally begins in early to late adolescence. For men, the prevalence of anxiety disorders peaks around 35- 44 years (14.9%) and then declines with age ^[9].

Affective Disorders

Affective disorders are disturbances in emotions, thought patterns and behaviour. In the 12 months prior to the 2007 National Survey, "6.2% of Australians aged 16-85 years had reported affective disorders (7.1% in females compared to 5.3% in males). For females, the prevalence started high and declined in the older age groups. While for males the prevalence started lower, peaked for 35-44 year olds and then declined with increasing age" ^[9, 34].

Depressive episode is the most common type of affective disorder in Australia with a prevalence of around one in twenty-five (4.1%) of the population; and dysthymia and bipolar affective disorder of 1.3% and 1.8%, respectively ^[9]. Depression can be pathological related to or caused by disease, and non-pathological which can be related to life circumstances often caused by loss and grief (such as bereavement, loss of self-esteem or respect, or loss of relationship with partner or children). Sometimes it can be more appropriate to speak of this non-pathological depression as 'despair' rather than using the clinical terminology of 'depression'. Aboriginal men tend to describe depression as 'excessive sadness or worry' or 'irritability', 'a weakened, displaced or misaligned spirit 'Kurunpa' ^[35].

Substance Use Disorders

According to the 2007 National Survey, "overall, males were more than twice as likely to have substance use disorders compared to females (7.0% compared

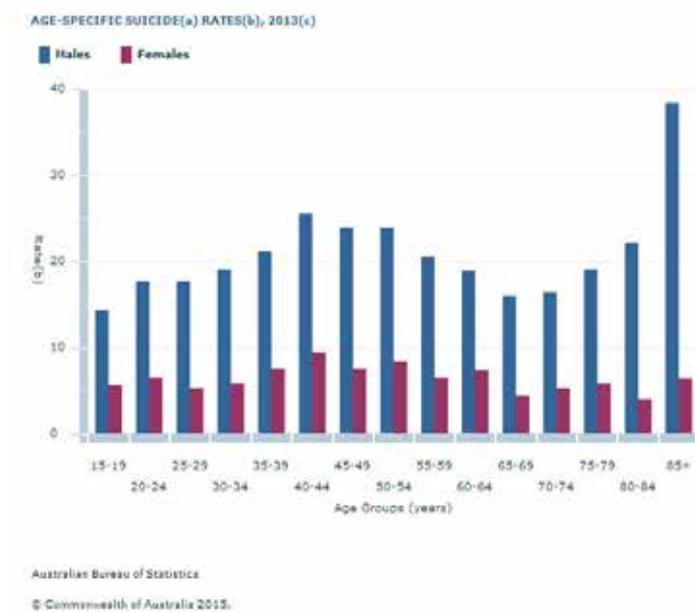
to 3.3%), with this difference being true for alcohol harmful use, dependence and any drug use disorder. In relation to specific drug use disorders, both harmful use of cannabis and dependence and stimulant harmful use were more common in males than in females" ^[9, 34]. Alcohol can be used by men to self-medicate feelings of depression ^[36].

Deliberate Self Harm and Suicide

The mental processes that bring a person to the dramatic point of suicide decision making are often characterised by a diminishing world view, an inhibited imagination, reduced intellectual diversity, a limited memory of good experiences, and an atmosphere of doom ^[37].

Suicide was the 15th most common cause of death in 2011 in Australia. Males accounted for approximately three quarters of suicide deaths and it remains the leading cause of death for males aged 15-44 ^[38] ^[30] and they are estimated to be four times more likely to die by suicide than females ^[39]. Male youth suicide rates in rural areas double those of metropolitan areas ^[40]. The following graph (Figure 2) highlights the gender difference in suicide rates ^[39].

Figure 2: Age-specific suicide rates 2013



Rate per 100 000 estimated resident population for each age group and sex [39].

This stark gender difference calls for symptom identification, a treatment regime, ongoing care and support and appropriate interventions as set out in the *NSW Suicide Prevention Strategy 2010-2015* with LIFE Framework's continuum of suicide prevention activities [41].

Risk factors for suicide include one or more attempts, copycat events, relationship problems and stressors and substance abuse. Methods specific to males include shooting, gassing (including carbon monoxide poisoning), poisoning, and drowning [42].

An interaction exists between significant factors including drug and alcohol abuse, work-related experiences, psycho-social health, adverse childhood experiences and relationship strain [18]. Relationship strain can lead to alcohol and drug abuse which can impact work situation or relationships [18]. For some men the burden of a series of difficult life events or 'cumulative effect' and a sense of not feeling valued is a significant characteristic of the pathway to suicide [18]. Moreover, suicide is not an individual act. It has social consequences. It can affect others and it can be the impetus for those who have been affected to enter the health system.

Not all individuals who are at risk of suicide will suicide [41]. It is vital to remember that "not all suicides can be attributed to mental health problems. Much of the causality lies in social, economic and cultural factors" [18].

Co-Morbidity

Of the 8,841 Australians aged 16-85 years surveyed in the 2007 National Survey of Mental Health and Wellbeing, 25.4% of people with an anxiety, affective or substance disorder had another mental disorder. Comorbidity was associated with greater health service use [43].

Depression and pain often occur together. Some researchers believe that this is due to pain and depression using the same neural pathways and neurotransmitters within the central nervous system. The presence of pain can make it difficult to diagnose depression [44]. When pain hides depression, depression is less likely to be discussed with practitioners as they may then miss the diagnosis or misdiagnose, which can lead to males not being appropriately treated. Men may instead report physical symptoms including loss of energy, sleep disturbance (too much or too little), weight loss, headaches, or aches and pain, or stomach upset.

Comorbidity of depression with aggression and alcohol abuse are significant predictors of severity of suicidal ideation [45].

The experience of mental health and ill health can affect men and women similarly, however, the expression of it can manifest differently in both sexes.

Men's Experience and Expression of Depression

Authors of the Diagnostic Statistical Manual of Mental Disorders (DSM, Version 5 released May 2013) [46] suggest that men and women experience depression similarly. However, the 'diagnosis' can be seen as not fully capturing the expression of depression in men.

An early study by Vredenburg and colleagues [47] of a clinical sample of men and women showed "both sexes presented with a cluster of core symptoms of depression (i.e. dysphoric mood, pessimism, sleep disturbance, weight loss, etc.). Males were more likely to report an inability to perform adequately at work, a marked difficulty in making decisions, a general lack of enjoyment and satisfaction, a concern with general physical health, and thoughts and/or plans of suicide" [47]. These comments point to Warren's call for "a sensitivity" on the part of practitioners "regarding the way in which men express feelings of depression" [48]. Depression in men can be hidden behind physical symptoms and missed in diagnosis which also makes measuring depression in men difficult. It can also (but not always) be mistaken for anti-social behaviour.

A trajectory of emotional distress labelled the 'Big Build' (Figure 3) extends the *meaning* of depression in men to include internal (acting in) and external (acting out) responses along

a continuum or upward escalation of depressive experience: *Avoiding it, Numbing it, Escaping it, Hating me Hurting you and Stepping over the line* [36]. These five elements are supported by examples from the literature and research evidence, as follows:

Figure 3 helps to identify avoidant, self-medicating, risk-taking, aggressive and escape behaviours on an upward trajectory which, left unchecked, can at some point escalate and be triggered with deleterious effect on men themselves, other men, women, children and even pets.

Men's behaviour may be out of character, more irritable or frustrated, indecisive, feelings of low self-esteem, lacking in energy, and physical pain or headaches, withdrawing, disorganisation, stopping usual activities, and unable to concentrate, negative thoughts of failure, worthlessness or hopelessness. Younger men with significant depressive symptoms may be missed by standard depression

screens and still be at elevated risk for negative outcomes associated with depression [19, 60]. If depression is not detected, it cannot be treated and may become severe and disabling [61].

The 'Big Build' model suggests that "depression is part of an inner emotional world that is contained, constrained or set free by gendered practices" [62].

"Focusing on antisocial behaviour or, more broadly, outward signs of mental health difficulties should not be at the expense of dealing with emotional difficulties. Neither should a focus on outward behaviour be seen as merely a way of reaching men so as to tackle their inner mental health" [62].

Not all men who are depressed will stay on this upward trajectory. Some men may bury themselves in work for years until something suffers – health, work or relationships.

Figure 3: 'Big Build': Men's experience and expression of depression

Theme	Manifestation	Examples from the Literature
Stepping over the line	Deliberate self-harm, suicide	Suicidal ideation/attempt, deliberate self-harm [39, 45] Suicide as leading cause of death for males aged 15-44 [38]
Hating me, hurting you	Aggression towards self and others, anti-social behaviour	Effect on mental health of men's partners [49, 50] Intimate partner aggression [51] Externalising behaviour [52] Road rage associated with alcohol use [53]
Escaping it	Escape behaviours, risk-taking	Risky sexual behaviour [54] Substance use disorders [52] Gambling related problems [55]
Numbing it	Self-medication	Internet and video game-playing [56] Drugs and alcohol [57]
Avoiding it	Avoidant behaviour	Over-work [58] Sickness absence /absenteeism [59]

Source and adapted from [36]

Asking men the right questions in the right way

Detecting depression in men can be a matter of guesswork [61][81] so it is important to ask men who are depressed the *right* questions (e.g. that tap into symptoms like the ones presented in the 'big build' model) in the *right way* (indirect) and in the *right manner* (non-threatening).

Here is an example of an indirect questioning route:

How are things at **home**? ...
How is your **relationship** with your partner/son/daughter? ...
How is **work**? Are things getting on top of you? ... Are you coping with the **demands of family life in general**?...
Have you been **feeling down lately**?
... depressed? ... or hopeless? [63][60]

Men often use a different vocabulary about the experience of 'depression' from women and health services [36, 63]. Knowing the person through continuity of care helps to identify behaviour that is out of character and to open up conversations with men on difficult-to-discuss, and actively listen to, issues that could be affecting their mental health.

POSITIVE HEALTH

- Check behaviours that may be out of character
- Identify presence of symptoms or signs of depression
- Identify causes of anxiety or irritability or anger
- Identify and explore problems in work performance, change in employment status, impairment in daily activities, relational strain, bullying, issues with sexual orientation or cultural identity
- Identify significant life events, both negative and positive
- Check physical effects (eg. stomach upset), disturbed patterns of sleeping and eating habits
- Explore men's perception of feeling valued or not or of self-worth
- Explore coping strategies
- Identify support networks (or lack thereof)
- Encourage access to appropriate support systems, eg. a trusted friend, counselling or telephone support.

CHAPTER 3:

POPULATIONS OF MEN AT RISK

The following populations of men at risk of poor mental health outcomes include those listed in the National Men's Health Policy [64]. This list is by no means a comprehensive one and there will be groups of men not listed here who have aspects of their lives that are health enhancing or risk factors for poor mental health.

Not all men in these population groups will have mental health concerns but they are at increased risk due to a range of factors and knowing this should help practitioners be more aware when working with these men.

Socioeconomically Disadvantaged

Social and economic disadvantage are directly associated with reduced life expectancy, premature mortality, injury and disease incidence and prevalence, biological and behavioural risk factors for ill health. In 2000-02, Australian men in the most disadvantaged areas experienced 21% higher death rates from heart, stroke and vascular diseases than their least disadvantaged area counterparts [64].

The social gradient is considered the most significant social determinant of health [16, 65]. This message has been reinforced by the WHO Report on the Global Commission on the social determinants of health [17], which highlighted the 27 year gap in life expectancy of a man born in a socially economically disadvantaged part of Glasgow in Scotland with a man born in a more affluent suburb.

Divorced, Separated, Widowed

Another determinant of mental health is, of course, the situation of being partnered or not. The 2007 National Survey of Mental Health and Wellbeing shows that one quarter of people who were separated, divorced or widowed (25.7% in males and 25.2% in females) had 12-month or longer mental disorders [9]. In other words, the lack of this form

of connectedness affects the mental health of both men and women.

Rural and Remote Living

Living and working in the country, especially the most remote parts of Australia may put people at a greater risk of health problems. The air may be cleaner than in the cities, the roads emptier, the noise levels lower, but the living is hazardous, especially for young men [66].

In Australian rural populations almost one-third of people have reported psychological distress. The highest rates of depression, anxiety and psychological distress were measured in middle-aged (45-54 years) men and women [40]. "Men in rural regions often have limited access to health services, recreational and support facilities. Men who own or manage farms commit suicide around twice the rate of the national average. Work for rural men is often physically demanding and potentially hazardous, particularly as they often work in isolated areas or on their own" [64]. The challenge to health services is to find ways of using what social contexts exist (including virtual ones) to support rural men and to find innovative ways of offering primary health care (PHC) mental health services to rural Australian men.

Aboriginal and Torres Strait Islander Men

Aboriginal and Torres Strait Islander (ATSI) males¹ have the worst health of any subgroup in Australia. Life expectancy of ATSI males is estimated at approximately 17 years less than average life expectancy for all Australian men (59 years and 76 years respectively for the period 1996-2001). There is also a 6 year gap in life expectancy between Indigenous men (59 years) and Indigenous women (65 years). Negative determinants include ongoing stresses of colonisation, experience of belonging to the Stolen

Generation, economic marginalisation, and bureaucratic surveillance, which have resulted in high rates of mental health problems including common psychiatric disorders, substance abuse and suicide. As community autonomy increases and Aboriginal people regain control of their local governments, services and cultural activities, suicide rates drop [67].

The primary explanation for the increasing burden of emotional distress in Aboriginal men has been described as 'severance from the foundations on which Aboriginal constructions of wellbeing were built – the Law [*Tjukurpa*], Family [*Walytja*], the Land [*Ngurra*], and the sense and obligations to care for and remain connected to the social, physical and emotional world around them [*Kanyini*]' [35].

Disability

Anxiety, depression and comorbid anxiety and depression have a differential effect on disability according to age. Older adults with any of these symptoms report higher levels of disability than younger adults [68].

Although the link between disability and mental health is well known, the gendered nature of this link remains another under-researched area.

Veterans

Australian veterans consistently self-assess their health below that of the general community and also below that of military personnel who have not been deployed to operational areas. Symptoms of common mental disorders and alcohol misuse are frequently reported in UK armed forces personnel [69]. Sons and daughters of Vietnam Veterans are also at greater risk of suicide [70].

1. Aboriginal and Torres Strait Islander people prefer to use the term 'male health' as a more inclusive expression as it includes men and boys of all ages.

Criminal Justice System

In 2012, there were 27,182 men in custody in Australia making up 95.5% of the prison population ^[71]. Men with a history of incarceration have death rates four times higher than men in the general community. Most of these deaths result from suicide, drug and alcohol abuse and homicide, and occur within the first few weeks of release from prison ^[72].

A preoccupation with the health of this population of men should include not only services for incarcerated men but services for released prisoners who are more at risk of suicide than many other groups. The work of the Shed in Mt Druitt (see case study) considers unnecessary imprisonment, especially of Aboriginal men, as a social determinant of ill health and sometimes suicide ^[73]. This is concerning given that ATSI people make up 27.2% of the Australian prison population ^[71].

Aged Care Residents

Depression among aged care residents is high. Between 36 and 50 percent of older men classified as 'high care' in residential aged care facilities are likely to have depression. Depression can be difficult to diagnose in this group because of other co-morbidities ^[74], such as dementia.

Sexual Minorities

Men from minority groups including those who are gay, bisexual, transgender or intersex, may face discrimination, marginalisation and social exclusion and as a result are more likely to experience anxiety and depression at higher rates than the general community and are at greater risk of suicide and self-harm ^[6, 75].

Refugees

Refugees have increased risk of poor health, cumulative trauma, including the loss of their traditional cultural male roles in Australia. Male refugees at risk of health problems include former soldiers

who have been exposed to injuries and trauma, elderly men, men separated from their families, including those who are seeking asylum in Australia and may be cut off from loved ones and living with the anxiety of their uncertain status ^[76].

Men from Culturally and Linguistically Diverse Backgrounds

Different cultures have different ways of understanding and talking about mental health and illness, as well as having various cultural practices and beliefs that enhance or impede a person's mental health ^[77].

The attitudes and practices of the wider culture also impact on CALD men's mental health. A person's health is dependent, to a considerable degree, on the extent that they feel accepted or excluded. Racism and xenophobia are health risks not just as a series of unpleasant or hurtful incidents, they can also be internalised by members of these groups leading to feelings of inferiority and low self-worth. There is also a growing body of evidence that those who perpetuate racism face increased health risks themselves ^[78].

It is beyond the scope of this kit to explore what is health enhancing and what is a risk factor for men from all the various cultural and linguistic groups in Australia. Information and resources on the mental health of men and boys from different cultures can be found at some of the websites listed in the Resources section' of this document.

It is also important to note that men can be a member of one or more groups. 'Consider, for example, a 70-year-old male who identifies as Indigenous and lives in a regional area of lower socioeconomic status' ^[13].

CHAPTER 4:

WORKING WITH MALES

Certain types of mental and behavioural disorders, such as anxiety and depression, can occur as the result of failing to cope adaptively to a stressful life event. Generally, people who try to avoid thinking about or dealing with stressors are more likely to develop anxiety or depression, whereas those who share their problems with others and attempt to find ways of managing stressors function better over time ^[33].

GROUPS OF MALES

Males can be grouped according to their 'life span' ^{[79][100]} and 'life stages' ^[11]. Capturing the sub-groupings of younger and older middle years can be helpful when considering issues such as peak suicide rates in the younger middle years and the under-researched older middle years.

- early childhood (0-5)
- early school years (5-12)
- adolescence and emerging adulthood (12-25)
- younger middle years (25-45)
- older middle years (45-65/70)
- later life (65/70+)

Embedded in these life stages are 'key transition points' as set out in the National Male Health Policy which include early childhood, commencing school, onset of puberty, adolescence, initiation (particularly in some Aboriginal and Torres Strait Islander communities), leaving school, becoming an adult, marriage/cohabitation, separation, divorce, becoming a widower, becoming a father and a grandfather, unemployment and retirement ^[6]. *Pathways to Manhood* (refer to 'Links' section of this resource) or rites of passage are intended to help males at these different stages to interact positively with their total environment and build confidence, self-esteem and healthy relationships from one stage or transition point to the next.

Early Childhood (0-5)

The physical, social and emotional environments of the first years of life have a determining influence on a person's skills development, education, and occupational opportunities and ultimately their health throughout life ^[4,17].

Parental mental health positively and negatively influences infants and young children. Children of depressed parents have been found to have high rates of anxiety, disruptive, and depressive disorders that begin early, often continue into adulthood, and are impairing ^[80]. Depressed parents are also less likely to engage in 'enrichment activity' with children such as reading, singing songs and story-telling ^[81]. However, research suggests that remission of maternal depression may have a positive effect on both mothers and their children ^[80].

POSITIVE HEALTH

- Promote safe, healthy environments that support parents of infants and young children
- Promote physical, social, emotional, cognitive and language development
- Promote engagement in enrichment activity with children
- Support families with young children
- Provide early intervention for fathers (*Goals by life stage* ^[11])

Early School Years (5-12)

School is an environment which can impact the mental health of children, both positively (e.g. encouragement and positive reinforcement) and negatively (e.g. bullying).

During these early school years, the mental health of both mothers and fathers continues to influence children. For example, "depression in fathers during the first year of a child's life can have a detrimental impact on their child's behaviour, and social and emotional development at the point of school entry" ^[82]. It has also been found to be significantly related to offspring internalizing and externalizing psychopathology and father-child conflict ^[83]. Children from low income, step-parent, solo parent and blended families tend to be most vulnerable.

POSITIVE HEALTH

- Promote schools as environments for building positive identities in boys
- Identify mental health problems within family and school contexts
- Target early intervention strategies to avoid increased risk of anxiety and depression in adolescence
- Build resilience and effective coping strategies
- Support children to establish basic skills to adapt educationally and socially (*Goals by life stage* 5-12 ^[11])

Adolescence and Emerging Adulthood (12-25)

Adolescent depression is one of the most frequently reported mental health problems, representing approximately 26.5% (one in four young people in this age group). 75% of onset of mental illness occurs prior to the age of 25. Causes may include, for example, identity/belonging, sexual orientation, body image, life expectations and establishing independence.

Repercussions include: lost productivity, lost working days per annum, lower rates of educational attainment further limiting skills development and earning potential, and related health and welfare costs [19][16]. On a positive note, Australian research suggests that interventions focused on the ages of 12-25 years have the potential for greater personal, social and economic benefit [19, 84].

POSITIVE HEALTH

- Identify peer group support, friends and family support
- Pursue education and employment options and opportunities
- Promote male-friendly family educational and employment and health care environments (Goals by life stage 12-25, Blueprints [11])

Younger Middle Years (25-45)

Dividing men's mid-life into two stages from 25-45 and 45-65 is not common but is something that this guide has done to highlight the different mental health challenges and outcomes that occur in these groups. These age ranges are somewhat arbitrary and many of the experiences in a man's 'younger' middle years will continue into the 'older' middle years. Changing social trends, such as early retirement and some men becoming fathers later in life, also means that the determinants of mental health are not clear cut and will vary from man to man.

The middle years are predominantly marked by increasing responsibility in adulthood including relationships, parenting, economic productivity, life events and transitions, "these have the potential to enhance mental health, but also pose challenges that can threaten mental health" [79]. This group is also at high risk of suicide, peaking in the 40's [39][20]. Since there are considerably more men than women dying by suicide in Australia, and many in this age group, it is clear that promoting positive mental health is crucial at this stage of life.

This is also the time when many men and women find themselves part of the so-called 'sandwich' generation caring for both young children and their ageing parents. This is increasingly becoming a source of stress for many as they negotiate this changing family dynamic [85].

POSITIVE HEALTH

- Acknowledge gender difference at key transition points - transition points occurring for this age group can have a particularly strong impact on men's mental health for better or for worse
- Identify specific needs, eg. risk of suicide, family relationship strain, peer support.
- Promote social engagement with peers and mentors - older men who have successfully lived through life experiences associated with this age group.

Older Middle Years (45-65)

The 'older middle years' of men encapsulate a number of major life circumstances including renewed satisfaction or otherwise with one's work environment, the raising of adolescents, career change as well as ageing concerns, chronic health conditions and changes in marital status including separation and loss. Cumulative losses around social bonds have been found to be central to older men's depression, apathy concerning living, and thoughts about suicide [86].

Another potential cause of stress for men of this age is the increasing phenomenon of mature aged unemployment. Work is an important social determinant of mental health [4] often providing real satisfaction for men, including that of providing for their family. However, people in their 50s who are retrenched or made redundant report difficulty in finding employment due to their age. According to Perry there are more men than women in this situation who are seeking fulltime work but are unlikely to find anything due to ageism. Men in this situation have to adjust to not only reduced income but decreased social status and feelings of self-worth [87].

Retirement from paid employment is a time when the mental state of men requires considerable resilience given that relationship to employment is an important determinant of health and that this group of men is one of those groups most at risk of suicide [39]. This time of transition is difficult for most men, having a supportive network of family and friends and finding meaningful activities is one way in which many men successfully negotiate this challenge and have a positive retirement. Men without such social networks and with only limited opportunities to participate in meaningful activities are at increased risk.

Notwithstanding that there is a certain amount known about older men, the population of men in middle age remains under-researched.

Older Middle Years (45-65) continued

POSITIVE HEALTH

- Acknowledge the positive contribution of men to society and their families
- Target early intervention strategies
- Recognise and acknowledge key transitions in this age group
- Encourage the identification of need in self and other men
- Promote social inclusion and engagement, e.g. The Men's Shed movement
- Support mid-life, manage health, stable home, caring relationships, meaningful activity (Goals by life stage 45-65/70 [11])

Later Life (65/70+)

This later life group includes sub-groups of older men and a growing population of very old men who are living into their 90's but often with chronic and co-morbid conditions. Both groups have lived through different social, economic and political eras shaped by wars, economic depressions and recessions, periods of austerity, and social change [2]. Yet 'many males in this age group make valuable contributions to their families and communities through unpaid household, volunteer and community work; paid work; and through care of children and grandchildren, spouses and relatives with disability' [13]. Moreover, this can also be a time in a man's life when wisdom, knowledge, life experiences and hard-earned skills can be handed down to younger generations.

POSITIVE HEALTH

- Encourage a culture of appreciation of the contribution of this group of men
- Identify any confounding factors related to this age group
- Promote initiatives which contribute to meaning in retirement: activities, contribution to family and others
- Support healthy ageing, capacity of living in own homes (Goals by life stage 65/70+ [11])

Essentially, "valuing the role of males at different stages of their lives can be an important way of fostering health and wellbeing.

A life span and key transition points approach acknowledges males at each stage of growth and development. Seeing health as the interaction with the total environment helps us see the importance of positive nurturing from early in life, whereas adverse life experiences such as neglect, abuse in childhood and an unsupportive early childhood environment can have a lasting deleterious effect on adult life [18]. It is therefore critical that healthy environments be sustained to enable different groups of men and practitioners working with them to engage positively and to manage effectively any stresses and losses men may encounter along the way. This is what Antonovsky meant by salutogenesis, the process of resisting ill health and building positive wellbeing [5, 28, 88].

POSITIVE HEALTH

- Respect gender differences in the expression of emotional distress
- Support environments which offer men the real possibility of getting off the trajectory of the 'big build'
- Ask men indirect questions or a question route that lead to sensitive issues in a non-threatening manner
- Identify barriers and explore facilitators

MENTAL HEALTH LITERACY FOR MALES

Mental health literacy for males
Health literacy ... is a key determinant of population health [89].

The way in which men and boys are sometimes portrayed in the media means that it can be difficult for boys to find appropriate role models [90]. "Young men need to see emotional expression as a skill that improves with practice, and need to build an emotional vocabulary and be able to access the vulnerable feelings that are likely to underpin expressions of anger" [60][p. 9]. Adaptive expression of emotion and help-seeking should be framed as a sign of responsibility, leadership and courage rather than weakness.

Mental health literacy is made up of several factors, including:

- the ability to recognise specific disorders or different types of psychological distress,
- knowledge and beliefs about risk factors and causes,
- knowledge and beliefs about self-help interventions,
- knowledge and beliefs about what professional help is available,
- attitudes which facilitate recognition and appropriate help-seeking, and
- knowledge of how to seek health, in this case mental health, information [91]

The level of available and appropriate support will either facilitate or hinder a person's coping. Men may need to rely on others to recognise the symptoms, e.g. acting out of character, sleeping too much, withdrawing from (potentially) helpful others, losing weight. A person who is suicidal may have a plan, may drop hints, and may not be able to reason through why they are feeling the way they do, they may convey a sense of shame, blame, guilt, diminished self-worth, and feelings of blackness, helplessness and hopelessness.

Practitioners are well-placed to introduce or incorporate mental health literacy into their practice with men and boys. By increasing men's mental health literacy, men may in turn positively influence other males. Thus the relationship between the practitioner and males and how mental

health is approached is aimed at improving the effectiveness of services offered towards health outcomes.

Practitioners can also provide men, opportunistically, with the know-how, know-where and know-why in terms of mental health literacy skills to prevent and promote mental health in themselves and in others. But working with men doesn't stop there. One of the aims for health professionals ought to be to steer men towards men working with other men to identify signs of emotional distress or relational strain.

POSITIVE HEALTH

Steps should be taken to:

- Identify need
- Promote men's health literacy
- Explore programs, type and level of intervention required
- Consider the environments which foster or threaten the balance of men's mental health
- Identify need with reference to determinant/s – employment status, job satisfaction
- Locate and refer to appropriate support
- Develop mental health promotion that targets men who are at risk, such as unemployed men, in locations where men are and in ways men will respond to

REMOVING THE BARRIERS TO MEN'S HELP-SEEKING AND HEALTH SERVICE USAGE

According to the 2007 National Health and Wellbeing Survey, service use for mental health problems was higher among females than males. Rates of help-seeking among young Australians, and particularly among young men, remain low in spite of adolescent depression being one of the most frequently reported mental health problems, representing approximately 26.5% (one in four young people) - only 13% of young men received any care at all for their mental illness [9].

Help-seeking patterns include use of the internet and on-line support, e-health, self-help, peer support and other informal networks which can delay seeking professional help [92]. For young men in particular, outreach services may make it as easy as possible for young men

to access care by taking professional services to them, rather than coming to the provider or practitioner [93].

Barriers to men's help-seeking can be both internal and external to men. Internal barriers can include men's perceived stigma, stereotyping (as weakness), discrimination often perpetuated by men themselves, but also by women and health practitioners. External barriers include inadequate or inappropriate (non-*male friendly*) health services. Removing internal and external barriers to men involves the persistent conveying of positive health messages at individual, community and health service levels, together with men taking responsibility for their healthy behaviours and of other men, boys and infants. Identifying and then removing the barriers to men's help-seeking is expected to yield positive mental health outcomes for men, women and children.

The National Male Health Policy speaks of *male-friendly* health services. This implies a heightened consciousness among GPs and community health services of the need for this approach and to understand that men may express their distress differently from women. It also points to the interesting phenomenon of the growth of the Shed movement in Australia (over 900 at the time of publication) which are clearly fostering supportive mental health environments for men especially in the older age group.

CHAPTER 5:

CONNECTING MEN WITH ESSENTIAL SERVICES

Male health in Australia can, and should, be improved but it can happen only if governments, health organisations, communities and individuals work together to take action.

National Male Health Policy, 2010

Depression tends to pull the person inwardly and introspectively. Getting involved and doing things for other people, particularly others in need, is a good pathway out of depression. Being connected and doing something helpful also adds purpose and meaning to life.

Practitioners are well placed to prompt positive thoughts in men and to promote participation in meaningful activities, to guide appropriate referral, and to provide men with information about programs and available resources.

A number of Programs and Resources are included in the Appendix to this guide.

INTERSECTORAL COLLABORATION: A CASE STUDY

One of the three pillars of the primary health care approach is that the health sector should work together with other sectors which contribute to health. This is what is meant by the policy of intersectoral collaboration [94].

The World Health Organization defines Intersectoral Collaboration as:

A recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes...in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone [95] [p.3].

'Intersectoral collaboration is complex. It is a dynamic unfolding of interrelated actions and processes that continually impact

each other. ... the focus and dynamics of collaborative efforts are very much driven by context and the specific social or community problems being addressed' [96].

The Mt Druitt Shed is an example of this approach. Services working separately from each other often have difficulties in reaching men, whose needs, in any case, are often inter-related - the social with the psychological and so on. This Shed, like all sheds, is a men's space and not an outreach office for mental health or other services, but on given days all the sectors can access men there. It is a genuine case of intersectoral collaboration [97].

THE SHED, MT DRUITT

The Shed is a case study providing an example of men (and women) helping men to shift from **NEGATIVE** effect (ill-health) Risk Factors of determinants of mental health to **POSITIVE** effect (health and well-being) Protective Factors (see Table 2).

Connecting men with essential services

The Shed was established in 2004 as a partnership between the Western Sydney University, Men's Health Information & Resource Centre and services in Western Sydney, including the Holy Family Church at Mount Druitt where it is located.

The Shed provides support to men at risk of serious stress and suicide, generally on account of cumulative stress often due to disadvantaged situations. Most of these men are of Aboriginal and Torres Strait Islander origin since these are often the men most at risk. The Commonwealth Department of Health and Ageing has funded the project since 2004 from funds available in the National Suicide Prevention Strategy [41][41].

The Shed is a 'mental health service' like no other. Rather than providing counselling or therapy workers at The Shed listen to the men and re-direct

them to points of service such as housing providers, legal services, mental health, or financial counsellors. Mental health cannot be achieved and maintained when other factors remain unresolved (as set out in Table 2).

Alternatively, service providers access men at The Shed, notably probation and parole, mental health housing and employment services. The services are encouraged to see the Shed as the men's space and not an extension of their offices. This creates a 'one stop shop' for men as they can access acute mental health services through The Shed, while at the same time some of the social determinants of their poor mental health, such as housing and legal concerns, are also being worked on.

This holistic concept of health enjoys enormous support from the Aboriginal and Torres Strait Islander community, with elders actively involved in The Shed's direction.

For further information see:

westernsydney.edu.au/mhirc/mens_health_information_and_resource_centre/research_projects/the_shed

RESPONDING TO MEN'S MENTAL HEALTH: SUMMARY

Practitioners will come into contact with males at every life stage and key transition point. The main messages from this guide emphasise:

- The importance of taking a life span, life stage, and key transition points approach to males across all age groups where each stage or transition point warrants care and attention to avert mental health problems and to strengthen positive mental health.
- Suicide rates in males remain a persistent and disturbing fact. All professionals in contact with men should be aware of men's expressions of distress.
- Determinants and their interaction can effect men's mental health bi-directionally – positively (protective factors) or negatively (risk factors).
- Particular attention needs to be given to men at risk of poor health outcomes with specific focus on key transitions and at risk groups.
- *Protective Factors, Internal and External Resources, and Mental Health Literacy* can all contribute to coping strategies which improve and sustain men's mental health.

Men's mental health involves the interaction within and between the positive determinants including the role of practitioners and the environments which foster or threaten the balance of a man's mental health. "Any attention on the individual should not be at the expense of considering the social structures that make problem-focused mental health difficulties a possibility in contemporary society" ^[62].

The quality of the practitioner/male relationship is crucial in engaging with men effectively and towards positive health. In contrast to the stereotypical view that 'men don't talk', there is evidence that men are indeed willing to talk about difficult issues including emotions that are hard to bear. Males at any life stage or transition point just need a safe, trusting environment in which to do so ^[61, 63].

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APPENDIX:

PROGRAMS AND RESOURCES

The following are a selection of programs relevant to men and mental health.

beyondblue	The national depression initiative. beyondblue also has specialised information on depression for men and for many of the groups discussed in this guide, including Aboriginal and Torres Strait Islanders, young people, GLBTI, and CALD.	http://www.beyondblue.org.au
Black Dog Institute	The Black Dog Institute is a leader in the diagnosis, treatment and prevention of mood disorders such as depression and bipolar disorder.	http://www.blackdoginstitute.org.au/
Mental Health First Aid	A course which teaches to identify and help people with mental health problems.	https://www.mhfa.com.au/
	Youth Mental Health First Aid Course Information.	https://www.mhfa.com.au/cms/youth-course-information/
Orygen Youth Health (OYH)	OYH is a youth mental health organisation, research centre and integrated training and communications program, based in Melbourne, Australia.	http://oyh.org.au/
Headspace	The Australian National Youth Mental Health Foundation which provides support, information and advice to young people aged 12 to 25.	http://www.headspace.org.au/
SANE Australia	The national charity working for a better life for people affected by mental illness.	https://www.sane.org/
Association of Relatives and Friends of the Mentally Ill	ARAFMI is a community organisation of families, carers and friends of people living with a mental illness.	http://www.arafmi.org/
Mengage	This site brings together diverse resources about different men's health programs, publications, and research projects.	http://www.mengage.org.au/
Mental Health in Multicultural Australia (MHIMA)	MHIMA provide a national focus for advice and support to providers and governments on mental health and suicide prevention for people from CALD backgrounds.	http://www.mhima.org.au/
NSW Transcultural Mental Health (TMHC)	TMHC is a NSW wide service that promotes access to mental health services for people of CALD backgrounds.	http://www.dhi.health.nsw.gov.au/tmhc/
STARTTS	The NSW Service for the Treatment and Rehabilitation of Torture and Trauma.	http://www.startts.org.au/
NSW Refugee Health Service	Report and factsheet on physical and mental health of refugees including refugee men.	http://www.swslhd.nsw.gov.au/refugee/
MoodGYM	MoodGYM is an interactive web-based program designed to prevent depression and anxiety. You can read about Cognitive Behaviour Therapy (CBT) on their website. MoodGYM was developed by The Centre for Mental Health Research at The Australian National University.	www.moodgym.anu.edu.au

National Rural Health Alliance	The peak non-government organisation for rural and remote health. Its vision is good health and wellbeing in rural and remote Australia. It has a broad representative base and works on a wide front, including through the social determinants of health, such as rural education.	http://nrha.ruralhealth.org.au/
ReachOut.com	ReachOut.com is Australia's leading online youth mental health service. It is an initiative of the Inspire Foundation. It offers a number of self-help resources including fact sheets to assist young people 'tackle life's challenges and become mentally fit and resilient'.	www.reachout.com.au
Alcoholics Anonymous	A non-profit group for people for whom alcohol use is a major problem. Also information for practitioners.	http://www.aa.org.au/
Narcotics Anonymous	A non-profit group for people for whom drugs are a major problem.	http://na.org.au/
Pathways Foundation	A national harm prevention charity that assists young people make the fundamental emotional shift from being a child to becoming a young adult. The way Pathways does this is by providing contemporary community based rites of passage for boys 13-15 years and for girls 12-15 years. The Pathways Foundation is a not for profit harm prevention charity. Pathways aims to assist in the transition from boy to young man – a critical period in the life of any teenage boy, and to inspire boys to have a vision and reach their potential.	http://www.pathwaysfoundation.com.au/
Australian Men's Shed Association (AMSA)	Men's sheds are not mental health 'services' but they have helped many men create meaning in their lives through connection with others and through contributing positively to their community. AMSA is the peak body for community men's sheds in Australia and contact details of local sheds across Australia can be found on their website.	http://www.mensshed.org/
Menshed Online	A partnership between AMSA, beyondblue and others providing information on men's sheds as well as mental and physical health tips.	http://www.theshedonline.org.au/
Wheatbelt Men's Health	Men's health community education program reducing the risk of suicide in regional WA.	http://www.regionalmenshealth.org.au/

There are a range of consumer and self-help groups for people going through potentially stressful life events (such as retirement or bereavement) or provide support and advice for coping and living with a mental illness. To find out what groups are available in your area contact your local community health centre, neighbourhood centre, or GP.

GLOSSARY

Affective (mood) disorders	Disorders that involve mood disturbance, examples include bipolar affective disorder, depressive episode and dysthymia. They include major depressive disorder, bipolar disorder, and dysthymia
Agoraphobia	Fear of being in public places from which it may be difficult to escape. Includes fears of leaving home, crowds, or travelling in trains, buses or planes. A compelling desire to avoid the phobic situation is often prominent.
Anxiety disorders	Disorders that involve feelings of tension, distress or nervousness. This may include: panic disorder, social phobia, agoraphobia, generalised anxiety disorder (GAD), post-traumatic stress disorder (PTSD) and obsessive-compulsive disorder (OCD).
Depressive episode	A state of gloom, despondency or sadness lasting at least two weeks. The person usually suffers from low mood, loss of interest and enjoyment, and reduced energy. Sleep, appetite and concentration may be affected.
Dysthymia	A disorder characterised by constant or constantly recurring chronic depression of mood, lasting at least two years, which is not sufficiently severe, or whose episodes are not sufficiently prolonged, to qualify as recurrent depressive disorder. The person feels tired and depressed, sleeps badly and feels inadequate, but is usually able to cope with the basic demands of everyday life.
Health	The positive interaction between a person and their total environment (physical, mental, social, emotional etc.). Illness being the reverse of this [5].
Major depression	A depressed mood that lasts for at least two weeks. This may also be referred to as clinical depression or unipolar depression
Psychosis	Any form of severe mental disorder in which the individual's contact with reality becomes highly distorted. Psychosis can involve hallucinations (seeing or hearing things that are not there), paranoia (feeling that everyone is against you), and delusions (false beliefs that are not shared by others).
Psychotic depression	A depressed mood that includes symptoms of psychosis.
Salutogenic	The internal and external factors that cause and maintain health.

For additional information: <http://www.beyondblue.org.au>



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