# National Male Health Policy Supporting Document

## HEALTHY MINDS

The National Male Health Policy has a focus on raising awareness about preventable health problems that affect males, and on targeting males with the poorest health outcomes. This document addresses some of the evidence from the literature about male mental health, including specific mental health issues and male help-seeking behaviour.*

## What's in this document?

This document first looks at various **issues** to do with male mental health:

- Mental health as part of a holistic approach
- Mental health in Australia
- Depression
- Anxiety
- Suicide
- Optimal health outcomes for males
- Help-seeking behaviours, and
- Equity between groups of males.

It then looks at **action** that is being taken:

- Government action – policies and initiatives
- Community action – working together, and
- Personal action – what males themselves can do.

* Most of the discussion refers to 'males', but on occasions the term 'men' is used to remain consistent with wording used in research papers. Wherever possible, male data is used but, when not available, data has been used for both males and females for particular population groups or issues where inferences for male health can reasonably be drawn.

## Mental health as part of a holistic approach

The consultation forums held for the National Male Health Policy overwhelmingly confirmed the importance of adopting a holistic definition of health which includes mental health and wellbeing. They also confirmed the need to promote better mental health and wellbeing. Participants were very keen for coping and resilience skills in young males to be considered as a building block for better mental health and wellbeing in adult life.

### What is mental health?

'Mental health' is defined as 'a state of emotional and social wellbeing. It influences how an individual copes with the normal stresses of life and whether he or she can achieve his or her potential.'[1]

A 'mental illness' is defined as 'a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities'.[2] The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or the International Classification of Diseases-10 (ICD-10). Mental illness accounts for 13 per cent of the total burden of disease in Australia, and 24 per cent of the non-fatal burden of disease.[3]

A 'mental health problem' is defined as diminished cognitive, emotional or social abilities but not to the extent that the criteria for a mental illness are met.

### Raising awareness

In terms of mental health, this document seeks to raise awareness about depression, anxiety and suicide. All three are leading causes of burden of disease in Australian males, and suicide is also a leading cause of death for young males.[4, 5] Some key equity issues in the experience of mental disorders must also be considered.

The focus is not just about preventing mental illnesses in males but about promoting the benefits of mental health and wellbeing, which reach into almost every aspect of health and life.

In many respects, having a healthy mind is the cornerstone of male health, as mental health and wellbeing act as significant determinants of physical health, social and economic outcomes.

As the World Health Organization (WHO) report *Mental Health: Resilience and Inequalities* (2009) states:[6]

> Mental health and mental wellbeing are fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens.

The WHO report outlines some of the benefits of mental health and wellbeing and the risks involved as these decline.

*Healthier lifestyles* – The absence of positive mental health has been shown to be an equal or greater risk factor for chronic disease than smoking, and an equal risk factor to high blood pressure and cholesterol. Also, the capability and motivation to choose a healthy lifestyle are strongly influenced by mental health and wellbeing. Promoting positive mental health has been shown to reduce behavioural risk factors for preventable diseases, and positive mental health is associated with improved sleep, exercise, diet, reduced alcohol intake, smoking, and delinquent activity.

- *Improved physical health* – Mental health problems are associated with much higher rates of physical illness, including higher prevalence of, and premature mortality from, coronary heart disease, stroke, diabetes, infections and respiratory disease. Positive mental health has been shown to improve overall health, stroke incidence survival and protect from heart disease. Also, the risk of coronary heart disease is directly related to the severity of depression, with a one- to two-fold increase in those with minor depression and a three- to five-fold increase in those with major depression[7]. On a gradient, those with positive mental health have the lowest risk of cardiovascular disease, compared to people with moderate levels of mental health and with depression, who have a higher risk.
- *Broader determinants of health* – Mental health and wellbeing are significant determinants of a wide range of social and economic outcomes (known as the broader determinants of health).

The benefits of positive mental health and wellbeing include:[8]

- Higher educational attainment
- Greater productivity, employment and earnings
- Better relationships with adults and children
- More social cohesion and engagement, including more pro-social behaviour and less crime, and
- Improved quality of life.

## Mental health in Australia[9]

The 2007 National Survey of Mental Health and Wellbeing found that around one in five Australian males (18 per cent) and females (22 per cent) met the diagnostic criteria for a mental disorder in the 12 months prior to the survey.

The survey found that males were more than twice as likely as females to have substance use disorders (7 per cent compared to 3 per cent). On the other hand, females were more likely than males to have experienced anxiety disorders (18 per cent compared to 11 per cent) and affective (depressive) disorders (7 per cent compared to 5 per cent).

The survey also found that approximately three-quarters (75 per cent) of males who experienced a mental disorder in the previous 12 months reported very high levels of psychological distress. However, despite not having experienced a mental disorder in the previous 12 months, one-quarter (26 per cent) of males reported high levels of psychological distress.

## Depression

A person may be depressed if, for more than two weeks, they:

- Feel sad, down or miserable most of the time, or lose interest or pleasure in most of their usual activities, **and**
- Experience symptoms in at least three of the following four categories (the full list is at www.beyondblue.org.au):
  - Behaviour (e.g. stopped going out, withdrawing from close family or friends, overuse or reliance on alcohol, illicit drugs or prescription drugs)
  - Thoughts (e.g. 'I'm a failure', 'Life's not worth living', 'Nothing good happens to me')
  - Feelings (e.g. overwhelmed, irritable, no confidence, indecisive, miserable)
  - Physical (e.g. tired all the time, change of appetite, sleep problems).

The 2007 National Survey of Mental Health and Wellbeing found that a depressive episode was experienced by 3 per cent of men and 5 per cent of women, and dysthymia was experienced by 1 per cent

of men and 1.5 per cent of women. Dysthymia is defined as 'at least two years of constant, or constantly recurring, chronic depressed mood, where intervening periods of normal mood rarely lasting for longer than a few weeks'.[10]

Research reported by *beyondblue*[11] has found that depression is one of the most common mental health problems experienced by young people[12], and highlights the importance of investing in the prevention and treatment of depression in younger people because:

- The onset of mental health issues such as depression, anxiety and substance use disorders is most common in the 12–26 age group[13]
- Depression arising in childhood and adolescence is associated with a range of long-term adverse impacts such as 'substance abuse, academic problems, high risk sexual behaviour, impaired social relations, increased risk of suicide' and depression in adulthood[14], and
- The most significant psychiatric risk factors for adolescent suicide include depression, bipolar disorder and substance use disorders[15].

The 2007 survey also found that the prevalence of mental disorders (anxiety and depression) was highest among young people and generally decreased with age, with 18 per cent of those aged 16–24 experiencing mental illness in the previous 12 months compared to 17 per cent of the general population.[16] This is equivalent to around 450,000 young people experiencing mental disorders in the 12-month period.

In its submission to the Policy, *beyondblue* noted that certain groups of males may experience higher rates of depression than others:[17]

- While the prevalence of depression in geographic regions is similar, males aged 45–64 in rural and remote areas are more likely to report depression than those living in major cities
- Research suggests that people with an intellectual disability may be at a greater risk of developing depression than the general population.
- Studies on depression in gay and other homosexually active men show a trend towards higher rates of depression that vary according to 12-month and longer prevalence timeframes when compared to heterosexual men. Across four representative population studies, 12-month prevalence rates of major depression varied between 10 and 31 per cent for homosexually active men compared to rates between 4 and 10 per cent for heterosexual men. Younger gay and homosexually active men appear to be at higher risk for 12-month prevalence of depression than their older counterparts, and
- Vietnam War, Gulf War and Korean War veterans report higher levels of depression than other Australians[18]. The Australian Defence Force (ADF) noted that a comprehensive mental health prevalence study has commenced in order to ascertain accurate rates of a variety of mental health conditions within the ADF population.[19]

More information about depression is available at www.beyondblue.org.au.

## Anxiety

The 2007 National Survey of Mental Health and Wellbeing found that 11 per cent of men experienced anxiety disorders compared to 18 per cent of women.[20]

'Anxiety' is a term used to describe a normal feeling people experience when faced with threat or danger, or when stressed. When people become anxious, they typically feel upset, uncomfortable and tense. Because feelings of anxiety are so common, it is important to understand the difference between *anxiety*, which is appropriate to a situation, and the symptoms of an *anxiety disorder*.[21]

People are likely to be diagnosed with an anxiety disorder when their level of anxiety becomes so extreme that it significantly interferes with their daily life and stops them doing what they want to do. Anxiety disorders are not just one illness but a group of illnesses characterised by persistent feelings of high anxiety and extreme discomfort and tension. They include:[22]

- *Panic disorder* – sudden bursts of extreme anxiety that are accompanied by symptoms like a pounding heart, sweaty palms and shortness of breath or nausea
- *Agoraphobia* – anxiety about being in places or situations from which it is difficult to escape should a panic attack occur
- *Social phobia (also called social anxiety disorder)* – strong fear of social interaction or performance situations because of the potential for embarrassment or humiliation
- *Generalised anxiety disorder* – long periods of uncontrollable worry about everyday issues or events, typically accompanied by feelings of fatigue, restlessness or difficulty concentrating
- *Post-traumatic stress disorder* – recurrent and intrusive memories of a trauma, feelings of emotional numbing and detachment, and increases in emotional arousal, such as irritability and disturbed sleep, resulting from a previous traumatic event, and
- *Obsessive-compulsive disorder* – repeated thoughts, images or impulses that the person feels are inappropriate, and repetitive behaviours, designed to reduce the anxiety generated by the thoughts.

A person is more at risk of experiencing anxiety problems if they have:

- A family history of mental health problems

- Stressful events such as changing jobs or living arrangements, family and relationship problems, experiencing abuse or trauma, or loss of a loved one, and
- Physical health issues such as heart disease or hormonal problems.

Groups more at risk of anxiety problems include:[23, 24]

- People who report being homosexual or bisexual, who have higher levels of anxiety disorders (32 per cent) than people who report being heterosexual, and
- Vietnam War, Gulf War and Korean War veterans, who report higher levels of anxiety disorders than other Australians.

More information about anxiety disorders and symptoms is available at www.beyondblue.org.au.

## Suicide[25, 26, 27, 28]

In 2007, there were 1881 registered suicides in Australia, representing an age-standardised death rate of 9.0 deaths per 100,000 population. Intentional self-harm or suicide was ranked fifteenth of all deaths registered in Australia in 2007.

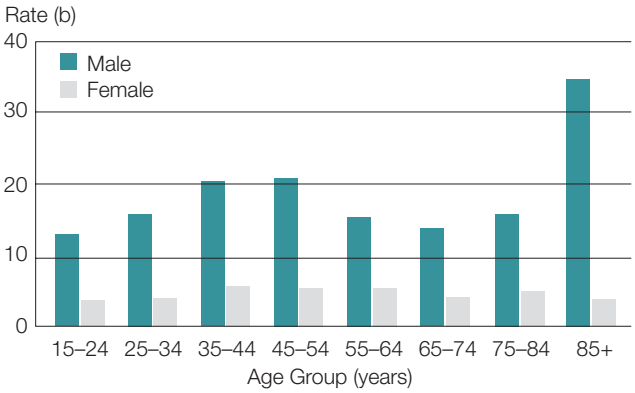
However, male suicides continue to outnumber female suicides, accounting for over three-quarters (77 per cent) of all suicide deaths in 2007. Suicide is the tenth leading cause of death among males and represents 2.1 per cent of all deaths for males.

In 2007, 96 young people aged 15–19 (69 males and 27 females) and 149 people aged 20–24 (118 males and 31 females) suicided. This is equivalent to a rate of 8.3 deaths per 100,000 population.

Rates for young males aged 15–24 (12.5 per 100,000) were low compared to males overall, yet this cause of death represented 20.2 per cent of deaths overall in this age group.

The figure below shows that, in 2006, male suicide rates were higher than female rates in every age group, and high age-specific suicide death rates for males occurred in the age groups 35–54 and over 85. These were highest in the elderly (34.5 per 100,000) but accounted for only 0.7 per cent of all male deaths in this age group. Suicide accounts for 20 per cent of deaths for males aged 20–24 years and around a quarter for males in their middle years. Rates for middle-aged males remain high, with the highest rates for males aged 35–39 years and 45–49 (21.5 and 22.0 per 100,000 compared to 13.6 per 100,000 across all ages). The lowest age-specific death rate of any age group for males and females was in the 15–19 age group (8.8 per 100,000 and 3.5 per 100,000 respectively).

### Age-specific suicide rates (2006)




(a) Care should be taken in interpreting numbers of suicide deaths due to limitations in data.

(b) Rate per 100,000 estimated resident population.

Data for people younger than 15 years is not reported by the Australian Bureau of Statistics (ABS), but an average of 10.1 suicide deaths per year was reported over the 1998–2007 period for children aged under 15. The highest number was registered in 1999 (17) and the lowest in 2006 (7), with around twice as many deaths of boys than girls.

Data from the 2007 National Survey of Mental Health and Wellbeing shows that, for males, suicidality (suicidal ideation, plans and attempts) varied relatively less across age groups. In males aged 25–34 and 35–44 the prevalence of suicidality was around 2.5 per cent, and across all other age groups it remained close to 1.5 per cent.

### Suicide among males from various backgrounds

While males from any age or background can commit suicide, groups of males (other than the age groups above) who are at higher risk include the following:

- *Aboriginal and Torres Strait Islander males* – The rate of suicide for Aboriginal and Torres Strait Islander males under 35 years is estimated to be three times that of non-Indigenous males of the same age. In 2007, suicide was the sixth leading cause of death among Aboriginal and Torres Strait Islander Australians, with 3.7 per cent of all deaths in this group being due to suicide. The rate of suicide in the Aboriginal and Torres Strait Islander population is almost three times greater than the proportion of deaths that are due to suicide in the non-Indigenous population (3.7 per cent compared to 1.3 per cent)
- *Males in prison or custody* – They have a suicide rate three times that of other Australians
- *Males living in rural and remote areas* – Suicide rates in rural and remote areas of Australia are significantly higher than the national average, and very remote regions have suicide rates more than double that of major capital cities.[29] A 2008 study found that the rural suicide rate for South Australia in 2001 was 23.8 per 100 000 for males and 5.6 for females, and that

the farm suicide rate in South Australia was much higher between 1997 and 2001, at 33.8 for males and 6.7 for females[30]

- *Gay and bisexual people* – Studies have found that the rate of attempted suicide for gay, lesbian and bisexual people is between 3.5 to 14 times higher than for their heterosexual peers,[31] and
- *Males from disadvantaged backgrounds* – The most disadvantaged males have the highest rates of suicide, and a gradient exists of increasing suicide rates from low to high socioeconomic status.[32]

Suicides in the Australian Defence Force (ADF) averaged seven per year over the period 2001–07.[33] This is approximately 60 per cent of the civilian rate when matched for demographics. The ADF continues to deliver comprehensive suicide prevention training for all ADF members and clinical up-skilling courses for health professionals, and has introduced other suicide prevention measures, including resilience training designed to teach ADF members stress-coping strategies.

### Factors associated with suicide

The National Suicide Prevention Strategy states that the causes of suicide include a 'complex mix of adverse life events, social and geographical isolation, cultural and family background, socioeconomic disadvantage, genetic makeup, mental and physical health, the extent of support of family and friends, and the ability of a person to manage life events and bounce back from adversity'.[34]

The Life is for Everyone Fact Sheet 21, *Suicide Warnings and Tipping Points*, provides a summary of risk factors, warning signs, tipping points ('The point at which a person's risk of taking their own life increases due to the occurrence of some precipitating event, such as a negative life event or an increase in symptoms of a mental disorder') and imminent risk factors for suicide, outlined in the table below.[35]

The Fact Sheet advises that people should respond quickly to someone acting strangely or out of character by talking to them about it and getting help, particularly as many males decide to suicide quickly.

Factors which put males at risk of suicide (and depression and anxiety) include:

- Traumatic events such as relationship breakdown and separation from children
- Unemployment
- Social isolation and lack of social support
- Financial or legal problems
- Drug and alcohol abuse
- Discrimination, and
- Chronic illness or pain (more common in older men).[37]

Employment is often closely tied with the male sense of identity and purpose. This can be undermined by a loss of work through retirement, unemployment or work-related injury and disability. Males can also lose contact with work friends and colleagues, and become isolated and lonely. A major reduction in income can also cause significant stress and financial pressure. High levels of work pressure can also be detrimental to male mental health and be a risk factor for suicide.

Married males generally have better mental and physical health outcomes than those who are divorced, bereaved or single, and relationship breakdown and separation may put men at higher risk of suicide, particularly where there is a loss of contact with children.[38, 39] The *beyondblue* submission to the Policy states that fathers who are separated or divorced 'are at high risk of developing depression, and a separated marital status is a risk factor for male suicide'.[40]

Abuse of alcohol, cannabis and opiates or other substances is also a significant risk for mental illness and suicide. In 2007, Australian males had double the

**Suicide risk factors, warning signs, tipping points and imminent risks[36]**

| Risk factors | Warning signs | Tipping points | Imminent risk |
|---|---|---|---|
| Mental health problems | Hopelessness | Relationship ending | Expressed intent to die |
| Male gender | Feeling trapped, like there is no way out | Loss of status or respect | Has plan in mind |
| Family discord, breakdown, violence or abuse | Increasing alcohol or drug use | Debilitating physical illness or accident | Has access to lethal means |
| Family history of suicide | Withdrawing from friends, family or society | Death or suicide of relative or friend | Impulsive, aggressive or antisocial behaviour |
| Alcohol or other substance abuse, such as marijuana | No reason for living, no sense of purpose in life | Suicide of someone famous or member of peer group | |
| Social or geographical isolation | Uncharacteristic or impaired judgement or behaviour | Argument at home | |
| Financial stress | | Being abused or bullied | |
| Bereavement | | Media report on suicide or suicide methods | |
| Prior suicide attempt | | | |

rate of substance use disorders of females, and young males had a higher rate of substance use disorders (16 per cent) compared to females of the same age (10 per cent).[41]

In 2004–05, substance use was more prevalent among Aboriginal and Torres Strait Islander males, of whom 56 per cent had tried drugs and 32 per cent had used at least one substance in the last 12 months. Between 2002 and 2006, after adjusting for age differences, Aboriginal and Torres Strait Islander males died from mental-health-related conditions due to psychoactive substance use at rates that were 9.2 times the rate of other Australian males.[42]

Around a third of people who attempt suicide are under the influence of alcohol, and it is estimated that a high proportion of suicides are completed under the influence of alcohol.

There are factors linking substance abuse, mental disorders and suicide.[43] For example, substance abuse decreases inhibitions and increases impulsive behaviour, which can increase the risk of suicide. Substance abuse can also induce psychiatric disorders, such as depression and psychosis, which also increase the risk of suicide.

Mental illnesses such as depression, anxiety and schizophrenia are major risk factors for suicide, yet mental illnesses, while correlated and recognised as significant risk factors for suicide, are not necessarily sufficient causal factors.

The risk of suicide also increases significantly after discharge from hospital or with changes to treatment, and people who have previously attempted suicide are at a particularly high risk of suicide.

## Optimal health outcomes for males

According to *beyondblue*'s submission to the Policy, males – and members of society in general – have a low level of awareness of male mental health problems. Other research has also identified a lack of awareness of mental health issues, which may contribute to low levels of help-seeking in relation to these issues.[44]

Mental health literacy enables people to have the knowledge and understanding to, for example:

- Find information on mental health disorders, risk factors and causes, and understand it
- Recognise specific disorders and their symptoms, and
- Act on information in a way that can prevent or minimise the progression of the disorder, including by obtaining the appropriate professional help.

The *beyondblue* Depression Monitor revealed that in 2007–08:

- Males were less likely than females to consider that mental health issues were a major health problem in Australia
- 21 per cent of males, compared to 10 per cent of females, did not know what the major mental health problems are, and
- Only 45 per cent of males, compared to 66 per cent of females, stated that depression is a major mental health problem.

The Royal Australian and New Zealand College of Psychiatrists' submission to the Inquiry of the Senate Select Committee on Men's Health states that 'gender specific symptomology of depression is not widely known or understood'.[45]

*Beyondblue* highlights that the male and female experience of depression and their responses to depression may be different.[46] Males are more likely to focus on physical symptoms such as tiredness and weight loss, and may acknowledge that they are feeling angry or irritable. However, they may not recognise or acknowledge that they are feeling down, and family, friends, colleagues and doctors may not recognise the symptoms of depression in males either.

The high level of male suicide and substance abuse in Australia indicates that mental health disorders may be under-recognised, under-diagnosed and under-treated. The Royal College of Psychiatrists' submission to the Select Committee further states that:[47]

> Depression which is an important risk factor for suicide is under diagnosed in men, partly because men are less likely to seek treatment or identify that they have depressive symptoms and often have different symptomology.

## Help-seeking behaviours

The 2007 National Mental Health Survey found that the use of services for mental health problems was much lower in men compared to females. Only 28 per cent of males experiencing a mental disorder in the 12 months prior to interview accessed services for mental health problems, compared to 41 per cent of females.

Service use by males was consistently lower than women across all age groups. However, while the prevalence of mental disorders was highest in the youngest age groups, service use was even lower. Use of services for mental health problems by 16–24 year old males was almost a third of that for females in the same age group (13 per cent compared to 31 per cent).

Analysis of Medicare Benefits Schedule (MBS) mental health items available under the Better Access to Psychiatrists, Psychologists and General Practitioners initiative also reveals that service use is lower than for other non-mental-health MBS items. MBS expenditure on males against Better Access items that are specific for mental-health-related services in 2008-09 represented 35 per cent of total expenditure for these items, compared to 41 per cent for other items.

Pharmaceutical Benefits Scheme (PBS) expenditure on antidepressants for males in 2007–08 was 35 per cent of the total, where gender was known.

However, males use public specialised mental health services, which are run by state and territory governments and deal with more severe cases, at a higher level than females. Male patients accounted for 53 per cent of mental health service contacts in community mental health and hospital outpatient services in 2005–06, and 61 per cent of episodes of residential mental health care.

### Consequences of not seeking help

Mental health problems in childhood and adolescence can have far-reaching effects on the physical wellbeing and educational, psychological and social development of individuals. When early signs of difficulty are not addressed, mental health problems can potentially become more serious and possibly extend into mental disorders.

Evidence shows that, when identified and treated early, mental disorders are less severe and of shorter duration, and some are less likely to recur. Early intervention is critical to promoting recovery and reducing the incidence of mental illness.

As stated earlier, males account for around 80 per cent of suicide deaths in Australia, and important risk factors for suicide, such as depression and other disorders, may be undiagnosed and untreated.

An indication of this is provided by a UK study that noted that, while more women than men report depression after bereavement, men are more at risk of suicide in this period.[48]

Males are also less likely to seek help from a service or health professional before a suicidal act.[49] Young males are the least likely to do so and have the longest gap between last consultation and suicide. In addition, prior to suicide, males are less likely to have been treated for mental illness in the previous 12 months and to have a history of treatment.

The UK study also notes that males are more likely than women to experience functional difficulties in daily living, with the same level of symptoms of mental disorder.[50] The connection between undiagnosed mental disorders and higher levels of drug and alcohol misuse is highlighted, as is the possible connection between higher levels of imprisonment, homelessness and exclusion from school and undiagnosed mental disorder.

### Barriers to seeking help

One study reported that three-quarters of the male participants reported that they managed emotional and mental health issues through silence or avoidance, and that 'control or denial of the emotional self' was also 'very apparent'.[51]

The Irish National Men's Health Policy states that 'many men conceal symptoms … and rely on more "acceptable" male outlets, such as alcohol abuse or aggression, to deal with mental health issues'.[52]

Australian males have higher levels of risky alcohol drinking and double the rate of substance use disorders as compared to females.

In addition to the barriers to help-seeking outlined above (and in the *Access to Health Services* supporting document), a fact sheet on *Suicide and Men* from the Living is For Everyone (LIFE) website suggests that males may not seek help for emotional and mental health problems because they may:[53]

- Not recognise symptoms of emotional distress
- Prefer to work things out themselves
- Not consider it a high priority
- Have difficulties accessing services, for example, because they are not 'male friendly'
- Not be aware of which services can help, and their location
- Not want to appear weak and may be embarrassed or ashamed about their distress, and
- Feel uncomfortable discussing their problems or talking about their feelings.

The Royal Australian and New Zealand College of Psychiatrists submission to the Senate Select Committee on Men's Health emphasises that 'men are less likely to access psychiatric support primarily related to the stigma associated with mental health and accessing psychiatrists'.

As outlined in the *Access to Health Services* supporting document, Andrology Australia's *GP Summary Guide*, *Engaging Men in Primary Care Settings* provides strategies for GPs to engage men in discussion about their health. GPs can help destigmatise and normalise mental health issues and help men to 'sidestep' feelings of embarrassment and shame by routinely taking a mental health history, within medical histories, and asking about mental health when risk factors are present. The guide suggests asking questions such as:[54]

- 'Are there any other issues you want to talk about … your relationship, family/work stress, feeling down?', and
- 'Many men experience periods of feeling down, but find it difficult to talk to anyone about it. I can help you, if you are having problems.'

## Equity between groups of males

Some males have and higher levels of mental health problems, and higher risk factor levels for experiencing mental health problems, than females and other males in general.

### Men's sheds

'Men's sheds' provide an opportunity for men to enjoy the company of other men and contribute to community life, including through activities such as making toys or furniture, building, or fixing things. Men can learn new skills or share their skills.

The sheds are popular with older men as a way of establishing friendships and social networks, and engaging in purposeful activity. But men of any age and background, including men who are unemployed or experiencing depression or social isolation, are also attending.

Men's sheds address social isolation, which has an impact on health, and also provide an important opportunity to raise awareness about health issues and services.

In 2009, it is estimated that there are 40,000 individual users of men's sheds throughout Australia.

Recognising this important role, the Australian Government will invest $3 million over four years to support the Australian Men's Sheds Association develop national infrastructure aimed at ensuring its future sustainability. This investment will result in a series of projects that will impact at the local level.

Since 2008, Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) has provided about $760,000 in funding to support local men's sheds.

Further information can be obtained from the Australian Men's Shed Association (1300 550 009, www.mensshed.org) or Mensheds Australia Ltd (02 8213 8699, www.mensheds.com.au).

## Personal action – what males themselves can do

If you are facing mental health issues, there are many ways to gain understanding and take positive action:

- Talk to family, friends, a doctor or mental health professional if you feel stressed or have mental health problems. It is a sign of strength to take action to fix a problem.
- Call a confidential, anonymous helpline:
  - MensLine – 1300 78 99 78
  - Lifeline – 13 11 14
  - *beyondblue* Info line – 1300 22 4636
  - SANE Helpline (wide range of information on mental illness and suicide prevention) – 1800 18 SANE (7763) or www.sane.org
  - Kids Helpline – 1800 55 1800
  - Veterans and Veterans Families Counselling Service – 1800 011 046
- Get information on mental health problems, how to build your coping skills and resilience, and where to get help:
  - *beyondblue* – www.beyondblue.org.au
  - *youthbeyondblue* – www.youthbeyondblue.com
  - Black Dog Institute – www.blackdoginstitute.org.au
  - Mental Health in Australia (Australian Government) – www.mentalhealth.gov.au
  - HealthInsite (Australian Government) – www.healthinsite.gov.au
  - The MoodGYM (an interactive online course for overcoming problem emotions and developing good coping skills) – http://moodgym.anu.edu.au
  - Reach Out (for young people) – http://au.reachout.org
  - SANE Australia – www.sane.org
- Get connected – join a social group or activity you are interested in:
  - Australian Men's Shed Association – www.mensshed.org
  - Mensheds Australia Ltd – www.mensheds.com.au
  - Volunteering Australia (information on volunteering) – www.volunteeringaustralia.org
- If you are caring for someone:
  - Commonwealth Respite and Carelink Centres (for respite and other community services) – 1800 052 222. Emergency (after hours) respite – 1800 059 059
  - Carers Australia (puts you in touch with other carers, and the National Carer Counselling Program) – 1800 242 636, www.carersaustralia.com.au

    Alzheimer's Australia (if you are caring for someone with dementia) – National Dementia Helpline 1800 100 500, www.alzheimers.org.au

**Endnotes**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**Note:**

This document provides links to external websites and contact information for various organisations. The external websites and contact information listed are provided as a guide only and should not be considered an exhaustive list. All contact details were correct at the time of publication, but may be subject to change. The Commonwealth of Australia does not control and accepts no liability for the content of the external websites or contact information or for any loss arising from use or reliance on the external websites or contact information. The Commonwealth of Australia does not endorse the content of any external website and does not warrant that the content of any external website is accurate, authentic or complete. Your use of any external website is governed by the terms of that website.