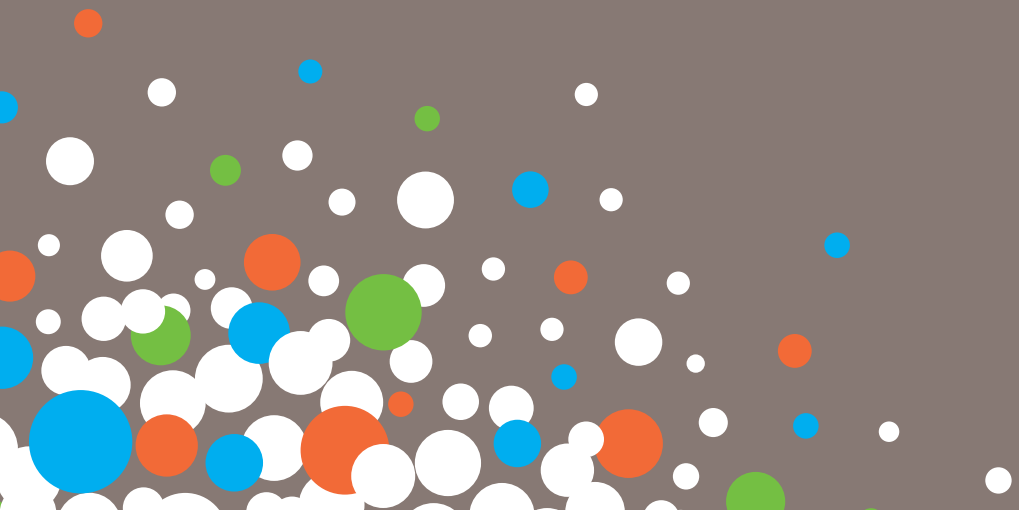
Orygen

The National Centre of Excellence in Youth Mental Health

Keeping it real

Reimagining mental health care for all young men



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Orygen, The National Centre of Excellence in Youth Mental Health
Locked Bag 10
Parkville Vic 3052
Australia

www.orygen.org.au

Keeping it real

Reimagining mental health care for all young men

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Dr Simon Rice
Orygen, The National Centre of Excellence in Youth Mental Health

Dr Dianne Currier
Melbourne School of Population and Global Health, The University of Melbourne

Dr Andrea Fogarty
Black Dog Institute, University of New South Wales

Dr Ryan Kaplan
Brain and Psychological Sciences Research Centre, Swinburne University

Zac Seidler
School of Psychology, The University of Sydney

Professor Pat McGorry AO
Orygen, The National Centre of Excellence in Youth Mental Health and The University of Melbourne

Professor Ian Hickie AM
Sydney Medical School, Brain and Mind Centre, The University of Sydney

Kerryn Pennell
Orygen, The National Centre of Excellence in Youth Mental Health

Abbreviations

CBT	Cognitive behavioural therapy
GP	General Practitioner
hYEPP	headspace Youth Early Psychosis Programme
MDRS-22	Male Depression Risk Scale

Reimagining

Adolescent and young adult males are an underserved population relative to their mental health needs. Targeted research is urgently required to deepen our understanding of how young men experience mental ill-health, and the kinds of next-generation service systems they will be likely to engage with. Novel initiatives are required to (1) develop services that young men find relevant, and (2) take services to young men, rather than waiting for them to walk in the door. Involving young men in the design of these initiatives will be essential to increasing the acceptability of mental health services for them.

Suicide is the leading cause of death among young men (aged 15-24 years) and the life expectancy of men with a mental disorder is 15.9 years less than their peers. A lower incidence of mood disorders yet higher rate of suicide among young men suggest that depression may be underdiagnosed. Differences in symptomology have been identified as masking the true incidence of mood disorders, in particular depression among men. Young men also continue to access mental health services at a lower rate than young women.

Key issues shaping the potential risk and experience of mental ill-health by young men include the symptoms they express being missed, the potential barrier that adherence to traditional masculine norms may exert on help-seeking and the influence of identity and background on their health related behaviours.

There is growing recognition that for young men, symptoms of mental ill-health manifest through externalising behaviours including anger, alcohol and other drug use and risk taking rather than affective symptoms such as feelings of worthlessness or hopelessness. As such, their symptoms can be missed as they do not readily fit with existing diagnostic criteria.

Traditional masculine norms, such as being tough and self-reliant mean that many young men learn to avoid expressing emotions or behaviours that show vulnerability. These dominant social norms have also been identified as a barrier to health professionals recognising mental health problems in young men.

The experiences of young men can be shaped by their identity and personal context. Mental health risks can be exacerbated for young men from non-Western cultural backgrounds, who identify as sexuality diverse or experience learning difficulties for example.

Experiences of anger, when disproportionate and repeated, can be a signal of mental ill-health in young men and may trigger a need for mental health care. Aggression, however, can be a barrier to service access. A new approach is needed that facilitates young men's engagement while ensuring the safety of health workers.

> "The hardest thing is making that first step. So I think the easier we can make that, the better.
>
> **– focus group***

* A group of consenting young men were consulted on issues concerning engagement by young men with mental health services as part of the research for this policy paper.

Reimagining services

Novel initiatives are needed to reimagine how services reach young men who are not following traditional help-seeking pathways. Engagement is more likely to be successful when services are co-designed with young men themselves and reach into their lives. Services need to: recognise behavioural symptoms; incorporate the role of peer support; and develop the potential of digital technologies.

Recognising the symptoms

Primary and specialist health professionals need to be aware of the potential link between mental ill-health and externalising behaviours when assessing young men. Recognition of the potential for presenting symptoms that do not align with existing diagnostic criteria requires training for health professionals and the use of assessment tools specific to young men.

The potential effect of traditional social norms related to masculinity (i.e. being tough or self-reliant) also need to be recognised. These effects can include: reduced emotional expression, greater mental and physical health risks and lower rates of help-seeking.

Peer support

The circles of support around a young man have the potential to provide a safety net for those experiencing mental ill-health. Peer support running parallel to clinical care can strengthen this support and facilitate engagement.

In some instances positive reinforcement within a peer group setting can be more effective than individual counselling. School-based programs that, in a safe environment, support male adolescents to develop awareness of their emotions and empathic responses may provide a foundation for self-awareness and alternate interpretations of traditional masculine norms.

Digital solutions

High rates of internet access and smartphone usage has made new technologies a focus of innovation in mental health services. Current evidence that new technologies will facilitate higher engagement from young men is, however, mixed.

Realising the potential of digital technologies will require the coordination of research into what works. The development of acceptable and effective services and treatment for young men must be informed by what engages young men in other digital fields, such as gaming.

Future directions

This policy paper has identified a number of opportunities to reimagine mental health services for all young men. The paper recognises that differences in how symptoms of mental ill-health can manifest in young men mean that services are not being designed to adequately meet the needs of young men. The missing focus on the needs of young men are contributing to lower rates of service access. A number of opportunities have been identified across policy; services and workforce; and data and research to improve the accessibility and acceptability of services for all young men.

While each policy opportunity has the potential to contribute to improved mental health services for young men, four policy actions have been identified as priorities.

Priority policy actions

Opportunity	Mechanism
Data and research	
A collaborative, coordinated research focus is required to expand knowledge of the developmental impact of young men's alignments to traditional masculine norms, including associations with help-seeking behaviours and mental health status. The research focus should include: • protective factors and health-related behaviours that may shield young men from mental ill-health. • validation and implementation of gender-appropriate assessment tools that are sensitive to young men's experience of distress and associated externalising behaviours. • data collection in partnership with existing Australian longitudinal cohort studies.	Orygen, The National Centre of Excellence in Youth Mental Health, key national and international research partners.
A national evidence base for young men's uptake of existing digital services and treatments, and current research initiatives needs to be established to inform future research priorities and funding.	Department of Health.
Policy	
Best practice guidelines for clinician engagement with young men are needed. Guidelines need to address the role of traditional masculine norms, the variations in young men's alignment with masculine norms and associated effects on their mental health. Guidelines should be co-created with young men. Guidelines should be used to inform the design of professional development modules and awareness materials and distributed by peak bodies of health professions.	Orygen, The National Centre of Excellence in Youth Mental Health, key Professional bodies and Peak organisations.

Opportunity	Mechanism
Services	
Mental health service providers (organisations and individual professionals) need to recognise the pressure traditional masculine norms can exert on young men, the variation in masculine forms young men identify with and how these factors influence help-seeking.	
Targeted funding for innovative co-design initiatives, developed in partnership with young men, is urgently needed to develop a new generation of mental health services that are acceptable to young men.	Commonwealth and State and Territory Governments, Departments of Health, Primary Health Networks.
Professional development modules and supporting awareness materials need to be designed and disseminated to increase understanding among primary and specialist health professionals of the potential link between mental ill-health and externalising behaviours in young men.	Service providers and Professional bodies.

Supporting policy actions

Opportunity	Mechanism
Policy	
Despite low rates of engagement in mental health services, young men are only identified as a distinct group in the mental health policies of two states. Specific policies are required within government mental health policies to address the needs of young men.	Commonwealth, State and Territory Governments and Departments of Health.
Services and workforce	
Training and best practice guidelines need to be updated to incorporate cultural awareness and safety in mental health services. Professional bodies need to make cultural and diversity awareness training a requisite component of continuing professional development.	Service providers, Cultural and Professional bodies.
Improved management of anger and aggression in young men is required to ensure the safety of themselves, health and emergency services staff and the public. New service approaches that focus on de-escalation and access to services need to be developed and implemented.	Emergency Departments and Emergency Services, including Police.
Young men with identified problems related to anger and aggression require timely access to acceptable interventions. These interventions should look to broaden young men's emotion recognition and management, and expand their adaptive coping skills.	Orygen, The National Centre of Excellence in Youth Mental Health, key national and international research partners.
Government policies for integrated mental health and alcohol and other drug use services need to be coordinated and implemented at a service delivery level. Implementation plans that include measurable workforce training and service delivery targets should be a condition for State and Territory funding, services commissioned by Primary Health Networks and forensic services for young men in contact with the justice system.	Primary Health Networks commissioned services, State and Territory funded health services, Police and forensic mental health services.
The evidence base for peer support workforce models in a youth mental health context need to be strengthened. The trial and evaluation of a co-designed model that can be implemented nationally across primary and specialist mental health services is required.	Orygen, The National Centre of Excellence in Youth Mental Health.

Opportunity	Mechanism
Data and research	
A number of avenues are available to strengthen existing data.	
A dedicated survey of this target age group to determine levels of engagement and explore the role of barriers and facilitators for different sub-groups.	Orygen, The National Centre of Excellence in Youth Mental Health.
Incorporate specific questions and sub-studies for boys and young men within The Australian Longitudinal Study of Male Health, *Ten to Men*.	Department of Health, Melbourne School of Population and Global Health, The University of Melbourne.
Over-sample young men in the next National Survey of Mental Health and Wellbeing and report data for the 12-24 year age group.	Australian Bureau of Statistics.
Extract and publish mental health services data for cultural and sexuality diverse young men from existing data sources.	Australian Institute of Health and Welfare.
More research is needed to understand the vulnerability of young men to illnesses related to body image. Protective and risk factors need to be identified to inform the development of awareness materials. Targeted interventions to support young men need to be developed and trialled.	Butterfly Foundation for Eating Disorders in collaboration with Orygen, The National Centre of Excellence in Youth Mental Health, key national and international research partners.

Introduction

Many young men will experience some form of mental ill-health but proportionally few of them will access mental health services or receive appropriate treatment. Notions of masculinity and social pressures exerted by traditional masculine norms can contribute to experiences of mental ill-health and reluctance to seek help. Other factors include a young man's culture or sexuality, learning difficulties and comorbid alcohol and other drug use.

There are differences in the reported prevalence of mental disorders among young men compared with young women. Suicide is the leading cause of death among young men (aged 15-24 years) and for men with a mental disorder. Higher rates of psychotic and alcohol and other drug use disorders have been identified among young men while rates of mood disorders and, to a lesser extent, anxiety, are lower. There is some debate as to whether the primacy of diagnostic criteria for mood disorders that emphasise internalising symptoms (i.e. sadness, tearfulness, guilt) effects this disparity due to men's greater propensity to externalising symptoms. Recognition of the incidence of body image disorders, generally associated with young women, is increasing among young men.

Access to mental health services by young men is lower than prevalence levels of mental ill-health. More than four-in-ten young people (43.1 percent) with a diagnosable mental disorder are young men. Yet young men only account for between 31.6 and 37.2 percent of mental health service use.

Greater engagement of young men in youth mental health services will be achieved through new approaches that ensure services are fit for purpose and designed to engage young men from the outset. Mental health services that are relevant and acceptable to young men need to reach in to their lives to overcome existing barriers faced by young men.

The mental ill-health of young men

Most major mental disorders onset before the age of 25 years (Kessler et al. 2005) and young men access services at lower rates than young women. Without treatment and the limited opportunity for early intervention more men are likely to experience greater severity of illness and suffer more long-term consequences. These consequences may include poorer educational or vocational outcomes, alcohol and other drug use disorders, increased risk seeking and risk taking and aggression and violence – including domestic violence (Jewkes, Flood, and Lang 2015). A number of barriers contribute to lower levels of engagement with services and treatment. Barriers include stigma, the influence of traditional masculine norms, socio-economic disadvantage, broader cultural factors and learning difficulties (see Appendix for an extended list of barriers and facilitators). Within current primary health services reliance on severe distress or disorder, or spontaneous patient reporting for detection by health professionals adds a further barrier (Ehmann et al. 2014). Differences in the magnitude of the problem, prevalence rates and barriers faced can vary depending on the type of disorder experienced.

Opportunity	Mechanism
Despite low rates of engagement in mental health services, young men are only identified as a distinct group in the mental health policies of two states. Specific policies are required within government mental health policies to address the needs of young men.	Commonwealth, State and Territory Governments and Departments of Health.

The size of the issue

Data on the prevalence of mental disorders in young people is disjointed. The most recent data is for 12-17 year olds in which the reported prevalence of a mental disorder among males was 15.9 percent (Lawrence et al. 2015). The rate of reported service use among adolescent males reporting a disorder was 63.5 percent. The best available national data for 16-24 year old males is now a decade old. A 2007 Australian Bureau of Statistics survey found the incidence of any 12-month mental disorder among young men was 22.8 percent (Australian Bureau of Statistics 2010a). Access to services by this group was markedly lower (13 percent) (McGorry, Bates, and Birchwood 2013) compared with data for 12-17 year old males.

DATA FOR YOUNG MEN IS DISJOINTED

2015 Males 12–17 years	**15.9%** Rate of mental disorder	**63.5%** Accessing treatment
2007 Males 16–24 years	**22.8%** Rate of mental disorder	**13.0%** Accessing treatment

Source: The Mental Health of Children and Adolescents: Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing (Lawrence et al. 2015) and Mental Health of Young People, 2007 (Australian Bureau of Statistics 2010a). For a breakdown by disorder type see Appendix.

Survey differences (i.e. age categories used, survey questions, ten year gap) hinder conclusions being used to direct mental health policy. A single survey of the mental health of 12-24 year olds is required that includes young people outside of normal survey sampling populations (i.e. experiencing homelessness, justice connected, living in remote Aboriginal communities and for whom language expression is difficult) on which to inform mental health policy and resourcing.

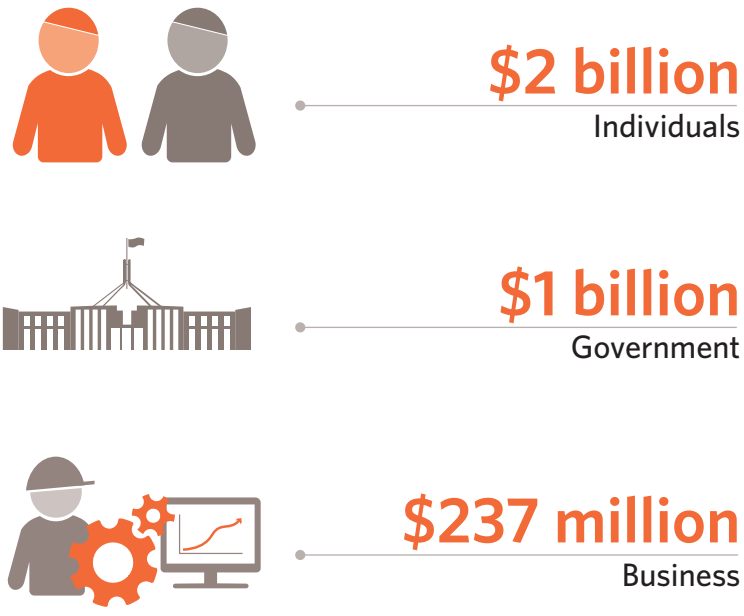
Opportunity	Mechanism
A number of avenues are available to strengthen existing data.	
A dedicated survey of this target age group to determine levels of engagement and explore the role of barriers and facilitators for different sub-groups.	Orygen, The National Centre of Excellence in Youth Mental Health.
Incorporate specific questions and sub-studies for boys and young men within The Australian Longitudinal Study of Male Health, *Ten to Men*.	Department of Health, Melbourne School of Population and Global Health, The University of Melbourne.
Over-sample young men in the next National Survey of Mental Health and Wellbeing and report data for the 12-24 year age group.	Australian Bureau of Statistics.
Extract and publish mental health services data for cultural and sexuality diverse young men from existing data sources.	Australian Institute of Health and Welfare.

Paying the price

Mental ill-health has a personal impact on individuals, family and friends that is hard to accurately quantify. Attempts have been made to calculate the economic impacts of young men not realising their full potential due to mental ill-health.

The cost to the Australian economy from mental ill-health in young men was calculated to be $3.27 billion annually through lost productivity. These costs are borne by individuals, government and employers. The highest cost was to individuals at $2 billion; followed by government ($1 billion) and employers ($237 million) (Degney et al. 2012).

WHO BEARS THE COST OF MENTAL ILL-HEALTH?

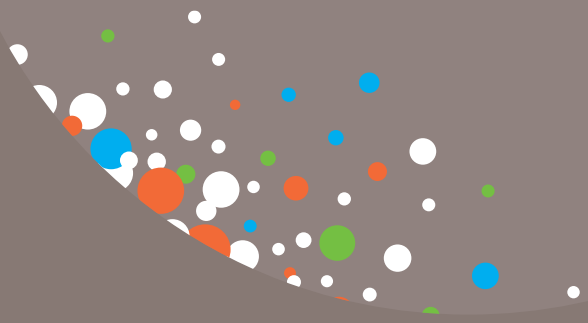


Young men face a higher likelihood of experiencing mental ill-health than at any other time in their life and access services at a lower rate than young women.

Data on the prevalence of mental disorders in young men is disjointed and a national survey of 12-24 year olds is required.

The annual economic impact of young men's mental health has been estimated to be $3.27 billion.

As boys grow into young men the social expectations and pressures of “being a man” can mean they learn to avoid behaviours that show vulnerability.



Risk factors

A young man's experience and environment is going to inform the potential risk of experiencing mental ill-health and point to domains in which policy opportunities may exist to improve service design and delivery. This paper considers the potential impacts of traditional masculine norms, the role of culture and sexuality and learning difficulties.

Traditional masculine ideals

As boys grow into young men the social expectations and pressures of "being a man" can assert positive and negative influences on their self-development. Traditional masculine norms include being tough and self-reliant. As such, young men learn to avoid expressing emotions or behaviours that show vulnerability, such as hopelessness, sadness, and worthlessness (Fields and Cochran 2011) or tearfulness/crying (Fischer et al. 2004).

> "Men are seen as you know hard, sturdy, you know, nothing can faze me sort of thing you know. Men, I've got a big shield on my chest. But it's not always like that.
>
> **– focus group**

For many young men, reconciling their own experience and identity formation to traditional masculine norms may generate or contribute to emotional distress. Many young men in Australia continue to use 'longstanding Western masculine ideals' as their ontological reference point (Oliffe et al. 2010). For some young men the societal expectations of traditional masculine norms can increase self-stigma around help-seeking. The accumulation of masculine capital can contribute positively and negatively to a young man's mental health. Accumulation of masculine capital through exercise and participation in sport for example will be more likely to have positive health outcomes than heavy drinking of alcohol (de Visser and McDonnell 2013).

As young men develop their self-identity, the pervasive influence of traditional masculine norms can negatively affect their mental health. There is evidence that the more closely a young man conforms to traditional masculine norms, the greater their mental and physical health risks, and the less likely they are to seek help or access services (Courtenay 2003; Rice et al. 2017). Young men typically need to be 'obviously injured, seriously ill or pressured to attend' health services (O'Brien, Hunt, and Hart 2005). Dominant notions of traditional masculine norms have also been identified as a barrier to health professionals recognising health problems in men (Courtenay 2000).

Conforming to traditional masculine norms have different effects for different men, some beneficial and others detrimental to their mental health. More research is needed to better understand this influence on young men. There is, however, growing recognition that for some young men mental ill-health manifests differently from the symptoms included in existing diagnostic criteria for mental disorders (Thompson and Bennett 2015). The potential for positive, as well as negative influences of traditional masculine norms on experiences of mental ill-health needs to be considered in developing approaches to encourage help-seeking and the design of interventions acceptable to young men.

Opportunity	Mechanism
Mental health service providers (organisations and individual professionals) need to recognise the pressure traditional masculine norms can exert on young men, the variation in masculine forms young men identify with and how these factors influence help-seeking.	
Targeted funding for innovative co-design initiatives, developed in partnership with young men, is urgently needed to develop a new generation of mental health services that are acceptable to young men.	Commonwealth and State and Territory Governments, Departments of Health, Primary Health Networks.
Professional development modules and supporting awareness materials need to be designed and disseminated to increase understanding among primary and specialist health professionals of the potential link between mental ill-health and externalising behaviours in young men.	Service providers and Professional bodies.

More than one way to be a man

Despite the emphasis on traditional masculine norms, how individuals understand, experience and embody these norms varies (Courtenay 2000). Many factors influence the masculinity young men will likely construct, such as ethnicity, economic status, education, sexual diversity and social context. The form this masculinity or masculinities take can in turn influence the health risks young men may face (Courtenay 2000). Men who are able to be flexible in their adoption of traditional masculine norms may be more open to help-seeking and accepting of interventions (Proudfoot et al. 2015).

> “What you perceive to be as possible or impossible will define your perceptions of masculinity, and where you can be on that spectrum.
>
> **– focus group**

There is mixed evidence on the benefits of not conforming to traditional masculine norms. A study of college-aged men from the United States found that not conforming was linked to a lower risk of negative health outcomes (Levant et al. 2009). However, broader social consequences of non-compliance can have negative outcomes, such as reduced self-esteem in the face of social pressures to conform to traditional masculine norms (O'Neil 2008). For others, identifying with a masculine ideal may provide a safe path among an emerging plurality of masculinities (Levant et al. 2009).

While there are potentially negative consequences from the social pressures and expectations of traditional masculine norms, for some young men there may be beneficial aspects. Positively framing masculinity by emphasising the strengths available to young men is more likely to foster positive health related behaviours. Psychological models of positive masculinity have been successful in developing relationships with young men (Kiselica and Englar-Carlson 2010). Psychoeducation based on positive masculinity should, therefore, be a part of preventive responses to mental ill-health for young men.

Culture

Young men from non-Western cultural backgrounds are less likely to access mental health services. Aboriginal and Torres Strait Islander young men report higher levels of psychological distress, are hospitalised more often for a mental health related condition and are more likely to die from suicide compared with other young men. headspace has been relatively successful in engaging young Aboriginal and Torres Strait Islander people as a consequence of targeted campaigns, with the difference greatest among 12-17 year olds (Hilferty et al. 2015). In the year following the launch of Yarn Safe initiative (and the opening of new centres) the number of Aboriginal and Torres Strait Islander young people accessing headspace centres increased by 32 percent (headspace).

In contrast, young men from culturally and linguistically diverse backgrounds remain under-represented. Limited awareness around the needs for young people from culturally diverse backgrounds within headspace has been identified as a barrier, but to what extent is not clear (Brown et al. 2016).Young people born overseas and speaking a language other than English at home

make up 15.4 percent of the young people living in Australia but only 2.4 percent of the demographic engaged in headspace services (Hilferty et al. 2015). Data for access and engagement with mental health services by culturally diverse populations is limited. Reference is still made (Rickwood et al. 2015) to a 1997 study from New South Wales (McDonald and Steel 1997) that found people (of all ages) born overseas from a non-English speaking background were less likely to use community mental health services. The lack of research into service use, engagement and efficacy by this group, and specifically young men restricts the development of targeted programs and services.

Opportunity	Mechanism
Training and best practice guidelines need to be updated to incorporate cultural awareness and safety in mental health services. Professional bodies need to make cultural and diversity awareness training a requisite component of continuing professional development.	Service providers, Cultural and Professional bodies.

Sexuality

Young men who are sexuality diverse experience higher rates of mental ill-health. Among young men attending headspace, 5.9 percent identify as sexuality diverse (Hilferty et al. 2015). Comparable population data for this group is sparse with suggestions that around one-in-ten Australians are sexuality diverse (Australian Human Rights Commission 2014). Young same-sex attracted men are more likely to experience mental ill-health than their heterosexual peers. Just over 40 percent of sexuality diverse young men (ages 16-24 years) in Australia have a high/very high level of psychological distress compared with a national average of seven percent (Leonard et al. 2012). The risk of self-harm and suicide is higher for young men who experience abuse related to being sexuality diverse (Hillier et al. 2010). There is suggestive evidence that young same-sex attracted men who more closely identify with traditional masculine norms are more likely to report experiences of discrimination attributed to their sexual orientation (Lyons and Hosking 2014). Consideration of the safety of sexuality diverse young men is needed in the design and provision of mental health services.

Learning difficulties

The ability to articulate the presence or experience of mental ill-health can be harder for young men with learning difficulties. Difficulties with emotional expression can delay access to mental health care, as can the mistaken attributing of symptoms to learning difficulties. In the United Kingdom, it is estimated that 36 percent of children and young people with learning disabilities experience mental health problems at any point in time (24 percent if problem behaviours are excluded) (NICE guideline 2016).

Higher rates of mental ill-health and disorders in people with learning difficulties underlines the importance of accurately identifying and diagnosing symptoms.

The presence of a mental disorder can also negatively affect a young man's ability to function in a learning environment. These difficulties can include; struggling to actively engage with school work, concentrate on tasks, tolerate uncertainty or demands, engage with social networks and cope with the various day-to-day demands of study (MindMatters). A study of Year 7, 8 and 9 students (aged 11-15 years) in Adelaide found a strong correlation between self-reported learning and wellbeing. The research authors noted that despite this link school wellbeing programs are more likely to focus on social contexts (i.e. bullying) than academic contexts (i.e. learning strategy capacity building). Young men scored lower for learning strategies, coping with schoolwork and how liked they felt they were, however, only the latter had a substantive effect size (Askell-Williams and Lawson 2015). The risk of delayed educational development compounds the negative life outcomes that can result from undiagnosed or untreated mental ill-health.

The potential bidirectional relationship between learning difficulties and mental ill-health indicates the mental health of young men who are struggling at school, including engaging in disruptive behaviour, needs to be considered and support provided. This support needs to be accessible and acceptable to young men who are likely to be finding school to be a pressured environment, and for who being linked with mental health treatment will likely increase perceived pressure and symptoms.

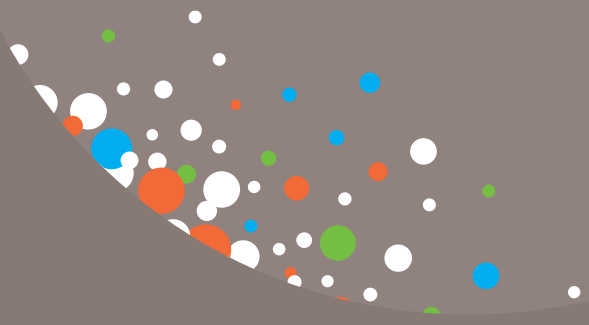
SUMMARY

Traditional masculine norms, such as being tough and self-reliant mean that many young men learn to avoid expressing emotions or behaviours that show vulnerability.

Psychoeducation based on positive masculinity should be a part of preventive responses to mental ill-health for young men.

There is growing recognition that for young men, symptoms of mental ill-health manifest through externalising behaviours and as such, their symptoms can be missed as they do not readily fit with existing diagnostic criteria.

Unrecognised, unmet or under-treated mental ill-health will likely exacerbate the consequences young men may experience.



Potential mental health consequences

Young men face a higher likelihood of experiencing mental ill-health than at any other time in their life. Unrecognised, unmet or under-treated mental ill-health will likely exacerbate the consequences.

Mood disorders

Self-reported rates of depression in Australian young men (18-25 years) are lower than the rate revealed using a standardised depression screen. While 11 percent of participants reported symptoms or treatment for depression in the prior 12 months, 16 percent screened positive for clinically significant depression in the two weeks prior to the survey (Currier et al. 2016). Despite more than four-in-ten young men (44.9 percent) identifying depression as the major mental health disorder confronting young people (Burns et al. 2013) there is poor personal recognition and reporting of emotional distress among young men (Brownhill et al. 2005). A lower incidence of mood disorders yet higher rate of suicide among young men (relative to young women) may reflect poor identification of depression in men due to potential differences in symptomatic expression. Mood disorders are largely diagnosed on the basis of awareness and expression of thoughts and feelings, and to some extent observable behaviour.

In the case of depression, the more closely a man adheres to traditional masculine norms the less likely they are to seek help (Fields and Cochran 2011). There is emerging evidence that depressive symptoms in men can manifest through externalising behaviours rather than affective symptoms such as internalised feelings of worthlessness or hopelessness (Fields and Cochran 2011). For many young men such externalising behaviours may be an enactment of mental ill-health, but these behaviours do not align with current diagnostic systems, precluding identification and intervention (Brownhill et al. 2005). Differences in symptomology have been identified as masking the true incidence of mood disorders, in particular among men (Rice et al. 2017; Martin, Neighbors, and Griffith 2013). Symptoms that may be particular to men are not currently included in diagnostic criteria (i.e. expressions of anger or risk taking) and this is reflected in the relative insensitivity of diagnostic tools to detect symptoms (Rice et al. 2013). Aside from the misrepresentation of the extent of illness, the potential masking of symptoms and propensity for delayed help-seeking means many young men experiencing mood disorders miss out on treatment.

Higher rates of alcohol and other drug use as a coping strategy for emotional distress is one example (Wilhelm 2014). A 2017 meta-analysis found that depressed men were more likely than depressed women to report alcohol and other drug misuse and risk taking/poor impulse control (Cavanagh et al. 2017). Analysis of data in the United States found that differences in rates of depression among people of all ages disappeared when substance use, risk taking and anger are included in diagnostic decision making (Martin, Neighbors, and Griffith 2013). The experience of emotional distress may be largely reflected in what men 'do', in contrast to women whose symptoms may be more evident in what they 'feel' (Wilhelm 2014). A more accurate picture would be drawn if outward behaviours or depressive equivalents (i.e. alcohol and other drug use, risk taking, aggression) were incorporated alongside disturbed mood and emotional expressions currently used to diagnose the presence of depression (Brownhill et al. 2005).

As indicated, anger may reflect psychological distress in young men. At present, services tend to respond to anger by limiting care. A new approach is needed that facilitates engagement with young men displaying anger or aggression that ensures the safety of health workers and other people present in a service setting or around a young man who is potentially hostile. Emergency services and departments need to be equipped to de-escalate anger to facilitate a safe environment and the provision of care.

Opportunity	Mechanism
Improved management of anger and aggression in young men is required to ensure the safety of themselves, health and emergency services staff and the public. New service approaches that focus on de-escalation and access to services need to be developed and implemented.	Emergency Departments and Emergency Services, including Police.
Young men with identified problems related to anger and aggression require timely access to acceptable interventions. These interventions should look to broaden young men's emotion recognition and management, and expand their adaptive coping skills.	Orygen, The National Centre of Excellence in Youth Mental Health, key national and international research partners.

To assist health professionals recognise depression in young men, a depression risk scale has been developed in Australia, and recently cross-validated in Canada. The Male Depression Risk Scale (MDRS-22) includes six symptom domains (emotion suppression, anger and aggression, drug use, alcohol use, somatic symptoms, and risk taking) yet is brief enough to be used in a primary care setting (Rice et al. 2013).

Opportunity	Mechanism
Best practice guidelines for clinician engagement with young men are needed. Guidelines need to address the role of traditional masculine norms, the variations in young men's alignment with masculine norms and associated effects on their mental health. Guidelines should be co-created with young men. Guidelines should be used to inform the design of professional development modules and awareness materials and distributed by peak bodies of health professions.	Orygen, The National Centre of Excellence in Youth Mental Health, key Professional bodies and Peak organisations.

Anxiety disorders

Identifying with traditional masculine norms has been found to decrease the risk of social anxiety (Moscovitch, Hofmann, and Litz 2005). While it is intuitive to conclude that young men may be more socially confident in a normative role, the higher prevalence of comorbid anxiety and alcohol and other drug use disorders among men may be evidence of attempts to cope with or mask symptoms of anxiety (similar to that found for depression). Men diagnosed with anxiety are more likely to have a comorbid alcohol or other drug use disorder (McLean et al. 2011).

Studies of adolescents have found that social anxiety symptoms peak in males during mid-adolescence (in particular ages 14-15 years) (Ranta et al. 2007). There is also indicative evidence that the presence of social phobia at the age of 15 years is associated with subsequent depression at age 17 years for young men (Väänänen et al. 2011). The experience of anxiety has been found to have more negative consequences for adolescent males than females (Derdikman-Eiron et al. 2012).

Schizophrenia spectrum and other psychotic disorders

Two-thirds of males with psychotic disorders experience their first episode of psychosis before the age of 25 years. The future lifetime health risks for these young men are worsened by high rates of alcohol and other drug use [tobacco smoking (71.1 percent); illicit drug use (63.2 percent); and alcohol (58.3 percent)] and poorer physical health. Low activity levels and poor nutrition contribute to higher rates of obesity compared with the general population (Morgan et al. 2011).

Young people with first episode psychosis and those with coexisting psychosis and alcohol and other drug use issues have historically been difficult to engage in treatment. The younger the age of onset the longer the treatment delay (Ehmann et al. 2014). Young people also have higher levels of treatment attrition once they do engage (Dixon, Holoshitz, and Nossel 2016). As a result, it is common for young men to initially receive treatment as a result of a crisis-based hospital admission, often as a result of disruptive behaviour. Despite hospitalisation, ongoing

engagement with treatment is not guaranteed (van Schalkwyk, Davidson, and Srihari 2015). Young men with psychosis have poorer outcomes relative to young women in part due to socially adverse behaviour and lower social support (Häfner 2003). The heightened risk of poorer outcomes faced by young men underlines the importance of achieving engagement with treatment. This failure to engage young men in treatment was the catalyst for specialised services such as the headspace Youth Early Psychosis Programme (hYEPP). The inclusion of the experiences and participation of young men as part of the evaluation of the hYEPP will inform how this program is implemented in the future. It is important that the evaluation considers barriers and facilitators of engagement.

Bipolar disorder

The estimated lifetime prevalence of bipolar disorder in young men (16-24 year olds) is 3.2 percent (Australian Institute of Health and Welfare 2011). The average age of onset is 17.5 years, but there is an approximate delay in diagnosis of 12.5 years (Berk et al. 2007). Although, about half of people who develop bipolar disorder will do so by the time they are in their early to mid-20s (Kessler et al. 2005) they are unlikely to receive treatment until their 30s. Unlike the barriers to diagnosing unipolar mood disorder in young men due to a focus on emotional symptoms, bipolar disorder symptoms can be evident across a range of domains (emotional, cognitive, behavioural and physical). Diagnostic guidelines from the United Kingdom stress that diagnosis of bipolar in a young person should only be made after a 'period of intensive, prospective longitudinal monitoring' and that a diagnosis should not be made based on depression or irritability alone (NICE guideline 2014). While medication is the primary treatment for bipolar disorder, alone it is typically insufficient to manage the disorder. There is some suggestive evidence that family psychosocial interventions may also assist (Justo, Soares, and Calil 2007).

Alcohol and other drug use disorders

Alcohol and other drug use is a serious short- and long-term health issue for young men. The occurrence of comorbid alcohol and other drug and mental health disorders among young men is high (48 percent) (Australian Bureau of Statistics 2010a). Alcohol and other drug use can be used by young people to manage their experiences of mental ill-health. Almost a quarter (24.7 percent) of young people used alcohol and other drugs to manage their illness, whereas 14.7 percent of young people reported that they stopped using alcohol and other drugs in an attempt to improve their mental health (Australian Bureau of Statistics 2010a). Using alcohol and other drugs as a coping mechanism is more prevalent among men, who consistently report alcohol use as an emotion regulation strategy at higher rates than women (Nolen-Hoeksema 2012).

> "Drinking is probably one of the biggest kind of avenues for men to kind of deal with their problems with emotions.
>
> **– focus group**

The high prevalence of alcohol and other drug use among young men is reflected in their perceptions of alcohol and other drug use as the number one health problem for young people (46 percent), followed by mental ill-health (39 percent) (Burns et al. 2013). Problematic or excessive alcohol and other drug use increases the risk of injury. More than four-in-ten young men (43 percent) aged 14-19 years are at risk of injury resulting from a single occasion of drinking alcohol (Australian Institute of Health and Welfare 2013).

For some young men addressing alcohol and other drug use may be complicated by cultural factors or be a bigger issue among certain population groups [i.e. higher prevalence rates among sexuality diverse young men (Australian Institute of Health and Welfare 2015b)]. Low rates of access to mental health services by young people has been linked to high rates of alcohol and other drug use, and low rates of help-seeking for this behaviour (Reavley et al. 2010). Historically alcohol and other drug treatment has been prioritised with low rates of subsequent mental health treatment (Deady et al. 2014).

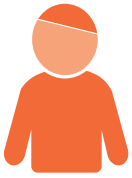
Health professionals, be they in primary care or working in alcohol and other drug or mental health services need to consider comorbid alcohol and other drug use disorders when assessing young men. The integration of mental health and alcohol and other drug services provides an opportunity to deliver improved services for young men and deliver improved service efficiencies.

Opportunity	Mechanism
Government policies for integrated mental health and alcohol and other drug use services need to be coordinated and implemented at a service delivery level. Implementation plans that include measurable workforce training and service delivery targets should be a condition for State and Territory funding, services commissioned by Primary Health Networks and forensic services for young men in contact with the justice system.	Primary Health Networks commissioned services, State and Territory funded health services, Police and forensic mental health services.

Mortality

Suicide is the leading cause of death among young men (aged 15-24 years). Young men are two and a half times (2.6) as likely to die by suicide as young women (Australian Bureau of Statistics 2016a). Comparative data for non-indigenous and Aboriginal and Torres Strait Islander young men is dated: 2011 data showed that Aboriginal and Torres Strait Islander young men were five times (5.1) more likely to die by suicide (Australian Bureau of Statistics 2013). The high rates of suicide in young people coincides with the highest rate of onset mental ill-health. Mental health problems are the strongest risk factor for suicide.

IMPACT OF MENTAL DISORDER ON LIFE EXPECTANCY



Men with a mental disorder
Decrease in life expectancy → 15.9 years

Women with a mental disorder
Decrease in life expectancy → 12 years

The physical health implications of untreated or under-treated mental ill-health also contributes to reduced life expectancy. Men with a mental disorder have an average decrease in life expectancy of 15.9 years compared with 12 years for women. The difference is greater for young men experiencing schizophrenia at 16.4 years (12.5 years for women), with depressive disorders resulting in a decrease of 15.3 years (12.5 years) and 13.4 years (12.1 years) for other disorders (Lawrence, Hancock, and Kisely 2013). Suicide is the leading cause of death among men with a diagnosed mental disorder (16.6 percent) and is higher for depressive disorders (22.7 percent) and schizophrenia (19.8 percent) (Lawrence, Hancock, and Kisely 2013).

Improved engagement of young men in help-seeking and early interventions, possibly through alternate avenues (i.e. education, sports, primary health) is urgently required to reduce intentional self-harm, suicide rates and improve longer-term health outcomes.

Bodyweight and mental wellbeing

The tension between the potential protective role of traditional masculine norms and risks of mental ill-health for young men is evident in the increased pressure on young men to conform to an ideal masculine physique. Between 40 percent and 46.6 percent of men aged 18-25 years are overweight or obese (Currier et al. 2016). Increased social pressures around body image will likely generate additional stress for young men experiencing first episode psychosis due to the risk of rapid weight gain and obesity triggered by treatment medication. Physical activity, along with nutrition, has the potential to attenuate these health risks associated with excessive body weight. Benefits have been shown for depression, anxiety, schizophrenia and bipolar disorders (Rosenbaum et al. 2015; Curtis et al. 2015).

Body image issues among young men are receiving increased attention. Recognition as a distinct mental health condition, along with the incidence of comorbid depression or anxiety highlights the potential health risks for young men. More than a third of young men (36.1 percent) aged 15-17 years with a probable serious mental illness were 'very' or 'extremely' concerned about their body image, following concerns about stress, problems at school and depression (Mission Australia 2015). A survey of male secondary-school students in the United Kingdom found that one-in-five (21 percent) had exercised in order to achieve the ideal male body, and 48 percent would consider doing so (YoungMinds 2016). Emerging pressures around body image illustrate the increasing complexity of multiple masculinities and increasing social pressures and expectations experienced by some young men (Coffey 2013). The need for more research on the prevalence and impact of eating disorders and effectiveness of interventions among young men has previously been identified in the policy paper *Nip it in the Bud: Intervening early for young people with eating disorders* from Orygen, The National Centre of Excellence in Youth Mental Health.

Opportunity	Mechanism
More research is needed to understand the vulnerability of young men to illnesses related to body image. Protective and risk factors need to be identified to inform the development of awareness materials. Targeted interventions to support young men need to be developed and trialled.	Butterfly Foundation for Eating Disorders in collaboration with Orygen, The National Centre of Excellence in Youth Mental Health, key national and international research partners.

Offending behaviour

Young men have a greater risk for offending. The rate of criminal behaviour peaks in adolescence and young adulthood (Moffitt 1993) coinciding with the highest rate of onset mental ill-health. The offending rate is higher among young men and peaks at 18 years compared with 15 years for young women (Australian Bureau of Statistics 2010b). The prevalence of mental ill-health is higher among young people engaged in the justice system and higher again among young people in residential detention (Kinner et al. 2014). Although they experience a higher prevalence of mental ill-health, young people connected with justice system are less likely to have accessed mental health services (Liebenberg and Ungar 2014). An increased risk of contact with the justice system due to undiagnosed or untreated mental ill-health further highlights the need to engage young men in mental health services earlier.

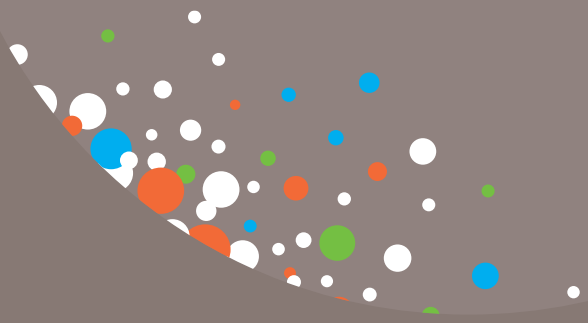
SUMMARY

Suicide is the leading cause of death among young men (aged 15-24 years) and is higher among young Aboriginal and Torres Strait Islander men.

Symptoms that may be particular to men are not currently included in diagnostic criteria (i.e. expressions of anger or risk taking).

Differences in symptomology have been identified as masking the true incidence of mood disorders, in particular depression among men despite the high incidence of suicide.

Services and interventions need to be delivered into the lives of young men in a form they find relevant and acceptable.



Engagement

The challenge of engaging young men in mental health services and treatment is threefold: firstly the circles of support around young men (friends, family, peers, teammates, co-workers, teachers, employers etc.) need to be aware of the signs that they may need help; secondly young men need to be prepared or supported to seek help; and thirdly, services and interventions need to be delivered into the lives of young men in a form they find relevant and acceptable.

Young men account for 43.1 percent of 12-25 year olds with a diagnosable mental disorder. Data for different pathways to care show that young men are under-represented in many of them.

Young men aged 12-25 years account for:

- 31.6 percent of services provided through the Access to Allied Psychological Services program (Australian Institute of Health and Welfare 2015a);
- 36 percent of GP prepared Mental Health Treatment Plans (Department of Human Services 2016);
- 37.2 percent of headspace clients, increasing to 40.8 percent among clients aged 18 years and over (Hilferty et al. 2015); and
- 46.1 percent of contacts per capita with specialist community mental health services (Australian Institute of Health and Welfare 2016)*.

While the need to develop health services that are relevant and meet the needs of young men has previously been identified (Burns et al. 2013), continuing low rates of engagement and higher rates of suicide and alcohol and other drug use shows that more needs to be done. Critically, this does not mean continuing to offer more of the same, but rather innovative new approaches that are co-designed with young men themselves need to be developed and trialled. The delivery must be more proactive, reaching into the lives of young men to facilitate increased engagement in help-seeking and treatment.

Health service disengagement

General disconnection from health services during early adolescence (Marcell et al. 2007) and into adulthood (Smith, Braunack-Mayer, and Wittert 2006) is a barrier to engagement with mental health services. The pathway for young men to mental health services will, in part, be influenced by the level of engagement in primary healthcare. National data shows that proportionally fewer young men (15-24 years) visit the doctor (63.9 percent) compared with young women (80.7 percent) (Australian Bureau of Statistics 2016b). Although young men are going to the GP less often, a survey of 18-25 year old men found that 29 percent had done so for a check-up rather than for a specific complaint (Currier et al. 2016). Primary health care is a central access point to health services for many young men who do seek help. There is a need to improve the ability of GPs to recognise symptoms of mental ill-health in young men (Rickwood, Deane, and Wilson 2007) who may present for other reasons, or be unable to articulate their mental health needs. A study of help-seeking behaviours found that services play a 'significant role in promoting, or limiting' help-seeking by men at risk of suicide (River 2016). Any visit by a young man provides an opportunity for GPs to assess mental health risks.

Stigma

Stigma associated with mental ill-health and treatment is sufficient to delay an individual's engagement with services (Rickwood, Deane, and Wilson 2007) and is the barrier most frequently identified by young people attending headspace services (Hilferty et al. 2015). The experience of stigma can be (extrinsic) in response to perceptions of social responses to one's behaviour or help-seeking, or (internally located) in the conflict between a person's identity and self-perceptions compared with socially conveyed expectations and norms (Seidler et al. 2016). Young men asked about ways to address stigma identified 'direct, positive, and solution-focused advertising that was relevant to their

* Community mental health care refers to government-funded and operated specialised mental health care provided by community mental health care services and hospital-based ambulatory care services, such as outpatient and day clinics.

lives and represented diverse young men' as part of the solution (Lynch, Long, and Moorhead 2016). Targeted actions and positive awareness messages to reduce the stigma associated with mental ill-health and help-seeking experienced by young men is required.

Diversity

Young men are not a homogenous group. Just as one traditional masculine norm does not fit every young man their sense of identity and background differ. These differences can also shape the preferences young men have for how a service is designed and delivered. In addition to preferences attributed to young men, diversity within the population is also likely to require refinements to how services are targeted and sensitivity in treatment delivery guidelines.

> “Some cultures obviously don't look at mental health or illness as a thing ... So if you talk to people about it and word gets around there is this whole sort of shame on your family or yourself. So that's a massive barrier.
>
> **– focus group**

New pathways to engagement

Barriers to engagement with face-to-face services by young men require new pathways to engagement that reach into their lives. Increased awareness that a young man's behaviour may be a symptom of mental ill-health is one path. An increased role for peer support both casual and structured is another. A third option is the potential of digital technologies.

Supporting help-seeking

Resistance to help-seeking informed by traditional masculine norms, health system complexity, socio-economic status and the experience of stigma are barriers for young men. For example, difficulties navigating the system (60 percent) and intake processes (40 percent) have been identified as barriers faced by young men who have engaged with youth mental health services (Rice et al. 2017). Delayed access to services and treatment reduces the opportunity for early interventions which have the greatest potential for reducing the level of treatment required and longer-term health effects.

To improve young men's access and engagement mental health services need to be designed to reach into the lives of young men. This reach will be facilitated by recognition of the barriers they face and variation in preferences within the in-group diversity among young men. Engagement is more likely to be successful when services are co-designed with young men themselves (Rickwood, Deane, and Wilson 2007). Options include health promotion and stigma-reduction activities in workplaces, schools and sporting clubs. The potential to reach young men through activities in schools and their participation in community activities to positively shape their mental health and ability to deal with adverse life events has previously been identified in the *National Male Health Policy* (Australian Government 2010). Novel initiatives are needed to engage young men who are not following traditional help-seeking pathways.

The potential to increase help-seeking by initially focusing on engagement with a mental health service as a pathway to treatment has been identified in a review of the headspace service delivery model (Hilferty et al. 2015). Clinician awareness of the impact of traditional masculine norms on symptom expression and help-seeking, and some discussion in relation to this could be used to promote help-seeking (Primack et al. 2010). A pilot study utilising motivational interviewing increased help-seeking from professionals among college men with mild depression and anxiety symptoms (Bedi and Richards 2011). The addition of psychoeducation that directly discussed masculinity within a Cognitive behaviour therapy (CBT) framework has been positively received by adult men with decreased symptoms observed (Primack et al. 2010). This finding provides indicative evidence for the development of services for young men to address the influence of traditional masculine norms. Similarly, mental health 'side benefits' of socialising and connecting with friends are part of the motivation for adult men to participate in activities that primarily support their physical health (Fogarty et al. 2015). A greater willingness to seek help for physical health issues could also provide an alternative pathway to mental health care.

Peer support

Positive reinforcement within a peer group setting can be more therapeutically effective than individual counselling (Augustyniak et al. 2009). Workshops for 10-18 year olds run by *Reach* are an example of this approach. School-based programs that, in a safe environment, support male adolescents to develop awareness of their emotions and empathic responses may provide a foundation for self-awareness and alternate interpretations of traditional masculine norms.

The circles of support around a young man have the potential to provide a safety net for those experiencing mental ill-health. For young people who go through a process of individuating from their families, the support of friends or peers becomes more important. The support of partners is also a strong influence on help-seeking by young men (Rickwood, Deane, and Wilson 2007). Support from a partner, family and friends increases the likelihood a young man will seek help. The potential of this support infers that help-seeking policies must include a focus on identifying and engaging socially isolated young men.

Peer support running parallel to clinical care can facilitate young men's engagement in treatment. Providing a positive youth-orientated peer group culture in a community based early psychosis program was found to counter negative past experiences of treatment (Stewart 2013). For young men receiving treatment for first episode psychosis, social support and inclusion helps maintain engagement (van Schalkwyk, Davidson, and Srihari 2015).

Opportunity	Mechanism
The evidence base for peer support workforce models in a youth mental health context need to be strengthened. The trial and evaluation of a co-designed model that can be implemented nationally across primary and specialist mental health services is required.	Orygen, The National Centre of Excellence in Youth Mental Health.

Digital solutions

High rates of internet access and smart phone usage has made new technologies a focus of efforts to provide knowledge sourcing and innovation in the delivery of mental health services for young people. eHealth has the potential to remove or reduce many of the key barriers to service use reported by young people with mental health and alcohol and other drug use problems (Kiluk et al. 2011). Evidence that new technologies will facilitate higher engagement from young men in mental health services is mixed.

Access

Digital platforms provide a new engagement option that avoids some of the barriers present in face-to-face service models. There is evidence that young men are open to digital options as a first step in help-seeking. Young men with moderate-to-very high psychological distress are more likely (41.4 percent compared with 30.9 percent among young men with low or no distress) to access health information online, and almost twice as likely to have talked about their problems online with other young people (43.6 percent compared with 22.6 percent) (Burns et al. 2013). The step from online information seeking to the accessing of online services, however, is only made by about half of them. There is also evidence that young men are less likely to seek help using online mental health services (Kauer, Mangan, and Sanci 2014).

Young men represent less than one-fifth of eheadspace users (18.9 percent) (Rickwood et al. 2016) and *ReachOut* found a similar level of engagement (17.7 percent) among young men responding to a user survey (Metcalf and Blake 2014). Although some young men experiencing mental ill-health are seeking information online and more are talking about it on social media or online forums, there remains relatively low uptake of online mental health services. Targeted eHealth interventions and campaigns may be needed to better engage young men in digital services.

Acceptance

For those young men who do take a second step and access services, there is evidence they find the digital delivery of interventions acceptable. This evidence includes: a reported preference for online services compared to face-to-face therapy (Bradford and Rickwood 2014) and acceptance to accessing online interventions from home (Clarke, Kuosmanen, and Barry 2015). Young people with psychosis also report being open to clinicians approaching them via social media during a crisis (Dixon, Holoshitz, and Nossel 2016). Digital platforms are a new development, however, and although some young men appear receptive to interventions being delivered online more research is required to determine levels of sustained engagement (Ellis et al. 2015).

Opportunity	Mechanism
A national evidence base for young men's uptake of existing digital services and treatments, and current research initiatives needs to be established to inform future research priorities and funding.	Department of Health.

Outcomes

There is also some evidence of improved treatment outcomes delivered through digital platforms, however, these too are inconsistent. Online delivery of CBT has been trialled for the treatment of depression (Rice et al. 2014) and anxiety (National Collaborating Centre for Mental Health 2014) in young people. In one study there was a significant lasting effect on anxiety and depression in male adolescents at six months follow up. Another study, however, found that young men are more likely to drop out of group delivered online CBT courses (Clarke, Kuosmanen, and Barry 2015). Where young men do engage in treatment, improvements in mental health (for young men with comorbid alcohol and other drug use disorders) similar to those achieved by face-to-face therapy have been found (Kay-Lambkin et al. 2009). The promise of digital solutions requires greater research and evidence evaluation.

Sustaining engagement

The reimagining of mental health services for young men is required to reach those currently not accessing services and engage them through relevant and acceptable services. Once this is achieved engagement needs to be sustained to maximise the potential benefits of treatment.

Therapeutic alliance

Once engaged with a mental health service ongoing engagement will be influenced by the quality of the relationship between a young man and the service he attends, the health professional he sees and the type of treatment he receives.

Improved mental health is a joint project between an individual and health professional, known as a therapeutic alliance. Positive framing of the strengths of masculinity and how these inform behaviour should be a cornerstone of the alliance built with young men.

A lack of understanding about what therapy entails has been identified as a barrier to headspace services for young men (Rickwood et al. 2015). A preference for male practitioners was also expressed by some young men engaged with headspace services (Rice et al. 2017). Factors that are going to facilitate the therapeutic alliance, such as choice in practitioner gender need to be identified in order to design more acceptable services.

Reimagining the therapy environment may also strengthen the therapeutic alliance. The effect of youth-friendly waiting room environments will be reduced if a one-on-one "oppositional" talking approach occurs as part of the counselling or therapy process. While health professionals can facilitate alliance by orienting and educating young men in the therapy environment, delivering therapeutic interventions for young men in contexts that do not look like a traditional therapy room may be more successful than trying to support men to accept the traditional therapy room environment.

A study of adult men in the United States participating in psychotherapy identified important components for forming a therapeutic alliance (Bedi and Richards 2011). A balance of 'empathy, paraphrases, normalization, and validation, with asking questions and providing

suggestions' coupled with formal respect – especially if the practitioner is a women. Offering practical help was found to play some part in forming a working relationship. Men also recognised the need to be responsible for their part in forming the therapy relationship.

Another study of adult men receiving treatment in the United States looked at factors that damage the therapeutic alliance (Richards and Bedi 2015). Being uncertain or untrusting of treatment, or unsure of what to expect, were key barriers to forming an alliance. Feeling pressured by a practitioner or the perception that they were acting on assumptions were also barriers, as was the feeling of unease toward the fit or approach taken by a practitioner. The responsibility of the client to play his part in forming an alliance was also identified, including the need to contribute enough effort to make the relationship constructive.

While this research cannot simply be extrapolated to young men, it does identify areas for further research. Interventions for young men need to be informed by their experience. Incorporating factors beyond the confines of existing diagnostic criteria and treatment as usual and seeking input from young men in the co-design of acceptable interventions will likely increase levels of engagement.

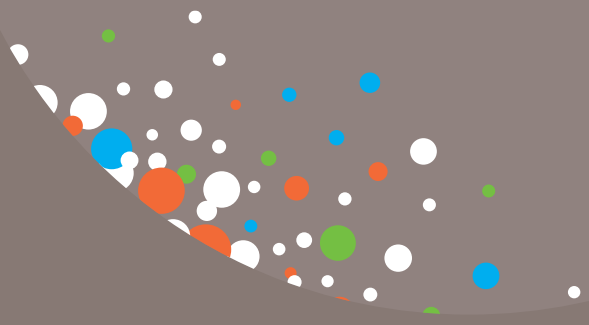
Opportunity	Mechanism
A collaborative, coordinated research focus is required to expand knowledge of the developmental impact of young men's alignments to traditional masculine norms, including associations with help-seeking behaviours and mental health status. The research focus should include: • protective factors and health-related behaviours that may shield young men from mental ill-health. • validation and implementation of gender-appropriate assessment tools that are sensitive to young men's experience of distress and associated externalising behaviours. • data collection in partnership with existing Australian longitudinal cohort studies.	Orygen, The National Centre of Excellence in Youth Mental Health, key national and international research partners.

SUMMARY

Engaging more young men requires strengthening circles of support, encouraging help seeking and delivering services into the lives of young men.

Services need to: recognise behavioural symptoms; incorporate the role of peer support; and develop the potential of digital technologies.

Mental health services that reach into the lives of young men have the potential to overcome many of the barriers they face in help-seeking.



Opportunities

Greater engagement of young men in mental health services requires reaching into their lives with services they will find relevant and acceptable. A reaching in approach has the potential to overcome many of the barriers young men face in help-seeking. The design and development of services need to reflect the influence of traditional masculine norms on the experiences of young men, including their mental health. This influence includes differences in the symptoms of mental ill-health and the embodiment of masculinity, influences that can be shaped by their cultural and sexual identity and background.

The circles of support around a young man provide avenues for reaching in to their lives. These circles of support include family and friends and primary health services. But the range of potential supporters needs to be expanded beyond reliance on these groups to increase the potential access into young men's lives. Examples include; peers, sporting teammates, coworkers, online social networks as well as people in professional roles that have contact with young men; teachers, coaches, employers and various social welfare workers.

Young men themselves have a role to play in developing relevant and acceptable services. Co-design of targeted services will increase the potential of services to reach into marginalized and population sub-groups. Policy opportunities identified in this paper provide direction for focusing on the needs of young men to achieve greater reach of mental health services into their lives.

Promising developments exist which are ready to be trialled in the development and evaluation of new innovative services and interventions for young men. Examples include the role of traditional masculine norms, peer support, the potential of new technologies for treatment delivery and creating safe services for culturally diverse and sexuality diverse young men. In other areas more evidence and/or development is needed, including how to address illnesses related to body image, professional awareness of the link between mental ill-health and external behaviours.

Appendix

TABLE 1 BARRIERS AND FACILITATORS TO ENGAGEMENT WITH MENTAL HEALTH SERVICES AND INTERVENTIONS BY YOUNG MEN

Help-seeking	
Barriers	Stigma
	Masculine ideal delays or prevents help-seeking
	Low mental health literacy; Reliance on symptom severity for identifying need
	Less developed emotional awareness
	Delayed access
Facilitators	Direct, positive targeted awareness messages to reduce stigma
	Professional development for health professionals; targeted awareness program for families and young people
	School-based programs targeting emotion regulation, awareness and communication
	Motivational interviewing
Service design and treatment acceptability	
Barriers	System navigation; intake process
	Long waiting times
	Lack of clinician awareness of the role played by masculinity in the experience of young men
	Lack of understanding what therapy entails; discomfort; new experience
	Preoccupation with discharge, frustration with processes for people in hospital
Facilitators	Co-design of acceptable services and treatments with young men
	Person-centred responses, positive framing of the strengths of masculinity
	Discuss role of masculinity directly

New technologies (eHealth)	
Barriers	Low uptake of online services
	Young men more likely to drop out
	Poor or missing validity of interventions
Facilitators	Promote services on social media; Stated willingness to engage online
	Young men access information and discuss mental ill-health online; Promising acceptance of digital interventions and treatment outcomes
	Co-designed development of specific online interventions for young men
Peer support	
Barriers	Socially isolated young men lack support
Facilitators	Facilitated peer support programs as part of treatment
	Supportive social environment, family and friends
	Counter negative past experience of treatment

TABLE 2 PREVALENCE OF MENTAL DISORDERS AMONG YOUNG MEN AND WOMEN

Disorder	Male		Female	
	12-17 years (Lawrence et al. 2015)	16-24 years (Australian Bureau of Statistics 2010a)	12-17 years (Lawrence et al. 2015)	16-24 years (Australian Bureau of Statistics 2010a)
Anxiety disorders	6.3%	9.3%	7.7%	21.7%
Major depressive disorder	4.3%	4.3%*	5.8%	8.4%*
Substance use disorders	n/a	15.5%	n/a	9.8%
Total mental disorders	15.9%	22.8%	12.8%	30.1%

* Includes Dysthymia and Bipolar affective disorder.

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