

Hall & Partners

OPENMIND



*Men's Help
Seeking
Behaviour*

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Executive Summary

Attitudes to mental health and specifically men’s mental health in the community have shifted significantly in the last 10-15 years. This is almost universally seen as a positive change and there is a sense of pride in ourselves and our society for giving a voice to an issue that was previously shrouded in secrecy and shame.

A number of organisations (government and private) are seen to have worked consistently to raise the profile of mental health as a community concern. beyondblue is spontaneously and widely mentioned here. Public sharing of experiences by well-known figures in the community has also contributed significantly to more open and empathetic discourse.

Both men and women are understood to be susceptible to mental illness, but how men deal with it – and their attitude to help seeking – is seen as different to women (by men and women alike). In exploring the issue of help seeking, our sample covered eleven key male segments encompassing: age (18 to 60+ years); life stage (pre-family, family and retirees); location (metro, urban-growth corridors, regional and rural); cultural background (general population mix, CALD and Indigenous groups) and men from the GBTI community. It also included men who have experienced or are currently experiencing depression and/or anxiety, as well as homeless men and those with co-morbid substance abuse issues. Further to this, we included a small sample of women who had a partner or close family member who had sought help for depression and/or anxiety and we also spoke with a small sample of health, mental health and welfare professionals who work with men as part of their practice.

Despite the breadth of our sample, we found far greater similarity than difference in the underlying attitudes and barriers to help seeking among men. Where notable differences exist we identify them accordingly.

Depression and anxiety at a community level

Whilst we can and do talk more openly about mental health – in particular depression and anxiety – as a society, understanding of what these conditions are is fairly superficial. Few men are able to speak with any confidence or insight – even those who have personal experience of either anxiety or depression. For example, there is little understanding of the difference between ‘feeling depressed’, ‘being depressed’ and having ‘clinical depression’. Furthermore very few could articulate what anxiety is as a condition. Men don’t necessarily understand that these are definable, diagnosable conditions. This limited understanding extends beyond definition to causes, impact on life and treatment. This combined uncertainty or lack of knowledge leads to a vague ‘woolliness’ that casts a shadow over depression and anxiety. Depression and anxiety are grouped together and often discussed as a ‘vast unknown’ lacking in clear parameters and easily comprehensible components. This then contributes to a superficial relationship with the issue and a narrow point of engagement.

Added to this, there are issues in life that we are aware of, and may even empathise with, but don't seek deeper understanding of unless we are personally impacted. These are 'need to know' issues. Only when we are personally or professionally connected or confronted with these issues do we seek information, demand a greater understanding or seek advice. When it comes to mental health, even then men often ignore the issue in the hope it will go away.

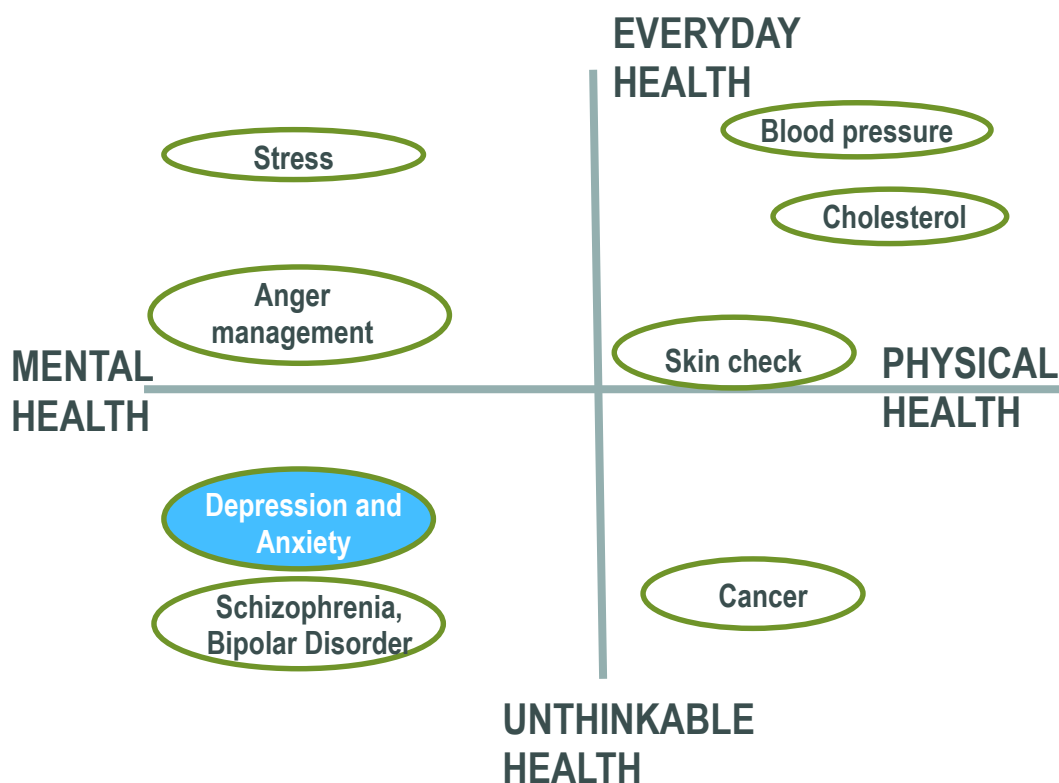
Depression and anxiety at the personal level

In contrast to our positive and proud societal attitude to acknowledgement and treatment of mental health, how men deal with it at an individual level is far less developed. There appears to be a lag between what men believe should happen and is happening at a community level and what many are comfortable with at a personal level. Many men are still hesitant and have difficulty talking about depression or anxiety at a personal level. This is driven in part by the lack of clarity in understanding of depression and anxiety; however, there are other factors that are also driving this.

- **Fear or actual experience of stigma.** The greatest stigma appears to come from within. It was common for men to speak supportively of friends, family or colleagues in the face of mental health issues, but then not afford themselves the same level of consideration or empathy in the same circumstances. Admitting mental health issues is confronting personally and, for some, amounts to admitting to not being the full man they like to see themselves as being or want to be.
- **Need for control.** There is a strong need among many men to control their world. This stems from their role as provider and family head – even among those who share the earning and child rearing responsibilities with their partner.
- **Lack of tools to express themselves or instigate conversations on mental health.** Across the sample we found men who admit to feeling ill-equipped to deal with the topic of mental health. Some spoke of not knowing how to even start a conversation with a friend or family member. Expressing in-depth emotions was one part of this, but it was also the case that the nature of their relationships and their lack of propensity to ever discuss personal matters meant that having such a conversation would materially change the nature of their relationship forever.
- **An absence of social support and community connections.** As we found from those people we spoke with who had sought help, family members and friends are usually the key motivators or instigators to help seeking. The absence of such support (for example in cases where relationships are fractured, in broken families, or for the socially isolated) can thus serve as a barrier to comfort with and readiness for help seeking.
- Another issue that emerged – either for oneself or in helping a friend – is the **point of action**. Men across the sample were inclined to delay action of any kind until crisis point. This was often driven by one or all of the above four points. With the best of intentions however, without understanding the signs of depression and anxiety, men are unlikely to know when crisis point is reached.

Despite increased acceptability of mental health at a community level, at a personal level stigmas and barriers prevail. Depression and anxiety are categorized as 'unthinkable conditions' (much like cancer) – men know they are real, but either they don't believe that they will happen to them, or they believe that they can't be predicted so why worry about them happening or do anything in advance. This is further

compounded by men's propensity to deny or ignore 'mental health' compared with physical health which is more tangible and felt to be more definitive. This combination of cultural reference and dismissal creates the lag in attitude toward mental health at a personal level. To impact this we need to reframe how men (and society as a whole) think of depression and anxiety. Currently it sits as an 'unthinkable', 'woolly' area that is too often 'best ignored'.



Avenues for support (hypothetical and current)

For those that have sought help, or in anticipating where one might seek help, a (limited) number of key sources emerged:

- **The internet** is the 'go to' resource in all aspects of life and is seen as especially relevant here – offering anonymous, non-verbal means of gaining information. There was little site specific identification and destination mentioned, far more search engine exploration.
- **Family and friends** are seen by many as a safe first step for reaching out – however, not all feel comfortable making their vulnerabilities known to their loved ones, as raised above.
- **Seeing a GP** is the first step to accessing professional help; however, there are clear barriers which need to be overcome before some will see a GP (a lack of trust appears to play a role here, as do the broader barriers relating to attitude and understanding identified earlier). Lack of privacy in rural locations was raised.
- **Seeing a mental health professional** is associated with 'serious conditions' and 'advanced cases' and is therefore unimaginable to many.
- Lastly, **helplines** are seen as a source of crisis support around the clock, if urgent assistance is needed.

There appear to be clear steps or stages of comfort in reaching out, with internet often being the first, then family, then GP – but these vary on an individual basis. Helplines may be the last or first and only step taken.

Men (and their significant others) are generally aware of the existence of support services channels available, but the barriers to help seeking identified earlier hold them back from feeling comfortable and ready to take that first step outside of their private world and inner support circle.

Notably, *beyondblue* was not mentioned unprompted as a support or help seeking destination.

We have identified the primary barriers and potential enablers in engaging men to seek help (see chart below)

AUDIENCE		BARRIERS	ENABLERS
Life stage	Young men (18-25)	<ul style="list-style-type: none"> • 'Self' focus: life stage that's 'all about me' • Health not top of mind – sense of invincibility • Want to fit in – not stand out or be different • Ill-equipped 	<ul style="list-style-type: none"> • For some, connections with communities (i.e. schools, universities, clubs) • Triggers and prompts by parents, peers • Driven to 'look out for mates' – assisting others
	Fathers (25-59) – young families	<ul style="list-style-type: none"> • 'Other' focus: family comes first, then myself • Infrequent and irregular visits to GPs • Belief help seeking is sign of weakness and failure 	<ul style="list-style-type: none"> • Where benefits to family are conveyed • Triggers and prompts by partners / spouses
	Fathers (25-49) – separated families	<ul style="list-style-type: none"> • Where separation is recent, life is chaotic, difficult to see clearly • Sense of social disconnection, isolation, resentment 	<ul style="list-style-type: none"> • A means of gaining control, avoiding crisis point • 'Do it for the kids', 'do it for yourself', 'get back on your feet'
	Older men (Over 60)	<ul style="list-style-type: none"> • An attitude of 'it's too late for my generation' (i.e. mental health awareness will naturally increase with the younger generation) • Discomfort acknowledging or discussing emotions 	<ul style="list-style-type: none"> • Greater likelihood to be in contact with GPs given life stage • Participation in clubs, social groups • Triggers and prompts by family (partners and children)
Geography	Rurally-based men	<ul style="list-style-type: none"> • More limited access to choice of service, proximity to services 	<ul style="list-style-type: none"> • Strong sense of community, community support • Linked to the above, driven to 'look out for others, mates'
	Men living in urban growth areas	<ul style="list-style-type: none"> • Relative to inner city, less choice in services (however do not necessarily see selves as being short of services) 	(Same as general population by age)
Cultural background	Men with CALD backgrounds	<ul style="list-style-type: none"> • For new migrants, understanding the Australian health system and how to navigate this can be particularly challenging • Cultural framing of mental illness (where inconsistent with available action pathways) 	<ul style="list-style-type: none"> • Strong family and community support
	Indigenous men	<ul style="list-style-type: none"> • Lack of trust in mainstream health services, feeling clinicians are not able to understand or empathise 	<ul style="list-style-type: none"> • Speaking with a male from their own community, or male Indigenous person
Unemployed men		<ul style="list-style-type: none"> • Potential for long-term unemployed to experience inertia 	<ul style="list-style-type: none"> • Pre-existing connections with unemployment and welfare organisations • If retrenched or experiencing workplace injury, workplace making connections with services
Men from the GBTI community		<ul style="list-style-type: none"> • Facing an additional layer of stigmatisation 	<ul style="list-style-type: none"> • Connections with existing support groups accessed via GBTI communities

<p><i>Men with substance use concerns</i></p>	<ul style="list-style-type: none"> • Potential limited motivation for change, sense of hopelessness (using alcohol / drugs as coping mechanism) • Potential for fractured family and other relationships • Self-harm can be an issue 	<ul style="list-style-type: none"> • If engaged with D&A support services, existing connections with health / mental health clinicians • Usual ‘role models’ don’t apply
<p><i>Homeless men</i></p>	<ul style="list-style-type: none"> • Many likely to be diagnosed with mental illness – potential to have experienced prior treatment which was unsuccessful • Opportunities for privacy to review or seek out information limited 	<ul style="list-style-type: none"> • At crisis point • Pre-existing connections with welfare, community services
<p><i>Female influencers</i></p>	<ul style="list-style-type: none"> • Own limited understanding, experience, misconceptions associated with depression / anxiety 	<ul style="list-style-type: none"> • Prompting male in their life to seek assistance • Provision of emotional support and encouragement to male • Can assist with navigating an action pathway • Taking the initiative to seek assistance / information on behalf of their spouse / son / father etc.

Current framing of depression, anxiety and help seeking

How issues are framed is central to how they are thought of, communicated and discussed. The framing of an issue is often long held, deeply-rooted and difficult to change because the ways of discussing and evaluating the topic are so entrenched that the patterns of engagement repeat themselves (i.e. we always speak about the issue in the same way and ask the same questions and get the same answers). There are a number of current frames around mental health on a personal level (which despite being ‘personal’ were widely held across the sample). The current frames we heard and observed are:

Current frame
Mental health is not on my radar / don’t want to think about it
Depression / anxiety only happens to weak ‘flawed’ people
Depression / anxiety is woolly and unknown. It is a black hole.
You don’t dwell on these things and you don’t talk about it – you just cope
Help seeking is a sign of weakness and failure
Help seeking / intervention takes place at crisis point
Drugs are the only treatment

These frames are well established and like many long (generationally) held opinions they are rarely easily or directly challenged. However changing opinion isn’t always necessary to change behaviour.

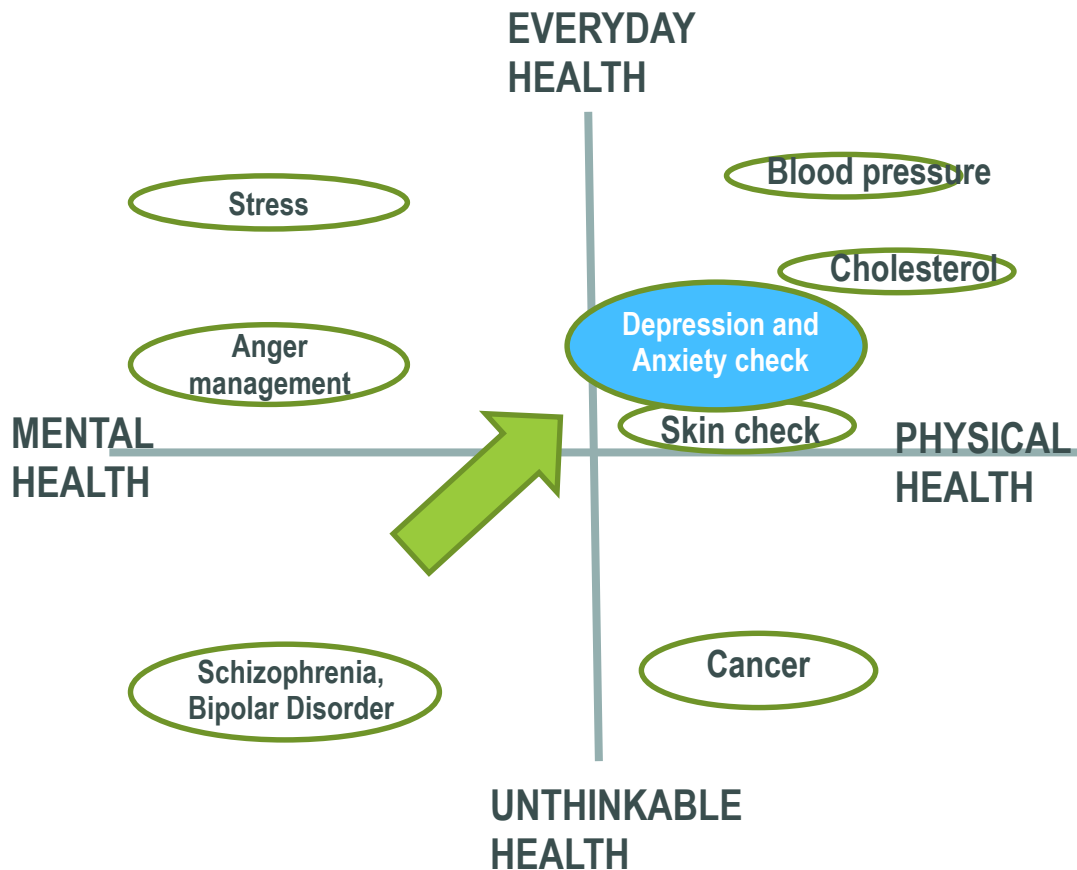
Reframing

Reframing is about altering the view of the issue and creating new ways in. In addition it is about using new language and adopting new frames of reference. Using acceptable frameworks in other areas can be very powerful to reframe or ‘reset’ the issue and allow a meaningful change in perspective. We believe in the case of Depression and Anxiety we need to do all three. Firstly we need to reframe each of these beliefs from ‘current’ to ‘new’.

Current frame	→	New frame
Not on my radar/ don’t want to think about it		Every man should know / No one is bulletproof
Depression / anxiety only happens to weak ‘flawed’ people		Depression / anxiety is an illness / condition that can strike anyone (x% of people will experience at some point)
Depression / anxiety is woolly and unknown. It is a black hole.		Depression / anxiety are diagnosable and treatable
You don’t dwell on these things and you don’t talk about it – you just cope		There’s no shame in suffering anxiety or depression – they are treatable health conditions
Help seeking is a sign of weakness and failure		Taking action is associated with taking control, staying strong Protecting self is protecting others
Help seeking/intervention takes place at crisis point		Early action is best
Drugs are the only treatment		There are a range of courses of action available, and treatment can be tailored

We also need to address language. For example, an implication of seeing depression and anxiety as weakness is that ‘help seeking’ can be seen as an indication of *failure to ‘handle the problem’* as an individual. Reframing the activity of help seeking in a more empowering way, such as ‘taking action’ or ‘taking control’ will likely resonate more closely with the ideals for many men of being strong, and being strong enough to be a protector of others. This language is far more active and in line with the way men like to handle issues, and it is an important component of providing new ways in.

Additionally we need to provide a far more tangible and everyday function around depression and anxiety to give men the tools they feel they lack. Men are far more comfortable with no-nonsense facts. Therefore information is best delivered in this way. Communicating 'the signs', 'the actions to take' and 'the treatment options' reframes the vague and ill-defined into tangible, achievable tasks. Furthermore it moves depression and anxiety away from the woolly and unthinkable and into everyday health, i.e.:



Implications and recommendations for communications

The role for communications

We see that there are two broad communications tasks that will assist *beyondblue* in achieving its communication objectives:

1. Reframe how people conceptualise and talk about depression and anxiety to enable and empower men to take action.
2. Clarify and enrich understanding of the scope of *beyondblue* so it is spontaneously identified as a 'go to' resource for men at any stage of mental health experience.

1. Reframe how people conceptualise depression and anxiety so as to increase help seeking behaviour

Reframing provides a powerful reset for messaging; the above reframing table sets out how each current frame can be addressed. Further to this we have developed a communications framework (see below). In keeping with the findings we have split this into three broad life stages as these were the most influential on message content. A detailed list of touch point / channel considerations is provided by sub-segment in the body of the report.

As you will see in the communications framework below, we recommend engaging men on the issue by focussing on tangible, actionable elements, i.e.:

- knowing the signs (of depression and anxiety)
- action plans
- treatment options
- all presented by and available through *beyondblue* (available 24/7 via the Info Line and the *beyondblue* website)

The tone should be ‘matter of fact’ and ‘to the point’ and addressed in the same way that other health checks are presented. The further benefit of this approach is that it will address a number of the wider communication goals for the campaign, i.e.:

- educate men on the signs and symptoms of depression and anxiety
- increase awareness of depression and anxiety as common and serious illnesses affecting men in Australia today
- challenge the perception among men that asking for help is a weakness
- encourage men who may be experiencing symptoms of depression and anxiety to seek help by calling the *beyondblue* Info Line, including reinforcing the importance of seeking help early, and
- inform men that treatment for depression and anxiety is available and that information is available 24/7 via the Info Line and the *beyondblue* website.

Communications framework

The communications framework overleaf brings the above together and highlights the particular nuances identified by life stage.

Communications framework:

The below chart is a starting point to feed into communications development against primary audiences. We have concentrated on lifestage as these emerged as the most consistent differentiators on attitudes to help seeking and barriers to help seeking behaviour.

	Young men (18-25)	Fathers (25-59)	Older men (60+)
Defining attitude	<ul style="list-style-type: none"> I got to think about what's best for me – this is my time 	<ul style="list-style-type: none"> I have to be strong for my family. I can't let myself fail 	<ul style="list-style-type: none"> It's good that young guys today don't have to 'bottle everything up' but are we getting soft?
Prevailing frame (current)	<ul style="list-style-type: none"> Not even on my radar 	<ul style="list-style-type: none"> Help seeking is a sign of weakness and failure 	<ul style="list-style-type: none"> You don't dwell on these things and you don't talk about it – you just cope
Triggers for engagement	<ul style="list-style-type: none"> Mates/ social life/keep fit 	<ul style="list-style-type: none"> Family responsibility 	<ul style="list-style-type: none"> Health management Balance of self focus & family
Communications task	<ul style="list-style-type: none"> Look out for your mates / know the signs 	<ul style="list-style-type: none"> See that taking action is taking control, 	<ul style="list-style-type: none"> Recognise they are not beyond help
Primary message	Mental health - don't ignore it (know the signs, actions you can take and treatments)		
Segment specific message (reframe)	<ul style="list-style-type: none"> Nobody is bulletproof/ don't ignore a mate in need 	<ul style="list-style-type: none"> Protecting self is protecting others 	<ul style="list-style-type: none"> There's no shame in suffering anxiety or depression – They are common but serious health conditions
Considerations	<ul style="list-style-type: none"> Reflect range of youth /role models 	Sensitive representation of fatherhood to engage separated fathers as well those living in the family unit	<ul style="list-style-type: none"> Roll up the sleeves approach to life could be asset in connecting

2. Clarify and enrich understanding of the scope of *beyondblue* to drive help seeking to *beyondblue* specifically

The second task for communications will be to enrich the current perceptions of *beyondblue* from an organisation which is about advocacy and education at a community level to an organisation which also has direct personal relevance and which can facilitate men (and those helping men) to move along a pathway of 'taking action'. This is essential if you are to increase call rates and web visits.

This extended brand positioning is credible to the majority of the sample (with support) and will be important in drawing men (and those acting on their behalf) to spontaneously think of *beyondblue* and calling or logging-on as a first port of call. However, there are a few segment-specific 'watch outs' which emerged:

- Indigenous men and the trust issue: Engagement of indigenous men comes from within –they are unlikely to respond to anyone other than an indigenous male, and preferably one from within their own community. This is because this kind of person is able to understand and empathise with their life and their challenges. To go to *beyondblue* (a mainstream 'outside' organisation) would be a significant step, especially for older indigenous men. If specific indigenous programs or community connections are already in place they were not recalled.
- Homeless men: It goes without saying that they are already at crisis point. Shelters and hospitality centres provide connection to assistance and resources. Access to phone or internet services severely limited.
- Young disenfranchised males: They are less likely to respond to conventional role models (i.e. footballers, celebrities); they are 'tough' and need someone equally 'tough' to speak to them (for example, bikies, hip hop and graffiti artists, cult heroes).

The tangible, action oriented approach recommended here will simultaneously enrich people's understanding of the scope of *beyondblue* and will directly draw men to the website or phone line. By challenging men to know the signs / action plans and treatment options, it cuts through the hesitation to reach out in advance of actual need and also invites engagement at numerous points – not just crisis.

Communications considerations and 'watch outs'

Lastly, in delivering the above framework, the research has flagged the following considerations and 'watchouts' which will be important to consider in developing a men's campaign:

- The tone of communications should be hopeful and empowering
- A clear purpose is essential – logical, factual, directional. Too vague and you immediately lose men.
- Create a personal connection and demonstrate relevance: show / represent a wide variety of men
- Understanding others' experiences can be powerful. Many of the men we encountered were keen to understand 'real life' examples of people who have experienced depression and

anxiety – and not just celebrity figures, but the ‘everyday Joe’. Seeking, sharing, discussing online is highly appealing, with video preferred over text.

- Be wary of overwhelming people: online provide clear navigation tools and clear sub-categories of information, easily accessible videos, checklists and action tools
- Be careful with using the word ‘consumer’. For those who had prior contact with *beyondblue*, concerns with the word ‘consumer’ emerged as it has been applied on the *beyondblue* website. People were left feeling depersonalised.

Summary and implications

There are a number of barriers that contribute to men’s willingness and ability to seek help in the face of depression and anxiety. Critical amongst these are: self stigma; perceived lack of skills and support; need for control; and preference for action over introspection.

The lag observed between public and private attitudes to mental health and help seeking; suggest communications need to move beyond awareness; however resistance to discussion (on many levels) indicates education alone is unlikely to be an effective solution.

To engage men personally and increase help seeking behaviour, messages need to be via *their world-view*, in terms that are non-confronting and provide permission to connect. To do this we recommend reframing the conversation on help seeking in regard to depression and anxiety in three key ways:

- Changing the current frames to new frames (as detailed above) to provide new ‘ways in’ to the issue;
- Changing the language from “help seeking” or “needing help” which is passive and even emasculating, to “taking action”/ “acting” on the issue;
- Using the existing physical health construct (i.e. how physical health conditions such as cholesterol and blood pressure are communicated as *routine but serious* issues health to be monitored) to create behaviours that increase awareness, access, and (importantly) ownership

Together these combine to attack the barriers that currently exist and provide alternative means of engaging with the issue (of depression and/or anxiety) and taking action.

This behaviour change approach, (lead by action paths and tangible tools along with the revised language of ‘taking action’ not ‘help-seeking’), goes directly to the campaign objective of increasing ‘help-seeking’ (‘taking action’) behaviours and driving awareness of Depression and Anxiety among men. By taking an active, ‘health check approach’ it also side steps the debate of whether or not admitting to suffering Depression or Anxiety is a sign of weakness. Furthermore by this approach being spearheaded by *beyondblue* will expand the organisations perceived scope and naturally draw action to the *beyondblue* helpline and website thus directly addressing the primary objectives of the campaign. Reframing Depression and Anxiety as serious but common health conditions, akin to cholesterol checks, is likely to

have the added benefit of translating awareness into regular and routine action. Finally, by encouraging men to know the signs, action paths and treatment options it will increase awareness of Depression and Anxiety in real terms and may enable men to recognise more easily the signs in themselves and in others and ensure they or their friend, loved one or colleague don't get to crisis point.

Recommendations

- Focus on the tangible and actionable, i.e.: the signs of depression and anxiety; the actions or steps they can take (contact *beyondblue*) and the treatment options available. This approach challenges men to be informed. It avoids the 'soft' or ill defined' and allows them to roll up their sleeves and be true to themselves
- Communications can challenge the current frames without referencing them. The approach should not seek to change opinions immediately or directly, but rather to change behaviour by removing barriers and facilitating ways in.
- Strike a tone that is factual (yet positive/ hopeful) to reassure that taking action is important and normal ('this is what we do now'),
- Demystify the woolly 'black dog' and challenge all men to know the signs, the actions they can take and treatment paths (via *beyondblue*)
 - Reframing "seeking help" as "taking action"
 - Reframe crisis response to early action (or intervention)
 - Reframe to 'serious' and 'common' – not 'lightweight' or 'minority experience'
- Address core life stages of pre-family singles, family men and post family/ retirees primarily with targeted touch-points for all 'at risk groups'
- *beyondblue* need to expand and enrich its brand profile to create credible and spontaneous associations with personally relevant information and pathways to action. (*beyondblue* will help me know the signs, the actions I can take and treatment paths available – for me or a mate)
- *beyondblue* delivering this tangible, action oriented approach underpinned by checklists, factsheets action paths and treatment options will challenge the current narrow perception of *beyondblue* and will act to directly draw men to *beyondblue* (web and phone lines) – thus address the campaign objectives of increased calls and visits
- Thoughtful media placement and targeted touch points will reinforce *beyondblue* as personally relevant 'go to' resource.
- Ensure communications demonstrate relevance to lifestage.
- Harness the power of connecting with others' experiences through use of online videos and or blogs profiling people who have experienced depression and/or anxiety.

Research context and methodology

Background

beyondblue has been engaged by the Australian Government Department of Health and Ageing to develop and implement national mental health initiatives for men, as part of its Mental Health: Taking Action to Tackle Suicide 2010 election commitments and response to *The Hidden Toll, Suicide in Australia* report by the Senate Community Affairs Reference Committee.

beyondblue is developing a multi-layered strategy to encourage help-seeking behaviour amongst men and to reduce barriers to seeking support, including stigma. The strategy will inform a multi-platform campaign to be implemented in collaboration and in partnership with relevant organisations to effectively and efficiently reach men across a range of target sub-groups.

A key outcome being sought through the strategy is an increased level of engagement with *beyondblue* by and about men, either online or via the *beyondblue Info Line*. An initial phase of the project has been the www.beyondblue-men.org.au microsite, which has demonstrated initial success in engaging men online to learn more about depression and anxiety.

The impacts expected to result from the strategy include:

- increased awareness of depression and anxiety as common and serious mental health problems affecting men in Australia today
- that the perception amongst men that asking for help is a weakness has been challenged
- men are educated on the signs and symptoms of depression and anxiety
- men who may be experiencing symptoms of depression and anxiety are encouraged to seek help
- men are informed that treatment for depression and anxiety is available

Measureable outcomes from the strategy are expected to include:

- increased visits to the *beyondblue* and associated websites
- increased calls to the *beyondblue Info Line* by and about men
- increased requests/downloads of *beyondblue*'s information resources for and about men
- increased reported awareness and understanding amongst male target groups in future *beyondblue* Depression Monitors
- other measures as determined through a future evaluation of the strategy

Through an array of platforms, and from a variety of settings, a suite of messages will be targeted to eleven population sub-groups of Australian men:

Life Stage	Young men (18-25 yrs)	Fathers	Older men (> 60 yrs)
Location	Men in urban growth areas		
	Rural men		
Priority Populations	Men from Culturally and Linguistically Diverse Backgrounds		
	Men from the GLBTI community		
	Indigenous men		
	Homeless men		
	Unemployed men		
	Men with co-morbid substance misuse		

There are differing concepts of mental health and wellbeing between and within the different sub-groups, and health promotion messages will respectively identify and challenge those concepts that have a negative health impact.

Research objectives

In the context of the communications objectives set out above, and to shape the national campaign, *beyondblue* sought qualitative research to build upon what it already knows about the barriers and motivators shaping men’s help seeking behaviours. Specific research objectives were to:

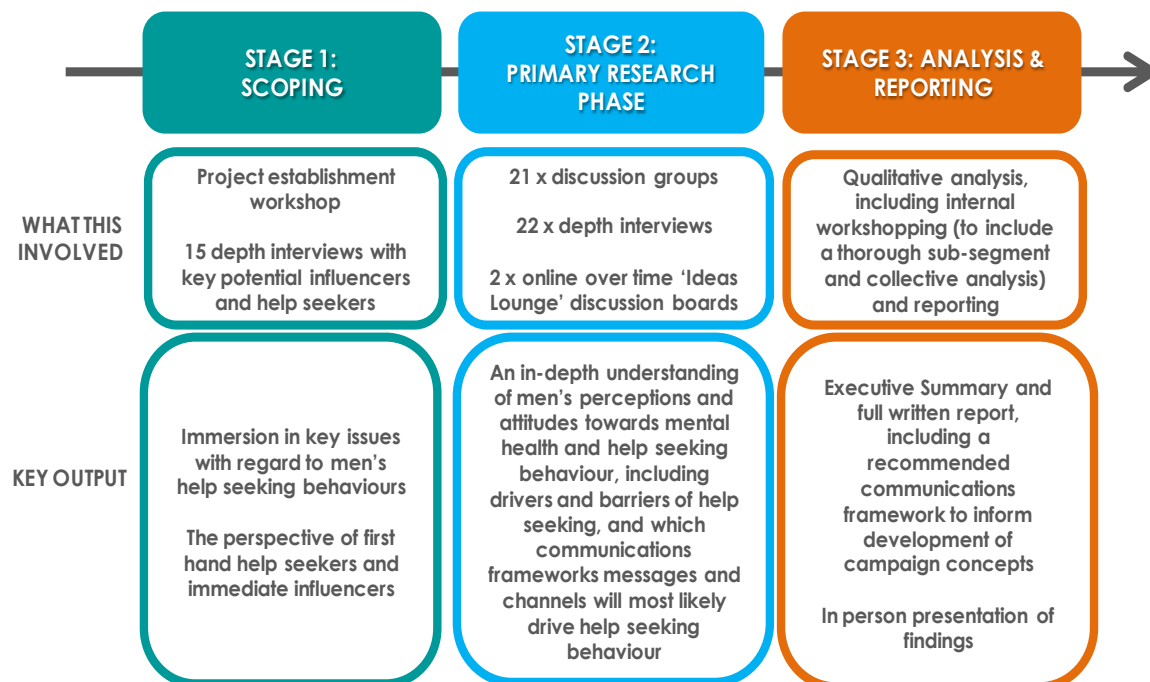
- identify barriers impacting on men’s help seeking
- understand the factors which would facilitate men’s help seeking
- identify enabling strategies for men to seek help
- identify any other information which may help inform the design and approach of a future national campaign.

In addition, we sought to explore the ways in which the issues are framed in the public discourse to set up barriers to help seeking behaviour, and how this thinking can be reframed to encourage the desired behaviour change. That is:

- determine the patterns that are currently evident in the way people think and reason about the issue which is creating the barrier to action
- explore the ways in which current public discourse constrains and directs this thinking
- scope the ways in which these faulty frameworks are being promoted and established in the community, and
- describe how the issue can be reframed to convey expert understanding and encourage help seeking behaviour amongst and on behalf of men.

Methodology

The qualitative methodology adopted comprised three key stages, two of which incorporated fieldwork. The adopted approach is summarised below, with each fieldwork stage then discussed in greater detail.



Fieldwork: Stage One, Scoping

Stage One fieldwork comprised in-depth interviews with 15 institutional influencers¹, male help seekers and partners / family members of male help seekers, as follows:

Audience		TOTALS:
Institutional influencers	1 x general practitioner 1 x psychiatrist practising in a public health setting 1 x counsellor working in a public community health service (plus a colleague) 1 x representative of a men's support network 1 x team leader / case worker from a welfare organisation 2 x beyondblue Info Line staff	7 x depths
Male help seekers	2 x men who had made contact with beyondblue 2 x men who had not made contact with beyondblue	4 x depths
Partners / family members of male help seekers	1 x partner of a male who had made contact with beyondblue 1 x parent of a male who had made contact with beyondblue 1 x partner of a male who had sought help via channels other than beyondblue 1 x parent of a male who had sought help via channels other than beyondblue	4 x depths
TOTALS	15 x depths	

The above fieldwork took place from 25th June – 23rd July 2012. All interviews were conducted face-to-face, apart from one telephone interview.

Fieldwork: Stage Two, Primary Research Phase

¹ One additional consultation took place on 10th August 2012 with a team of workers from an organisation which provides support and hospitality to homeless men.

Stage Two fieldwork comprised a combination of 21 discussion groups, 22 in-depth interviews and two 4-day online bulletin boards². Stage Two fieldwork included respondents living in six states and territories, across metropolitan, regional and rural locations.

The sample predominantly comprised men recruited from the general community, where it is noted they were not specifically recruited as men who had or who were experiencing depression and/or anxiety.

A small component of the sample comprised women who had a male partner or family member who was experiencing or who had experienced depression and/or anxiety, where some men had sought help and others had not.

The final sample achieved is set out in detail overleaf. Stage Two fieldwork took place from 18th July – 10th August 2012. All fieldwork was conducted face to face, apart from the online bulletin boards.

² It is noted that this equated to 205 respondents across the Stage 2 sample. It is further noted that sample sizes for some of our priority populations were very small, hence our ability to draw solid and in-depth insights into these audiences is limited.

Table 1: Stage Two Sample Achieved

Audience	Location 1: VIC - MELBOURNE	Location 2: VIC - TRARALGON	Location 3: NSW - DUBBO	Location 4: QLD - BRISBANE	Location 5: SA - WHYALLA	Location 6: NT - DARWIN	TOTALS:
Young men (18- 25)	<i>1 x group (urban growth)</i>	<i>1 x group</i>		<i>1 x group (unemployed)</i>	<i>1 x group (unemployed)</i>		4 x groups
Fathers (25- 49) - young families		<i>1 x group (unemployed)</i>				<i>1 x group</i>	2 x groups
Fathers (35- 59) - older families	<i>1 x group</i>				<i>1 x group</i>		2 x groups
Fathers (25- 49) - separated families			<i>1 x group</i>	<i>1 x group</i>			2 x groups
Older men (Over 60)		<i>1 x group (not working)</i>	<i>1 x group (employed)</i>	<i>1 x group (not working)</i>		<i>1 x group</i>	4 x groups
Indigenous men			<i>1 x group</i>		<i>1 x group</i>	<i>1 x group</i>	3 x groups
Female influencers	<i>1 x group (female family members of non help seekers, 25- 49)</i>		<i>1 x group (female family members of help seekers, 25-49)</i>	<i>1 x group (female family members of help seekers, 50+)</i>		<i>1 x group (female family members, of non help seekers, 50+)</i>	4x groups
Men with CALD backgrounds	<i>4 x depths</i>			<i>2 x depths</i>	<i>2 x depths</i>	<i>2 x depths</i>	10 x depths
Men from the LGBTI community	<i>2 x depths</i>		<i>2 x depths</i>				4 x depths
Men with substance use concerns	<i>2 x depths</i>			<i>2 x depths</i>			4 x depths
Homeless men	<i>2 x depths</i>			<i>2 x depths</i>			4 x depths
Rurally- based men	<i>1 x bulletin board (Vic, NSW, QLD, SA)</i>						1 x online board
Men living in urban growth areas	<i>1 x bulletin board (Vic, NSW, QLD, WA)</i>						1 x online board
TOTALS	21 x groups, 22 x depths, 2 x online bulletin boards						

Lines of Enquiry and Moderating Approach

In close collaboration with *beyondblue*, the research team developed discussion guides for this study's fieldwork. The moderating approach adopted was largely non-directional, where the aim is to encourage respondents to 'own' the discussion. The approach encourages conversation, rather than simply obtaining answers to a set of questions. Our focus was on creating a comfortable and relaxed setting in which our respondents felt able to express themselves freely and without constraint.

Notably, more than a few respondents commented how they found participation in this study extremely valuable and the opportunity to share their perspectives and even personal experiences with others and/or the researchers. This included both those who had experienced depression and/or anxiety and those who had not.

The discussion guides reflected the following key themes:

- being a man in Australia today
- men and health, and taking action
- men and mental health, with a focus on depression and anxiety
- seeking support for depression and anxiety, including perceptions of when support might be needed, sources of support,
- awareness and understanding of *beyondblue*
- views on developing a communications campaign focusing on men and depression and anxiety, with a view to driving help seeking behaviour
- response to a mix of existing communications collateral, both collateral developed by *beyondblue* as well as other Australian and international organisations (a list is provided at Appendix 1).

The discussion flow and lines of questioning were tailored to relevant audiences as required. It is noted that the communications collateral were not evaluated piece by piece, however these pieces were used selectively to stimulate discussion and to understand communications tools and approaches that will likely resonate and engage with men and those close to them, so as to inform our recommendations for communications and communications framework.

Qualitative Statement

In reading this report it must be borne in mind that this research is qualitative and must be interpreted as such. Qualitative research is not intended to be a precise and definitive index of what happens in the population of interest. As noted above, the approach adopted in the study was interpretive and relied upon a relatively free and unprompted conversation between the researchers and the participants, directed by a discussion guide. Verbatim comments from respondents have been included in this report to illustrate ideas and experiences.

Detailed findings

Context: Depression and anxiety at a community level

Mental health in general, and male depression in particular, are topics that are being spoken about much more frequently and with far less stigma across society today. This shift in community sentiment is seen by most as a positive change.

A number of mental health organisations, including *beyondblue*, are credited with raising the profile of mental health as a serious and important issue in our community. Public sharing of experiences by well-known figures has also contributed significantly and positively to the discourse. On a more personal level, people spoke of family members and friends talking more openly about their own experiences than they perhaps would have in the past, with older respondents in particular acknowledging significant difference versus previous generations.



“My old man would never have talked about this stuff. You kept your problems to yourself and just got on with it”
(Male, father, Traralgon)

“Yes, I think we are more open to talk about personal issues and there are constant reminders on TV telling you who to speak to. So personal health problems are more out there in the public eye”
(Male, urban fringe)

Conversations of mental health in the community playback those held in the media with men highlighting the cost to society – both financial and human – of not addressing the issue, along with the very real toll of depression which is the alarming suicide rates in men. Some spoke of the perpetuation of problems and the cycle repeating if attitudes didn’t change.

The increased public profile of mental health also has coincided with a generational shift in society whereby people have become less bound or defined by traditional roles and mores. More specifically it is felt that: males are encouraged to be more ‘in touch with their feelings’ and to take a more hands-on role in parenting; females are now more active within the workforce and less likely to be characterised as the ‘gentler sex’ and society as a whole has become more accepting of individual choices and lifestyles. Such societal changes are seen to have had a significant impact upon the permissiveness society now

displays in being open and accepting of issues that have been traditionally not discussed – with this extending to include discussion of mental health.

*“It just seems to be more common these days, but that is probably because people talk about it whereas before it would have been like airing your dirty laundry”
(Female, Dubbo)*

*“It is a good thing... we are the better for it”
(Older male, Traralgon)*



While it was acknowledged at a rational level that males and females are both susceptible to experiencing poor mental health, the males and females that we spoke to both felt that the manner in which each gender tends to respond to mental health issues differs. More specifically it was felt that women tend to be more naturally prone to talk about their concerns and actively seek advice or help, while many males are still more inclined to ‘bottle things up’ with any discussion of feelings still felt to be ‘unmanly’ (despite growing societal encouragement for males to be more in touch with their feelings). Such behaviours were felt to impact heavily upon the nature of both community conversations being had around mental health as well as the relative focus that is placed upon male mental health in particular.



*“Females tend to get together and after a natter it’s all OK, but with males you just have a few beers and hope it works out”
(Older male, Dubbo)*

“It’s not surprising there is so much focus on male depression in the press, there was another suicide of a young bloke here this week, seemed Ok but something obviously was worrying him and he topped himself, That’s the thing with males they tend to grab a gun and top themselves but when females try it’s with pills or something and you can get to them, it’s more a cry for help” (Male, father, Dubbo)

Although depression and to a lesser extent anxiety are increasingly present in community conversation, it is apparent that across our sample there is quite a shallow understanding of what depression and anxiety are, and that these are not easily defined. For instance, with respect to depression, the boundary between ‘feeling depressed’, ‘being depressed’ and having ‘clinical depression’ is unclear. For instance: Is depression a way of describing sad feelings? Is it a psychiatric illness or separate from these? Is it a physical illness, i.e. a chemical imbalance in the brain? Is it reflective of an individual’s lack of ability to cope, to not be ‘tough enough’ to cope with life’s challenges? Is it an emotional illness?

*“It’s quite difficult to understand.”
(Male, father, Melbourne)*

*“Depression, it’s something you experience day to day and it’s to do with feeling stress and worry”
(Male, 18-24, unemployed, Whyalla)*

*“As for depression and anxiety, I believe this is a case of stress and worry ‘bout things that can be talk[ed] about and resolved most of the time”
(Male, urban fringe)*



Anxiety is even less understood. Is anxiety as a disorder or illness the same as being anxious or stressed? Is it restricted to those who are highly-strung and less likely to impact the majority of people? Is it more female than male?

Health professionals we spoke with concurred, noting that many clients presenting with depressive or anxious symptoms came with a vague and nebulous understanding of these conditions.

This issue of definition is important because it not only shapes the way people view the existence of depression or anxiety in society, but how they in turn are likely to respond should they, or someone close to them, actually experience it. For instance, if a person frames their personal experience of depression as ‘just being sad’, or ‘something to get over’ they are unlikely to seek help or believe treatment is necessary or appropriate. If they understand that depression and anxiety are serious but treatable conditions their consideration and expectation of treatment is likely to be significantly different.

Among females there was a strong sense had that depression and anxiety are cause for concern when they impact on the ability to function effectively in daily life or impact on relationships with others. They are seemingly less concerned with defining mental health issues and instead are strong advocates for discussing issues with friends and family how they feel and if issues persist of seeking professional help. (Although it is noted that such advocacy is a rational expression of behaviour only, with acknowledgement made that barriers exist to the actual undertaking of such behaviour).

In comparison males tended to categorise issues of mental health as being on a continuum, with one end being the feeling of emotions such as being a bit down, sad or stressed to more physical manifestations such as episodes of psychosis at the other. They tend to categorise a need for discussion and professional help to increase as the mental health continuum moves more towards the physical meaning.

This blurred or limited understanding of depression and anxiety as mental illnesses relates to not only how to define depression and anxiety, but continues into the cause; the nature and extent of impact on one's life; and understanding of treatment available.

People we spoke with were often uncertain as to what causes depression. More specifically they were not sure as to whether depression and anxiety are purely the result of a person's genetics and biology, their personality, their social context, their environmental contexts, or a mix of these. Reframing the conversation to focus on the indiscriminate nature as to who may be affected by mental health will help to broaden social acceptance of the issue.

A seeming scepticism as to whether all mental health issues are truly cause for concern is driven by uncertainty and lack of understanding as to what the actual impact of mental health is. More specifically there appears to be limited understanding of the potential impacts of having a depressive illness, both on the life of the person being diagnosed, i.e. social, occupational, emotional functioning impacts, as well as on their friends, family, place of employment and society as a whole. This is not an area that we believe is best addressed directly, but rather indirectly (as addressed later in the report).

Many hold the belief that medication is the primary or only treatment option, and are unable to talk about the range and nature of treatment options and therapies available. Many shy away from the idea of talking therapy, which can be viewed as a feminine form of treatment and as 'all talk, no action'. For some, this lack of understanding of what treatment and support involves translates into a distinct mistrust in mental health clinicians and their ability to assist (as do also some negative past experiences). In addition, the cost of psychological services is seen as high and for many unaffordable, with a lack of understanding of low cost or subsidised options available.

The limited or confused understanding that is had at multiple levels around mental health, and especially as it relates to understanding options for treatment and taking action, is a key barrier to help seeking behaviour, whether help seeking is talking to a friend or family member, looking for information or seeking professional support. As such this research identifies that there is some way to go in assisting members of the community with understanding depression and anxiety in greater depth, with respect to what they are, what it means to experience them, when should issues be cause for concern and treatment options.



*“If someone breaks their arm there is a standard recovery period, but there are no such guarantees in matters of the mind”
(Male, father, Traralgon)*

*“I find that many of the people I speak with have not a lot of understanding of the difference between psychologists, psychiatrists and counsellors.”
(Telephone operator, beyondblue Info Line)*

A further issue relates to the cost of psychological services, which is seen or assumed to be high and for many unaffordable. Awareness of low cost or subsidised options was limited to only those with personal experience in seeking treatment.

This limited or confused understanding (of definition, cause, impact and treatment) keeps engagement with the issue of depression and anxiety at ‘arms-length’. Even with a higher profile, it remains a relatively ‘unknown entity’. But information alone will not be enough to shift attitudes and behaviour, as most people only engage with the issue of mental health when faced with it directly (be it for themselves or one close to them). Moving attitudes and behaviour on will require new ways into the issue and this becomes even more apparent when we explore attitudes to depression and anxiety at a *personal level*.

Context: Unpacking our audiences

Before delving more deeply into exploring depression and anxiety at a personal level, we feel it is important to touch upon each of the different audiences which have comprised this study. Although there was more consistency than difference across each of these audiences, we have touched below upon what we see as notable viewpoints and situational factors pertinent to each of these groups.

Young men (18-25)

Across the 18-25 age group, we spoke with young men studying at university, working full time, completing an apprenticeship or vocational training and the unemployed. Each of their circumstances came with their own unique pressures and priorities: for the university students and those completing apprenticeships and training, there is pressure to complete their course and find a good job; for the working, it’s about buying a house, getting ahead; for the unemployed, it’s about finding work or gaining access to training that can help them to do so. Thus, although the late teens and early 20s are a time of fun, enjoyment and self-focus, the young men we spoke with are feeling the pressures to succeed placed on them by society, by their schools and universities, by their parents, by their peers and by themselves. Where they fall short, it’s difficult to know where to turn, as revealing their inner struggles can be a sign of failure. Alcohol and drugs are a common part of life and are used to cope with life’s challenges and low points.

Health is not top of mind for this group, which is characterised by a sense of indestructibility (“*Ten foot tall and bullet-proof*”). Young men agree that mental health is an important issue for our society, and although exposed to conditions such as depression and anxiety through the school system and via media, young men’s understanding of depression and anxiety was low relative to the older members of our sample. In some instances, young people were quite open to discussing mental health with peers and willing to take an active role in supporting friends who may be suffering, however it was clear that young men struggled with how to have this discussion and lacked the tools to do so at a meaningful level.

Amongst this group there was a stronger sentiment against medication for the treatment of anxiety and depression than in other groups. There was a sense that medication is overprescribed for mental health conditions and that this form of treatment should be a last rather than first resort. For some, this left them feeling hesitant towards engaging with GPs on these issues.

*“Medication is just a band-aid solution”
(Young male, urban fringe, Melbourne)*

Fathers (25-59)

For both fathers of younger and older children we spoke with, their families are their world. They pride themselves that they are more actively involved in their children’s lives than their fathers and grandfathers were.

Although many share wage-earning and household responsibilities with their wives, they still see themselves as the breadwinner, provider and protector of their family. Holding down a stable job is a core part of this role. Where there is job loss or inability to work due to injury, men appeared to be struggling to adjust to the loss of their breadwinning role and were looking for meaning in their new role and identity within the family unit. What does this mean for their proud role as a provider and protector?

Men in this age group/ generation acknowledge the importance of good mental health and were the most open to discussing real and immediate experiences (of their own or of friends/ family). Despite this, clear hesitations still remain, particularly when it comes to opening up in the workplace.

Mates can play an important support role for many, although men were willing to share emotional distress with their mates to differing degrees

Fathers – separated families (25-49)

Fathers from separated families are living a chaotic life. The more recent their separation, the more chaotic their life appears to be. During this time men are grappling with legal and custody issues. They can be looking for a new home, and financial strain is common. To cover increased financial demands, separated men can be working long hours, where their health and wellbeing is put on the backburner.

Where separation is recent, this group is characterised by an overwhelming sense of losing control. These men are grappling with a new identity as a separated father.

Separated men acknowledge that marriage or relationship breakdown and resultant social isolation of separated men as triggers to depression.

“Isolation is a big thing for men when they are separated, not having someone to talk to. It’s too easy to crack a beer and all of a sudden you realise you’re knocking back a carton. Men don’t tend to get out or go on trips or have social circles like women do. As you get older it gets harder to do”

(Male, separated/divorced father, Brisbane)

Older men (over 60)

As with the younger group of fathers we encountered, for many men over 60 their families remain a key focus of their world. As they transition or move into retirement, men of this age group are giving their time and resources to doing what they can for their adult children and grandchildren, whether it’s fixing things around their children’s homes, picking the grandkids up from school or kindergarten, servicing their children’s cars, or lending them money. Some are single and live alone without family nearby. Their focus is much more on their own needs, however this rarely extends to introspection.

Men in this age group are increasingly experiencing more health problems as they become older. Hence they are more often visiting the GP as they become more reliant on medications. But they do see themselves as more active than were their counterparts a generation or two ago.

These men grew up in a generation in which those with mental illness were institutionalised and consequently characterised as ‘crazy’, rather than as something that anyone could experience. Many of the older men we encountered were sceptical about the significance given to depression at a societal level; however, overall they acknowledged the increasing prevalence and community discussion on the issue. To some extent, men in this group see that when it comes to depression and anxiety, it’s perhaps “too late” for their generation, and something that naturally our society will become better at handling with each generation.

Rurally-based men

Men from rural areas of Australia we spoke with ranged in age from young men in their late teens and early 20s through to older men aged in their 60s and above. What distinguished this sample most from the groups referred to above was the significance and prevalence of 'mateship' and community in their lives. Rural men were more likely to be involved in their local communities at a practical level; they see that looking out for others in the community is part of the rural Australian lifestyle.

"I take great pride in knowing that when the chips are down my mates will be there to help out same as I would do for them"
(Male, rural Australia)

Attitudinally, rural men view depression and anxiety similarly to the above groups. However, they do acknowledge the lack of health services and mental health services in rural areas (and health professionals often form part of their social or community circle with may create additional barriers to seeking help).

Men living in urban growth areas

As with the rural men we encountered, the men we spoke with living in urban growth areas on the outskirts of Australian cities reflected a range of age groups and life stages. At a general level, men living on the urban fringe were contented with their lot and their decision to live on the city outskirts. They acknowledge some disadvantages relative to their inner city counterparts (such as travel times into their respective cities, access to a range of health and community services) however they do not see these as having a significant impact on their day to day lives. Although there is a hypothesis that men living on the urban fringe may be particularly vulnerable to mental health concerns such as depression, the men in this sample did not consider their geography to significantly influence their wellbeing.

Men with CALD backgrounds

The CALD men we spoke with included men across a range of age groups and cultural backgrounds. We spoke with men with Polish, Italian, Romanian, Bhutanese, Liberian, Chinese, Filipino, Croatian, Indian and Vietnamese heritage; most were born overseas and three had come to Australia as refugees, however none more recently than 10 years ago). Family was a consistently raised as the focus of their world and family support is seen as a vital part of coping with life's struggles. In terms of mental health, Australian-born, younger CALD men see that they have more open views than their fathers, where their attitudes largely reflected those of the broader sample. For newer migrants, navigating the Australian public health system can be particularly daunting, especially where English skills are limited, impacting on their ability not only to understand how the health system works in Australia, and the information which is delivered or provided to them, but also their capacity to articulate their physical and/or emotional experience.

Indigenous men

Indigenous men we spoke with ranged in age from young men in their late teens through to fathers in their 40s and 50s. Many of the younger Indigenous men we spoke with were grappling with unemployment and searching for meaningful activity and direction in their lives. For Indigenous men who were fathers, employment could also be a cause for concern. However some spoke of having to grapple with broader changes to the role of the male in the family unit, in the context of more women earning their own living, or of family breakdown where women were leaving them and removing their children. In both instances, their traditional position of power in the family is felt to be diminished.

Indigenous men reflect with anger upon the situation around health in Indigenous communities. Whilst the approach to how they deal with it is very similar to non-Indigenous males (a lack of desire to admit if something is wrong), the fact that problems in their community around alcoholism and drugs are so widespread acts as what they describe as ‘a poison’ which is omnipresent, and they see this as something which is more closely tied to their community than the rest of Australia. There are services available to get assistance, through the likes of the Aboriginal Medical Service, however these services aren’t seen to get to the root cause of the problem.

Mental health is seen as a major problem by these men in Indigenous communities, and is often a byproduct of the health issues that arise around alcoholism and drugs. They share personal stories, of a brother who committed suicide from smoking too much ‘ganja’, of their own experiences of losing their family because of their own drug use which in turn led to serious bouts of depression. They feel that these depressive episodes are often triggered by a domino effect of incidents, which will often culminate in time spent in custody.

One Indigenous man reflected that a particular barrier for Indigenous communities is that of language, where they use a mix of their native language and some English to communicate. Whilst the services are available, these individuals are unable to express themselves as they would like to in English, and as such will often avoid the conversation all together.

“It’s a bit hopeless for these blokes on Bathurst Island. I know they get really frustrated. They’re trapped because they can’t speak English well”
(Indigenous male, Darwin)

For these Indigenous men, those in the mental health medical profession are largely viewed with contempt. There is the feeling that these are ‘white men in white coats’ who simply want to prescribe medication and not really listen. They ‘look down on people’ and are old fashioned in their approach and simply want to get you ‘out the door and on to the next person’. One speaks of his time with a psychiatrist after he experienced psychotic episodes from smoking too much ganja.

*“I didn’t take to him at all. I told him that everything he said was bulls**t and didn’t go back”*
(Indigenous male, Darwin)

For these men, they feel the real support needs to come from elders in the community or those with whom they can have a 'spiritual connection'. It's about face to face contact and time where they can sit down and talk deeply about their issues, and in most cases they feel they can only do this with an Indigenous person as only they will truly understand the issues that these men face. Whilst a couple had called Lifeline during a moment of crisis, it was the face-to-face contact with people out in their community which helped them most.

Unemployed men

Again, unemployed men we encountered across the sample reflected a range of age groups. Not surprisingly, there is a sense of hopelessness that is ubiquitous amongst this group, although the younger unemployed men are perhaps a little more hopeful than the rest.

Most unemployed men we spoke with were connected in with unemployment services, although their attitudes towards these services were not always positive. Nevertheless, this is an important mechanism for conveying support options.

Men from the GBTI community

Of our very small sample of men from the GBTI community, we spoke with two younger and two middle-aged GBTI men. By and large, attitudes towards mental health, depression, anxiety and help seeking were consistent with the larger sample. Of note however, is that these GBTI men see themselves as subject to a 'double stigmatisation' when it comes to mental health, both due to their potential mental health condition and their sexuality, which can place them at a point of particular vulnerability.

GBTI men spoke of particular pressures to 'look good' in the context of a younger GBTI 'partying scene'. As they become older, a youthful outward appearance becomes harder to maintain. One middle aged GBTI man we spoke with felt particularly prone to loneliness and highlighted the difficulty of meeting partners where there is significant pressure to look younger.

Men with substance use concerns

Amongst our very small sample of men who identified as experiencing drug or alcohol concerns, all had experienced or were experiencing depression and/or anxiety. A few were able to see their alcohol and drug use as a coping mechanism in response to emotional distress, whilst the others did not necessarily make this connection.

Across the sample, alcohol use was prominent amongst some young men and Indigenous men (the latter discussed above). For young men in particular, drinking is a core part of their social scene, which makes it an easy outlet through which to cope with stresses and emotional distress.

Homeless men

Men who are homeless are already at a point of crisis. Their lives are chaotic and focused on the fundamentals of food and shelter. Although homeless men may be likely to be experiencing mental illness, treatment may not be seen as a priority or even a feasible option amongst this group. Their health and mental health by necessity takes a back seat to their day to day survival. However, many homeless men are connected in with welfare organisations, whether these are service providers or organisations which provide food and hospitality. These organisations are a channel via which homeless men can obtain information or even support with mental health concerns; however, lack of private spaces in which to seek out information such as reviewing a pamphlet or surfing the internet can be a challenge.

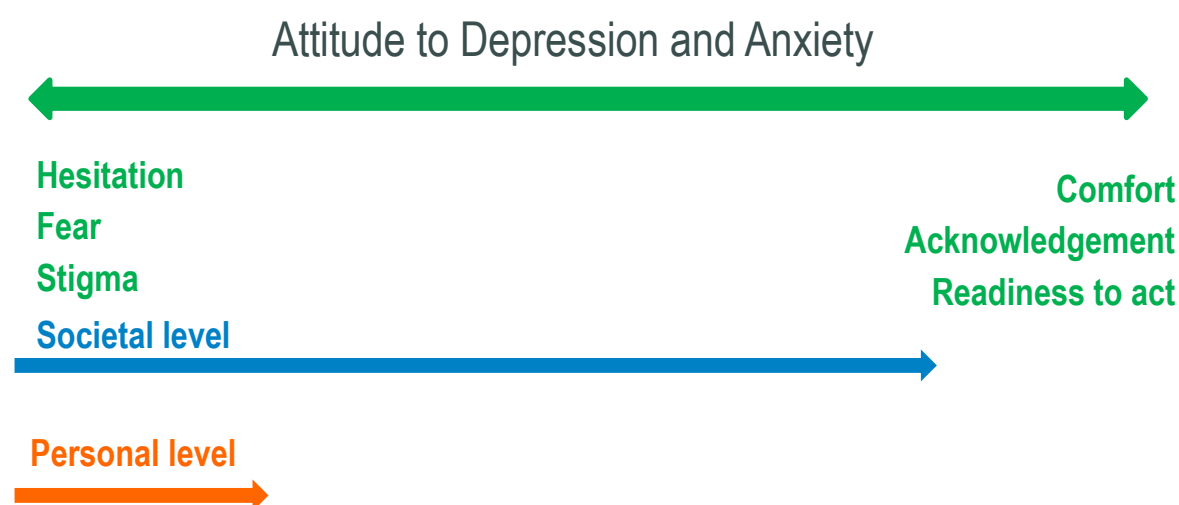
Female influencers

We spoke with a small sample of women who had a close family member who had suffered from a mental illness. Quite a few had sought assistance for their affected family member, while others had done little more than speaking with other family members or close friends. Broadly, women see men as resistant to taking action when it comes to health, and especially so with mental health. They see themselves as essentially the opposite: open and 'ready to have a chat'.

Their view is that what prevents men from taking action on mental health is avoiding being seen as weak, driven by their 'male pride' in being tough. Female significant others do see themselves as having a vital support role for males, in this context of male avoidance of help seeking. However, they feel that their prompts to men are essentially 'falling on deaf ears', when they see limited response to their suggestions. Continued persistence without success can subsequently take an emotional toll on them as a family member; but their love for their partner, husband, father or son means that they are unlikely to 'give up' on their loved one.

Depression and anxiety at the personal level: barriers and enablers to help seeking

Although at a societal level depression and anxiety are talked of more openly and more often, this research revealed that there is a lag between what men believe *should happen* and *is happening* at a **community or societal level** and what many are comfortable with at a **personal level**. Many men are still hesitant and have difficulty talking about depression or anxiety at a personal level. There are exceptions, of course, where there are individuals who are completely comfortable and open about the issue and others who are feeling their way. It is a continuum of experience and *personal belief* lags behind *public belief*.



Whilst this may be driven by the abovementioned lack of clarity in understanding of depression and anxiety (at multiple levels), there are other factors that are also driving this.

Fear and/or actual experience of stigma: There are two issues at play here – a paradoxical clash between outward public acceptance of the prevalence of depression and anxiety today and the need to address this, as opposed to the personal fear of attaching a stigma to oneself, one which they may never be able to shake off. Having to admit to a mental illness (depression or anxiety) to family, partner, friends, workmates, means having to let go of the image one has of oneself. One is required to forego the sense of self they have constructed, whether that be: the abundant provider; the confident and supportive friend; the capable and earnest workmate; or simply the group’s ‘cheerleader’. The ‘black dog’ of depression is just that, something they have been carrying around (and trying to conceal) for quite some time. Even the way people talk about depression is indicative of the ‘not quite acceptable’ nature of it: i.e. ‘the black dog’, ‘falling off the horse’, ‘locking oneself away’, ‘bottling everything up’, ‘not coping’, ‘the cloud’ and so on.

Depression is a burden and people are loath to burden themselves with that label. By admitting to depression one is joining ‘the other side’ and notwithstanding all of the work and achievements to date in breaking down the barriers with mental illness, depression retains that sense of ‘not being good enough, strong enough, capable enough’ to get through daily life unscathed. Many spoke of being worried about what other people will think if they were to find out and, for many men, this includes their workplaces. There was also some fear with respect to how they will be perceived by professionals, including GPs and psychologists.

“You are the head of the family or the boss in the office and you have to show you are in control all the time and nothing gets you down and always have a joke or the smile on your face even though it’s killing you inside” (Male, rural Australia)

“You need to man up. It’s not said. [The wife] needs you to be strong. You can’t fall apart” (Male, father, Melbourne)

“I would suggest pride would be the main reason a man would not seek help, because of the fear of being talked about by his friends” (Male, rural Australia)

“Pressure at work was what prompted all of this. There was no way though that he’d ever tell work about what he was going through, he was so fearful of the repercussions, whether he’d lose his job” (Female, husband experiencing depression, Melbourne)



Further, a parent of an 18 year old with depression spoke of feeling judged by other parents in the schoolyard, that somehow because her son was experiencing depression this reflected badly on her as a parent.

*“If my child has depression, I’m worried other parents will think I’m a failure as a parent, even though I know that’s not true.”
(Mother of teenager with depression, Melbourne)*

How individuals frame issues and make meaning of their personal experiences directly impacts how they respond to them. Mental illness, in particular depression and anxiety, is associated with weakness. And weakness for many men is all too synonymous with failure. This is how they frame the issue. This then not only impacts their *willingness to talk about it or seek help*, it impacts their willingness to *admit it even to themselves*.

*“It’s...embarrassing to think that you are failing.”
(Male, urban fringe)*

One man who had been diagnosed with depression following a workplace injury and who was now unemployed spoke of his difficulty coming to terms with his new role within the family network, given he saw himself as the family breadwinner and ‘protector’.

An implication of seeing depression and anxiety (or potential symptoms of) as a relative weakness is that ‘help seeking’ can be seen as an indication of failure to ‘handle the problem’ as an individual. Reframing the activity of help seeking in a more empowering way, such as ‘taking action’ or ‘taking control’ will likely resonate more closely with the ideals for many men of being strong and being strong enough to be a protector of others.



*“Men in particular are deemed ‘weak’ if suffering and need to ‘suck it up’”
(Male, rural Australia)*

*“The wife god bless her over the years has seen me depressed and I always say I will work it out. I do and I’m proud that I did it by myself, it shows mental strength/toughness the qualities of being a man, it’s what separates us from the weaker sex”
(Male, rural Australia)*

This leaves men not seeking help until they get to a point of crisis or breaking point, where earlier action would most likely be beneficial.

“Men will not take action until it is drastically needed, this is seen in weight issues and well as health and mental health included. Most of us know where to go if really needed, [but] we will just hang in there and move forward each day and deal with it”

(Male, rural Australia)

“[Men seek help] only once they have to, only once it is inescapable that they are actually suffering from an illness. Even when diagnosed, denial seems to be the order of the day.”

(Male, rural Australia)



With the best of intentions however, without understanding the signs of depression and anxiety, many men are unlikely to know when crisis point is reached.

“There was a guy at work who took his life last month. He seemed fine” (Male, father, Traralgon)

Another critical issue that emerged is that **men often speak of being ill-equipped or not having the tools** to enable them to discuss their experiences or broach the topic with a friend for whom they are concerned. For example, some spoke of not knowing how to even start a conversation with a friend or family member. If they are not accustomed to speaking of such things the chasm can feel too great. This was the case if they were suffering or suspect a friend is. Although excessive drinking is often seen as a sign of ‘something not right’, and where for many men drinking is a form of coping with their emotional distress – the only way many men feel comfortable to ask a friend if everything is OK is by going out ‘for a few drinks’. Further to this most felt uncomfortable to broach the subject with a mate only once it was at crisis point.

*“I’d step in if I thought he was at risk of self harm”
(Male, father, Traralgon)*

Women significant others we spoke with acknowledge that men appear to be better at talking about their emotional distress ‘than before’, however are still less likely than women to speak of their emotional experience. We observed that men we spoke with in Stage 1 of this study who had experienced depression spoke using language that clearly reflected the physical elements of their experience, rather than the emotional (for instance, noting symptoms of depression as tiredness, lack of appetite or difficulty

sleeping, and shying away from the emotional domain). Health professionals also acknowledge that, at a high level, men tend to have more difficulty articulating their emotional experience in a clinical setting than do women. Articulating both their physical and emotional experience becomes more difficult for men with low literacy skills or for men with limited English language skills. The ‘jargon’ of depression can become even more overwhelming for these men and make it more difficult to share with friends, family or health professionals.

“I think it’s interesting if you think about the other words you could use for depression... Men just don’t have the words, they have no vocabulary whatsoever to even begin to describe what they are going through.” (Female, significant other male with depression, Brisbane)

Social support and linkages with health and community services: As we found from the people we spoke with who had sought help, family members and friends are usually the key motivators or instigators to help seeking. Help seeking can be a daunting task for someone who hasn’t taken action before, especially where there is uncertainty as to what help seeking looks like and what kinds of support are available. Having the support and encouragement of loved ones appears to be a key facilitator to taking that first step. Loved ones also often take the initiative to seek out information on behalf of the male in question; some men spoke of not being in the ‘right frame of mind’ for information to clearly register and connect with them when going through a depressive episode. The absence of such support (for example in cases where relationships are fractured, in broken families, or for the socially isolated) can thus serve as a barrier to comfort with and readiness for help seeking.

Men across the sample talked about the importance of ‘looking out for mates’ and loved ones. Hence, although it is difficult for many men to acknowledge their own emotional experiences as potentially being a mental health concern, looking out for others is easier. This may be because the latter is associated with personal strength and their role as protector, rather weakness or personal failure.

Linkages with existing community or health services serve to make the help seeking process smoother; for example, an existing trusted relationship with a GP or an ongoing relationship with a welfare organisation. However, few of the men we spoke with were regularly visiting a GP (a fact they often note with pride – some have bragging rights in relation to how long it’s been since they used their Medicare card), or where men did visit a GP, they didn’t necessarily trust their GP or feel comfortable raising mental health concerns with him or her (there are some fears as to what health professionals would think of them). This is further explored in the next section of this report.

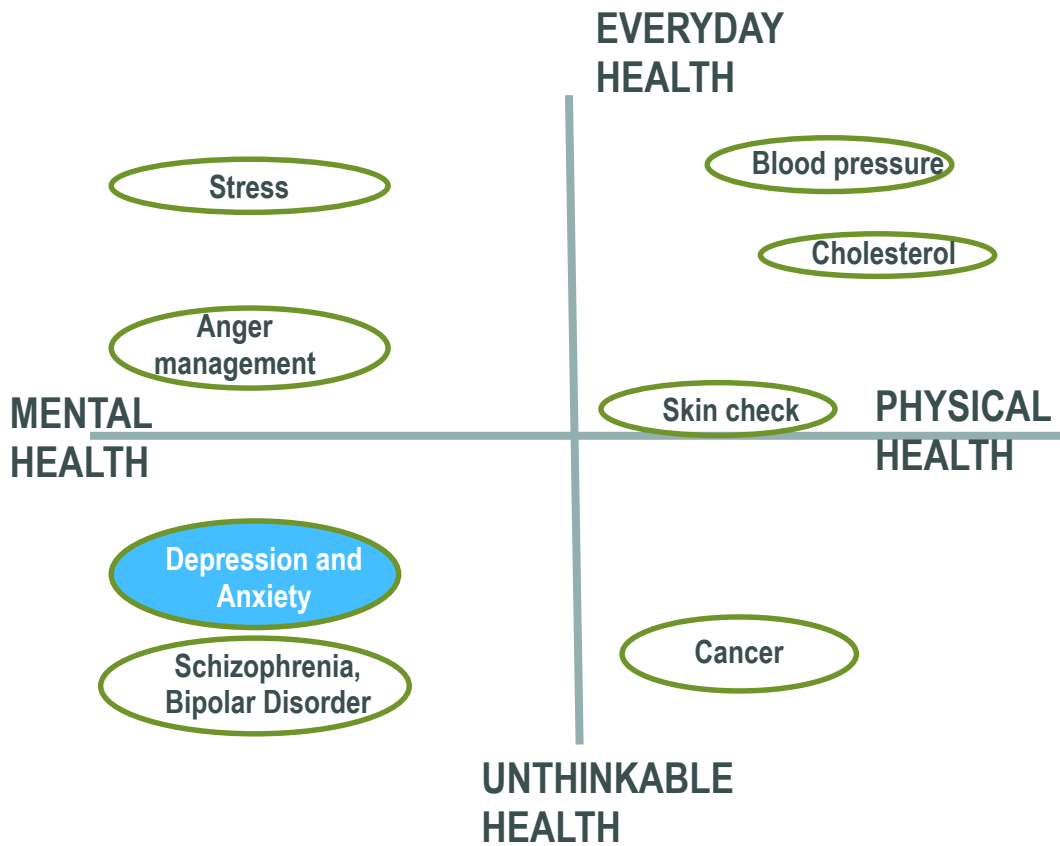
On the subject of poor community connections, this study did unearth signs of specific target groups standing out on this dimension: young, disenfranchised men; separated or divorced fathers; substance abusers; and middle-aged and older single men. All reflect what looks like below average engagement with society at large. These men tend to report staying at home more often, and drinking and smoking more than average. At times, we heard of instances of self-harm and illegal drug use. Where there is an overwhelming sense of helplessness, there appears to be low confidence and/or motivation amongst

these men to create new social supports where old ones have been fractured, or to seek out community connections. These disenfranchised men are particularly vulnerable.

Last, limited prior experience of depression and/or anxiety, either personally or by a significant other appeared to influence a person's comfort with both talking about depression or anxiety and with taking action. We observed that where people know someone who has experienced depression or anxiety, or where they had experienced it themselves, there is a greater level of comfort with the condition and with the idea of help seeking. Experience facilitates understanding, and depression and/or anxiety are no longer 'the great unknown'.

Where depression and anxiety sit in men’s minds

Despite increased acceptability of mental health at a community level. Self stigmas and barriers prevail. Depression and anxiety categorized as ‘unthinkable conditions’ (much like cancer) - men know they are real but don’t believe they will happen to them or they can’t be predicted, so we why worry about them happening or do anything in advance. This is further compounded by men’s propensity to deny or ignore ‘mental health’ compared with physical health which is more tangible and felt to be more definitive. This combination of cultural reference and dismissal creates the lag in attitude toward mental health personally. To impact this we need to reframe how men (and society as a whole) think of depression and anxiety. Currently it sits as an ‘unthinkable’, ‘woolly’ area that is too often “best ignored”.



Barriers and enablers: specific audiences

While the earlier model showing the lag between community and personal attitude is largely a reflection of the sample of men we spoke with as a whole (across life stages, locations, cultural background and social vulnerability), we have highlighted in the table below what we see as particular nuances each of the specific audiences we encountered. These nuances have been considered in shaping our proposed communications framework and communications recommendations.

Barriers and enablers: Campaign target audiences

AUDIENCE		BARRIERS	ENABLERS
Life stage	Young men (18-25)	<ul style="list-style-type: none"> • 'Self' focus: life stage that's 'all about me' • Health not top of mind – sense of invincibility 	<ul style="list-style-type: none"> • For some, connections with communities (i.e. schools, universities, clubs) • Triggers and prompts by parents, peers • Driven to 'look out for mates' – assisting others
	Fathers (25-59) – young families	<ul style="list-style-type: none"> • 'Other' focus: family comes first, then myself • Infrequent and irregular visits to GPs 	<ul style="list-style-type: none"> • Where benefits to family are conveyed • Triggers and prompts by partners / spouses
	Fathers (25-49) – separated families	<ul style="list-style-type: none"> • Where separation is recent, life is chaotic, difficult to see clearly • Sense of social disconnection, isolation, resentment 	<ul style="list-style-type: none"> • A means of gaining control, avoiding crisis point • 'Do it for the kids', 'do it for yourself', 'get back on your feet'
	Older men (Over 60)	<ul style="list-style-type: none"> • An attitude of 'it's too late for my generation', (i.e. mental health awareness will naturally increase with the younger generation) 	<ul style="list-style-type: none"> • Greater likelihood to be in contact with GPs given life stage • Participation in clubs, social groups • Triggers and prompts by family (partners and children)
Geography	Rurally-based men	<ul style="list-style-type: none"> • More limited access to choice of service, proximity to services 	<ul style="list-style-type: none"> • Strong sense of community, community support • Linked to the above, driven to 'look out for others, mates'
	Men living in urban growth areas	<ul style="list-style-type: none"> • Relative to inner city, less choice in services (however do not necessarily see as being short of services) 	(Same as general population by age)
Cultural background	Men with CALD backgrounds	<ul style="list-style-type: none"> • For new migrants, understanding the Australian health system and how to navigate this can be particularly challenging • Cultural framing of mental illness (where inconsistent with available action pathways) 	<ul style="list-style-type: none"> • Strong family and community support

	Indigenous men	<ul style="list-style-type: none"> • Lack of trust in mainstream health services as feeling clinicians are not able to understand or empathise 	<ul style="list-style-type: none"> • Speaking with a male from their own community, or male Indigenous person
Unemployed men		<ul style="list-style-type: none"> • Potential for long-term unemployed to experience inertia 	<ul style="list-style-type: none"> • Pre-existing connections with unemployment and welfare organisations • If retrenched or experiencing workplace injury, workplace making connections with services
Men from the GBTI community		<ul style="list-style-type: none"> • Facing an additional layer of stigmatisation 	<ul style="list-style-type: none"> • Connections with existing support groups accessed via GBTI communities
Men with substance use concerns		<ul style="list-style-type: none"> • Potential limited motivation for change, sense of hopelessness (using alcohol / drugs as coping mechanism) • Potential for fractured family and other relationships • Self-harm can be an issue 	<ul style="list-style-type: none"> • If engaged with D&A support services, existing connections with health / mental health clinicians • Usual ‘role models’ don’t apply
Homeless men		<ul style="list-style-type: none"> • Many likely to be diagnosed with mental illness – potential to have experienced prior treatment which was unsuccessful • Opportunities for privacy to review or seek out information limited 	<ul style="list-style-type: none"> • At crisis point • Pre-existing connections with welfare, community services
Female influencers		<ul style="list-style-type: none"> • Own limited understanding, experience, misconceptions associated with depression / anxiety 	<ul style="list-style-type: none"> • Prompting male in their life to seek assistance • Provision of emotional support and encouragement to male • Can assist with navigating an action pathway • Taking the initiative to seek assistance / information on behalf of their spouse / son / father etc.

Therefore, in summary, there are see a range of barriers that serve to keep individuals at a point of hesitation or fear when it comes to depression and anxiety, holding them back from help seeking or taking action where it may be needed. Moving people along the personal spectrum from a position characterised by fear and/or ignorance to one of comfort and acknowledgement, and, where needed, readiness to act will require a challenge of current conventions.

Some barriers may be more salient to some individuals than others; however the presence of such barriers can impact not only on how an individual frames their own personal experience when it comes to depression and anxiety, but they perpetuate misconceptions and inhibit the possibility of moving opinions on.

Common frames we heard were 'I'm weak if I admit something's wrong', 'I need to be at crisis point to take action', 'others won't understand what I'm going through / I'm part of the minority', 'there's only one treatment / nothing's going to help').

We see that key enablers to help seeking are a reflection of overcoming the barriers identified above. Hence, key enablers to help seeking are:

- Greater clarity around the seriousness of depression and anxiety, as it relates to definition, causes, treatment and impact, and thereby an increased respect for depression and anxiety as serious conditions
- Comfort and openness with depression and anxiety in the personal context, as well as the societal context.
- Increased sense of the prevalence of depression and anxiety (and appreciation of widespread experiences)
- Presence of social support and encouragement (such as through family and friends), and community connections (e.g. a trusted GP).

How communications can achieve this is addressed in the ***Implications and Recommendations for Communications*** section of this report.

Understanding support avenues available

In exploring support avenues for assistance, men spoke either of their personal experiences and choices or they hypothesised about where they would go if they were faced with mental health issues. It became clear that there are several pathways through which they are either currently seeking assistance or would think to go for assistance *if they identified the need*:

The internet: As with so many areas of life today, the internet is our first port of call on new topics or issues. Many spoke of Googling 'depression' or 'anxiety' as a first step and seeing where this took them. This was a private and 'safe' way of gathering information in order to understand what they were experiencing and what and whether any 'next steps' are needed. We found that the internet was a likely first port of call in particular for socially disconnected male (i.e. separated/divorced father, young

disenfranchised substance abuser); however for men experiencing homelessness there was limited opportunity to search the internet in a private setting.



“I would do research on the internet first to see what the options are and then make a decision. I would call on the phone if I was worried about someone else with depression... if I had depression I probably wouldn't call on the phone”

(M, 18-24, unemployed, Brisbane)

“Online is discreet”

(Male, father, Melbourne)

Some had encountered the *beyondblue* website through Google searching, and noted that whilst there was a wealth of information accessible there, it was not entirely clear who the website is for – health professionals, individuals, fundraisers? Given that the internet is seen as the first port of call for many, the *beyondblue* website can play a pivotal role in providing information about pathways to assistance.

Some men in our sample were aware of online chat forums for men, however few if any admitted to using them. However, for many men there is still a need to know that this kind of support avenue exists:

“The internet offers things such as chat sites, [forums]... but if we don't know how to access them or if they are not easy to find or access... another brick wall and a sense of helplessness”

(Male, urban fringe)

Family/friends: Family is an obvious source of help and support, especially for those with a safe and trusting relationship with a partner. Speaking with a partner, family member or a friend is a safe first step in verbally sharing their inner experience, before consulting a health professional.

“I know there are services available in the form of help lines, the internet and medical help, but I'm more likely to try talking it out with family.”

(Male, urban fringe)

“There are many places to go to get support. We should start with our own families and talk through the problems we have and get them out into the open. Next we should go and see our family doctor, as they are a fantastic source of information”

(Male, urban fringe)



However, for some men in our broader sample, it was not always seen as easy to open up to family members, especially where there is fear judgement or being seen as a failure or weak if they are admitting that something is wrong.

“A lot of people don’t feel comfortable talking to their family because they have a different type of relationship with family than with their friends. They are not always comfortable revealing themselves to the people that are closest to them.”

(Male, 20s, substance abuse, Brisbane)

Some men spoke of not wanting to admit their depression to their wives, because as this conveyed a weakness they didn’t want their wives to see:

“I don’t want to show my weakness in front of my wife”

(Male, father, Melbourne)

As noted earlier, for many men who had experienced depression or anxiety family members played an important role in prompting them to seek help. Some men would wait for others to prompt them prior to taking action:



“I think a man might seek help if someone close to him suggest[ed] it”

(Male, urban fringe)

“We talked about talking therapy. I searched online, looked for local counsellors in the area. I printed out a list and I suggested this to him”

(Female, husband experienced depression, Melbourne)

However, there were more than a few women in our sample who had tried to assist their husband / son / father to seek help who noted that this wasn’t easy, where their suggestions for help were frequently rejected. Women spoke of trying to help their significant others as like ‘speaking to a brick wall’. Women

do express a desire to have more tools to aid their men to take the first step, but there are also assumptions that it may fall on deaf ears.

*“Men just won't talk. My husband wouldn't talk about it”
(Female, significant other male with depression,
Brisbane)*

*“My dad would never ask a woman for help”
(Female, significant other male with depression,
Melbourne)*

*“There just isn't anything I can do. What can you
do if they absolutely don't want to talk about it?”
(Female, significant other male with depression,
Melbourne)*

*“I tried to support him as much as I could. I
suggested talking to a GP. He said no a quite few
times.” (Female, husband with depression,
Melbourne)*

*“All I can do is be there for him to listen. If I tell
him to get help he gets annoyed” (Female,
significant other male with depression, Darwin)*



The above creates an opportunity to better equip women (and other friends/family) in how to deal with depression for someone close to them.

Friends or 'mates' are also seen as an important source of support for many men across our sample. Especially in rural areas, mateship and a sense of community are seen as particularly important for community wellbeing. Some men spoke of being very open with their mates where they could 'discuss anything' (in most instances this took place over a beer) but there were still others didn't want to burden them with their 'issues'.

*“If I need to seek help with something it's usually in the
form of talking to a mate over a beer at the pub.”
(Male, urban fringe)*

*“I know I can talk about anything with my best mate. I
don't care what he thinks of me”
(Male, father, Whyalla)*



For young men, comfort with sharing with mates (and female friends) was more pronounced, and we heard of instances where friends had taken an active role in helping their mate to seek help:



“I’ve been really open with my friends about this. We’ve grown up with mental health issues being more open and accepted in the community. And all of us know someone who has experienced depression.”
(Young male help seeker, Melbourne)

“I had a friend who found me some information and some fact sheets online”
(Young male help seeker, Melbourne)

However, as noted above, not all men have strong circles of friends or mates that are available to them, these being the socially disconnected.

The GP: For many, seeking assistance from a GP is seen as the first step in engaging professional support. We found that this does, however, depend on their relationship with their GP. Those who have a longstanding relationship feel they could or would be comfortable to open up with their doctor; whereas others who have no existing, trusting relationship with a GP do not experience this comfort and remain hesitant towards the idea of approaching a medical professional. These men can feel that the GP wouldn't understand or take them seriously, or wouldn't have the time and would want to 'get them out the door'. Those in regional areas in particular spoke of concerns around 'bumping into their GP in the street' and being embarrassed about this.

“I think having a chat to your own doctor would be a good first step. Then enquiring where best to go to for help”(Male, rural Australia)

“The GP doesn’t even look me in the eye when he talks to me – he’s always staring at the bloody screen”
(Older male, Darwin)

“I don’t have confidence in them, that’s my trouble” (Male, father, Whyalla)

“What’s worked for me is finding a good general practice. Someone you can talk to. I don’t want to go to a psychologist or psychiatrist or anyone like that”
(Male, father, Melbourne)



As noted above, many younger and middle aged men do not regularly attend a GP clinic, with many speaking with pride about how they never go to a doctor. They are thus less likely to have a trusting, ongoing relationship with a GP. Older men, however, by virtue of their age, are more likely to require GP assistance and thereby are more likely to have a trusting and ongoing relationship they can turn to if required.

Further, many men expected that visiting a GP for depression or anxiety would involve instant prescription of medication, and there were very mixed attitudes towards this form of treatment across the sample. There are concerns and even fears around what the medication might do to them and this certainly appeared to keep some men away from seeking help. Young men in particular appeared to be most against medication as a treatment option; however, there were some older men who also shared this sentiment:

“I’m sceptical about going to a GP. A couple of years ago I had a series of mini strokes and I think that could have been brought on by stress. They gave me a handout when I left the hospital and one of them said depression was common after having a stroke. I definitely slipped into depression. I would sit at the table and my mind would go blank. But I didn’t go to the doctor because I didn’t want to take the drugs. I think they resort to drugs as quickly as they can and I don’t think that’s the most advisable thing to do. I got into self-help things, positive thinking, now I can see that your thinking controls what you are. You can be happy or sad, depending on what you’re thinking.”
(Older male, Brisbane)

It should be noted that for Indigenous men, any help seeking must be face to face, however we encountered some strong attitudes against seeking support from a GP or from other health professionals. There is a sense amongst these men that these health professionals would not be able to understand or empathise with their lived experience. For Indigenous men, emotional and spiritual support is very much the domain of their local community and the support role is traditionally filled by community leaders and elders. If they were to seek any face to face assistance for depression or anxiety, this would need to be through special Aboriginal liaison officers within local mental health services.

“I don’t want some whitefella in a white coat sitting there giving me drugs and telling me what to do. He doesn’t understand me” (Indigenous male, Darwin)

Mental health professionals: Men across our sample acknowledge that mental health professionals such as counsellors, psychologists and psychiatrists are a source of help for managing anxiety and depression. However, they are a first port of call for few, and for most are seen as a last resort, when things are really critical or the condition is particularly severe. We heard of multiple examples of where a GP had referred a man to a mental health clinician, but they had decided not to take the GPs advice. There appears to be fear and uncertainty towards talking therapy, which is a big unknown for those who haven't experienced it for themselves. Many questioned the value of what they see as 'just sitting there and talking'. There appears to be limited understanding of the differences between the different kinds of mental health professionals and what therapy with each actually involves. The image of the clinician in a 'white coat who issues medicine just for the sake of it' was strong, even for some who had used these services. Some men expressed concerns around the therapist being so far removed from their own lives that they wouldn't be able to relate to them. This lack of understanding, even fear, presents a clear opportunity for demystifying (and destigmatising) the role of the mental health professional.



“The idea of sitting down and talking to someone just makes me feel uncomfortable. I don't know how well I would deal with that” (Male, father, Dubbo)

“I went to the doctor when I started having the episodes and he told me what it was and he suggested the prescription drugs as a short-term solution... so, if it came on when you were out somewhere you could pop a pill. He also suggested I see a psychiatrist. There was one at the surgery where my doctor was and you could get six free sessions. But that freaked me out and I didn't do it. It felt quite extreme going to a psychiatrist.” (Male with drug / alcohol concerns, Brisbane)

“Most psychs don't know what they're talking about. They've never gone through what I've gone through, they only read about it in a book. How are they expected to help? I'd rather talk to someone who's gone through it themselves and really understands.” (Young male, Melbourne)

“Whenever I think of a psychiatrist, I think ‘I'm not going to a shrink, I'm not mad!’” (Older male, Darwin)

Some people who had sought help with mental health professionals in our sample had done so via the public mental health system. Although our sample here was small, it is worth noting that for these people navigating the public mental health system was a key challenge in their help seeking journey. This viewpoint was supported by mental health professionals we spoke with as institutional influencers. In particular, finding a point of entry was difficult, and experiences of ringing around and being 'hand balled' elsewhere were noted. Beyond this, once these respondents had engaged with services, the challenges continued, with examples of having engaged with tens of clinicians over the course of a year or two. This hindered their capacity to form a trusting and effective therapeutic relationship with their clinicians.

"We've had such an experience of chopping and changing hands. My son's probably seen 50 or 60 different health practitioners in the last few years, and seven psychiatrists."

(Female, son with depression, Melbourne)

"I really hate how it's run. There's no constancy. Just because I moved I had to completely change practitioner. It disrupts everything"

(Young male help seeker, 20s, Melbourne)



Despite a predominant sentiment of uncertainty and scepticism towards mental health professionals, and hearing examples of where engaging with mental health professionals / services hadn't worked, we did encounter some success stories amongst our sub-sample of help seekers:



"I was seeing a psychologist every fortnight at ISIS primary care... I originally thought I'm a man, I don't need that... [but] it was so beneficial. Speaking with a non-judgemental person, an outsider looking in. Their specialty is to help. They weren't pushy, but kind and gentle. They don't tell you what's wrong with you, and there's suggestions"

(Male with drug / alcohol concerns, Melbourne)

"I didn't find the psychologist stigmatising. I was wondering whether they were going to be effective or not, based on my experience with previous psychs. I had found talking all the time didn't really achieve anything"

(Male, GBTI, Melbourne)

Helplines are also mentioned as a potential source of help. They tend to be thought of as the 'moment of crisis' option, when one has nowhere else to turn, whether that be family/friends or a medical professional, or where assistance is needed immediately. The sense of urgency that attaches to helplines tends to position them as almost useless in the minds of some (*"if it got to that point with my son I'd take him straight to the hospital"*). In this study, we found that Lifeline and Men's Line were frequently mentioned, however *beyondblue* as an option for speaking to someone was not, which has important implications for the framing of *beyondblue*.

"I would do research on the internet first to see what the options are and then make a decision. I would call on the phone if I was worried about someone else with depression... if I had depression I probably wouldn't call on the phone. It's not like there is a time limit, like if you call Lifeline. I would probably want to see someone face to face and that's what I would inform someone around me to do."

(Young male, unemployed, Brisbane)

As part of the study, we touched upon whether men would prefer to have a man at the end of the line, if they were to call a help line or info line. Many men acknowledged they would feel more comfortable with a man, although this was by no means definitive. For some, it was the person's professionalism and their ability to assist which was most important. This then largely appears to be an issue of personal preference.

Summarising the above:

- The internet is therefore primarily being used as a source of information to assist men with identifying whether or not their symptoms are those which may warrant further action. This is a safe and private way to explore depression and anxiety and gain understanding.
- Family and friends are a safe first step for verbalising their experience for many, where men can talk with someone they trust and access emotional support. However, not all feel comfortable making their vulnerabilities known to their loved ones.
- Seeing a GP is the first step to accessing professional help; however for many, there are clear barriers which need to be overcome before they see a GP (a lack of trust appears to play a role here, as are the broader barriers relating to attitude and understanding identified earlier).
- However, GPs are less daunting than seeing a mental health professional for many, where seeking assistance here is associated with where conditions are serious.
- Lastly, helplines are seen as a source of crisis support around the clock, if urgent assistance is needed.

There therefore appears to be a distinction between seeking out information online and sharing with family and friends *and* seeking assistance with a health or mental health professional. Men (and their significant others) are generally aware of the availability of support channels, with barriers to help seeking

identified earlier holding them back from feeling comfortable and ready to take that first step outside of their private world and inner support circle.

Notably, *beyondblue* was not mentioned unprompted as a support or help seeking destination. Perceptions and understanding of *beyondblue* are explored in the remainder of this section.

Understanding and awareness of beyondblue

There is fairly high awareness of *beyondblue* across the sample, with people spontaneously mentioning it in discussion. Most had heard of the organisation prior to taking part in the study and had encountered it through a range of sources including: link-ups with news articles on depression (press or television), posters on the back of toilet doors in pubs, some mention of television advertising (the advert featuring the young man playing football was recalled both unprompted and prompted), and the connection with Movember through the workplace. Only a few (mainly from rural locations) admitted to never having heard of the organisation before.

“We get involved with Movember each year which is great fun. beyondblue has something to do with this doesn't it? That and prostate cancer”
(Male, father, Darwin)

“I've seen posters on toilet doors. They seem to be everywhere these days!” (Young male, Traralgon)

“A service that provides counselling and also raising awareness and getting people talking about the issue. That's the first step, they are trying to do that.” (Young male, unemployed, Brisbane)

“The first organisation of its kind that is devoted to this issue.”
(Young male, unemployed, Brisbane)



Encouragingly for this study, there is a strong association between *beyondblue* and men, both amongst the males and females we spoke with. As an example, for our group of women in Melbourne, their perception is that *beyondblue* is set up only for men and would not be able to help them as women. This is attributed to some of the male specific channels such as pubs and the featuring of men in the

advertising, but was also the association with Jeff Kennett, for whom there was awareness outside Victoria in cities as far north as Brisbane and Darwin.



*“I believe [beyondblue] exists to raise awareness of men’s mental health issues”
(Male, urban fringe)*

*“beyondblue, it’s about men’s health. It’s a support service”
(Male, father, Melbourne)*

*“It has something to do with Movember”
(Male, father, Melbourne)*

*“beyondblue’s aiming to target grown men. Just from the way it’s being advertised”
(Male, substance use concerns, Melbourne)*

*“beyondblue are for males. Because they mention blue. And they use men in the ads”
(Male, 18-24, urban fringe, Melbourne)*

“I know they advocate for men’s mental health” (Female, husband experiencing depression, Melbourne)

*“Is it specifically for men?”
(M, 18-24, unemployed, Brisbane)*

While there is generally strong awareness of the *beyondblue* name, there is a weaker understanding of its range of roles and functions. Most people view the organisation as one which takes on a broader education, advocacy and awareness role around ‘mental health’ or ‘depression’ (and to a lesser extent anxiety). They interpret the role as one of de-stigmatising depression and working to help raise awareness of how it impacts at a societal level and, for the majority, this is seen as a positive and important issue to be addressing and indeed an important role for an organisation to be playing in society.

However when it comes to how *beyondblue* could help them at a personal level, people are less clear. Few have heard of the Info Line, and when prompted, there is an assumption that this would take on the form of support similar to that offered by the likes of Lifeline, Men’s Line or the Salvation Army, that is a trained counsellor at end of the phone to talk through issues at a time of crisis. This evokes the response that these other services have already ‘got it covered’ so why call *beyondblue*?

“I would assume they are trained counsellors on the end of the phone”

(F, 50+, family member non help seeker, Darwin)

“I’ve heard of [beyondblue] but I’m a bit unclear about them. They do research and are connected in with mental health professionals. They’re more there for the mental health industry”

(Male, GBTI, Melbourne)



This gap in people’s understanding of *beyondblue*’s role, as well as the identified gap between its role of advocate or supposed crisis manager, creates an opportunity for *beyondblue* to expand its *perceived remit* – from ‘advocate’, exclusively focussed on awareness-raising around depression and anxiety (especially targeting men), to one of providing personal support and activation tools to impact personal experience of depression and/or anxiety. Further, being known as the provider of tools and resources can prompt earlier engagement. Rather than leaving things to a point of crisis, individuals can take control of their situation by going to *beyondblue*. *beyondblue* can play a support role as a provider of information to those seeking to know more (either via the website or the Info Line), but through these channels it can also take an active role in supporting an individual take steps beyond information seeking and sharing with their inner circle of family and friends towards gaining external, professional assistance where this may be beneficial. How this can be achieved is addressed in the ***Implications and Recommendations for Communications*** section below.

Current framing of depression, anxiety and help seeking

How issues are framed is central to how they are thought of, communicated and discussed. The framing of an issue is often long held and deeply-rooted and difficult to change because the ways of discussing and evaluating the topic are so entrenched that the patterns of engagement repeat themselves (e.g. we always speak about the issue in the same way and ask the same questions and get the same answers). There are a number of current frames around mental health on a personal level (which despite being ‘personal’ they were widely held across the sample). The current frames we heard and observed are:

Current frame
Mental health is not on my radar / don’t want to think about it
Depression / anxiety only happens to weak ‘flawed’ people
Depression / anxiety is woolly and unknown. It is a black hole.
You don’t dwell on these things and you don’t talk about it – you just cope
Help seeking is a sign of weakness and failure
Help seeking / intervention takes place at crisis point
Drugs are the only treatment

These frames are well established and like many long (generationally) held opinions they are rarely easily or directly challenged. However changing *opinion* isn’t always necessary to change *behaviour*.

Reframing

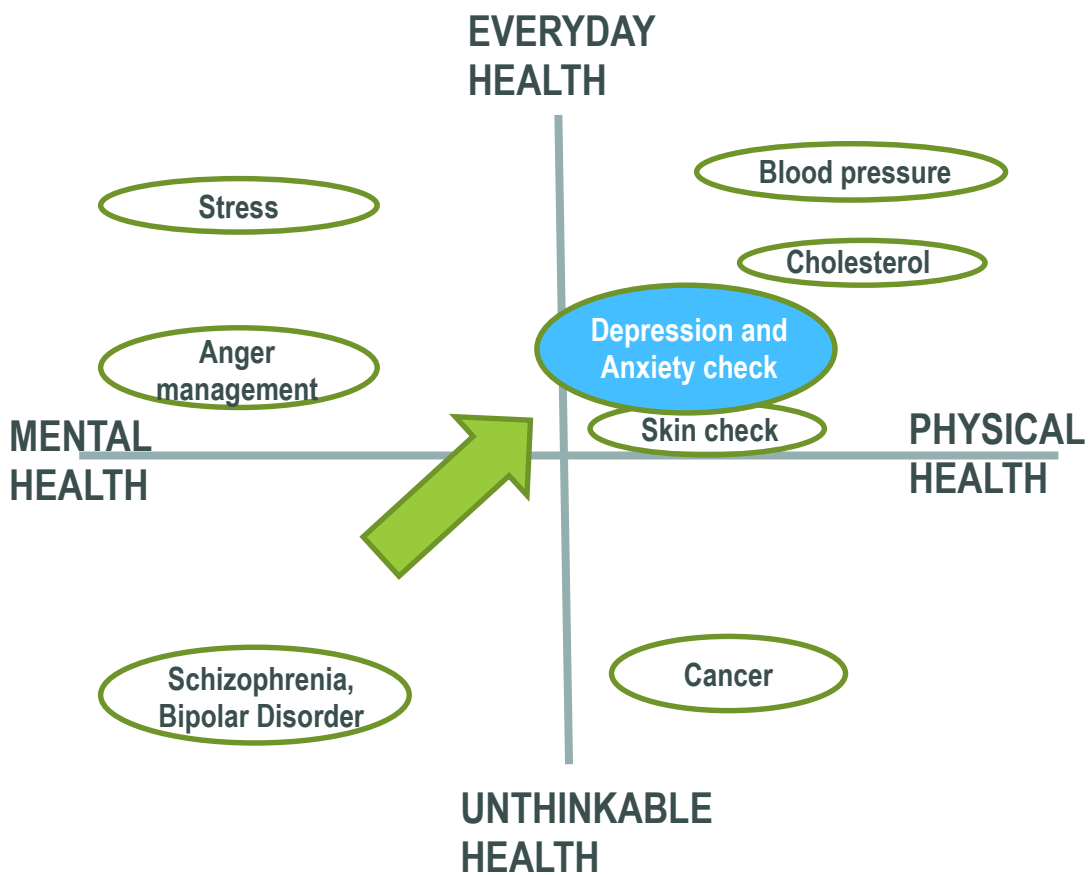
Reframing is about altering the view of the issue and creating new ways in. In addition it is about using new language and adopting new frames of reference. Using acceptable frameworks in other areas can be very powerful to reframe or ‘reset’ the issue and allows a meaningful change in perspective. We believe in the case of Depression and Anxiety we need to do all three.

Firstly we need to reframe each of these beliefs from ‘current’ to ‘new’.

Current frame	→	New frame
Not on my radar/ don’t want to think about it		Every man should know / No one is bulletproof
Depression / anxiety only happens to weak ‘flawed’ people		Depression / anxiety is an illness / condition that can strike anyone (x% of people will experience at some point)
Depression / anxiety is woolly and unknown. It is a black hole.		Depression / anxiety are diagnosable and treatable
You don’t dwell on these things and you don’t talk about it – you just cope		There’s no shame in suffering anxiety or depression – they are treatable health conditions
Help seeking is a sign of weakness and failure		Taking action is associated with taking control, staying strong Protecting self is protecting others
Help seeking/intervention takes place at crisis point		Early action is best
Drugs are the only treatment		There are a range of courses of action available, and treatment can be tailored

We also need to address language, for example, an implication of seeing depression and anxiety as weakness is that ‘help seeking’ can be seen as an indication of *failure to ‘handle the problem’* as an individual. Reframing the activity of help seeking in a more empowering way, such as ‘taking action’ or ‘taking control’ will likely resonate more closely with the ideals for many men of being strong and being strong enough to be a protector of others. This language is far more active and in line with the way men like to handle issues, and is an important component of providing new ways in.

Additionally we need to provide a far more tangible and everyday function around depression and anxiety to give men the tools they feel they lack. Men are far more comfortable with no-nonsense facts. Therefore information is best delivered in this way. Communicating ‘the signs’, ‘the actions to take’ and ‘the treatment options’ reframes the vague and ill-defined into tangible, achievable tasks. Furthermore it moves depression and anxiety away from the woolly and unthinkable and into everyday health. i.e.:



Implications and recommendations for communications

The role for communications

Based on the findings detailed above, we see that there are two broad communications tasks that will assist *beyondblue* achieve its communication objectives:

1. Reframe how people conceptualise and talk about depression and anxiety to enable and empower men to take action.
2. Clarify and enrich understanding of the scope of *beyondblue* so it is spontaneously identified as a go to resource for men at any stage of mental health experience

There are many entrenched and unchallenged beliefs that are holding men back from thinking or acting in a way they believe others are entitled to. To address these we need to 'reframe' how people conceptualise and talk about depression and anxiety so as to enable men to take action.

The essence of this approach is that in order to achieve behavioural change, the proposed campaign will need to reframe the way the community conceptualises and talks about depression and anxiety amongst for all, but especially men.

In doing so we believe that it will also be possible to address the broader campaign objectives, i.e.

- increase awareness of depression and anxiety as common and serious illnesses affecting men in Australia today
- challenge the perception among men that asking for help is a weakness
- educate men on the signs and symptoms of depression and anxiety
- encourage men who may be experiencing symptoms of depression and anxiety to seek help by calling the *beyondblue* Info Line, including reinforcing the importance of seeking help early, and
- inform men that treatment for depression and anxiety is available and that information is available 24/7 via the Info Line and the *beyondblue* website.

The first three will be addressed via the reframing the conversation of mental health. Enriching and clarifying *beyondblue*'s remit beyond advocate and men's mental health champion will address the latter two.

1. Reframe how people conceptualise depression and anxiety so as to increase help seeking behaviour

This research uncovered various frames that individuals widely and repeatedly expressed with respect to depression and anxiety (‘current frames’). These largely reflect misconceptions arising from the barriers identified earlier in this report. Communications can serve to create ‘new frames’ which will empower men to take action.

Referring back to the model discussed earlier, communications have an important role to play in overcoming these barriers through facilitating a deeper understanding of depression anxiety and overcoming personal frames and misconceptions which may be holding men back from identifying a need to take action where it is warranted. Through doing so, communications can help, **at a personal level**, to ‘move people along’ from a position of fear and uncertainty to one where there is greater comfort with, and acknowledgement of, the issue and hence create greater readiness to act.

Importantly, it is noted that reframing the very language ‘*help seeking*’ to the more assertive vernacular ‘*taking action*’ or ‘*taking control*’ is an important element of this task. Equally reframing the task from a position of weakness to strength will be vital

Current and new frames identified are set out below:

Current frame	→	New frame
Not on my radar/ don’t want to think about it		Every man should know / No one is bulletproof
Depression / anxiety only happens to weak ‘flawed’ people		Depression / anxiety is an illness / condition that can strike anyone (x% of people will experience at some point)
Depression / anxiety is woolly and unknown. It is a black hole.		Depression / anxiety are diagnosable and treatable
You don’t dwell on these things and you don’t talk about it – you just cope		There’s no shame in suffering anxiety or depression – they are treatable health conditions
Help seeking is a sign of weakness and failure		Taking action is associated with taking control, staying strong Protecting self is protecting others
Help seeking/intervention takes place at crisis point		Early action is best
Drugs are the only treatment		There are a range of courses of action available, and treatment can be tailored

These frames are broadly applicable across the different campaign targeted audiences. We do not see noticeable differences or distinctions across segments at this level. Some frames are perhaps more pertinent than others across life stage, and this is addressed in the communications framework presented below. However, we feel that the above provides a foundation for the overall men’s campaign strategy.

2. Clarify and enrich understanding of the scope of *beyondblue* to drive help seeking to *beyondblue* specifically

The second task for communications will be to enrich the current perceptions of *beyondblue* from an organisation which is about advocacy and education at a community level to an organisation which also has direct personal relevance and which can facilitate men (and those helping men) to move along a pathway of 'taking action'. This is essential if you are to increase call rates and web visits.

This extended brand positioning is credible to the majority of the sample (with support) and will be important in drawing men (and those acting on their behalf) to spontaneously think of *beyondblue* and calling or logging-on as a first port of call. However, there are a few segment-specific 'watch outs' which emerged:

- Indigenous men and the trust issue: Engagement of indigenous men comes from within –they are unlikely to respond to anyone other than an indigenous male, and preferably one from within their own community. This is because this kind of person is able to understand and empathise with their life and their challenges. To go to *beyondblue* (a mainstream 'outside' organisation) would be a significant step, especially for older indigenous men. If specific indigenous programs or community connections are already in place they were not recalled.
- Homeless men: It goes without saying that they are already at crisis point. Shelters and hospitality centres provide connection to assistance and resources. Access to phone or internet services severely limited.
- Young disenfranchised males: They are less likely to respond to conventional role models (i.e. footballers, celebrities); they are 'tough' and need someone equally 'tough' to speak to them (for example, bikies, hip hop and graffiti artists, cult heroes).

The tangible, action oriented approach recommended here will simultaneously enrich people's understanding of the scope of *beyondblue* and will directly draw men to the website or phone line. By challenging men to know the signs / action plans and treatment options, it cuts through the hesitation to reach out in advance of actual need and also invites engagement at numerous points – not just crisis.

A communications framework

The communications framework overleaf brings the above together and highlights the particular nuances identified across life stage

Communications framework:

The below chart is a starting point to feed into communications development against primary audiences. We have concentrated on lifestage as these emerged as the most consistent differentiators on attitudes to help seeking and barriers to help seeking behaviour.

	Young men (18-25)	Fathers (25-59)	Older men (60+)
Defining attitude	<ul style="list-style-type: none"> I got to think about what's best for me – this is my time 	<ul style="list-style-type: none"> I have to be strong for my family. I can't let myself fail 	<ul style="list-style-type: none"> It's good that young guys today don't have to 'bottle everything up' but are we getting soft?
Prevailing frame (current)	<ul style="list-style-type: none"> Not even on my radar 	<ul style="list-style-type: none"> Help seeking is a sign of weakness and failure 	<ul style="list-style-type: none"> You don't dwell on these things and you don't talk about it – you just cope
Triggers for engagement	<ul style="list-style-type: none"> Mates/ social life/keep fit 	<ul style="list-style-type: none"> Family responsibility 	<ul style="list-style-type: none"> Health management Balance of self focus & family
Communications task	<ul style="list-style-type: none"> Look out for your mates / know the signs 	<ul style="list-style-type: none"> See that taking action is taking control, 	<ul style="list-style-type: none"> Recognise they are not beyond help
Primary message	Mental health - don't ignore it (know the signs, actions you can take and treatments)		
Segment specific message (reframe)	<ul style="list-style-type: none"> Nobody is bulletproof/ don't ignore a mate in need 	<ul style="list-style-type: none"> Protecting self is protecting others 	<ul style="list-style-type: none"> There's no shame in suffering anxiety or depression – They are common but serious health conditions
Considerations	<ul style="list-style-type: none"> Reflect range of youth /role models 	<ul style="list-style-type: none"> Sensitive representation of fatherhood to engage separated fathers as well those living in the family unit 	<ul style="list-style-type: none"> Roll up the sleeves approach to life could be asset in connecting

Communications considerations and ‘watch outs’

Lastly, in delivering the above framework, the research has flagged the following considerations and ‘watchouts’ which will be important to consider in developing a men’s campaign:

- **The tone of communications should be hopeful and empowering:** As we worked through current examples of communications collateral with the men in our sample, it became clear that communications pieces which adopted a dark, gloomy tone were instantly off-putting (for instance, use of dark colours in imagery and video; sad or glum appearing characters). Even sufferers of depression or anxiety failed to relate to this tone or approach.

*“When you are in that state you probably wouldn’t pay attention anyway. Any you certainly won’t pay attention if you are not depressed”
(Male, father, Traralgon)*

“Someone talking about how they got through – that’s what you want to know” (Young male, Traralgon)



Rather than focussing on ‘rock bottom’, an empowering and hopeful approach focuses men on the destination rather than the starting point. **Being matter of fact can also be empowering because it downplays the drama.** This approach can be used to communicate ‘serious but common’.

Use of humour in one UK spot³ included demonstrated that you don’t always have to discuss serious topics in a serious manner. This approach was polarising. Refreshing and engaging for younger audiences it gives permission to discuss on a personal (not societal) level. But it fell short of showing what to say and as such left younger ill-equipped men none the wiser on how to proceed. Older audiences tended to dismiss this as flippant.

³ The United Kingdom Department of Health funded “It’s Time to Change” campaign. Television advert can be viewed at <http://www.youtube.com/watch?v=aIArbJULkPA>

- **A clear purpose is essential:** A number of the communication pieces tested were felt to be vague and the target or purpose of the message unclear. This reinforces the wooliness associated with the issue and reconfirms that it is hard to define. Being targeted and specific in messages will likely sharpen the issue and speak more powerfully to the viewer (listener/reader).



*“Is that for us about us or is it about helping a friend, it’s confusing”
(Young male, unemployed, Whyalla)*

“I don’t think they know who they are talking to” (Father, young family, unemployed, Traralgon)

- **Creating a personal connection and demonstrate relevance:** men do not universally engage with communications with this issue - messages need to be personally relevant in content and look to draw them in. Men either instantly connected or disconnected from communications pieces depending on whether or not the ‘characters’ were ‘someone like me’. For example, young men tended to ‘switch off’ an ad featuring an older businessman. One of the most effective pieces was the *beyondblue* men’s campaign TVC featuring a mix of men across life stage and geography speaking of their experience. This TVC could connect with a mix of men across our sample, prompting responses such as: *“This could be me”*.

As noted above, the young disenfranchised male (who can be into illicit drugs, self-harm, alternate lifestyle) does not respond in the same way as other young men to the aspirational male depicted in the sporting hero. These young men are already feeling like ‘a loser’ and putting them up against a clean-cut role model only makes them feel more so: for them, alternate cult figures need to be sought – graffiti and hip hop artists, bikies, those with a harder edge to them. Need to illustrate empathy and acknowledge broader life experience, i.e. that they get tattoos to cover up self-harm scars. Explore specific social media avenues for this target (perhaps more YouTube than Google)

- **Understanding others’ experiences can be powerful:** Many men we encountered were keen to understand ‘real life’ examples of people who have experienced depression and/or anxiety – and not just celebrity figures, but the ‘everyday Joe’ (for instance, this was demonstrated directly in the groups towards other men who shared their own experiences of seeking help). Understanding the experience of others was a way of increasing comfort with and understanding of depression and/or anxiety in a less daunting way than seeking professional assistance. Video or written case studies could potentially be a powerful tool, as could be support networks or opportunities to share with others during action-taking process. Understanding the experiences of others can address the abovementioned frame of ‘I’m in the minority’, creating comfort and

understanding and a sense of wider community. Seeking, sharing, discussing online is highly appealing.

- **Be wary of overwhelming people:** Ultimately, the stated aim of this campaign is to direct people to the *beyondblue* website or Info Line, but once they get there, care needs to be taken in ensuring people are not overwhelmed with great volumes of information. One way of addressing this is to consider communications in tiers of information (i.e. starting out broadly, then narrowing down as needed). Creating understanding needs to be done carefully.
- **Be careful with using the word 'consumer':** For those who had prior contact with *beyondblue*, concerns with the word 'consumer' emerged as it has been applied on the *beyondblue* website. People were left feeling depersonalised.

Summary, conclusions and recommendations

- While sense of stigma towards mental illness in general and depression and anxiety in particular, in the community is believed to have shifted significantly in recent years, self stigma remains alive and well.
- In addition to self stigma (and resistance to acknowledging depression or anxiety for fear of self and peer judgement) barriers to engagement are due primarily to long held, culturally inherited beliefs; woolly and ill-defined understanding of the issue, as well as lack of perceived support which fuel, fears and misconceptions.
- Generation / life stage emerged as the greatest influences on attitudes and barriers to engagement. Despite the breadth of sample and range of pressures and priorities there was far more common ground regarding motivations, barriers and means of engagement, For this reason communications recommendations are broadly framed to three life stage groups (pre family; family; post family/retiree)
- Due to the size of the sample it is difficult to draw conclusions on some of the smaller sample segments such as unemployed and separated fathers, but depending on emotional rawness of their personal circumstance they tended towards the disenfranchised experiences of those with substance abuse problems and the homeless. Further, our small sample of men from the GBTI community suggest extra sensitivities and pressures which may increase resistance to take action (seek help).
- Location – those based in regional, rural or urban growth corridors did not pull apart from the sample attitudinally, but will need to be considered in terms of media and communication touch points.
- Indigenous and CALD audiences are likely to bring specific cultural frames to the issue of mental health including most notably what and where messages are delivered and by whom (an elder or community member/ trusted source). Advice, resources and assistance from within their own community was far more likely to engage than broadcast messages, sponsorship or mainstream media. Indigenous men see depression and anxiety as particularly complex and strongly linked to drug and alcohol abuse in their communities. They believe breaking the cycle of drugs, crime, relationship breakdown and depression can only come from understanding the causes and compounding factors (which are considerable) and to succeed will need to engage from within
- To drive change across the core sample the issue of mental health needs to be reset and framed. To do this, discourse needs to side-step long held personal beliefs and stigmas that currently inhibit men's willingness to acknowledge, discuss and seek treatment for depression and anxiety. The new frames need to empower men to in their own terms, bearing in mind that men:
 - would rather act than talk

- are more likely to engage with physical symptoms and tangible 'facts' than with concepts and emotional exploration.
 - They are unlikely to explore the nature of depression and anxiety or paths to treatment until directly impacted and even then often only at crisis point
 - May be more likely to look out for a mate than themselves
- Reframing "seeking help" in three key ways
 - Reframe "help seeking" as "taking action"
 - Reframe key barriers into new frames to empower action
 - Use the physical health approach of and challenging men to not ignore depression and anxiety and ensuring they know the signs, actions to take and treatments available directly targets the woolly and shallow understanding of the issue and seeks to drive engagement by treating mental health as the might any other male health issue.
- Reframing the issue of "Help Seeking" in this way has the potential to also address a number of the additional communications goals
 - educate men on the signs and symptoms of depression and anxiety
 - increase awareness of depression and anxiety as common and serious illnesses affecting men in Australia today
 - challenge the perception among men that asking for help is a weakness
 - encourage men who may be experiencing symptoms of depression and anxiety to seek help by calling the *beyondblue* Info Line, including reinforcing the importance of seeking help early, and
 - inform men that treatment for depression and anxiety is available and that information is available 24/7 via the Info Line and the *beyondblue* website.

Recommendations

- Focus on the tangible and actionable, i.e.: the signs of depression and anxiety; the actions or steps they can take (contact *beyondblue*) and the treatment options available. This approach challenges men to be informed. It avoids the 'soft' or ill defined' and allows them to roll up their sleeves and be true to themselves
- Communications can challenge the current frames without referencing them. The approach should not seek to change opinions immediately or directly, but rather to change behaviour by removing barriers and facilitating ways in.
- Strike a tone that is factual (yet positive/ hopeful) to reassure that taking action is important and normal ('this is what we do now'),
- Demystify the woolly 'black dog' and challenge all men to know the signs, the actions they can take and treatment paths (via *beyondblue*)
 - Reframing "seeking help" as "taking action"
 - Reframe crisis response to early action (or intervention)
 - Reframe to 'serious' and 'common' – not 'lightweight' or 'minority experience'

- Address core life stages of pre-family singles, family men and post family/ retirees primarily with targeted touch-points for all 'at risk groups'
- *beyondblue* need to expand and enrich its brand profile to create credible and spontaneous associations with personally relevant information and pathways to action. (*beyondblue* will help me know the signs, the actions I can take and treatment paths available – for me or a mate)
- *beyondblue* delivering this tangible, action oriented approach underpinned by checklists, factsheets action paths and treatment options will challenge the current narrow perception of *beyondblue* and will act to directly draw men to *beyondblue* (web and phone lines) – thus address the campaign objectives of increased calls and visits
- Thoughtful media placement and targeted touch points will reinforce *beyondblue* as personally relevant 'go to' resource.
- Ensure communications demonstrate relevance to lifestage.
- Harness the power of connecting with others' experiences through use of online videos and or blogs profiling people who have experienced depression and/or anxiety.

Appendix 1: Communications collateral used as stimulus material

Developed by beyondblue:

- Flyer: Understanding anxiety and depression
- Flyer: Understanding depression - Information for adults
- Flyer/brochure: Depression and men
- Fact sheet 1: How can you help someone with depression / anxiety
- Youth *beyondblue* Fact Sheet 22: Depression and anxiety in young people who are GLBTI
- Posters x 3: 'I drink', 'More than Stress', 'I didn't give a stuff'
- TVCs x 3: 'I drink', 'Men's depression', 'Workplace'

Posters and TVCs downloaded from:

http://www.beyondblue.org.au/index.aspx?link_id=89

PLUS: a selection of materials provided by *beyondblue* as part of a men's specific kit.

Developed by other organisations:

- Mensline flyer x 1
- Mensline poster x 1 (flyer and poster accessible at <http://www.mensline.org.au/Download-Materials.html>)
- Posters x 3: 'Start talking' (<http://positive-posters.com/posters/profiles/?pid=2326>)
- TVC/video: Better if You're Around Soften the Fck Up
<http://www.youtube.com/watch?v=ZH26I7fqycM>
- TVC/video: Time to change <http://www.youtube.com/watch?v=alArbJULkPA>

Web screenshots:

- Men's sheds x 1 (www.mensheds.org.au)
- Mensline x 1 (www.mensline.org)
- Shots from beyondblue-men.org.au x 3 (www.beyondblue-men.org.au, www.beyondblue-men.org.au/what-is-anxiety, www.beyondblue-men.org.au/what-is-depression)