MOVEMBER® CHANGING THE FACE OF MEN'S HEALTH

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MOVEMBER® INSTITUTE OF MEN'S HEALTH

Re: Movember Submission to the final review of the National Mental Health and Suicide Prevention Agreement.

Executive summary

The agreement

Commencing in 2022, the National Mental Health and Suicide Prevention Agreement (Agreement) has reflected steps towards cross jurisdictional approaches to supporting the mental health and wellbeing of the people of Australia, including through targeted efforts to reduce suicide.

The purpose of the agreement is to describe the shared intentions of the Commonwealth, state and territory governments (the States) to partner in efforts to improve the mental health for all Australians, as well as seeking to both sustain and enhance the services of the Australian mental health and suicide prevention system. The agreement sets out principles, objectives, outcomes and outputs, roles, responsibilities, governance and funding arrangements between the Commonwealth and the States.

The commitment to increasing spending on mental health and realising a 3% growth since 2017 is a good start. However further investment is required as mental health outcomes, particularly for young people (and young men) are unacceptably poor in Australia and have continued to worsen over the past two decades[1], including over the period this agreement prevailed[2]. Seismic action is required to turn the trends around and support people's mental health, in particular for that of the next generations.

While Movember appreciates the ambition of the agreement, it does not go far enough, particularly as it relates to young people, and young men. A key omission from the agreement is a focus on gender responsiveness – noting that gender is not mentioned in the current agreement. It does not effectively account for the complexity of mental health and how it is influenced and therefore does little to introduce sound preventative strategy.

This submission

The drivers of poor mental health, and the response to this, cannot solely be addressed through the mental health system. Social, economic and commercial factors are contributing to the burden of disease associated by poor mental health and suicide, including:

- family environment, social relationships, education, health and lifestyle, experiences of abuse or neglect, bullying and cyberbullying, and the role of social media[1].
- labour and housing markets, socio-economic disadvantage and inequality, climate change, and political factors[1].
- the direct and indirect effects of the consumption of produced commodities[3], including tobacco, alcohol, fossil fuels and ultra processed foods[4].

Thus, having a mental health agreement focused primarily on the mental health system, and the specific roles of governments within that system, is a folly. For mental health in this country to improve, and for people to flourish and live the lives they want, to their fullest, the way in which mental health is conceptualised and nurtured needs to dramatically shift. In this context, prevention necessarily is a core pillar – with a fundamental requirement being a shift to focus on supporting families, rebuilding communities and creating environments that people can prosper in.

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This submission is focussed on sharing insights to highlight gaps in the current agreement (and by extension, the Australian mental health system) and to inform the design of any future arrangements beyond June 2026, ensuring continued progress in mental health and suicide prevention efforts.

Three core contributors to societal mental health and wellbeing are explored:

1. Lifespan perspective to men's health.
2. Locating men within the mental health system (as well as adjacent systems which contribute to mental health).
3. Leveraging where men meet to improve their wellbeing.

Alongside continued investments in women's health, Movember recommend the final review of the National Mental Health and Suicide Prevention Agreement, and any new agreement consider:

1. Reconceptualization of mental health in Australia to better reflect its true complexity, including responding to the factors it is both driven by and perpetuates. Prevention becomes a fundamental requirement with a shift to focus on supporting families, rebuilding communities (including online and school communities) and creating environments that people can prosper in.
2. The importance of a lifespan perspective in providing interventions for young men. This must consider our evolving understanding of masculinity. Online interventions cannot follow traditional means of health promotion, and we need to invest in innovative research and program design to ensure interventions resonate with their users.
3. Reviews of adjacent systems, such as AOD, food systems, and gambling, need to consider the relationship between poor mental health and the impact they are having in terms of contributing to demand in the mental health system (i.e. cost).
4. We must drive demand by strengthening men's health literacy, with a focus on the most at-risk groups, so men are well equipped to get the care they need, when they need it.
5. Gender should be considered as a sociocultural determinant in future agreements and included in a clearer set of national priorities for preventative mental health, including via workforce development.
6. Evidence based programs in sports and gaming environments should be built into the service ecosystem.
7. Budget investment to successfully operationalise Australia's National Men's Health Strategy 2020-2030 and support sustainable translation of what we know works into practice so that its desired outcomes can be achieved – particularly for priority populations of men.
8. Investment in research that works to build, evaluate and translate evidence into practice to reach and benefit all men.

1. Insights into men's mental health across the lifespan

The Agreement set out to reduce the incidence of suicide of all Australians, including to provide an effective approach to the needs of people at risk of suicide (Clause 122). Despite some investment in this in Australia, the rates of suicide for men remain tragically high. This occurs despite reductions in stigma

to seek support and greater help seeking behaviours, perhaps driven then by factors not well enough considered in the Agreement.

1.1 Young men's mental health influences health across the lifespan. Approximately 60-75% of all mental illnesses onset by age 25[5] meaning that if we can understand more about this life stage and respond with appropriate interventions, we can greatly reduce downstream mental health issues and associated costs. Movember are leading research in this area on behalf of young men.

We know that suicide remains the leading cause of death for young men aged 15-44 years of age in Australia[6]. Further that one in four young men aged 16-24 years of age in Australia experience an anxiety disorder[7] and one in ten depression[8]. Mental illness and poor wellbeing are perpetuated by social isolation which has increased over the last 20 years with 25% of young men aged 15-24 years reporting feeling socially isolated[9]. The advent of social media and concurrent social comparison may have increased experiences of depression and anxiety without contributing to positive change on isolation or loneliness[10]. Since 2012, the prevalence of eating disorders in young people aged 10-19 has risen by 86%[11]. Adolescence and early adulthood are a period of great social and interpersonal uncertainty for young men and is a period of peak onset of mental disorders. This developmental vulnerability was of course, exacerbated by Covid-19[12]. Life stressors congregating around transition periods (i.e., school stress, leaving home, starting work, initiating and ending relationships) are common yet ineffectively supported within our health system. Often this is due to the complexity of presenting issues by the time they reach the mental health system. Prevention during childhood and adolescence and treatment with greater awareness of this stage is therefore critical.

Stress during adolescence will be harder to navigate for those who have experienced adverse childhood experiences (ACE's) which mediate neurodevelopment[13] especially in the absence of secure attachment relationships[14]. A lack of safety in childhood is mirrored in the internal neurophysiology of children and ACE's have consistently been found to correlate with emotional dysregulation across the lifespan[14]. This is exacerbated if the adverse experiences occur during key periods of neurodevelopmental vulnerability[15] when the brain systems are rapidly organising[16].

Following exposure to ACE's boys will often present with maladaptive externalising behaviours in responding to stress by expressing anger, rage and acting out aggressively[17]. They are more likely to display other risk taking behaviours (e.g., alcohol and drug misuse, reckless driving, unsafe sex practices) which are particularly high amongst young men 15 to 25 years, with 15% of young men (14-24 years) engaging in risky drinking behaviours[18]. Social systems (structures, institutions, communities, families etc) often identify this expression as anti-social behaviour, albeit with inconsistency, and the subsequent outing/ exclusion can mean that their brains become organised around disconnectedness and control rather than empathy[19]. This builds towards a trajectory across the lifespan where boys become men with impaired self-regulatory capacity[20]. Our prevention efforts should focus on high quality social support as a protective factor for adolescents who have experienced ACE's[21].

Men account for 75% of deaths by suicide, and Australian research has reported that the death of a person by suicide has a ripple effect impacting, on average, 135 people directly and many more indirectly, and can have a range of profound psychological, physical, emotional and financial effects on those left behind[22].

The National agreement highlights that a *broad suicide prevention policy response is needed to promote the protective factors, address the economic, environmental and social drivers of distress, and support social, emotional and cultural wellbeing (page 26).* A lifespan perspective, taken together with the following recommendations offers an approach to reaching this goal – a goal that has not been met through the current agreement given continued too high rates of suicide.

Over the past 20 years there has been a 31% increase in the levels of disability and premature death associated with mental health conditions[23]. If we can respond appropriately to meet the needs of young men earlier in life, we can arrest the trajectory where boys become unhealthy men. **A lifespan perspective in providing interventions for young men must be prioritised in future agreements on mental health, wellbeing and to prevent suicide.** However, we also need to better understand and respond to the broader societal factors that drive poor mental health.

1.2 Masculinity. Many men report valuing strength, toughness and self-reliance and think they should control or restrict their emotions. Adherence to more traditional masculine norms can increase men's likelihood of experiencing distress and simultaneously maintain negative attitudes toward seeking help[242526].

Men with symptoms of depression and higher conformity to traditional masculine norms are significantly less likely to access mental healthcare than those with lower conformity to masculine norms[27]. In the most extreme cases, strict conformity to these masculine norms can lead to some men reporting feelings of vulnerability to being more anxiety-inducing than the thought of being dead, which plays a role in explaining low help-seeking for suicidality[28]. **Gender (and its expressions) should be considered as a sociocultural determinant in future agreements and included in a clearer set of national priorities for preventative mental health.**

1.3 Young men and social media. Social media is playing a significant role in young men's lives - young men are spending an average of 2 hours on social media everyday and frequently turn to social media for health related information[29]. Social media is now foundational in how young men live their lives, with the manosphere and its associated communities and ideologies representing risk of harm[30]. Movember seek to embed all programs within community and while the existing Agreement (clause 126) and broader social policy identifies the value of psychosocial supports, more can be done to leverage the strengths of individuals and communities as we continue to prioritise place-based approaches. In a modern world this must consider healthy online influencers as agents in young people's lives. Simply restricting access to social media for young people is not the right approach, where greater regulation would have greater effect[1].

Interventions for men must consider modern masculinity and potential social harms and cannot follow traditional means of health promotion. We need to invest in innovative research and program design to ensure interventions are strengths based and resonate with their user. These must reflect the ever-evolving nature of the social media landscape.

1.4 Social harms – including diet, alcohol and gambling. Men's poor mental health can be associated with risky coping behaviours, including gambling and over-consumption of ultra processed foods, alcohol and other drugs. These coping behaviours can, in turn, contribute to significant harms to those around them. Gambling can damage family finances and have emotional, physical, mental and social costs to partners, children, wider family and friends[31]. Heavy alcohol and substance use can contribute to violence against

partners, family members or complete strangers[3233]. There is also a body of research which evidences the relationship between ultra processed foods and poorer mental health. This is food which people often consume owing to necessity (i.e. cost of living pressures, and/or coping). There appears to be a disconnect between factors such as these which are influencing poor mental health, and policy. For example, accountabilities for mental health and alcohol and other drug (AOD) sit between mental health and health portfolios in different jurisdictions around Australia. There also appears to be different approaches to regulation in the context of harm minimisation.

So, while the agreement seeks to reduce mental health system fragmentation, fragmentation across adjacent service systems equally require remediation. Policy, funding, and regulation around mental health cannot be made in a vacuum if the desire for change and improvement in outcomes genuinely exists. In parallel to the review of the agreement, there is currently an Inquiry into the health impacts of alcohol and other drugs in Australia – which hopefully will explore this. The proliferation of poorly regulated alcohol home delivery services, and advertisements for alcohol, fast foods, and gambling during televised sporting events, demonstrates that Australian governments are not yet ready to have difficult conversations about the two-way role these factors play in the mental health of the population, and particularly in the lives of men.

While Schedule A of the agreement acknowledges *the intersections between mental health and family, domestic and sexual violence, including sexual harassment, and child maltreatment* (Schedule A. 6) *and substance use* (Schedule A. 8) our efforts need to go beyond improved referral pathways and strengthening collaboration, integration or co-location between existing services into better intervention design and much better prevention efforts that reflect the complexity of the combined factors that drive mental ill health. **Reviews of adjacent systems, such as AOD, food systems, and gambling, need to consider the relationship between poor mental health and the impact they are having in terms of contributing to demand in the mental health system (i.e. cost).**

2. Locating men and their help seeking within the mental health (and broader social service systems)

2.1. Improving health literacy and system access. Men are less likely than women to ask for help when they need it, and when they do, the mental health system does not always respond to their needs[25]. Two in five (37%) men living in Australia die prematurely, before they are 75 years old[34]. The cost of getting this wrong is huge, Australia spent approximately $10.7 billion in 2023 alone on avoidable cases across five conditions that cause the most years of life lost in men (coronary heart disease, lung cancer, self-harm/suicide, chronic obstructive pulmonary disease, and stroke)[35].

The National Men's Health Strategy 2020-2030 identifies the groups of men that are disproportionately affected by poor health[36]. These groups are: Aboriginal and Torres Strait Islander men, socioeconomically disadvantaged men, men living in rural and remote areas, members of the LGBTQIA+ community, men living with a disability, men from culturally and linguistically diverse backgrounds, male veterans, socially isolated men and men in contact with the criminal justice system. This is consistent with the priority population groups identified in the Agreement *(clause 111)* which, given the low gains experienced in the health outcomes of these groups, indicates the need for more effort to prioritise effective intervention design for these men in future agreements. While it is positive that this clause prioritises young people, greater consideration is required to the specific needs of this cohort based on their identified gender.

Despite being motivated to engage with primary healthcare services for preventative healthcare, Aboriginal and Torres Strait Islander men face gendered barriers such as feelings of invisibility, discomfort, fear, shame which along with waiting times, a lack of health literacy, and a lack of culturally appropriate and responsive services greatly impacts mental health outcomes[37].

The barriers preventing boys and men from seeking help or seeking help in a timely manner are often reduced to simple stereotypes, when in fact the reasons are typically diverse, complex and interact with one another. There is an association between strong health literacy and engagement with mental health care. Men with higher levels of health literacy are more likely to regard preventive health services that promote healthy lifestyle and help-seeking as important[38]. Health literacy may also help to overcome men's embarrassment to talk about health issues or fear screening, testing, diagnosis, treatment and/or mortality. Those with lower health literacy levels are far more likely to have more advanced illness at the point when they engage with health services, meaning delayed diagnosis and treatment, and ultimately worse health outcomes[3940].

Any future agreement requires a continued focus on building the health literacy of men, especially for at risk cohorts. This must include more than *Stigma Reduction* as it is highlighted in the current agreement, it requires future policy to improve both access to care and then assurances that people receive the right care. It is strongly recommended that the existing *clause 120* be adapted to include gender responsive activities to improve effectiveness, access and equity of care.

2.2 Getting the right care. Although gains in literacy are still required, Australian men are seeking professional help for their mental health more than ever. However, they are often not getting the support they need when they arrive. In a nationally representative sample Movember polled 1,658 men in Australia on their experiences of engaging with primary care. Nearly two out of every three men (63%) feel that gender stereotypes (e.g. 'toughing it out') have affected their health behaviours and experiences in healthcare settings. 58% reported that they faced one or more barriers to effective engagement with healthcare providers. Many men (67%) report having felt like wanting to leave their practitioner or having left their practitioner, due to a lack of personal connection. This is worse for younger men with 21% of 25-34-year-old men reporting communication that lacked empathy or connection (compared with 16% of men overall).

Seidler et al. (2021) explored Australian men's dropout from mental health services via a national survey of 1,907 men. Overall, 44.8% of participants had dropped out of therapy without discussing this with their practitioner. The most common reasons for dropout were lack of connection with the therapist and the sense that therapy lacked progress (20.2%). Several predictors of dropout were identified, including younger age, unemployment, and self-reported identification with traditional masculinity[41].

A Movember-led scoping review of the literature[42] identified a range of gender responsive strategies that can be applied by health practitioners to effectively engage and keep men in care:

- Tailoring communication to reach men and keep them connected throughout health care encounters.
- Purposefully structuring treatment in a collaborative manner to effectively respond to men's health care needs, and
- Centring the therapeutic alliance to be receptive to, affirming and responsive to men's gendered patterns of health and help seeking in order to retain men in care.

Many men still experience typical manifestations of suicidality, driven by low mood, hopelessness and anhedonia. However, in assessing and treating men, mental health professionals should understand, assess and treat the depressive traits that may look different for men, a factor that does not seem to have been considered within clause 124 (f - g) of the existing agreement. Seidler et al. (2018) interviewed 20 men about their experiences in therapy. Men's preferred structure included focusing on individualised goals and expected progress, establishment of trust, and a sharing of decisional control. Providing an action-oriented, functional treatment with targeted skills attainment was recommended as most engaging[43] .

One reason the health system is not responding well to men's needs is the lack of formative education and training about men's health. While the Agreement recognises that *workforce is a key enabler for the generational reforms being undertaken in Australia's mental health and suicide prevention system* (*144)* sex and gender considerations in provision of mental health services have not been consistently incorporated, or are entirely lacking from undergraduate, and post-graduate medical and allied health curricula[44] as well as in continuing professional education. Alarmingly, evidence shows mental health practitioners have a significantly lower willingness to treat and refer male patients experiencing suicidality than females, with practitioners self-perceived competence the strongest predictor of outcome[45]. Moreover, men's health was seldom referenced across university curricula for nursing, pharmacy, psychology, social work and public health[46].

The National Suicide Prevention Office is a good step towards coordinated suicide prevention. However, we need a stronger focus on prevention and must offer a mental health care experience that better resonates with men, positively integrating healthcare into their lives. Upskilling of the health workforce with competencies to effectively engage with men in care is critical and here we point to practical approaches that work. **We must take this evidence to respond to demand with a gender responsive mental health system and workforce.**

Movember's Men in Mind program is a great example of this work in action. The world-first online training program for mental health professionals equips therapists with the skills and confidence to better engage, connect with, and respond to male clients. A randomised controlled trial found the program significantly improved healthcare professionals self-reported confidence and competence in engaging and responding to help-seeking men[47]. The program is currently being scaled across Australia and can be adapted for health professionals across other public and clinical health disciplines. It can also be incorporated into tertiary curricula to develop gender competencies for working with men in our future healthcare practitioners.

3. **Leveraging where men meet to improve their wellbeing**

Community based men's health promotion aims to reach men in both community and online places and spaces of meaning to them. These programs are specifically designed to bring men together in peer groups for the purpose of sharing health literacy information and/or providing social connection. These programs can overcome structural and gendered barriers that some men face in accessing relevant health information and services[25].

3.1 Sport. Sport influences the formation of many young men's identities, with significant potential to cultivate healthy behaviours, relationships, and life skills. Sport is uniquely positioned to set and affirm cultural and social norms for young men, and it should do so through a strengths-based healthy

masculinities approach[48]. A recent systematic review reported the positive effects of sports-based interventions on the mental health and mental health literacy outcomes of young males[49]. Current evaluations of these programs indicate that there would be a significant return on investment, regarding men's health literacy, from further funding and scaling of these programs. Sport provides a suitable platform to grow health literacy and resilience and present a safe investment if we scale evidence based programs like Ahead of the Game.

3.2 Esports and Gaming. 70% of men and 49% of women under 30 play video games. This platform is used to unwind from everyday life and to build and strengthen social connection[50]. While further research is required into the potential harms of this environment it may be a useful channel to engage and work with men.

Rather than continuing to focus on traditional settings for provision of mental health interventions, the current focus within the Agreement, **evidence-based programs in sports and gaming environments should be built into the service ecosystem.**

Conclusion

Too many men in Australia are dying too young, of causes which are often avoidable. Too many men face challenges and have poor experiences when they do engage with mental health care. Certain men are more impacted than others: your Indigenous status and where you live in Australia have a significant impact on how long you live. There isn't yet a full picture of men's experience of mental health care, and more research is needed. Indeed, much needs to be done to create a mental health system that is sensitive and responsive to all men's needs and preferences, so men don't slip through the cracks. We are overdue in holding hard conversations about the drivers of poor mental health in this country, it's time to make the tough decisions to turn things around. This includes systems change related to diet, gambling, alcohol, social media and the interaction effects of masculinity. Without reform across these domains, efforts to improve mental health outcomes via the mental health system alone are likely to fall short.

Budget investment to successfully operationalise Australia's National Men's Health Strategy 2020-2030 and support sustainable translation of what we know works into practice, particularly for priority populations of men, must be integrated within any new Agreement. **This must be matched with research that works to build, evaluate and translate evidence into practice to reach and benefit all men. Such research must respond to the changing social determinants of mental health for young people.**

The Agreement brings together a mandate for whole of government approach, encouraging cross-jurisdictional and portfolio practice and Schedule A highlights the role of living experience. However more effort is required to bring the whole mental health ecosystem and its adjacent systems into design and decision making.

Recommendations

We want men and boys to better understand their mental health and see the mental health system as a place where they belong, where they are understood, and are responded to effectively in ways they want and need. Movember recommend the final review of the National Mental Health and Suicide Prevention Agreement, and any new agreement consider:

1. Reconceptualization of mental health in Australia to better reflect its true complexity, including responding to the factors it is both driven by and perpetuates. Prevention becomes a fundamental requirement with a shift to focus on supporting families, rebuilding communities (including online and school communities) and creating environments that people can prosper in.
2. The importance of a lifespan perspective in providing interventions for young men. This must consider our evolving understanding of masculinity. Online interventions cannot follow traditional means of health promotion, and we need to invest in innovative research and program design to ensure interventions resonate with their users.
3. Reviews of adjacent systems, such as AOD, food systems, and gambling, need to consider the relationship between poor mental health and the impact they are having in terms of contributing to demand in the mental health system (i.e. cost).
4. We must drive demand by strengthening men's health literacy, with a focus on the most at-risk groups, so men are well equipped to get the care they need, when they need it.
5. Consideration should be given to gender being considered as a sociocultural determinant in future agreements and included in a clearer set of national priorities for preventative mental health, including via workforce development.
6. Evidence based programs in sports and gaming environments should be built into the service ecosystem.
7. Increased investment in research that works to build, evaluate and translate evidence into practice to reach and benefit all men.
8. Greater investment to successfully operationalise Australia's National Men's Health Strategy 2020-2030 and support sustainable translation of what we know works into practice so that its desired outcomes can be achieved – particularly for priority populations of men.

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