Game On:

Exploring the Impact of Technologies on Young Men's Mental Health and Wellbeing

Findings from the first Young and Well National Survey
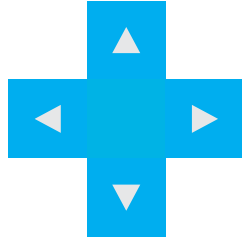
Jane M. Burns, Tracey A. Davenport, Helen Christensen, Georgina M. Luscombe, John A. Mendoza, Amanda Bresnan, Michelle E. Blanchard, Ian B. Hickie

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"Movember believes that it is time to take a game–changing approach to improve the mental health of men. There is no one simple solution. One organisation alone does not and has not had 'the answer'. A challenge for the sector, and the impetus for Movember, is to build powerful partnerships locally and globally that are committed, through research and development, to a vision of having a revolutionary impact on the mental health of men. While not the only answer, we believe that technology provides a platform that could, for the first time in history, reduce the disparities in access to support and care across populations."

Paul Villanti, Chief Executive Officer,
Movember Foundation

"One of the most important things about the Young and Well CRC is that there's a real focus on the value of youth participation, and we're seeing this gap between service providers, researchers and young people closing in."

Bronte O'Brien, 22, Youth Brains Trust member,
Young and Well CRC

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A PDF of this report can be downloaded from *youngandwellcrc.org.au*

Young and Well CRC

The Young and Well CRC is an Australian–based, international research centre that unites young people with researchers, practitioners, innovators and policy–makers from over 70 partner organisations. Together, we explore the role of technology in young people's lives, and how it can be used to improve the mental health and wellbeing of young people aged 12 to 25 years. The Young and Well CRC is established and funded under the Australian Government's Cooperative Research Centres Program.

Partners

Brain & Mind Research Institute

The University of Sydney's Brain & Mind Research Institute (BMRI) is dedicated to reducing the burden of disease due to brain and mind disorders through interdisciplinary, collaborative, basic, translational and clinical research and education. The BMRI works to develop new procedures, technologies and medicines, and to provide immediate access to the most advanced treatments for mental and neurological disorders, thereby contributing to the prevention or cure of these disorders.

Black Dog Institute

The Black Dog Institute is a world leader in the diagnosis, treatment and prevention of mood disorders such as depression and bipolar disorder. Founded in 2002, the Institute combines expertise in clinical management with cutting edge research.

beyondblue: the national depression and anxiety initiative

beyondblue is a national, independent, not–for–profit organisation working to address issues associated with depression, anxiety and related disorders in Australia. beyondblue is a bipartisan initiative of the Australian national, state and territory governments with a key goal of raising community awareness of depression and anxiety, and reducing the stigma associated with these illnesses.

Movember Foundation

During November each year, Movember is responsible for the sprouting of millions of moustaches around the world. With their "Mo's" men raise vital funds and awareness for prostate and testicular cancers, and mental health. As an independent global charity, Movember's vision is to have an everlasting impact on the face of men's health.

Foreword

In 1912, following drought and hard times, a young farmer in South Australia could no longer cope with the pressures of life. He left behind his wife and four children. Five decades later one of his sons, after the stress of another drought, was discovered not knowing his name or where he was. He spent a month in Parkside Mental Hospital.

These men were my great–grandfather and grandfather. I did not know their stories until my grandmother shared them with me in 2003. Mental illness was not something you ever spoke about in a close–knit country community. Men were the providers, they were tough and they felt the weight of responsibility for their families and their farms.

Today, in 2013, it is a tragedy that despite a growing awareness of mental illness and an increase in knowledge about symptoms, causes and where to seek help, young men in Australia are still not getting the right help at the right time. The consequences are often dire, with men having higher rates of suicide, alcohol or other substance misuse, violent and antisocial behaviours than women.

Young people are, however, increasingly relying on the internet to find information, contact relevant health organisations, and reach out to others in need. The internet can be empowering for those who are marginalised and geographically isolated. A fundamental and powerful shift is apparent in the way technologies have been used. While the commercial sector has embraced this to incorporate online services as a core component of their service offering, the mental health and broader human services sector has largely not.

In mental health and youth health, there is an urgent need to capitalise on technologies to promote access to online self–directed wellness management and the development of best–practice models that provide seamless and continuous support and care across online and offline services. For those experiencing mental illness, the strategic use of technologies by professionals to enhance engagement and support treatment is critical, along with new service models of online therapy that can include care plans negotiated between the young person, their families and the teams that care for them.

This report is written with enthusiasm and hope. It highlights the significant advances that Australia, through the work of *beyondblue:* the national depression and anxiety initiative, has made in creating a more tolerant and accepting society that understands that mental illnesses, like physical illnesses, are preventable and treatable. Australia should be proud of the investment it has made in developing world–class mental health services like headspace, Australia's National Youth Mental Health Foundation and the EPPIC (Early Psychosis Prevention and Intervention Centre) model developed at Orygen Youth Health; of leading the way in the development of a world–first online mental health resource for young people with the introduction of ReachOut.com in 1998; and for producing some of the most innovative and exciting research in e–mental health.

Over the last decade, we have created a foundation in youth mental health that positions us to move quickly and decisively to invest further in the development of e–mental health in both wellness promotion and the prevention of mental illness and in early intervention, treatment and recovery.

We are uniquely positioned to act, and the time to do this is now.

Associate Professor Jane Burns
Chief Executive Officer
Young and Well CRC
July 2013

Main messages

1. Suicide, motor vehicle accidents and violence are the major killers of young men in Australia – good mental health and wellbeing are critical to their prevention, and lay the foundation for a healthy and happy adulthood.

2. Young men do not seek help and many young men are not using services until they reach crisis point.

3. Technology presents an unprecedented opportunity to work directly with young men to create new ways of engagement, new service models of care, and greater empowerment for young men in their management of stress and life pressure.

In 2008, the Brain & Mind Research Institute (BMRI) oversaw an Australian national telephone survey of 1,341 young people aged 16 to 25 years. In 2012, the Young and Well Cooperative Research Centre (Young and Well CRC) replicated some aspects of this survey interviewing 1,400 young people aged 16 to 25 years. The data described in this report provide us with information about the significant shift in the ways in which Australia's young people engage with technologies and the impact this has on their mental health and wellbeing.

Poor mental health touches on each domain of life: education, family, employment, and social engagement with friends and the broader community, both locally and globally. Given the critical role of technologies in connecting young people and potentially empowering them to make positive choices about their mental health and wellbeing, it is essential that we start thinking broadly about building these foundations for a flourishing, thriving, vibrant and exciting country.

THIS REPORT MAKES A NUMBER OF IMPORTANT RECOMMENDATIONS, BUT THREE ARE CRITICAL:

1. Australia leads the world in its provision of youth mental health services. Australia is also a world leader in e–mental health research. We have the foundations for a comprehensive e–mental health system but we must ensure that it reaches all young people and is relevant to young men.

2. Community awareness initiatives about depression have paid real dividends and it is clear that young men in Australia are knowledgeable about mental health issues. We must build on this knowledge with concise instruction about help–seeking, stress and wellness management and crisis support, and this must include strategies that include social messaging and targeted approaches for those most at risk, including the unemployed, men who 'fly–in, fly–out' and those who are geographically isolated.

3. We require further investment in education and training to ensure that professionals are as competent in the use of technologies as the young people they support. Young people are best placed to provide this training.

In 2010, the youth and mental health sectors joined forces with a shared vision to explore the use of technologies to improve the mental health and wellbeing of young people. Each of the major partners invested significant cash to form a groundbreaking collaboration – the Young and Well CRC. In a cash–strapped, competitive environment, this was an extraordinary display of commitment to a vision bigger than that of each individual organisation.

This joint effort was recognised by the Australian Government's Cooperative Research Centres program. It recognised the substantial shift in the sector and a commitment to partnership, and realised the potential that Australia, through the establishment of the Young and Well CRC, might have in leading the world in the development of a truly innovative approach to the mental health and wellbeing of young people through technologies.

This report on young men provides data that can be used by the youth and mental health sectors, policy–makers and professional bodies to enact change to address the real needs of young men in a way that is engaging, supportive and empowering.

Case study

TAYLOR'S STORY

When one of my closest mates talked to me about how he was feeling and told me that he might have depression, I urged him to speak to a professional. I was glad that he talked to me, but he didn't want to see a professional. *"Nah, I'm stronger than that. I don't need their help, I can get through this without medications,"* he said. I was left there being the only one to talk to him about it. We tend to not share our feelings and thoughts as we feel it appears un–masculine and because we fear being ridiculed by our peers and society.

Unfortunately, men are portrayed in media, and especially fictional tales, as powerful, solitary and confident heroes. (Not to say there aren't strong females in media and fiction either.) While this appears to be brilliant at first as we get to boost our egos and feel extra confident when relating to characters like Goku, or the protagonist in our video games, or our favourite athlete; it's becoming a dilemma when we find ourselves attempting to emulate how we perceive these role models.

Unfortunately, as men get older the close relationships with our mates can tend to drift apart, so they lose the few they feel they're able to speak to. This results in even more solitude for older men who don't see their mates often. I think my Dad displays symptoms of bipolar disorder, but I have no idea how to convince him to see someone. We don't talk enough about personal stuff to be anywhere near close. I mentioned it once, and he later agreed in a private message online, but I've never seen him doing anything about it.

'Taylor' (18)   Name changed. To retain authenticity, this story has not been edited.

Contents

Executive summary

Technologies have changed the way young people communicate, connect and engage with each other and with society. Young people use the internet to find and share information, to support their friends and to reach out via social networks to others who might be experiencing similar challenges. With the introduction of smartphones, information and services provided online or via mobile applications can be accessed privately and at any time. This can be empowering for individuals who are marginalised or geographically or socially isolated. For the first time in history, it is possible to reduce the disparities in access to health care as a result of isolation, stigma or cost.

In the last decade, researchers have examined both the risks and opportunities of technologies. Service providers, policy–makers and the community have grappled with the rapid uptake of technologies and how to keep pace with an evolving new social space. It is only now, with faster internet speeds, the monumental growth in online communities and the universal uptake of smart devices, that we have capacity to revolutionise mental health services, and to build communities focused on wellbeing in settings such as schools and workplaces.

The data presented in this report are results from the first Young and Well National Survey focused on young men aged 16 to 25 years, and provide a snapshot of their mental health, wellbeing and technology use.

Change in technology use 2008 to 2012 for all young people

Technology use by young people has fundamentally changed:

| Daily internet use has increased from 95% to 99%.

| Frequency of use has increased from two to three hours per day.

| Internet use after 11.00pm has increased from 44% to 63%.

| Accessing the internet at home has declined from 91% to 80%, while access at a friend's, neighbour's or relative's place rose dramatically from 4% to 73%.

All online activities have increased with a proliferation in the availability of social networks, use of digital content production and the use of online services such as banking and shopping – all of which is entirely due to the increased availability of smart devices such as smartphones, iPods and tablets.

| From 2008 to 2012 rates of psychological distress remained stable despite a significant and dramatic increase in the use of social networks, digital content production and smart devices during those years.

50%
Almost 50% of young men said coping with stress was their biggest issue

Less than one in four young men would recommend professional support, either face–to–face or online

19%
Internet use by young people after 11.00pm has increased from 44% in 2008 to 63% in 2012

69%
Accessing the internet at a friend's, neighbours or relative's place rose from 4% in 2008 to 73% in 2012

General health, mental health and wellbeing of young men

| Despite reporting generally good health, 15% of young men have 'high' to 'very high' psychological distress, while 28% have 'moderate' psychological distress.

| Nearly one in five young men in the past 12 months have felt that life is hardly worth living. Nearly one in 10 young men have thought about taking their own life, while 4% reported making plans, and 2% reported an attempt. Suicidal ideation increased with age and significant predictors were unemployment and psychological distress.

| Coping with stress is the biggest issue facing young men – almost 50% reported stress as their main concern. One in four young men were concerned about depression (27%) and body image (26%).

| 41% of young men felt concerned about their physical appearance on a daily basis.

| When asked about happiness, approximately 80% of young men 'moderately' or 'strongly agreed' that they felt fully mentally alert and that life is very rewarding, while 65% felt well satisfied with everything in life and 60% felt they could fit everything in they wanted to.

| When asked about 'coping' on a resilient coping scale, approximately 75% of young men said they could look to creative ways to manage difficult situations and control their reactions, over 90% felt they could grow in positive ways when dealing with adversity, and over 70% could actively look to replace losses.

| Young men recognised alcohol or other substance misuse (46%) and mental health (39%) as the major health problems affecting young people aged 12 to 25 years.

| Young men were knowledgeable about the age of onset for mental health problems and alcohol or other substance misuse as well as the duration of such problems prior to seeking help. Fifty–eight percent reported feeling confident that they could access care or treatment for a close friend or family member with a mental health problem, while just one–third were confident that such care would be affordable.

| Less than one in four young men would recommend professional support, either face–to–face or online.

| Use of the internet to find information about physical health problems (66%) and mental health, alcohol or other substance use problems (43%) was acceptable to young men.

Technology use and psychological distress in young men

| Young men with 'moderate' to 'very high' psychological distress spent longer on the internet than those with 'no or low' psychological distress (four vs three hours respectively).

| 13% of young men with 'moderate' to 'very high' levels of psychological distress spent greater than 10 hours a day on the internet compared to 4% with 'no or low' levels of psychological distress.

| 33% of young men with 'moderate' to 'very high' levels of psychological distress accessed the internet after 11.00pm six to seven nights a week, compared to 25% with 'no or low' psychological distress.

| Accessing social networks, checking email, watching or downloading/uploading videos and gaming alone were all popular activities and participating in them did not differ across levels of psychological distress.

| Young men who reported higher levels of psychological distress were more likely to access health information, listen to (or download/upload) music and play games with others on the internet.

| Online gambling was not a common activity.

| Despite 'moderate' to 'very high' levels of psychological distress, the use of online or email counselling was low.

| Young men with 'moderate' to 'very high' levels of psychological distress were more likely to:

Talk about problems on the internet, with 66% finding it helpful.

Use the internet to find information for a mental health, alcohol or other substance use problem (48%).

| 95% were 'somewhat' to 'very satisfied' with the information they received.

These findings suggest that young men in Australia are knowledgeable about mental health issues and have positive attitudes to help–seeking. Young men report feeling happy and overwhelmingly feel that they have the capacity to manage adversity.

This is at odds with their levels of psychological distress and suicidal ideation. Psychological distress is pervasive and, consistent with findings from the National Survey of Mental Health and Wellbeing (NSMHW) (Australian Bureau of Statistics, 2008), prevalence of mental illness is high and has not declined over the last decade.

Despite young men feeling confident in their capacity to find a service that can assist them, they still report that affordability and accessibility is a challenge. The findings relating to psychological distress and technology use provide some insight into how technologies might be employed to support greater engagement between young men and mental health services.

The Young and Well CRC has prioritised young men's mental health as a matter of urgency. In 2012, Young and Well CRC partners Movember and *beyondblue* committed funds to build a shared vision for young men's mental health with other partners in the Young and Well CRC. This partnership aims to achieve:

| Greater understanding of men's attitudes and behaviours to understand mental health and wellbeing.

| Creative solutions to major challenges for vulnerable populations of young men at risk of mental health problems.

| Innovation in service delivery to young men at risk of mental health problems including depression, anxiety, and alcohol or other substance misuse.

| Research knowledge to build an evidence base to support system change in early interventions for young men.

As a first step in creating a national young men's mental health alliance, a Young Men's Advisory Committee has been established. This group has been involved in shaping this report and will continue to provide support and advice to the Young and Well CRC and its partners who are leading projects relevant to young men. The cash provided has been matched by the Young and Well CRC and other partners to build evidence where lacking, to trial innovative approaches where needed, and to create a critical mass of new and emerging research leaders dedicated to improving the mental health and wellbeing of young men.

Whilst the research funded by the Young and Well CRC will begin to build new knowledge and expertise, it is clear that change can only occur with a collective and shared vision across all sectors of the community.

13%

13% of young men with 'moderate' to 'very high' levels of psychological distress spent more than 10 hours a day on the internet compared to 4% with 'no or low' levels of psychological distress

66%

Of the 44% of young men with 'moderate' to 'very high' levels of psychological distress, 66% found talking about their problems on the internet helpful

Case study

XIN'S STORY

When I was 12 I was bullied quite extensively in high school. Of all the people in my year group, I could count on one hand the number of people who didn't tease me. My brother was also cruel to me, and so between school and home, I had no refuge from the pain. They were dark times.

I began to go online in the early hours of the morning when everyone else was asleep. It became my own private refuge, always available at my fingertips, silent and invisible to the other members of my household, yet connected to people all across the world. I spent a lot of time on the computer in those pre–dawn hours, escaping my own life and forging a new one online. The only relationships that were meaningful to me were those I had across the internet, and as a result I became reclusive and withdrawn, hardly speaking to anyone and shutting myself away in my room.

Despite everything I was going through, it hadn't once occurred to me that I could get help for my problems. I believed that this was just the reality of my life and that I needed to get through it on my own. In my heart, I didn't really think anyone else could help me. The adults in my life offered little comfort or support, and I didn't believe things could really change.

I wish I had known how easy it was to get help, and how much of a difference it would have made to my life. I had no idea of the wealth of resources that could have helped me with what I was going through. I had no idea how many people cared and were willing to reach out and help me if only I had known where to look. If only I had realised that what I was going through wasn't normal, and that more importantly there was something I could have done about it. I might have saved myself years of needless suffering if only I had known help was there. I eventually worked through the problems I was facing on my own, but I wish I had known about services like ReachOut.com or headspace in those early mornings when I felt so alone.

My hope is that other young people know that they are worth being helped, and that help is always there online when they need it.

Xin (22)

To retain authenticity, this story has not been edited.

Health

01 Young men must be involved in the design of e–mental health services. Services must be simple to use, accessible, provide choice to suit individual needs and be cost–effective.

02 Technology solutions must be tailored to vulnerable populations including young men who are Indigenous, unemployed, living with a disability or living and working in remote areas.

03 Existing online services must be responsive 24/7.

04 Evidence–based online interventions for young men need to incorporate technologies that young men use, including digital content, gamification and music. To enhance access they must be available on a portable device.

05 Youth–led education should be provided to families, mental health and allied health professionals on how young men use technology to connect, communicate and engage online.

Education

06 All schools should have a social networking policy that manages risk (suicide contagion and cyberbullying) and promotes opportunities such as valued participation, respectful relationships and acceptance of diversity.

07 Professional development should be provided to school counsellors, psychologists and chaplains to use online resources and tools.

08 All tertiary campuses should provide e–mental health support to complement existing health services thus ensuring ongoing availability after hours and during holidays.

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Employment and workplaces

09 — Australian workplaces should prioritise wellness and mental fitness for young men. This must focus on stress management, excessive alcohol or other substance misuse and prioritise e–mental health to support clear pathways to care. Financial incentives (e.g. tax credits) provided by government would cement this as a matter of national urgency.

10 — Employment services should explore online solutions to support young men who are unemployed. This could include e–mentoring and the provision of online support.

Communications and media

11 — Campaigns for young men should be delivered in the social networks they frequent and focus on changing attitudes to help–seeking, stress management, alcohol or other substance misuse, bullying and violence and body image. These campaigns must be developed in partnership with young men.

Research and innovation

12 — An innovation fund is needed to support the development and/or evaluation of tailored web services and social media channels for young men.

13 — Funding, including that provided by our major research councils, private trusts and donors, should prioritise young men's mental health.

These key recommendations are explained in detail from page 45 of this report.

Key
mendations

Case study

KIM'S STORY

For almost nine months, my boyfriend Jacob and I struggled in silence on a path to self–destruction. He had an ongoing drug and alcohol addiction; a coping mechanism induced by dark spells of overwhelming emotions. He would frequently spend a solid week intoxicated or be too depressed to leave the house, which caused him to fail his final year of high school and threatened his job. Jacob's behaviour affected virtually every aspect of my life too, from grades and work, to finances and relationships. I finally realised his mental health difficulties were too tough for us to handle on our own.

Despite the obvious changes in Jacob's lifestyle, his family were convinced he was behaving in a way that was typical for a teenage boy, and that he would eventually 'grow out' of this phase. I tried endlessly to encourage Jacob to speak to a friend, doctor or counsellor, yet he believed doing this would mean he was weak or effeminate. Breaking down the stigma barrier took months, followed by further hesitation before Jacob agreed with me that the next time he felt overwhelmed he would visit an online counselling service instead of turning to alcohol and drugs.

He logged onto his first session with eheadspace at 11.30pm one Saturday. This provided him with support at a time when he needed it most and in the comfort of his own bedroom. Slowly, and with regular online appointments, he began to turn to music and fitness as alternatives to alcohol and drugs. These changes improved both our lives immeasurably, and eventually he felt confident enough to speak to his general practitioner. Now, one year on, Jacob has completely turned his life around, rarely returning to alcohol and drugs for support. I am so grateful for the technology that granted Jacob the privacy he desired during his struggle. Without this Jacob would most likely be continuing his battle against depression alone.

'Kim' (18)   Name changed. To retain authenticity, this story has not been edited.

What we already know

THE BIG CHALLENGES IN YOUTH MENTAL HEALTH

Poor mental health is the single largest health issue facing young Australians.

One in four young people experience a mental health disorder (Slade et al. 2009), **and 75% of the serious mental health, alcohol or other substance use problems that disrupt life emerge before the age of 24 years** (Kessler et al. 2005). **The delay between the onset of symptoms and the provision of first effective treatment can span 15 years. Without effective treatment, mental health problems can deteriorate, impacting significantly on a young person's quality of life, posing challenges to relationships with family, friends and participation in educational and vocational pursuits. Moreover, young people may self–medicate with alcohol or other drugs, finding themselves in a cycle of co–morbid depression, anxiety and substance misuse** (Kendall & Kessler 2002).

Mental health and behavioural problems are major causes of disability. Major depressive disorder is one of the top four causes of years lost to disability (YLDs). Anxiety disorders, alcohol or other substance misuse, schizophrenia, and bipolar affective disorder all rank in the top 25 causes of disability, far higher than other conditions. By age five years, mental health and behavioural problems become an important and soon dominant cause of YLDs, peaking between ages 20 to 29 years (Vos et al. 2012). Depression is expected to carry the highest disease burden in high–income countries by 2030 (Mathers & Loncar 2006).

Mental health problems have enormous economic implications.

Economic modelling estimates in 2009 found direct costs of untreated mental disorders in Australian young people totalled $10.6 billion (Access Economics 2009). In 2012, the Young and Well CRC published a report in partnership with Ernst & Young and the Inspire Foundation, *'Counting the Cost: The Impact of Young Men's Mental Health on the Australian Economy'* (Degney et al. 2012). The report examined the costs associated with mental illness in young men specifically in relation to lost productivity, health costs, disability welfare payments, unemployment, educational attainment and direct costs of imprisonment. The modelling estimated that mental illness in young men aged 12 to 25 years cost the Australian economy $3.27 billion per annum in lost productivity; this was in addition to the $5.32 billion overall spending on mental health care and the additional $4.4 billion on other services to support people with mental illness (Degney et al. 2012). If not addressed, the effects of mental ill–health can persist over an individual's lifetime (Costello, Foley & Angold 2006) and lead to further occupational, economic and interpersonal difficulties. Responding to the mental health needs of young people is critical if we are to ensure that they are able to contribute to the economy, lead fulfilling lives and participate actively in their communities (Patel et al. 2007).

Australia's young men are particularly vulnerable to the impact of poor mental health.

Suicide is the leading cause of death for young men in Australia, accounting for between 26% and 29% of deaths in males aged 15 to 24 years (Australian Bureau of Statistics 2013). Male youth suicide rates in rural areas are double those of metropolitan areas (Cheung et al. 2012).

Young men have higher rates of substance use disorders than women (16% vs 10%) (Australian Bureau of Statistics 2008) and the rate of suicide is almost two and a half times higher in young men than young women (Australian Bureau of Statistics 2013). Despite the perception that self–harm is a female problem, the Australian National Epidemiological Study of Self–Injury reported that rates of self–injury for females peaked at 18 to 24 years and for males at 10 to 17 years, and prevalence was no greater in females compared to males (Centre for Suicide Prevention Studies 2010).

"Like any other provider of youth mental health services, headspace knows that young women are more likely to seek help than young men. So we're working hard to make headspace – through our centres, our online and telephone counselling service eheadspace, and our School Support Suicide Postvention Program – a safe place for young males aged 12 to 25 years. Just as importantly, headspace is working toward a broader goal: to destigmatise help–seeking for boys and young men so that, one day, seeking mental health support is just something you do to feel good, like heading to the gym or going for a surf."

Chris Tanti, Chief Executive Officer, headspace

HELP–SEEKING AND SERVICE UTILISATION

Young people do not seek help when experiencing a mental health difficulty.

Australia's National Survey of Mental Health and Wellbeing (Australian Bureau of Statistics 2008) confirmed that while 23% of young men reported experiencing a significant mental health problem in the last 12 months, 87% of young men did not receive any professional help. The reasons for this are complex and not well understood. Wilson and colleagues investigated the help–negation effect, the theory that higher levels of suicidal ideation predict lower intention to seek help from both formal and informal sources (including peers, parents, mental health professionals, general practitioners and telephone helplines) and higher intention to seek no help at all (Gibb, Fergusson & Horwood 2010; Wilson et al. 2010). Additional factors shown to have an impact on a young person's willingness to seek help include having no experience of previous professional mental health care and negative beliefs about the usefulness of therapy and therapists (Kuhl, Jarkon–Horlick & Morrissey 1997). When young people do receive care, timely and evidence–based treatments are only encountered by a small proportion (Andrews et al. 2000; Libby et al. 2007).

Even when young men are able to identify sources of help, there is a reluctance to use this help.

The factors associated with poorer help–seeking practices in young men are complex (Du Plessis et al. 2009; Rickwood, Deane & Wilson 2007; Smith, Braunack–Mayer & Wittert 2006). Earlier research suggests that young men have poorer mental health knowledge and higher mental health stigma than young females (Chandra & Minkovitz 2006; Cotton et al. 2006). Research also shows that young men do not seek help because of the emphasis on masculinity and that being 'a man' is to appear to be independent, to take control, to suppress emotion, and to be seen to be invincible (Emslie et al. 2006; Moller–Leimkuhler 2002; O'Brien, Hunt & Hart 2005). A recent shift has argued that rather than attempting to 're–educate' young men, a greater focus should be placed on providing health services that are relevant and meet the needs of young men (Burns, Webb et al. 2010; Ellis et al. 2012; Macdonald 2006; Smith, Braunack–Mayer & Wittert 2006).

Both approaches rely on generalisations about what it means to be 'a man' and do not account for cultural, generational or individual differences across groups and situations. An alternative approach explores the social psychology of giving and receiving help (Addis & Mahalik 2003). Addis and Mahalik argue that men are more likely to seek help if a problem is considered 'normal', if it can be controlled, if there is an opportunity to reciprocate, if a reaction to help–seeking is positive, and if they can retain control of the situation.

YOUNG PEOPLE'S USE OF TECHNOLOGIES

The online environment is a critical setting for young people.

At a basic level, the internet can be conceived of as a broker of health information. However, as the internet is integrated into the everyday lives of young people, the need to acknowledge the internet as a 'virtual environment' or setting in which young people spend time becomes more important (Burns, Davenport et al. 2010). In addition, broadband technology and easy–to–use software tools have seen a transformation from Web 1.0 (a static, one–way method of deliveringinformation), to Web 2.0 (an interactive, participatory and collaborative approachthat encourages self–expression and the building of online communities) to Web 3.0 (a smarter faster search engine that learns from online interactions). The Web 2.0 environment includes user–generated content, social networking websites (e.g. Facebook and Twitter), 'question and answer' sites, Wikis, mashups, blogsand virtual worlds while Web 3.0 will use individual user–generated content, location and online interactions to provide solutions to complex questions quickly and simply.

Technologies are a part of everyday life.

Over 95% of young Australians use the internet (Ewing, Thomas & Schiessl 2008). Young people are most likely to use the internet to connect with others and engage in activities such as social networking, messaging, online games and emailing (Australian Bureau of Statistics 2011). A total of 3.9 million Australians aged over 14 years went online via their mobile phone in June 2011 alone, while 8.6 million Australians aged over 14 years accessed social networking sites from home in the same time period (Australian Communications and Media Authority 2011).

WORKING IN PARTNERSHIP WITH YOUNG PEOPLE

Young people have an important role to play in driving change and innovation in the area of youth mental health.

The Adolescent Health series in The Lancet argues, *"...it is now time to put the young person, not the specific issue, centre stage."* (Lancet 2012, p. 1561). Youth participation can be defined as young people's involvement in decision–making processes from which, traditionally, they have been excluded (Livingstone, Bober & Helsper 2005; Wierenga 2003). Adopting a youth participation approach is an effective way of ensuring that organisations keep abreast of developments in the technological environment and develop a deep understanding of the ways in which young people are engaging with technologies. Young people are in an *"...optimal position to determine the relevance of efforts geared towards youth."* (Wong, Zimmerman & Parker 2010, p. 101). To encourage and support adolescents and young adults to seek professional help early for emerging mental health problems, services must be informed and guided by the young people they serve (Rickwood, Deane & Wilson 2007).

There is growing evidence that youth participation brings about benefits for the individual young person as well as the service being delivered. At an individual level, participation promotes social connectedness and self–efficacy (Glover et al.

"To help young men we have to reach them first. To achieve this we need to find new and innovative ways of engaging young men and design services to meet their needs. Each year ReachOut.com is accessed hundreds of thousands of times by young men all over the country but we know there is more that we can do to engage them and deliver services that meet their needs. Through projects such as "Counting the Cost: The Impact of Young Men's Mental Health on the Australian Economy," we have laid the important economic groundwork to explain why this issue is of critical national importance. We are excited to work with the Young and Well CRC and its partners to develop and trial cutting–edge services that respond to this challenge and help reach more young men in new and innovative ways."

Jonathan Nicholas, Chief Executive Officer, Inspire Foundation, the organisation behind ReachOut.com

1998; VicHealth 2005; Wilkinson & Marmot 2003). Furthermore, it has been suggested that youth participation may foster resilience (Oliver et al. 2006) as well as contribute to the development of mental health services that are appealing, relevant and engaging for young people (James 2007; Oliver et al. 2007; Swanton et al. 2007).

CURRENT STATE OF RESEARCH IN E–MENTAL HEALTH

The internet is a valuable information source and can promote early help–seeking.

The internet has been described as accessible, anonymous, engaging and informative, and as providing a space in which young people can feel empowered and confident to talk about sensitive issues (Burns, Webb et al. 2010; Gould et al. 2002) such as depression, sexuality or sexually transmitted diseases (Suzuki & Calzo 2004), physical activity and nutrition (Spittaels & De Bourdeaudhuij 2006). It offers low–cost, anonymous, and 24/7 access for young people while also reducing costs for providers (Santor et al. 2007). Most importantly, young people report feeling comfortable accessing online information about mental health issues, and the anonymity of online interventions extends access to young people who would otherwise avoid services (Oh, Jorm & Wright 2008).

Twenty percent of young Australians surveyed in the 2008 National Youth and Parent Community Survey had personally experienced a mental disorder, alcohol or other substance use problem in the five years prior to the survey (Burns, Davenport et al. 2010; Burns et al. submitted). When asked about the sources of information they had used to assist with this difficulty, 21% of 12 to 17–year–olds and 34% of 18 to 25–year–olds reported that they had specifically searched the internet for information to help themselves. Variables that predicted using the internet as an information source included being female and using the internet after 11.00pm (Burns, Davenport et al. 2010; Burns et al. submitted).

The same study found that while 78% of young people aged 12 to 25 years felt that the internet had helped a little or a lot with a mental health, alcohol or other substance use problem, 85% would recommend it to a friend or family member and 94% felt somewhat satisfied or very satisfied with the information they received. Additionally, 55% of 12 to 17–year–olds and 45% of 18 to 25 year–olds felt the internet provided the kind of information they needed (Burns, Davenport et al. 2010). The study found that young people's first step to sourcing information online was consistently a search engine rather than direct access to a website but, once 'Googled', mental health and generalist websites were more popular than forums, bulletin boards and discussion or peer support groups. While general information and question and answer forums rated highly, anonymity, the availability of fact sheets, online journals and other people's stories did not (Burns, Davenport et al. 2010).

Social networking can benefit young people's mental health.

An evidence–based literature review of over 50 studies examining young people's use of social networking showed significant benefits to young people's mental health, including: delivering educational outcomes; facilitating supportive relationships; identity formation; and, promoting

a sense of belonging and self–esteem. Collin et al. further argue that the *"…strong sense of community and belonging fostered by SNS* [social networking services] *has the potential to promote resilience, which helps young people to successfully adapt to change and stressful events"* (2011, p. 7). For those wishing to improve their overall wellbeing, technologies can assist in promoting social inclusion, access to material resources and freedom from discrimination and violence (Burns & Blanchard 2009; Burns, Blanchard & Metcalf 2009).

Technologies play an important role in early intervention, treatment and recovery.

Australia has been at the forefront of international innovations in its use of e–health platforms to promote better mental health and deliver enhanced mental health care (Christensen & Petrie 2013; Griffiths 2013; Proudfoot 2013). Good evidence exists that technologies can be used effectively in improving mental health and wellbeing (Cuijpers et al. 2008; Griffiths, Farrer & Christensen 2010), especially among young people (Christensen & Hickie 2010). Given workforce shortages in mental health, the geographical and cost barriers to effective service provision, and the reluctance of key groups (such as young people and men) to use formal clinical services, e–health innovations will be central to real reforms (Rosenberg, Hickie & Mendoza 2009).

Online interventions for a range of mental disorders (e.g. depression, anxiety) and problematic health behaviours (e.g. smoking, weight, alcohol or other substance misuse) have demonstrated efficacy, and the number of programs available is growing rapidly (Mitchell, Vella–Brodrick & Klein 2010). A review of 26 randomised controlled trials (RCTs) found the internet to be an effective medium for the delivery of interventions designed to reduce the symptoms of depression and anxiety conditions in 88% of the studies (Griffiths, Farrer & Christensen, 2010). Calear and Christensen (2010) conducted a systematic review of internet–based prevention and treatment programs for children and adolescents, identifying eight studies across schools, primary health care, mental health clinics and via open–access websites. The authors concluded that the *"…findings provide early support for the effectiveness…"* but more *"…research is needed to further establish the conditions through which effectiveness is enhanced"* (p. S12). Tait and Christensen (2010) conducted a systematic review of RCTs of web–based interventions for problematic substance use by adolescents and young adults. The authors identified 16 studies largely from tertiary students and concluded that web–based interventions were as effective as brief in–person interventions.

While positive results are seen from the use of self–directed e–health interventions, there is some evidence that these are most effective if used as part of a stepped–care model (van Straten et al. 2010), with the support of a trained professional (Perini, Titov & Andrews 2009; Titov et al. 2009) or as an adjunct to face–to–face treatment (Hickie et al. 2010).

E–mental health on the web is effective.

The advantages of internet–mediated therapy and support include greater access to remote and rural areas, reduced cost and ease of communication. Patients report that online discussion of problems is easier and allows them to discuss issues they feel unable to raise in a face–to–face interaction. The internet provides a service for those who are dissatisfied with traditional intervention methods for various reasons, including stigma (Kurioka, Muto & Tarumi 2001).

Beyond the convenience and accessibility of the internet as a setting for mental health services, there are now a number of studies, including RCTs, that point to the effectiveness of a range of internet–based mental health therapies for

both adolescents and adults. Bergström and colleagues (2010) demonstrated that internet–based cognitive–behavioural therapy (CBT) for panic disorder was equally effective as group–administered CBT treatment for adult patients in an outpatient psychiatric care setting, while Gerrits and colleagues (2007) found an online CBT course for 140 adolescents with depressive disorders to have sustained and significant reductions in depressive symptoms. Rotondi and colleagues (2010) reported on the effectiveness of an online family psycho–education program in conjunction with professionally–moderated patient and carer forums, which showed improved engagement and education for patients with schizophrenia and their carers. Similar results for another group of adults with schizophrenia were shown by Glynn and colleagues (2010). van der Zanden and colleagues (2010) engaged a group of 48 parents with a mental illness to demonstrate the effectiveness of an online group program to improving parenting skills.

A more extensive study by van der Zanden and colleagues on the effectiveness of a web–based group course for depression involving 244 adolescents and young adults between the ages of 16 and 25 years showed that the online group course was effective in reducing symptoms of depression and anxiety and in increasing mastery in young people. These effects were present in the initial review at three months and persisted in the online course group at six months (van der Zanden et al. 2012).

Technologies help engage and support the youth health workforce.

Youth health workers believe that using technologies will enable them to have a greater impact on young people's mental health (Blanchard et al, 2012). The same study reports that youth health workers believed that technologies play a considerable role in the lives of most young people and that these technologies have the potential to influence mental health and wellbeing, both positively and negatively. However, participants also felt that these technologies are poorly understood and under–utilised in mental health promotion and in the prevention, early intervention and treatment of mental ill–health. If barriers to the use of technologies were overcome, the youth health workforce would be able to use technologies more effectively in their practice. Such barriers include poor infrastructure, lack of guidelines or policies to support safe and constructive use of technologies and lack of awareness about which technology–based strategies or approaches are most effective, and in which contexts (Blanchard et al. 2012).

Further investment needs to be made in securing appropriate technological infrastructure in youth mental health services, and in training staff members to develop an adequate understanding of young people's technology use and the range of strategies that can be applied to improve and promote young people's wellbeing (Blanchard et al. 2012).

Case study

MATT'S STORY

It's the most terrifying feeling I have ever felt, and the most frightened I have ever been, to know what is good for me—friends, family, or seizing opportunities—but to inexplicably avoid it. I had been stuck inside for three months following surgery related to my ileostomy. It was Christmas, so there was nothing on television (I was driven to watching a full test match of cricket). But despite that, I couldn't bring myself to leave the house. The first time I tried, I got a migraine. I hadn't been to school in almost six months and my only contact with friends had been through instant messaging. I was so anxious I couldn't even bring myself to call them.

Instant messaging had its benefits and, in hindsight, its costs. I chatted with friends who I hadn't seen in months, but it also made me take my friendships for granted assuming that everything would be the same when I got back out of the house. Had I not had access to instant messaging, I may have gotten out of the house a lot sooner in order to talk to friends, or I may have lost them altogether.

I had gotten a mobile phone that summer, although I was hardly mobile. I would text friends, too. I had these ways of maintaining some level of contact. It wasn't ideal, but while I was struggling it was enough to keep me going.

I have a bad week now and then when I don't want to see any friends. But with the incredible ways we can keep in contact, they are never far away when I snap out of it. Our mental health can be greatly affected by our relationships and how connected to others we feel. We can ignore it, or we can take advantage of the connections that technology enables. For me, technology provided a sense of normalcy in a really tough period of my life.

'Matt' (22) Name changed. To retain authenticity, this story has not been edited.

Service snapshot

## HEADSPACE AND EHEADSPACE

Youth–friendly health services improving access and help–seeking

A headspace centre is a youth–friendly community–based health service for young people aged 12 to 25 years. headspace centres provide an integrated service where young people can seek and receive help for a broad range of issues including mental and physical health, education, employment and substance misuse (McGorry et al. 2007). The centres are multidisciplinary with staff including general practitioners, allied health, mental health, youth workers and drug and alcohol workers who have specific experience working with young people (McGorry et al. 2007).

A 2012 study investigating the experience of attendees of one local and one outer suburban Sydney headspace centre revealed that more than half of service users were young males (Scott et al. 2012). In the study, one–third of male service users had a primary diagnosis of a behavioural or developmental disorder, and two–thirds of service users diagnosed with a psychotic disorder were male. Most of these young men were in the early stages of illness but showed notable levels of disability. Service users also comprised a remarkable rate of self–referrals, indicating that young people find the headspace model appealing.

The headspace model combines a number of characteristics which contribute to making the service engaging for young people. headspace welcomes parents, family or friends to join young people attending care, provides both general medical and specialised care, creates a youth–friendly environment, bulk bills, and allows young people to present directly to the service.

Building on the youth–focused headspace model, eheadspace.org.au provides an online gateway for young people to access help. An evaluation of eheadspace is currently underway.
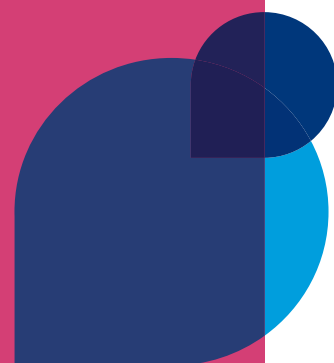
Service snapshot

REACHOUT.COM
AND REACHOUT CENTRAL

Innovative online youth mental health services driven by young people

Inspire Foundation's ReachOut.com is a comprehensive mental health promotion and prevention service which provides information, support and resources to help develop resilience, increase coping skills and self–efficacy, facilitate help–seeking behaviour and improve young people's understanding of mental health issues (Burns, Durkin & Nicholas 2009; Burns et al. 2007). Developed and maintained in partnership with young people, ReachOut.com has been shown to effectively engage young people in mental health promotion and prevention material (Collin et al. 2011).

Used as a strategy to aid in the prevention of mental ill–health, serious games such as ReachOut.com's ReachOut Central can act as an early–intervention tool for those in the early stages of a mental disorder. Drawing on the principles of CBT, ReachOut Central is designed to improve the mental health and wellbeing of young people, particularly young men (Burns, Webb et al. 2010), and has been shown to enhance protective factors vital for the prevention or early intervention of mental health problems (Shandley et al. 2010). It has also been shown that, amongst others, e–mental health initiatives such as ReachOut Central may complement clinical treatments (Shandley et al. 2010).

With only 13% of young men experiencing a diagnosable mental disorder accessing a clinical service in 2007 (Slade et al. 2009), there is evidently a great need for gateway services. ReachOut.com has been shown to appeal to young people who are experiencing high levels of psychological distress, and successfully supports them to seek help from a professional (Collin et al. 2011). Furthermore, with many young men experiencing psychological distress using the internet late at night (Burns, Davenport et al. 2010), online youth mental health services like ReachOut.com are available during an opportune window for intervention.

Given this opportunity, services such as ReachOut.com and ReachOut Central demonstrate the potential for online youth–friendly mental health information and referral services and games to positively impact young men's mental health and wellbeing.

Methods

The Young and Well National Surveys aim to assess young people's use of technologies, as well as their overall health and wellbeing. The first survey includes questions relating to demographics, general health, mental health and wellbeing, health perceptions of Australian youth, use of the internet, online and communication risks, digital literacy and safety skills.

FEATURES OF THE SURVEY

Participants

A cross–sectional CATI (computer–assisted telephone interview) methodology was used to conduct a survey of 1,400 participants across Australia. Participants were randomly selected using random digit dialling. Participants included 700 young men and 700 young women aged 16 to 25 years (note: existing protocols for telephone interviews with people aged below 18 years of age were used). Depending on participant answers, the survey took 10 to 20 minutes to complete.

Participants were excluded if they had English language difficulties or if they were uncomfortable with the interview being conducted in English. Stratification ensured that the sample was representative of the normal population in terms of age, gender and geographic location across all Australian states by selecting respondents to match the current Australian Bureau of Statistics records for age, gender and geographic location (see **abs.gov.au**). While the survey was designed by the investigators, the telephone interviews were conducted by an independent company, The Social Research Centre (Melbourne, Victoria).

Ethics

This study had institutional ethics committee approval from The University of Sydney Human Research Ethics Committee (Protocol No. 14633). Importantly, for all participants aged 16 to 17 years, consent was sought from a co–resident parent or guardian as well as the young person before commencement of the survey. Under–aged participants were advised they could cease participation at any time, and that their responses were confidential and were not identifiable. The Social Research Centre's code of practice requires that all interviewers speaking with people aged less than 18 years must pass both police and 'working with children' checks.

Data analyses

In the tables, column percentages are shown and it should be noted that some denominators vary with missing data. Responses proffered by less than 5% of the total sample have not been reported. All statistical analyses utilised the IBM SPSS Statistics for Windows, Version 19.0 (IBM Corp. 2010).

Survey items

The 43 items of the Survey are intended to measure:

1. **Module A** Scoping demographics including age, gender, postcode, language spoken at home and Aboriginal or Torres Strait Islander origin.

2. **Module B** Demographics including information about occupation, highest level of education for respondent and household, living with a parent or guardian and receipt of government benefits.

3. **Module C** General health and wellbeing including specific questions about the respondent's current mental health using the 10–item Kessler Psychological Distress Scale (K10) (Kessler et al. 2003) and the suicidal ideation items from the Psychiatric Frequency Symptom Scale (Lindelow, Hardy & Rogers 1997). This module also explored a previous diagnosis for a mental health and/or alcohol or other substance use problem as well as treatment sought for that problem. A further question to investigate burden was asked about 'days out of role' (von Korff et al. 1996).

4. **Module D** Health, happiness and resilience including four items from the Oxford Happiness Questionnaire (Hills & Argyle 2002) and the Brief Resilient Coping Scale (Sinclair & Wallston 2004).

5. **Module E** Health perceptions of Australian youth asked about the respondent's perceptions about general health and wellbeing of Australian youth. This included major health problems as well as major mental health and behavioural problems. It also asked what age respondents think such problems start, how long problems need to be present before seeking help and if help were to be sought, what the respondent thought they would do. These latter items are also asked about alcohol or other substance use problems.

6. **Module F** Eating behaviours and body image including items to assess three eating disorder behaviours, namely binge eating, purging and strict dieting or fasting. Current regular use of these behaviours was defined as the behaviour occurring at least weekly over the three months prior to the interview. In order to assess eating disorder attitudes, respondents were asked to self–evaluate the importance of weight and/or shape.

7. **Module G** Internet use by young people including current everyday habits, access to information for mental health and physical health problems, attitudes towards that information and use of that information in terms of health care utilisation. It also asked about digital abuse (including cyberbullying and sexting) and internet strategies and education.

Key findings

BACKGROUND

This report is the first in a series to be published by the Young and Well CRC, and specifically explores technology use and its impact on young men's mental health and wellbeing.

The findings are presented in three sections. The first explores the shift in technology use for all young people from 2008 to 2012 and contextualises the current climate relating to technology use. The second specifically examines young men's mental health and wellbeing, and the third its relationship to technology use.

By way of background, in 2008 the BMRI oversaw an Australian national telephone survey of 1,341 young people aged 16 to 25 years which asked about awareness, perceptions, knowledge and attitudes regarding accessing care for mental health and alcohol or other substance misuse among young Australians (Burns, Davenport et al. 2010). Internet use was also explored in relation to searching for appropriate mental health information and services.

In 2012, the Young and Well CRC and its partners extracted core questions (and methods) from this survey and conducted the first of its Young and Well National Surveys, interviewing 1,400 young people in Australia aged 16 to 25 years, with the aim to assess young people's use of information and communication technologies, as well as their overall mental health and wellbeing.

SECTION 1: CHANGE IN TECHNOLOGY USE 2008 TO 2012

Current use of the internet by young people rose significantly from 2008 to 2012 to become almost universal, growing from 95% in previous national data sets (Burns, Davenport et al. 2010; Ewing, Thomas & Schiessl 2008) to 99% amongst respondents to this survey.

Over the four years between surveys, the frequency of use also increased (from 2.0 to 3.4 hours) as did the proportion using the internet after 11.00pm (44% to 63%) (Burns, Davenport et al. 2010), which was most prominent among the 18 to 19–year–olds). In the earlier survey, 14% of young people used the internet after 11.00pm frequently (i.e. six to seven nights a week), which rose to 27% in the later survey. Approximately 20% of those with late–night internet use had 'high'

Figure 1 Changes in the ways young people commonly use the internet, from 2008 to 2012

93.9%

86.4%

78.8%

13.4%

6.8%

11.2%

81%↑
Checking email

80%↑
Watching, or downloading /uploading videos

68%↑
Listening to, or download-ing/upload-ing music
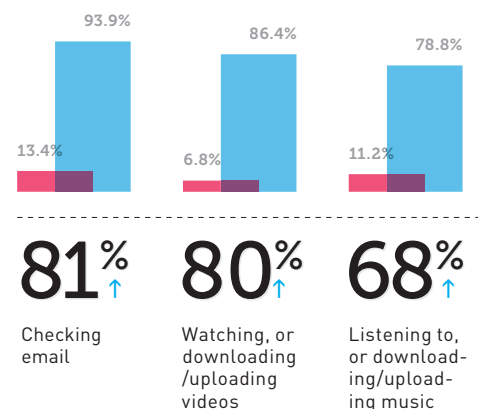
to 'very high' levels of psychological distress, but this did not shift between surveys. Rates of 'high' to 'very high' psychological distress, determined using the 10–item K10 (Kessler et al. 2003), were similar across time (18% vs 21%; Appendix A).
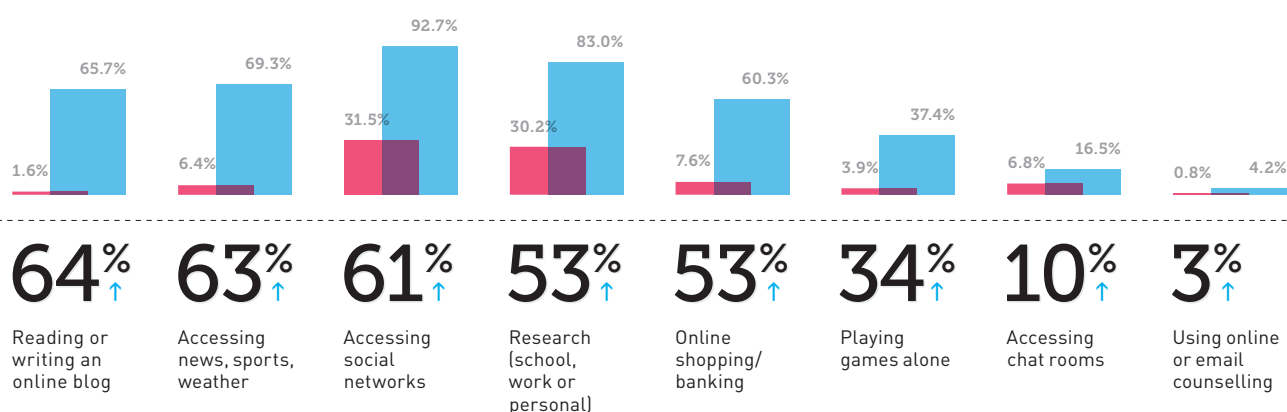
Most commonly, the internet was accessed in the respondent's own home, but this had declined since the 2008 survey (91% to 80%). In contrast, accessing the internet at a friend's, neighbour's or relative's house rose dramatically (4% to 73%) as did access at educational facilities, at work and at other public places (Appendix A).

The ways that young people reported commonly spending time using the internet also differed substantially between surveys, with all activities increasing. Notable rises from the 2008 to the 2012 surveys include checking email from 13% to 94%; accessing social network websites rising from 32% to 93%; watching or downloading/ uploading videos from 7% to 86%; using the internet for research (for school, work or personal) from 30% to 83%; listening to or downloading/uploading music rising from 11% to 79%; reading or writing blogs or online diaries from 2% to 66%; posting or viewing photos from 1% to 54%; and accessing health information rising from 1% to 44%. Online shopping/banking and accessing the news, sports or weather increased significantly from 8% to 60% and 6% to 69%, respectively. Playing games alone increased from 4% to 37%, and a small increase was also seen in online or email counselling from 1% to 4% (Table 1; Appendix A).

Table 1 Changes in the ways young people commonly use the internet*, from 2008 to 2012

Common ways young people use the internet	2008 survey* %	2012 survey %
N	1,270	1,386
Checking email	13.4	93.9
Watching, or downloading/uploading videos	6.8	86.4
Listening to, or downloading/uploading music	11.2	78.8
Reading or writing an online blog	1.6	65.7
Accessing news, sports, weather	6.4	69.3
Accessing social networks	31.5	92.7
Posting or viewing photos	1.0	54.0
Research – school, work, personal	30.2	83.0
Online shopping/banking	7.6	60.3
Accessing health information	0.7	43.9
Making or receiving phone calls over the internet	0.0	38.2
Playing games alone	3.9	37.4
Using forums	2.9	34.6
Playing games with others	7.1	32.8
Using a webcam	0.0	25.4
Using an instant messenger	27.1	41.6
Accessing chat rooms	6.8	16.5
Accessing online virtual worlds	0.9	7.9
Gambling	0.0	4.0
Using online or email counselling	0.8	4.2

*(Burns, Davenport et al. 2010)

64%↑	63%↑	61%↑	53%↑	53%↑	34%↑	10%↑	3%↑
Reading or writing an online blog	Accessing news, sports, weather	Accessing social networks	Research (school, work or personal)	Online shopping/ banking	Playing games alone	Accessing chat rooms	Using online or email counselling

Despite significant increases in the types of internet activity, the proportion of young people claiming to use the internet to find information for a physical health problem only rose slightly (from 55% to 66%), and for a mental health, alcohol or other substance use problem dropped slightly (from 45% to 43%).

Using a search engine (as opposed to accessing a specific site) was the most popular way to find information for a mental health, alcohol or other substance use problem in both surveys (each 93%; Appendix A). The extent to which the internet provided needed information remained relatively stable (47% to 43% responding 'very much'), as did the opinion that the internet helped the young person deal with a problem 'a little' or 'a lot' (78% vs 80%) and overall satisfaction with information received (93% in both surveys were 'somewhat' or 'very satisfied').
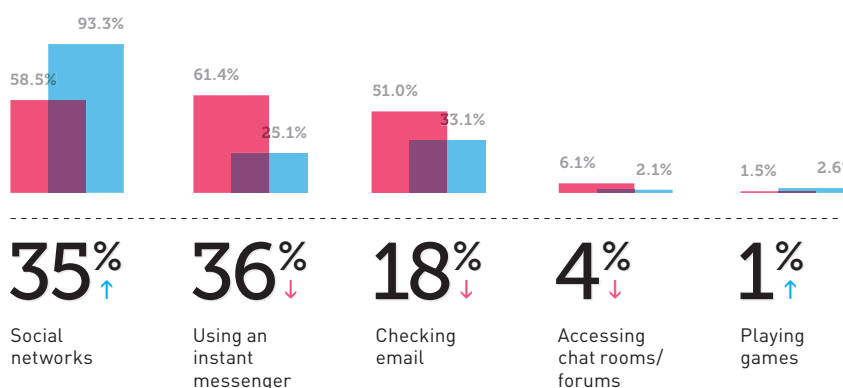
The use of the internet to contact other young people remained fairly stable (from 78% to 84%) and generally declined with age (Appendix A). In 2008, this kind of contact was made most commonly by using an instant messenger (61%), social networking (59%) or by checking email (51%). In 2012, social networking sites were the most predominant means of contact with other young people (93%), while checking email and using an instant messenger had dropped to 33% and 25%, respectively (Table 2; Appendix A). Talking about problems on the internet remained stable between surveys (34% vs 33%), as did its perceived usefulness, being considered as helpful by 72% of both samples.

Table 2 Changes in the way the internet is used to contact other young people*, from 2008 to 2012

	2008 survey* %	2012 survey %
N	989	1,157
Social networks	58.5	93.3
Using an instant messenger**	61.4	25.1
Checking email	51.0	33.1
Accessing chat rooms/forums	6.1	2.1
Playing games	1.5	2.6

*(Burns, Davenport et al. 2010) **Using an instant messenger includes (in alphabetical order) Gmail messenger, Instagram, msn, QQ, Skype, SMS, Tumblr, Twitter, Viber, VoIP, WhatsApp, Yahoo!, YouTube.

Figure 2 Changes in the way the internet is used to contact other young people, from 2008 to 2012

35% ↑	36% ↓	18% ↓	4% ↓	1% ↑
Social networks	Using an instant messenger	Checking email	Accessing chat rooms/ forums	Playing games

Game On: Exploring the Impact of Technologies on Young Men's Mental Health and Wellbeing

SECTION 2: GENERAL HEALTH, MENTAL HEALTH AND WELLBEING OF YOUNG MEN

The following information relates specifically to the 700 young men who completed the first Young and Well National Survey in 2012. Survey participants came from all States and Territories in Australia with 30% living in regional, rural or remote communities and 2% identifying as Indigenous. Seventy–six percent of young men lived with a parent or guardian, 23% spoke a language other than English at home, 62% were attending school, TAFE or university, and 5% were unemployed (Appendix B).

Three–quarters of young men (75%) rated their general health and wellbeing as 'good' to 'very good' and this did not vary by age. Similarly, the majority (78%) of young men rated their mental health as 'good' to 'very good' (Appendix B). In contrast, 42% of young men experienced 'moderate' to 'very high' levels of psychological distress according to the K10 (Figure 3; Appendix B). The K10 is a standardised measure, so despite reporting symptoms indicative of significant psychological distress, young men still described their general health and mental health as 'good' to 'very good'.

One in five young men (19%) reported they had been diagnosed with a mental health or behavioural problem and 26% reported seeking treatment. Diagnoses for alcohol or other substance use problems were low (3%), as were rates of treatment–seeking (4%). Diagnoses and treatment–seeking, for both mental health or behavioural problems and alcohol or other substance use problems, all increased with age (Appendix B).

42% of young men experienced 'moderate' to 'very high' levels of psychological distress
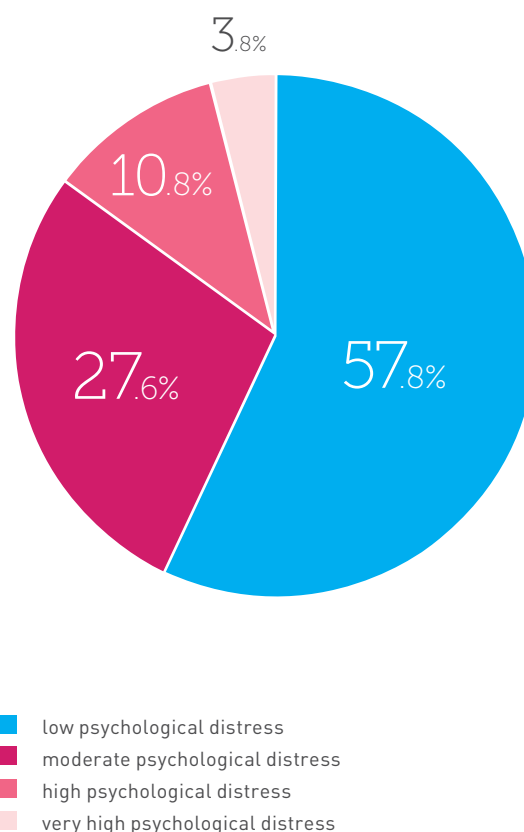

- low psychological distress
- moderate psychological distress
- high psychological distress
- very high psychological distress

Figure 3 Levels of psychological distress in young men aged 16 to 25 years (N = 688)

In the past 12 months have you ever...

Age in years

Felt that life is hardly worth living?

17.6%	16 to 18
17.8%	19 to 21
18.7%	22 to 25

Thought that you really would be better off dead?

10.9%	16 to 18
11.0%	19 to 21
13.5%	22 to 25

Thought about taking your own life?

7.9%	16 to 18
8.9%	19 to 21
12.4%	22 to 25

Made plans to take your own life?

3.7%	16 to 18
2.1%	19 to 21
7.8%	22 to 25

Attempted to take your own life?

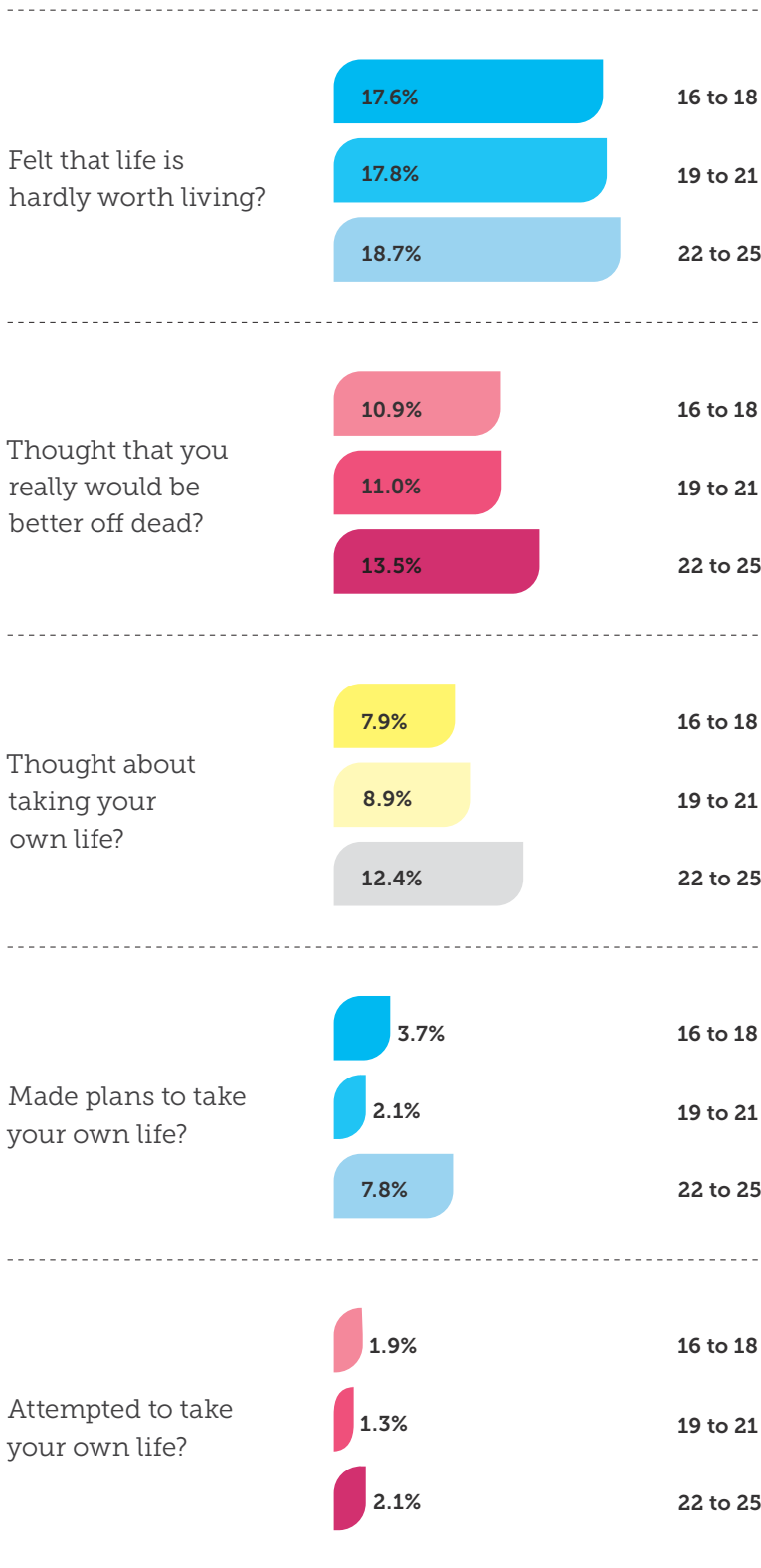|	
1.9%	16 to 18
1.3%	19 to 21
2.1%	22 to 25

Figure 4 Questions about suicidal ideation in young men aged 16 to 25 years (N = 700) Scale used is the Psychiatric Symptom Frequency Scale (Lindelow, Hardy & Rodgers 1997)

Suicidal ideation

Young men aged 22 to 25 years consistently reported higher rates of suicidal ideation and acts than younger age groups (Figure 4; Appendix B) as measured by the Psychiatric Symptom Frequency Scale (Lindelow, Hardy & Rodgers 1997). Alarmingly, 12% of these young men had *'thought of taking their own life'* in the year prior to survey, 8% had *'made plans to take their own life'*, and 2% had *'attempted to take their own life'*.

The suicidal ideation and act items were also dichotomised to contrast individuals who reported neither (at most stating that at some point over the past year they had *'felt that life was hardly worth living'*) with those who admitted having *'thought that they would be better off dead'*, *'thought of taking their own life'*, *'made plans to take their own life'*, or *'attempted to take their own life'*. Overall, 15% of young men reported suicidal ideation and this increased steadily with age (Figure 5; Appendix B). Using regression analyses, significant predictors of this suicidal ideation included unemployment status (odds ratio = 2.38, 95% CI = 1.30 - 4.38; p < 0.01) and 'moderate' to 'very high' psychological distress (odds ratio = 7.67, 95% CI = 5.33 - 11.03; p < 0.001).

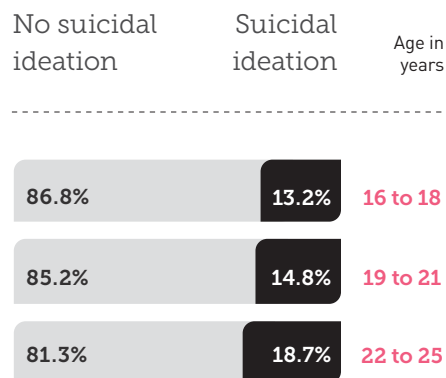| No suicidal ideation	Suicidal ideation	Age in years
86.8%	13.2%	16 to 18
85.2%	14.8%	19 to 21
81.3%	18.7%	22 to 25

Figure 5 Rates of suicidal ideation in young men aged 16 to 25 years (N = 695) Scale used is the Psychiatric Symptom Frequency Scale (Lindelow, Hardy & Rodgers 1997)

Significant predictors of suicidal ideation include unemployment and 'moderate' to 'very high' psychological distress

Issues of personal concern

Almost half (48%) of the young men surveyed, expressed concerns about coping with stress, followed by depression (27%) and body image (26%) in regard to their personal wellbeing (Figure 6; Appendix B). Of these issues, only body image concerns appeared to decline slightly with age. One in five respondents also listed bullying or emotional abuse as an important issue.
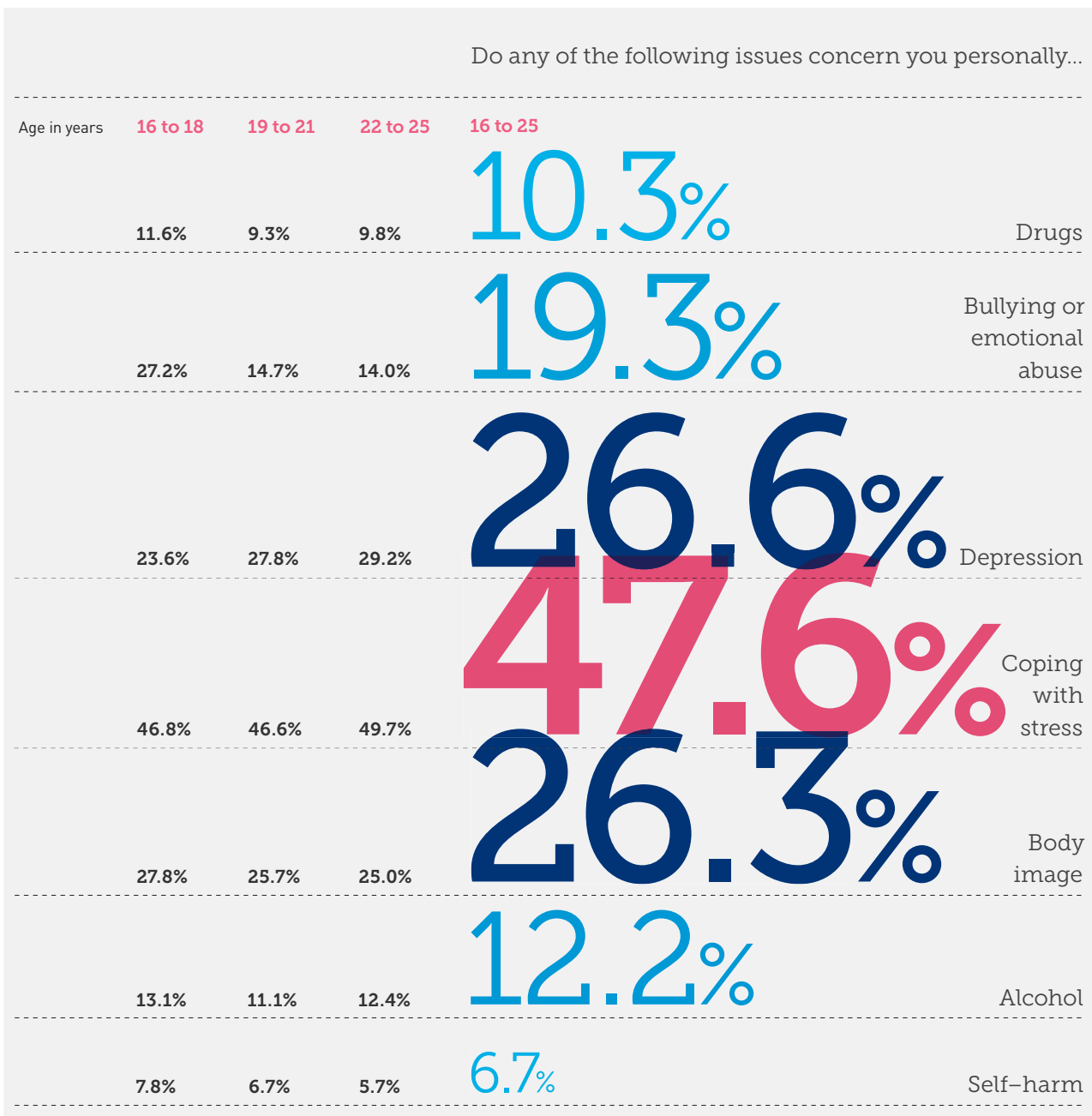
Do any of the following issues concern you personally...

Age in years	16 to 18	19 to 21	22 to 25	16 to 25	
	11.6%	9.3%	9.8%	10.3%	Drugs
	27.2%	14.7%	14.0%	19.3%	Bullying or emotional abuse
	23.6%	27.8%	29.2%	26.6%	Depression
	46.8%	46.6%	49.7%	47.6%	Coping with stress
	27.8%	25.7%	25.0%	26.3%	Body image
	13.1%	11.1%	12.4%	12.2%	Alcohol
	7.8%	6.7%	5.7%	6.7%	Self–harm

Figure 6 Issues of personal concern in young men aged 16 to 25 years (N = 700)

Happiness and resilience

When young men were asked questions relating to their personal happiness (Figure 7; Appendix B), the majority 'moderately' or 'strongly agreed' that they felt *'fully mentally alert'* (81%) and that *'life is very rewarding'* (80%). However, only 65% were *'well satisfied about everything in life'* and 60% felt they can *'fit in everything they want to'*. When asked four short questions on the Brief Resilient Coping Scale (a self–report measure that captures an individual's ability to feel challenged by, and cope adaptively, with adversity; Sinclair & Wallston 2004), the majority 'agreed' or 'strongly agreed' with the following statements (Table 3; Appendix B): *'I look for creative ways to alter difficult situations'* (75%); *'regardless of what happens to me, I believe I can control my reaction'* (78%); *'I believe I can grow in positive ways by dealing with difficult situations'* (92%); and *'I actively look for ways to replace the losses I encounter in life'* (74%).

How much do you 'agree' or 'disagree' with the following statements...
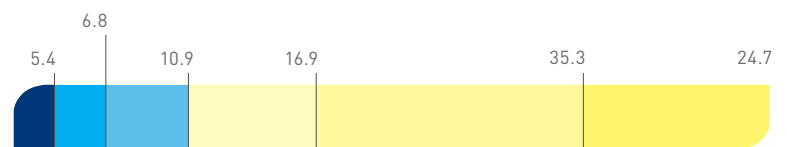
Strongly Disagree — Strongly Agree
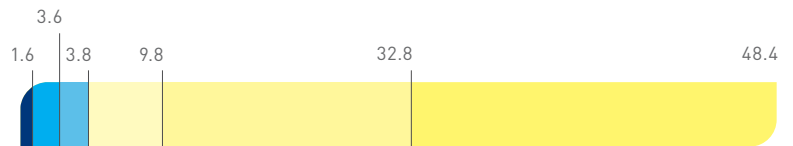
I feel fully mentally alert (%) N = 692

1.6 | 3.6 | 3.8 | 9.8 | 32.8 | 48.4
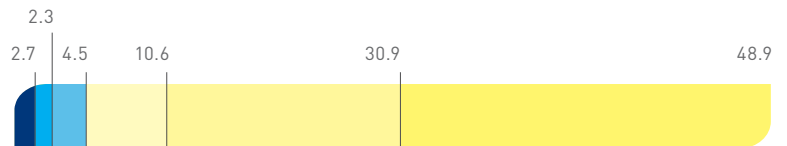
I feel that life is very rewarding (%) N = 695

2.7 | 2.3 | 4.5 | 10.6 | 30.9 | 48.9

I am well satisfied about everything in my life (%) N = 699

3.1 | 5.7 | 7.9 | 17.9 | 32.9 | 32.5

I can fit in everything I want to (%) N = 688

5.4 | 6.8 | 10.9 | 16.9 | 35.3 | 24.7

Figure 7 Happiness of young men aged 16 to 25 years
Scale used is the Oxford Happiness Questionnaire (Hills & Argyle 2002)

- strongly disagree
- moderately disagree
- slightly disagree
- slightly agree
- moderately agree
- strongly agree

Table 3 Resilience of young men aged 16 to 25 years

Scale used is the Brief Resilient Coping Scale (Sinclair & Wallston 2004)

Age in years	16 to 25 %	16 to 18 %	19 to 21 %	22 to 25 %
How much do you 'agree' or 'disagree' with the following statements...				
I look for creative ways to alter difficult situations, N	687	263	233	191
Strongly disagree	2.3	2.7	1.3	3.1
Disagree	5.7	5.3	4.7	7.3
Neutral	17.3	19.8	18.5	12.6
Agree	39.3	38.0	41.2	38.7
Strongly agree	35.4	34.2	34.3	38.2
Regardless of what happens to me, I believe I can control my reaction to it, N	697	267	237	193
Strongly disagree	2.7	1.9	2.1	4.7
Disagree	9.9	8.2	11.4	10.4
Neutral	9.8	10.1	10.5	8.3
Agree	39.5	40.1	38.4	39.9
Strongly agree	38.2	39.7	37.6	36.8
I believe I can grow in positive ways by dealing with difficult situations, N	693	265	236	192
Strongly disagree	0.6	0.8	0.4	0.5
Disagree	2.0	1.1	2.5	2.6
Neutral	5.5	3.8	6.8	6.3
Agree	41.1	41.5	36.9	45.8
Strongly agree	50.8	52.8	53.4	44.8
I actively look for ways to replace the losses I encounter in life, N	687	266	232	189
Strongly disagree	1.6	1.1	0.9	3.2
Disagree	8.9	7.9	8.6	10.6
Neutral	16.0	13.9	18.1	16.4
Agree	43.4	44.7	38.4	47.6
Strongly agree	30.1	32.3	34.1	22.2

HEALTH PERCEPTIONS OF AUSTRALIA'S YOUNG PEOPLE

Health vs mental health problems

When young men were asked to consider what were the major health problems for young people aged 12 to 25 years in Australia (Table 4; Figure 8), recognition of alcohol or other substance misuse was high (46%). Obesity, smoking, motor vehicle accidents, cancer, diabetes and asthma were infrequently considered major health problems. A little over one–third of respondents (39%) spontaneously mentioned a mental health problem as a major general health problem.

When considering mental health problems (Table 5), 45% of young men were able to spontaneously recognise depression as a mental health problem, with recognition increasing with age. Anxiety and alcohol or other substance misuse were not well–recognised as mental health problems (10%–12%) and one in five young men (21%) did not know what the major mental health problems were for young people (aged 12 to 25 years) in Australia. Suicide was rarely identified as a major mental health problem (1%).

Age of onset

Young men's knowledge about the age of onset for mental health problems is fairly accurate and for alcohol or other substance misuse is highly accurate (Appendix B).

Table 4 Disorders considered by young men aged 16 to 25 years to be the major health problems for young people in Australia at present, by age bands

Age in years	16 to 18 %	19 to 21 %	22 to 25 %
N	268	238	194
Alcohol or other substance misuse	45.9	48.7	44.3
Mental health†	32.1	42.4	40.6
Obesity	24.6	21.0	19.1
Smoking	19.4	17.6	13.4
Diet and exercise	10.0	10.1	12.4
Accidents	3.4	1.7	0.5
Flu and allergies	1.5	2.1	5.2
Sexually transmitted disease	1.9	4.2	2.1
Cancer	3.4	1.7	2.6
Diabetes	2.2	2.1	3.1
Asthma	1.1	1.3	2.6
Other§	19.4	17.6	16.5
Don't know	13.8	14.3	18.0

†Mental health includes: attention deficit hyperactivity disorder; behavioural issues; depression; eating disorders; pressure; self–esteem issues; stress; and suicide. §Other includes: cardiovascular; dental; health system access/affordability; lack of education/information; sport injuries; sun exposure/sunburn; and too much television/computers/gaming.
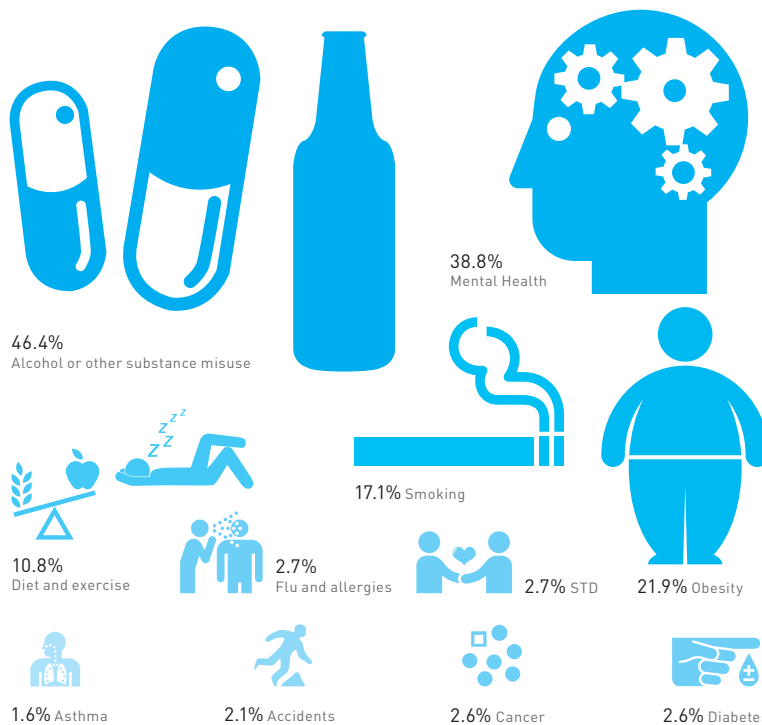

46.4% Alcohol or other substance misuse

38.8% Mental Health

17.1% Smoking

21.9% Obesity

10.8% Diet and exercise

2.7% Flu and allergies

2.7% STD

1.6% Asthma

2.1% Accidents

2.6% Cancer

2.6% Diabetes

Figure 8 Disorders considered by young men aged 16 to 25 years to be the major health problems for young people in Australia at present (N = 700)

Table 5 Disorders considered by young men aged 16 to 25 years to be the major mental health and behavioural problems for young people in Australia at present

Age in years	16 to 25 %	16 to 18 %	19 to 21 %	22 to 25 %
N	700	268	238	194
Depression	44.9	42.9	44.5	47.9
Anxiety	11.9	11.6	15.5	8.8
Alcohol or other substance misuse	10.1	6.7	11.3	13.4
Attention deficit disorders	9.3	11.9	9.7	5.2
Behavioural problems/anger	7.0	7.5	5.0	8.8
Stress/pressure	6.1	6.3	4.6	7.7
Self–esteem issues	4.1	4.1	3.8	4.6
Schizophrenia/psychosis	3.1	2.6	3.4	3.6
Family issues/problems	2.0	1.9	2.1	2.1
Bipolar disorder	1.7	1.5	1.7	2.1
Eating disorders	1.6	1.5	1.3	2.1
Suicide	1.0	1.1	0.8	1.0
Other§	26.9	26.9	28.6	25.3
Don't know	21.4	21.6	21.0	21.6

§Other includes: abuse/bullying/violence; developmental disorders; health system/lack of information/education; isolation/lack of support; learning problems/dyslexia; physical disorders; too much television/computers/gaming; and uncertainty/lack of motivation.

Duration of problem prior to seeking help

When asked how long a health problem needs to be present before a young person should seek help, two–thirds (66%) of young men responded *'less than one month'* for a mental health problem; and 60% *'less than one month'* for an alcohol or other substance use problem (Appendix B).

Preferred sources of help

Young men were asked to imagine a young person, who was a close friend or family member, who needed help for a mental health or behavioural problem (Figure 9). They were asked, *'...if that person needed help what would they do?'.* First and foremost, young men said that they would support and encourage them to get help (57%) and secondly they would talk with and listen to them (45%). Respondents recommended seeking help from a mental health professional (25%) before they would recommend talking with parents, friends or family (19%) or seeking assistance from a general practitioner (11%). Imagined referrals to online organisations, counsellors and mental health specialists such as a psychiatrist or psychologist were very low (2%–7%). Similar patterns were observed for imagined assistance for someone with an alcohol or other substance use problem.

"Research findings such as these help to reinforce and confirm the important work beyondblue has been doing for the past 13 years, especially in the area of men's mental health. We know that men are often reluctant to seek help for depression or anxiety, but we also know that young men in particular, are very comfortable getting and exchanging information online via their smart phones, computers and tablets. beyondblue looks forward to working with young people, health professionals, the youth mental health sector and all tiers of government to ensure that we are able to use new media, in the same way we have utilised traditional media, to get our message out and to help all Australians get the help they need, when they need it, regardless of where they live. Because of beyondblue's work over the last decade, awareness about and understanding of depression in young men is high. This is a great foundation for new campaigns that focus on changing attitudes to taking action to get help."

Kate Carnell AO, Chief Executive Officer, beyondblue: the national depression and anxiety initiative

Confidence in accessing information and care for someone else

Only a little over half (58%) of the young men sampled felt confident they could access psychological care for another young person with a mental health or behavioural problem if it was required. One–third (33%) were confident that the care would be affordable, and two–thirds (71%) that it would be helpful. In contrast, when asked to consider helping a young person to access care for an alcohol or other substance use problem, 66% of young men felt confident they could access psychological care for the problem, 42% were confident it would be affordable, and 77% that it would be helpful. Confidence in affordability and helpfulness declined with age (Appendix B). When considering access to care or treatment for a physical health problem, 70% of young men felt confident they could access psychological care for the problem, 45% were confident it would be affordable, and 83% that it would be helpful.

What you would do if a close friend or family member needed help for a mental health or behavioural problem

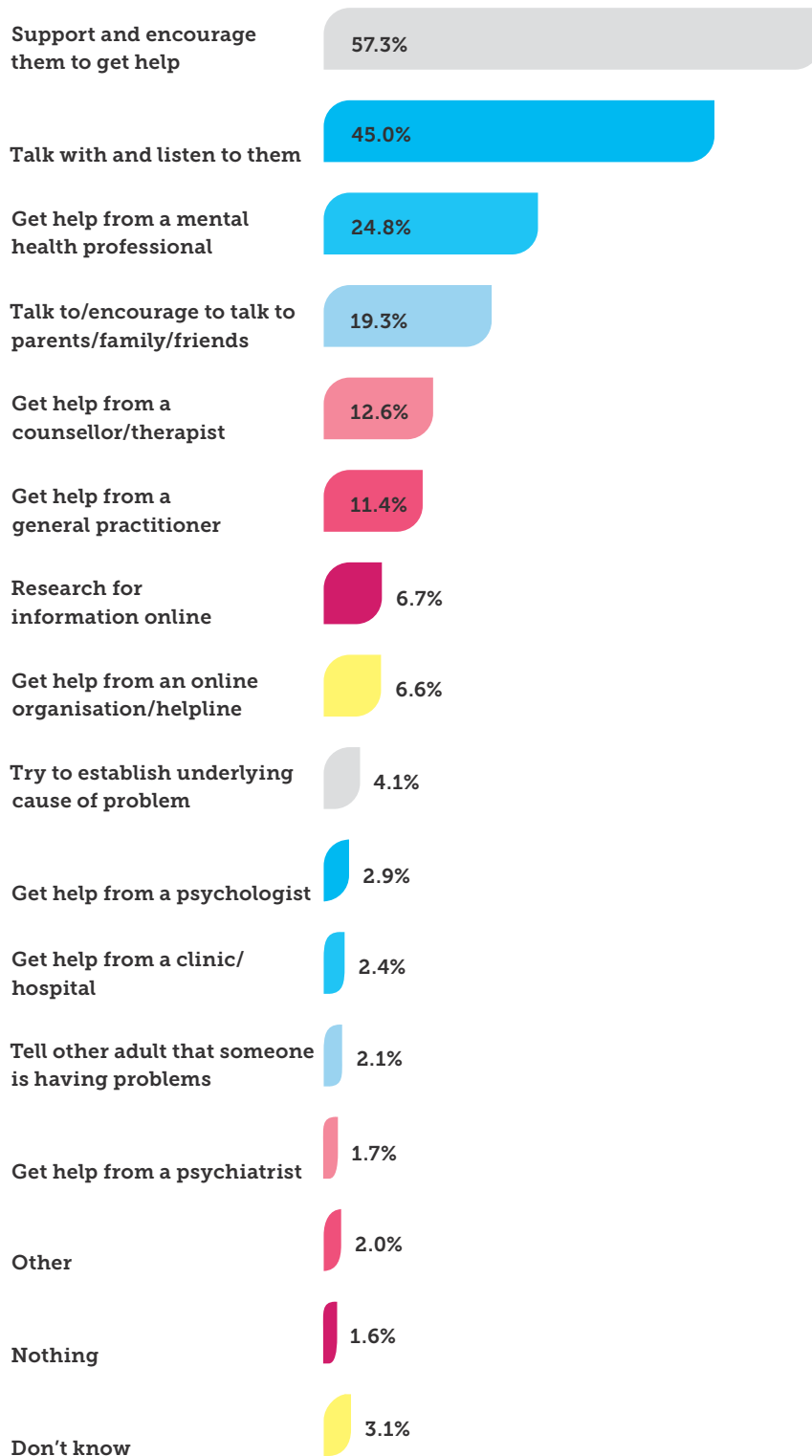|	
Support and encourage them to get help	57.3%
Talk with and listen to them	45.0%
Get help from a mental health professional	24.8%
Talk to/encourage to talk to parents/family/friends	19.3%
Get help from a counsellor/therapist	12.6%
Get help from a general practitioner	11.4%
Research for information online	6.7%
Get help from an online organisation/helpline	6.6%
Try to establish underlying cause of problem	4.1%
Get help from a psychologist	2.9%
Get help from a clinic/hospital	2.4%
Tell other adult that someone is having problems	2.1%
Get help from a psychiatrist	1.7%
Other	2.0%
Nothing	1.6%
Don't know	3.1%

Figure 9 Young men's (aged 16 to 25 years) beliefs about what they would do if a young person, who was a close friend or family member, needed help for a mental health or behavioural problem (N = 700)

EATING BEHAVIOURS AND BODY IMAGE

Ten percent of young men reported experiencing binge eating at least weekly during the three months prior to survey, 7% strict dieting or food restriction to control shape or weight, and only 1% regular purging to control shape or weight. Only strict dieting or food restriction appeared to increase with age (Appendix B).

Twenty percent of young men rated the importance of their weight or shape on influencing how they thought about themselves as a person during the three months prior to survey as *'not at all'*. In contrast, 13% rated the importance of weight or shape as 'very' or 'extremely important'.

Distress or preoccupation with a specific aspect of their physical appearance was reported by 21% of young men (decreasing with age), with 41% having concerns just about every day (Appendix B). The most common aspect of physical appearance of concern was weight (being overweight or too skinny; 36%), followed by muscular size, tone and/or mass (14%) (Figure 10). Only 4% of young men claimed to be very unhappy with their appearance.

Which aspect of physical appearance

Weight (being overweight or too skinny): 35.9%

Muscles (including size, tone, mass): 14.1%

Stomach or waist: 12.7%

Skin imperfections (including scars, acne, eczema): 11.9%

Body (shape or type): 7.7%

General overall appearance: 7.0%

Hair (including body hair): 7.0%

Facial features (including eyes, nose, teeth): 5.6%

Figure 10 Aspects of physical appearance causing worry for young men aged 16 to 25 years (N = 700)

21% of young men were distressed or preoccupied with their physical appearance

"One of the most disturbing trends that we see when working with young men is the significant increase in negative body image. Body dissatisfaction is on the rise amongst our young men – and it is driving them to dangerous behaviours to try and change their shape in a mistaken belief this will make them worthwhile and successful in life. In fact, the excessive exercise, substance abuse and highly disordered eating that can result seriously impact on their mental and physical health, and their social confidence. It is no surprise we are also seeing an increase in clinical eating disorders in young men. Urgent attention and resources must be focused on helping our young men – we need to help them accept their value as a person is not determined by their size and shape, to accept diversity, and to celebrate their natural abilities and good health. Negative body image and eating disorders are not just female issues – our men can be, and are, affected just as severely."

Christine Morgan, Chief Executive Officer, The Butterfly Foundation and National Director, National Eating Disorders Collaboration
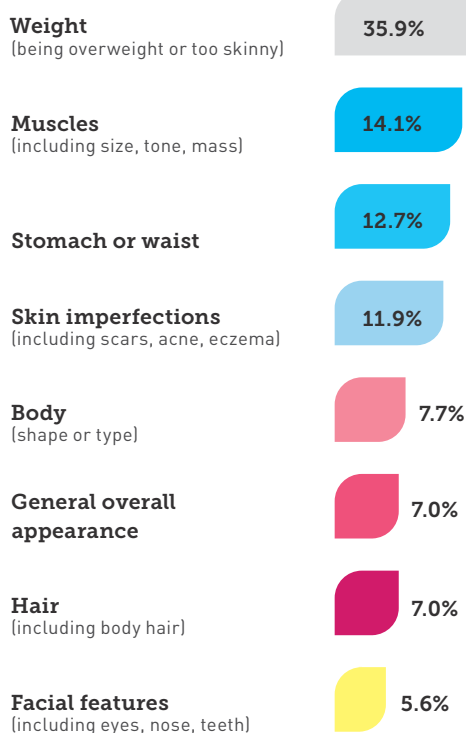
Case study

TASMAN'S STORY

I was a bit of a perfectionist in high school and I focused mostly on my academic work. I didn't put a lot of effort into maintaining a healthy level of exercise and consequently I gained weight, made 'worse' by my remaining baby fat.

One day a few of the 'jocks' offhandedly commented on my weight. I felt extremely uncomfortable with myself, even though I wasn't an unhealthy weight.

At the end of Year 9, I took up running and also began to change my eating habits by limiting junk food, sugar and fat. When I began Year 10, I had become obsessive about running 10 kilometres everyday at 5.30pm on the dot. I started starving myself and I became a master at throwing out my lunch at school and hiding my dinner at home. I lost a lot of weight. My parents realised something was wrong when they started finding all the food I was throwing out. They sent me to our family general practitioner who didn't diagnose me as having an eating disorder. Eventually, through my parents' persistence with my school's psychologist, it was recommended I see a private psychiatrist and a dietician.

Despite all their good intentions, they were largely ineffective in treating me at that time because I had become very good at hiding what I was really going through. My parents were at a loss, and everything was deteriorating. I didn't like myself and I occasionally had thoughts of suicide. I was physically unwell and suffered from anaemia and hypotension. I was emotionally and socially cut off at school, and I felt alienated being a young guy with anorexia nervosa because of the common perception that eating disorders only affect women or gay men. Life was terrible so to find more information and attempt to feel part of a group I signed up to an online pro-anorexia community.

Fortunately, by the middle of 2009, I realised how ill I was and I began to pull myself out of the mental downward spiral and work towards recovery. Ownership of my role in treatment was an important part of my recovery. I became active in community service and I became motivated to help those less fortunate than myself. I have now largely recovered from the illness but through my story I want people to know that men get eating disorders too. We as a society need to understand this, de-stigmatise eating disorders, and provide much better avenues for prevention, engagement and treatment. I couldn't find positive websites when I needed information and support online, but fortunately there are now many more options available for people seeking help.

Tasman (19)

To retain authenticity, this story has not been edited.

SECTION 3: TECHNOLOGY, MENTAL HEALTH AND WELLBEING

Regardless of level of psychological distress, use of the internet was almost universal (98%) and frequent, with 94% of the sample accessing it daily or almost every day. The most commonly used device to access the internet was a smartphone (71%), followed by the respondent's own laptop or a laptop that they mainly used and could take to their own room (62%). Most commonly, the internet was accessed in the respondent's own bedroom or other private room at home (74%), or in the respondent's living room or other public room at home (52%). Facebook was identified by 32% of young men as the website that would be most missed if the respondent no longer had access to the internet (Appendix C).

On average, young men spent 3.1 hours a day on the internet during the school or work week and 3.7 hours a day during the normal non–school or workday. The time spent on the internet was higher among those young men with higher levels of psychological distress (Figure 11; Appendix C). This was particularly marked on non–school/non–work days, with 4% of those with 'no or low' psychological distress spending 10 hours or more on the internet, compared with 13% of those with 'moderate' to 'very high' levels of psychological distress (Figure 12; Appendix C). Two–thirds (67%) of young men used the internet after 11.00pm (29% of whom did so six to seven nights a week, (Figure 13; Appendix C), with significantly higher rates of late night use amongst those men with 'moderate' to 'very high' psychological distress (64% vs 72%).

98% of young men use the internet, and their most common device of choice is a smartphone (71%)

Average number of hours spent using the internet

Non–school/ non–workday
- 4.6 hours
- 3.2 hours

School/workday
- 3.6 hours
- 2.8 hours

☐ 'no or low' psychological distress
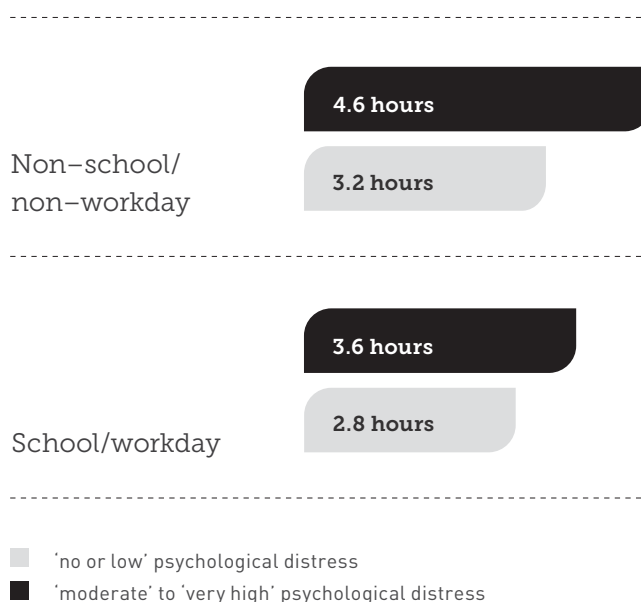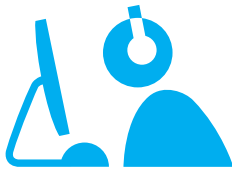■ 'moderate' to 'very high' psychological distress

Figure 11 Average number of hours young men aged 16 to 25 years use the internet on a school/workday and on a non–school/non–workday, by level of psychological distress (N = 688)

Most young men are online for less than four hours a day. As distress increases the number of hours online also increases. Just over 10% spend 10–19 hours online and a small proportion (1.4%) spend more than 20 hours online
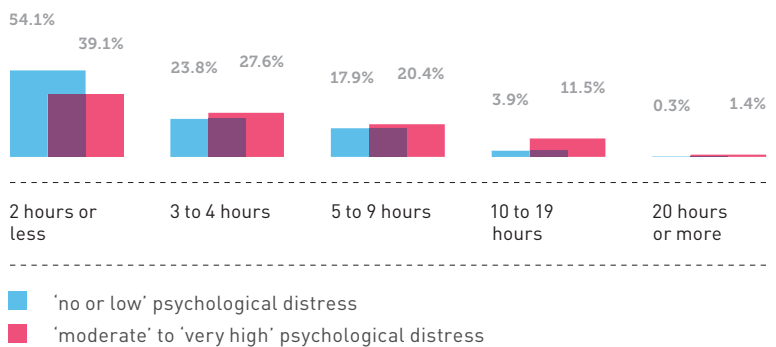
Hours spent using the internet

	2 hours or less	3 to 4 hours	5 to 9 hours	10 to 19 hours	20 hours or more
'no or low'	54.1%	23.8%	17.9%	3.9%	0.3%
'moderate' to 'very high'	39.1%	27.6%	20.4%	11.5%	1.4%

■ 'no or low' psychological distress
■ 'moderate' to 'very high' psychological distress

Figure 12 Frequency of hours young men aged 16 to 25 years use the internet during the week, by level of psychological distress (N = 688)

Frequency of internet use after 11.00pm

	Less than once a week	1 to 3 nights a week	4 to 5 nights a week	6 to 7 nights a week
'no or low'	9.2%	47.4%	18.1%	25.3%
'moderate' to 'very high'	12.3%	33.0%	21.7%	33.0%

■ 'no or low' psychological distress
■ 'moderate' to 'very high' psychological distress
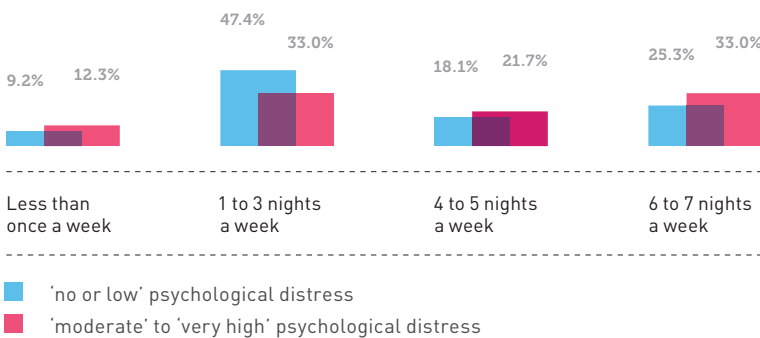
Figure 13 Frequency of internet use by young men aged 16 to 25 years after 11.00pm, by level of psychological distress (N = 452)

33% of young men experiencing 'moderate' to 'very high' psychological distress are online six to seven nights a week after 11.00pm
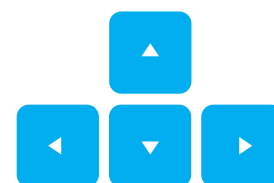
Table 6 Ways young men aged 16 to 25 years commonly spend time using the internet, by level of psychological distress

Activities during past month on the internet	'No or low' psychological distress %	'Moderate' to 'very high' psychological distress %	χ2
N	391	285	
Accessed health information	30.9	41.4	7.89**
Accessed social network websites (eg. Facebook, Twitter)	90.5	90.9	0.02
Checked email	93.9	89.8	3.72
Gambled	5.1	7.0	1.07
Listened to, downloaded or uploaded music (eg. iTunes)	76.2	84.2	6.49*
Used online or email counselling	4.1	3.9	0.02
Played games alone	46.0	53.0	3.18
Played games with others	44.5	53.0	4.75*
Used the Internet for school or work	80.1	80.4	0.01
Watched, downloaded or uploaded video clips, cartoons, movies, etc (eg. YouTube)	88.7	91.2	1.11

Notes: *p←.05, **p←.01

Young men with 'moderate' to 'very high' psychological distress were significantly more likely to access health information (41%), listen to or download/ upload music (84%) and play games with others (53%)

With regards to internet activities, the most common during the month prior to the survey were checking email (92%), accessing social network websites (91%), watching or downloading/uploading videos (90%), using the internet for school or work (80%), and gaming alone or with others (59%). Internet gambling and using online or email counselling were relatively rare activities. Respondents with 'moderate' to 'very high' psychological distress were significantly more likely to access health information (41%), listen to or download/upload music (84%) and play games with others (53%). For even more ways young men commonly spend time using the internet, see Appendix C.

The internet was used to contact other young people by 82% of the sample, with no difference in rates by level of psychological distress (Appendix C). Those with 'moderate' to 'very high' psychological distress were significantly more likely to have talked about their problems on the internet with other young people (23% vs 44%; Table 7), and two–thirds of these (66%) found it helpful. When doing activities online, respondents with 'moderate' to 'very high' psychological distress were significantly more likely to have contact with people who they first met on the internet than those respondents with 'no or low' psychological distress (38% vs 25%; Table 8).

Young men with 'moderate' to 'very high' psychological distress were significantly more likely to have talked about their problems on the internet with other young people (23% vs 44%)

Table 7 Percentage of young men aged 16 to 25 years who talk about problems on the internet, by level of psychological distress

Ever talked about your problems on the internet with other young people?	'No or low' psychological distress %	'Moderate' to 'very high' psychological distress %	χ2
N	319	236	
No	77.4	56.4	
Yes	22.6	43.6	27.90***

Note: ***p←.001

Respondents with 'moderate' to 'very high' psychological distress were significantly more likely to have used the internet to find information for a physical health problem (66% vs 54%) and mental health, alcohol or other substance use problem (48% vs 30%). Most respondents felt that the internet provided them with the kind of information they needed and only a very small proportion of those with 'moderate' to 'very high' levels of psychological distress reported that the internet made their problem worse (2%). Most young men would recommend the internet to close friends or family members who were in need of similar information (78%) and the majority (95%) were 'somewhat' or 'very satisfied' with the information they received on the internet. Information from the internet was discussed 'always' or 'nearly always' most often with a close friend (16%) or family member (12%), but rarely with health professionals (5%–7%; Appendix C).

Table 8 Types of people young men aged 16 to 25 years have contact with online, by level of psychological distress

Types of people you have contact with using the internet	'No or low' psychological distress %	'Moderate' to 'very high' psychological distress %	χ2
N	391	285	
People who you first met in person face–to–face	94.6	92.3	1.53
People who you first met on the internet, but who are friends or family of other people who you know in person	40.2	51.2	8.18**
People who you first met on the internet, but who have no other connection to your life outside the internet	24.8	38.2	14.05***

Notes: **p←.01, ***p←.001

Recommendations

This report provides a snapshot of the mental health and wellbeing of young men aged 16 to 25 years in Australia, with a focus on technology use. It provides a richness of information that, when coupled with the current evidence base, gives a number of clear ideas about next steps and directions for immediate action.

The issue of youth mental health, and specifically young men's mental health, is a complex societal, cultural, family, community and individual challenge. It is not simply addressed with new or different services, through schools, families or workplaces or with a focus on just the individual. The following recommendations are practical and build on existing efforts.

Health

1. Young men must be involved in the design of e–mental health services. Services must be simple to use, accessible, provide choice to suit individual needs and be cost–effective.

2. Technology solutions must be tailored to vulnerable populations including young men who are Indigenous, unemployed, living with a disability or living and working in remote areas.

3. Existing online services must be responsive 24/7.

4. Evidence–based online interventions for young men need to incorporate technologies that young men use, including digital content, gamification and music. To enhance access they must be available on a portable device.

5. Youth–led education should be provided to families, mental health and allied health professionals on how young men use technology to connect, communicate and engage online.

Education

6. All schools should have a social networking policy that manages risk (suicide contagion and cyberbullying) and promotes opportunities such as valued participation, respectful relationships and acceptance of diversity.

7. Professional development should be provided to school counsellors, psychologists and chaplains to use online resources and tools.

8. All tertiary campuses should provide e–mental health support to complement existing health services thus ensuring ongoing availability after hours and during holidays.

Employment and workplaces

9. Australian workplaces should prioritise wellness and mental fitness for young men. This must focus on stress management, excessive alcohol or other substance misuse and prioritise e–mental health to support clear pathways to care. Financial incentives (e.g. tax credits) provided by government would cement this as a matter of national urgency.

10. Employment services should explore online solutions to support young men who are unemployed. This could include e–mentoring and the provision of online support.

Communications and media

11. Campaigns for young men should be delivered in the social networks they frequent and focus on changing attitudes to help– seeking, stress management, alcohol or other substance misuse, bullying and violence and body image. These campaigns must be developed in partnership with young men.

Research and innovation

12. An innovation fund is needed to support the development and/or evaluation of tailored web services and social media channels for young men.

13. Funding, including that provided by our major research councils, private trusts and donors, should prioritise young men's mental health.

01

HEALTH

Priority Recommendation One

Relevant to

| Policy-makers
in government

| Program managers
in government
and the community
sector

| Service providers

Young men must be involved in the design of e-mental health services. Services must be simple to use, accessible, provide choice to suit individual needs and be cost-effective

Rationale

Eighteen percent of young men felt that life was hardly worth living and 42% reported 'moderate' to 'very high' levels of psychological distress. Less than one in four young men would recommend professional support, either face-to-face or online. Fifty-eight percent reported feeling confident that they could access care or treatment for a close friend or family member with a mental health problem, while just one-third were confident that such care would be affordable. Other research shows that services are more engaging and relevant when young people are involved in their design (Oliver et al. 2006; Rickwood, Deane & Wilson 2007; Swanton et al. 2007; Webb, Burns & Collin 2008) and that involving them brings about benefits for the individual young person, the service being delivered and the organisation (Collin et al. 2009; Collin et al. 2011; Hagen et al. 2012; Lancet 2012).

The evidence

Australia leads the world in its development of services specifically aimed at addressing the key needs of young Australians, including e-health services (Hirshfeld et al. 1992). headspace is the stand-out example of a national model of integrated, evidence-based face-to-face mental health services for young people (McGorry et al. 2007; Muir et al. 2009). ReachOut.com is the world's first online community of young people dedicated entirely to the promotion of mental health and wellbeing with a focus on help-seeking (Burns, Webb et al. 2010; Burns, Durkin & Nicholas 2009; Burns et al. 2008; Burns et al. 2007). Nationally, 40% of headspace clients are young men (Scott et al. 2012) while ReachOut.com receives over 1.4 million unique visits to its service each year. This level of youth engagement is unprecedented and a significant improvement on the use of other Medicare-funded models of primary care (Hickie et al. 2001; Hickie et al. 2004; Hickie et al. 2007).

Policy implications

| Funding to extend the capacity of headspace and ReachOut.com to engage young men in a comprehensive model of e-mental health is needed.

| National initiatives, including the mindhealthconnect portal (*mindhealthconnect.org.au)* and the 'Virtual Clinic' (*virtualclinic.org.au)*, an online clinic delivering CBT via the telephone and internet for adults engaged through the Access to Allied Psychological Services (ATAPS) program, should be evaluated and data collected routinely to determine if they are meeting the needs of young men. This must include process *(how many young men used the service?)* and outcome *(did it improve mental health or result in a clear pathway to care?)* data.

| In Australia we have a range of online services but we do not yet understand the pathways young men take within and between these services. Standards for digital content and mobile apps must be developed to ensure resources are shared and evaluated across online services targeting young men. Measures should include how engaging a service is for young men, what impact it has on help-seeking both online and offline, and whether this translates to better mental health outcomes. Creating one single platform and applying standards to the development of new mental health content and interventions would enable this use to be evaluated comprehensively.

02
HEALTH

Priority Recommendation Two

Relevant to

| **Policy–makers in government**

| **Program managers in government and the community sector**

| **Service providers**

| **Researchers**

Technology solutions must be tailored to vulnerable populations including young men who are Indigenous, unemployed, living with a disability or living and working in remote areas

Rationale

Suicidal ideation increased with age and significant predictors were unemployment and psychological distress. Generalisations of young men as a homogenous group fail to recognise individual differences across and between groups. A 'one size fits all' solution to the mental health needs of young men will further alienate and increase disparities in access to resources and care for mental health and wellbeing.

The evidence

| Suicide completion rates for Indigenous young men were 3.8 times the rate of their non–Indigenous counterparts (Australian Institute of Health and Welfare 2004). Less than one in 10 Indigenous young people aged 15 to 24 years report fair or good health (Australian Institute of Health and Welfare 2008).

| Young people with an intellectual disability are more likely to experience both physical and mental disorders (Einfeld et al. 2006; Tonge & Einfeld 2000).

| Young people who are vulnerable are at greater risk of experiencing stigma and social isolation, reduced educational attainment and low levels of workforce participation (Burns, Blanchard & Metcalf 2009; Burns et al. 2008; Stephens–Reicher et al. 2010). Experience of these risk factors often spans a number of generations within one family.

| Young men living in rural, regional or remote Australia face geographic barriers to accessing care and support for a mental health problem (Boyd et al. 2007). Barriers to utilisation and support include: a lack of reliable transport to and from the mental health service; a lack of qualified professionals who specialise in child and adolescent mental health; long waiting lists; and the lack of an after–hours service. Aisbett et al. report *'rural gossip networks and social visibility within rural communities compound the experience of stigma and social exclusion for young people'* (2007, p. 1).

Policy implications

| More research is needed to understand how young men who are vulnerable use technologies, the impact on their mental health and wellbeing, and how services could be tailored to respond to needs.

| Specific resources should be made available to engage young men from diverse backgrounds. Engaging young men who identify as Aboriginal or Torres Strait Islander, those with a disability or living and working in rural or remote areas may incur additional costs such as time taken to build relationships with community elders; the provision of accessible spaces, support workers or Australian Sign Language interpreters; or additional travel for project staff to engage young people in their own local communities (Hagen et al. 2012).

03

HEALTH

Priority Recommendation Three

Relevant to

| **Policy–makers in government**

| **Service providers**

Existing online services must be responsive 24/7

Rationale

More than seven out of 10 participants in this survey who experienced 'moderate' to 'very high' levels of psychological distress accessed the internet after 11.00pm.

The evidence

Further and ongoing research is required to understand and monitor the needs of young men particularly in relation to technology use, help–seeking and ensuring services are effective. Access to the internet after 11.00pm could be both helpful and harmful for young men experiencing 'moderate' to 'very high' levels of psychological distress. Helpful, given that services are not available after 11.00pm and yet this is the time when people most often feel stressed, anxious and upset. Consequently, real time information and support with advice on managing difficulties might be useful. Access to the internet after 11.00pm could also be harmful, given the importance of adequate sleep in the prevention and treatment of depression and anxiety.

Policy implications

Online support services such as e–counselling and moderated online forums need to have clear strategies for after–hours engagement using technologies such as virtual avatars or be sufficiently funded to operate 24/7. There is an opportunity for international partnerships to ensure services can operate beyond the normal business hours of 9.00am to 5.00pm.

04
HEALTH

Priority Recommendation Four

Relevant to

| **Policy–makers in government**

| **Program managers in government and the community sector**

| **Researchers**

Evidence–based online interventions for young men need to incorporate technologies that young men use, including digital content, gamification and music. To enhance access they must be available on a portable device

Rationale

Participants in this survey reported that the most frequent activities they engaged in online included: accessing social networking services, listening to or downloading/uploading music, producing digital content (e.g. blogs, videos) or playing games. As the technical capacity of the internet grows with new service offerings including Web 2.0 and Web 3.0, and with faster internet speeds as a result of Australia's National Broadband Network, it is increasingly evident that the provision of mental health services and resources will need to keep pace with innovation.

The evidence

| Research evidence is strong relating to the effectiveness of online interventions (the literature in this report) however translating research to practice and ensuring uptake is a challenge.

| Gamification has shown some promise in mental health interventions (see service snapshot on ReachOut Central; Burns, Webb et al. 2010; Merry 2012).

Policy implications

Online services structured specifically for young men need to use technology solutions such as gaming, digital content production, music and social networks to promote the practical management of issues – clear information, directive rather than exploratory, solutions–focused, challenging and multi–platform.

05
HEALTH

Priority Recommendation Five

Relevant to

| **Policy–makers in government**

| **Program managers in government and the community sector**

| **Health Workforce Australia**

| **Professional associations**

Youth–led education should be provided to families, mental health and allied health professionals on how young men use technology to connect, communicate and engage online

Rationale

Participants in this survey are prolific users of technologies, including social networking services, digital content production and the use of online services such as banking and shopping.

The evidence

Mental health and allied health professionals report that technologies are poorly understood and underutilised. They report a need for training and support to better understand the role that technologies have on young people's lives, the impacts of technologies (positive and negative) and where they can go online to support a young person they care for (Blanchard et al. 2011; Blanchard et al. 2008). Approaches which bring young people together with adults through a process of intergenerational dialogue show promise in equipping parents and other significant adults to better understand the role of technologies in young people's lives (Third et al. 2011).

Policy implications

| Investment should be made in skilling young people to provide training to adults, which build their understanding of the role of technologies in young people's lives.

| Increasingly, young people are using digital tools for planning, monitoring and self–managing mental health needs. A national strategy, developed in partnership with Health Workforce Australia, universities and training institutions, needs to be implemented as a priority to support greater utilisation of technology–based platforms by health professionals and the integration of these into professional practice. Long term, this will address skill needs and workforce shortages.

| Barriers which need to be overcome in order for technologies to be utilised more effectively by professionals include poor infrastructure, lack of guidelines or policies to support safe and constructive use of technologies, and lack of awareness about which technology–based strategies or approaches are most effective and in which contexts.

06
EDUCATION

Priority Recommendation Six

Relevant to

| Policy–makers in government

| Program managers in government and the community sector

| Australian school principals

| Educational systems across States and Territories

All schools should have a social networking policy that manages risk (suicide contagion and cyberbullying) and promotes opportunities such as valued participation, respectful relationships and acceptance of diversity

Rationale

Participants in this survey accessed the internet from locations other than their home. Technology use by young people has fundamentally changed from 2008 to 2012.

The evidence

National research is urgently needed across primary and secondary schools and colleges to understand the prevalence of online risk–taking including cyberbullying.

Policy implications

| The eSmart program (*esmartschools.org.au*) is a whole–school approach developed by the Alannah and Madeline Foundation to ensure safe and supportive school communities for young people. It inherently builds the capacity of teachers, parents and other significant adults in the school community to support young people's wellbeing and safety online.

| To complement this, school policies on social networking service use should be developed in partnership with young people and include information about how to manage the risks associated with internet use (digital permanency, privacy, bullying and harassment, and over–use), balanced against the potential benefits (access to services and information, pro–social connections with others).

| Young people rely on their peers for information and support. Peer–mentoring for children and younger adolescents should be explored as a strategy for teaching young people the skills to navigate and use the internet safely and confidently.

07

EDUCATION

Priority Recommendation Seven

Relevant to

| Education systems

| Policy–makers in
government

| Program managers
in government
and the community
sector

| Professional
associations

Professional development should be provided to school counsellors, psychologists and chaplains to use online resources and tools

Rationale

Less than one in four participants in this survey would recommend professional support, either face–to–face or online, yet information on health and mental health on the internet was acceptable to young men.

The evidence

Young people prefer online resources. The Mission Australia Youth Survey (Mission Australia 2012) asked young people if they were comfortable seeking information, advice and support – 61% reported they were not comfortable using a telephone hotline and 47% a community agency. The internet was the main source of information for young people, with over three–quarters of young people nominating the internet as their primary source. Despite young people preferring online resources, counsellors and psychologists report that they don't yet have enough knowledge regarding online resources to be able to use these effectively in their practice with young people (Blanchard et al. 2012).

Policy implications

Technology literacy is a barrier to effective utilisation and engagement with young people. Barriers in schools need to be overcome in order for technologies to be utilised more effectively. Barriers include poor infrastructure, lack of guidelines or policies to support safe and constructive use of technologies, and lack of awareness about which technology–based strategies or approaches are most effective and in which contexts.

08
EDUCATION

Priority Recommendation Eight

Relevant to

| Policy–makers in
government

| Program managers
in government
and the community
sector

| Health Workforce
Australia

| Professional
associations

All tertiary campuses should provide e–mental health support to complement existing health services thus ensuring ongoing availability after hours and during holidays

Rationale

Over 60% of all participants in this survey were attending school, TAFE or university and approximately 50% report that coping with stress is a major issue of concern. The stress associated with study and looking for employment can lead to significant mental health difficulties.

The evidence

| In a large–scale epidemiological study of over 2,000 college students in the US, the 12–month prevalence of mental disorder was almost 50%, with the highest rates being substance misuse (29%) followed by anxiety (12%) and mood (11%) disorders (Blanco et al. 2008).

| Almost 1.2 million students were enrolled in Australian higher education institutions in 2010, of whom 80% were aged between 20 and 28 years. In 2009, almost 22% of Australia's tertiary education students were from overseas (OECD 2011).

| One study reported a doubling and tripling of students presenting in a face–to–face university clinic for depression and suicidal ideation over a 13–year period (Benton et al. 2003).

Policy implications

Led by a team from the Australian National University, the BMRI, the Black Dog Institute and Queensland University of Technology, the Young and Well CRC is developing and trialling a university–based Virtual Clinic which will enable young people attending university to engage with an online service which is integrated with resources from their university community. If proven successful, services such as this should be taken to scale and made available in all Australian tertiary institutions.

09
EMPLOYMENT AND WORKPLACES

Priority Recommendation Nine

Relevant to

| Policy–makers in government

| Program managers in government and the community sector

| Workplace health and safety authorities

| Employers with large male and young male workforces

| Unions

Australian workplaces should prioritise wellness and mental fitness for young men. This must focus on stress management, excessive alcohol or substance misuse and prioritise e–mental health to support clear pathways to care. Financial incentives (e.g. tax credits) provided by government would cement this as a matter of national urgency

Rationale

Fifteen percent of participants in this survey reported 'high' to 'very high' levels of psychological distress. Almost one in five young men felt at some point in the last 12 months that life was hardly worth living. Approximately half of all participants in this survey report that coping with stress was a major issue of concern.

The evidence

| High psychological distress has a significant impact on a young person's productivity, with considerably higher numbers of '*days out of role*' when compared to those with low or moderate levels of psychological distress (Degney et al. 2012).

| Poor mental health in young men aged 12 to 25 years costs the Australian economy more than $3 billion each year (Degney et al. 2012).

| The impacts of poor mental health in adolescence can be lifelong, with poorer educational attainment, lower lifetime earnings, lower productivity and poorer health (Patel et al. 2007).

Policy implications

| Policies and practices need to be considered in workplace wellbeing planning to ensure that the environment supports 'healthy choices' for employees and management. This could include online stress management, sleep, diet and exercise. Individuals could self–monitor changes linked to performance. Practical, action–oriented approaches are more likely to engage young men.

| Workplace health and safety emphasise physical injury and risk mitigation. Equal attention should be given to wellbeing as envisaged under the new nationally harmonised Workplace Health and Safety legislation. This should include an active role for unions and may require policy changes to enshrine this role.

| Young men must be engaged in the design and delivery of worksite–based mental health services in industries with large male workforces such as mining and construction. There must be a shift from crisis–driven interventions to mental health promotion.

| The development of outreach models of care that deliver both guided and self–directed resources online and offline to reach young men where they work particularly in remote locations and 'fly–in, fly–out' or 'drive–in, drive–out', and sporting clubs need to be trialled and, if successful, scaled up.

10
EMPLOYMENT AND WORKPLACES

Priority Recommendation 10

Relevant to

| **Policy–makers in government, including Centrelink**

| **Employment services**

Employment services should explore online solutions to support young men who are unemployed. This could include e–mentoring and the provision of online support

Rationale

Participants in this survey reported a greater risk of suicidal ideation if they were unemployed. Mental illness can result in a cycle of chronic and long–term unemployment.

The evidence

Online models provide young men with the tools to learn about their mental health issues and use self–help programs to improve their overall health, and to connect with peers. This can occur at any stage of a person's recovery and be an option whether or not there is engagement with health professionals (Bennett et al. 2010).

Policy implications

| Increased access to technological infrastructure within employment services or to the unemployed must be provided to enable these initiatives to be taken up.

| Staff training in digital literacy is required.

11

COMMUNICATIONS AND MEDIA

Priority Recommendation 11

Relevant to

| Policy–makers in government

| Program managers in government and the community sector

| Service providers

| Researchers

Campaigns for young men should be delivered in the social networks they frequent and focus on changing attitudes to help–seeking, stress management, alcohol or other substance misuse, bullying and violence and body image. These campaigns must be developed in partnership with young men

Rationale

Participants in this survey used social networking services such as Facebook and Twitter and both uploaded and downloaded digital content. Participants recognised alcohol or other substance misuse and mental health as the major health problems affecting young people aged 16 to 25 years. They understood when such problems began; their beliefs regarding when to seek help were accurate; and they reported feeling confident that they could get help for a close friend or family member. Coping with stress was the biggest issue facing young men, with almost 50% reporting stress as their main concern. One in four young men were concerned about depression (27%) and body image (26%) and 41% of young men felt concerned about their physical appearance on a daily basis. This suggests campaigns need to focus more on behaviour change and less on either awareness or knowledge. This should include practical solutions to managing stress, getting the right help at the right time and taking appropriate steps to help–seeking.

The evidence

| Thornely and Marsh (2010) identified seven factors that characterise successful social marketing campaigns for young people. Campaigns must be youth–centred; informed by research and theory; comprehensive and multi–faceted; ethnic and age–specific; apply successful commercial tools; use appropriate messages that empower young people; and work across sectors and organisations.

| Donovan (2011, p. 26) makes the point that an emphasis on the individual in most social marketing campaigns *"...largely ignores the social, economic and environmental factors that influence individual [health] behaviour"*. While Ellis and colleagues (2012) argue that campaigns and services must be informed by the views of young men and how they use technology, and leverage the role that their peers play in seeking help. This Australian research is consistent with research from the US which argues that any approach should normalise help–seeking; promote help–seeking as 'taking control'; promote reciprocity and the concept that 'mates help mates'; build communities of support which encourage help–seeking; and empower young men as active participants in recovery (Addis & Mahalik 2003).

Policy implications

Programs that normalise help–seeking need to be part of an integrated strategy for young men. These programs must be tested to measure their effectiveness. Social marketing campaigns need to be focused on population segments rather than generic campaigns for all young men (see Priority Recommendation Two).

12
RESEARCH
AND INNOVATION

Priority Recommendation 12

Relevant to

| Policy–makers in
government

| Digital platform
providers

| Researchers

An innovation fund is needed to support the development and/or evaluation of tailored web services and social media channels for young men

Rationale

New online services built around social networks require further research investment to determine their effectiveness in changing behaviour. Promising examples include:

| Hello Sunday Morning's *(hellosundaymorning.org)* approach to reducing binge drinking through an online community dedicated to shifting cultural norms relating to alcohol consumption.

| 'The Fifth Army' *(fiftharmy.com.au)* which is a new awareness campaign by headspace that involves young people downloading a mobile app, completing tasks to improve their wellbeing and help support their friends. Young people receive points for each task they complete and go into the running to win prizes.

| Viral and global campaigns that integrate with local sporting clubs and other spaces where young men congregate. A recent example is the 'Silence is Deadly' campaign developed by Menslink in partnership with the Canberra Raiders *(silenceisdeadly.com.au)*.

| An international example that has been attributed to reducing young men's suicide rates by 55% in Merseyside (England) in the past 10 years, is the Campaign Against Living Miserably (CALM) website developed in the UK for men aged 15 to 35 years *(thecalmzone.net)*.

The evidence

Further and ongoing research is required.

Policy implications

| At least 20% of all program funding should be allocated to measuring engagement *(did people like it?)* and impact *(did it improve mental health?)*.

| An innovation fund dedicated purely to evaluation should be established using a matched and leveraged funding model. This approach would pair service providers with high quality researchers to determine the effectiveness of different approaches.

13

RESEARCH AND INNOVATION

Priority Recommendation 13

Relevant to

| **Research Councils including NHMRC and the Australian Research Council**

| **Policy–makers in government**

| **Other funding bodies including philanthropic foundations**

| **Researchers**

Funding, including that provided by our major research councils, private trusts and donors, should prioritise young men's mental health

Rationale

Limited research investment is made in growing an evidence base that helps to understand young men's mental health.

The evidence

Despite considerable investment in mental health over the last decade, we are yet to see a positive shift in the number of young men experiencing mental illness or those seeking help. In 1999, a study funded by the Department of Health and Aged Care and endorsed by the National Health and Medical Research Council (NHMRC) *'National Youth Suicide Prevention Strategy – setting the evidence–based research agenda for Australia (a literature review)'* recommended the following *"...an exploration of the attitudes and responses of young men to intervention services, including strategies of engagement and service provision."* (NHMRC 1999, p.iv). It is not clear if this was ever acted upon.

Policy implications

Funding bodies should allocate specific resources to research, which prioritises young men's mental health.

Service snapshot

CALM (UK)

CALM (Campaign Against Living Miserably) delivers a free, confidential, anonymous helpline and website targeted at young men. The CALM helpline is staffed 24/7, 365 days of the year from 5.00pm until midnight. The website is invariably designed to capture the interest of young men using modern, arthouse media, and communications and materials are developed by young men themselves (CALM 2013).

The CALM website *(thecalmzone.net)* invites people to be active and participate (all anonymously) by uploading short films, writing posts, poetry, blogs – including a 'masculine mantra'. They encourage young men to confront stereotypes, challenge norms and create a space for them to be outspoken about everything they are and everything they want to be. CALM focuses on inspiring young men to feel that they do not have to conform to stereotypes. The website is full of articles, stories, information and statistics on young men's mental health and closely follows the activities of CALM staff and their supporters as they reach out to new communities.

CALM also produces a bi–monthly magazine that is distributed around inner London and initiates work with local authorities to promote CALM within their area through local clubs, community and entertainment industries. The first 'Merseyside CALMzone' was launched in 2000, and since then suicide in that region has dropped year after year among young men and sits below the average for both the North West of England as well as Wales. The 'London CALMzone' was launched in November 2011 (CALM 2013).

The CALM philosophy is a best–practice example of a socially attractive and interactive website relating to youth mental health that young men are willing to use. It supports all aspects of best practice: it is practical; anonymous; provides confidential support from professionals; uses creative media; invites the individual to participate; encourages conversation and interaction; and is non–exclusive to age and/or gender.

Service snapshot

HELLO SUNDAY MORNING

Hello Sunday Morning is a movement towards a better drinking culture

Hello Sunday Morning (HSM) is an online community that encourages people to undertake a period of sobriety (referred to as a 'HSM') and reflect on the role that alcohol plays in their life. Thousands of people have registered for the HSM program (Hello Sunday Morning 2013).

Uniquely for a health promotion program, HSM's online platform guides participants to develop and share the stories that make up the program content. Peer–to–peer conversations in the online community spur participants to examine the impact of the HSM experience on their cultural values and sense of identity.

The HSM model demonstrates how social media platforms can engage individuals in the consumption, creation and dissemination of health promotion messages. Additionally, participation in social media spaces such as HSM can offer a record for the change in individuals' identities, values, and health–related practices (Hamley & Carah 2012).

One male HSMer reflects on the role of the online community in driving critical reflection on drinking practices: *"But the mere presence of an opposing view – in this case, not drinking – is enough to make people stop and think about their own choice."*

A 2012 evaluation of user–generated blog content on *hellosundaymorning.org* shows that participants demonstrate a shift and a deepening in their understanding of the role alcohol plays in their lives. The course of this shift tracks from personal change and reflection on drinking practices, to broader observations of drinking culture, and eventuates in the sharing of advice and strategies for behaviour change with others (Hamley & Carah 2012). HSM has also been shown to reduce hazardous alcohol consumption behaviours, and participants report improved wellbeing following completion of a HSM experience (Hamley & Carah 2012).

By empowering HSMers to reflect on and establish their attitudes toward drinking culture, be accountable for their own actions, and honour their own achievements and challenges in an online community setting, HSM provides a structure for young Australians to drive their own positive behaviour change to improve their wellbeing.
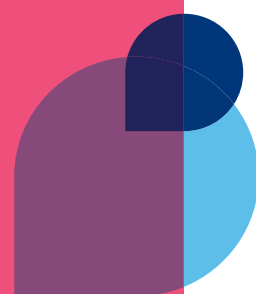
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Tables and figures

The authors

Associate Professor Jane Burns

Associate Professor Jane Burns is the founder and Chief Executive Officer of the Young and Well CRC. Its establishment is a culmination of Jane's work in suicide and depression prevention and builds on her national and international partnerships with the corporate, philanthropic and not–for–profit sectors. Jane holds a VicHealth Principal Research Fellowship at Orygen Youth Health Research Centre, Centre for Youth Mental Health at The University of Melbourne and an Honorary Fellowship at the Brain & Mind Research Institute, The University of Sydney. She was a Commonwealth Fund Harkness Fellow at the University of California, San Francisco. She joined *beyondblue* in its start up phase and established and managed the youth agenda. Jane completed her PhD in Medicine as a National Health and Medical Research Council Scholar at The University of Adelaide. Jane was a Victorian Finalist in the 2012 Telstra Business Women's Awards and was listed in the Financial Review and Westpac Group 100 Women of Influence in 2012.

Tracey Davenport

From 1997 to 2004, Tracey worked alongside Professor Ian Hickie as the Research Director of the Academic Department of Psychiatry and later the Brain & Mind Research Institute. In this role, Tracey was responsible for all research methodologies pertaining to associated mental health projects in the Australian community and more specifically primary care psychiatry. Tracey has also been involved in several large–scale public health and government initiatives aimed at improving patient knowledge and understanding of depression and doctor recognition and treatment. Further, in 2003, Tracey earned the honour of Research Fellow with the Centers for Disease Control and Prevention (USA) where she conducted an important project that utilised International epidemiological and clinical research data to test the validity of the diagnosis of chronic fatigue syndrome and related chronic fatigue states. During her research career, Tracey found one of her strengths to be statistics and its application to the health sector. As a result, Tracey set up a private consultative company Academic Research and Statistical Consulting (ARSC) with Dr Georgina Luscombe in 2005. ARSC has consequently allowed Tracey to continue her work with the Brain & Mind Research Institute as well as apply her statistical expertise to a number of different projects associated with several other government, non–government and private organisations.

Professor Helen Christensen

Professor Helen Christensen is the Director of the Black Dog Institute, The University of New South Wales, and an NHMRC Senior Principal Research Fellow. She is the immediate past President of the Australasian Society for Psychiatric Research (ASPR), and immediate past president of the International Society for Research on Internet Interventions (ISRII), currently Treasurer of ISRII, which leads efforts to incorporate an international society of researchers and to establish an international exchange program for young researchers in e–health. She has more than 350 research publications, and the author of e–health websites, some of which are used throughout the world to deliver automated cognitive therapy for depression.

Dr Georgina Luscombe

Dr Georgina Luscombe is a Lecturer in Medical Statistics at the School of Rural Health and Adjunct Lecturer in the Discipline of Obstetrics, Gynaecology and Neonatology at the University of Sydney. She is also Co–director of Academic Research and Statistical Consulting. Georgina has consulted on research design and statistical analysis for a wide range of medical disciplines within universities, hospitals and private clinics as well as for not–for–profit community organisations such as *beyondblue*, headspace and Family Planning (NSW and QLD).

Adjunct Professor John Mendoza

Adjunct Professor John Mendoza is a Director of ConNetica after a career that has seen him hold several executive positions including the inaugural Chair of the Australian Government's National Advisory Council on Mental Health, Chief Executive Officer of the Mental Health Council of Australia and Chief Executive Officer of a Commonwealth Statutory Authority, the Australian Sports Drug Agency. John's current professional appointments include Adjunct Professor, Faculty of Health and Sport Science, University of the Sunshine Coast; Adjunct Associate Professor, Faculty of Medicine, University of Sydney; Board member of the Young and Well CRC; Chairperson, headspace Sunshine Coast; and Foundation Member of the Queensland Mind and Neuroscience Institute, chaired by Angus Houston AC. John has authored and co–authored dozens of reports and submissions to public inquiries on mental health and suicide in the past decade including the landmark *Not for Service Report* in 2005. In 2002, John was awarded the Queensland University of Technology, Vice Chancellor's Alumni Award for Innovation and Excellence and the Faculty of Health's Outstanding Alumni recipient. In 2008 he was a selected participant for the Australia 2020 Summit and in 2010 he received a 'Life Achievement Award' for his contribution to suicide prevention in Australia.

Associate Professor Amanda Bresnan

From October 2008 to 2012 Associate Professor Amanda Bresnan was an elected Member of the ACT Legislative Assembly (MLA) for the ACT Greens. Amanda was the ACT Greens spokesperson for health, disability, housing, ageing, multicultural affairs, transport and corrections. During her term, Amanda was Chair of the Standing Committee on Education, Training and Youth Affairs, and Deputy Chair of the Standing Committee on Health, Community and Social Services. Amanda was also Chair of the 2012 ACT Budget Estimates Committee. Prior to being elected as an MLA, Amanda was the Acting Director of Policy and Projects for the Mental Health Council of Australia (MHCA), and prior to that the Policy Manager at the Consumers' Health Forum of Australia. Amanda is a Board Member of the Asthma Foundation ACT and member of the Global Sisters Advisory Group, an Australian microcredit project for women who are disadvantaged.

Dr Michelle Blanchard

Dr Michelle Blanchard is the Head of Projects and Partnerships at the Young and Well CRC and an Honorary Research Fellow at Orygen Youth Health Research Centre, Centre for Youth Mental Health, The University of Melbourne. Michelle holds a PhD in Youth Mental Health from The University of Melbourne, as well as a Bachelor of Arts (Hons) degree and a Graduate Diploma in Adolescent Health and Welfare. In 2010, as part of the Inspire Foundation team, Michelle project managed the bid to establish the Young and Well CRC. Prior to that she was a Senior Research Officer at Inspire working on a range of research projects exploring the role of technology in improving wellbeing for young people, with a particular focus on young people vulnerable to the development of mental health difficulties. Prior to joining Inspire, Michelle worked in state and local government on projects promoting social, civic and cultural participation for young people. She was also a co–director of a peer–led youth leadership program for three years.

Professor Ian Hickie

In 2003, Professor Ian Hickie was appointed as the inaugural executive director of the flagship Brain & Mind Research Institute at The University of Sydney. Since then he has overseen its development as a major hub in translational neuroscience and clinical psychiatry. Prior to this, in October 2000 he was appointed as the inaugural Chief Executive Officer of *beyondblue* and from 2003 to 2006 served as its Clinical Advisor. In 2006, Professor Hickie received the Australian Honours Award of Member (AM) in the General Division; for services to medicine in the development of key national mental health initiatives and general practice services in both the public and non–government sectors. From 2006 he was a founding member of headspace. In 2007, Professor Hickie was elected as a Fellow of the Academy of the Social Sciences in Australia. From 2007 to 2012, Professor Hickie was one of the first round of NHMRC Australian Research Fellows, recognising excellence in Australian medical research. From 2008 to 2010, he was appointed to the Federal Health Minister's National Advisory Council on Mental Health and then in 2010 to 2011, the Federal Minister's Mental Health Expert Advisory Group. From 2012, Professor Hickie was appointed as a Commissioner in the new National Mental Health Commission, to oversee enhanced accountability for mental health reform in Australia. He was also appointed as Chair of the Scientific Leadership Council for the Young and Well CRC.
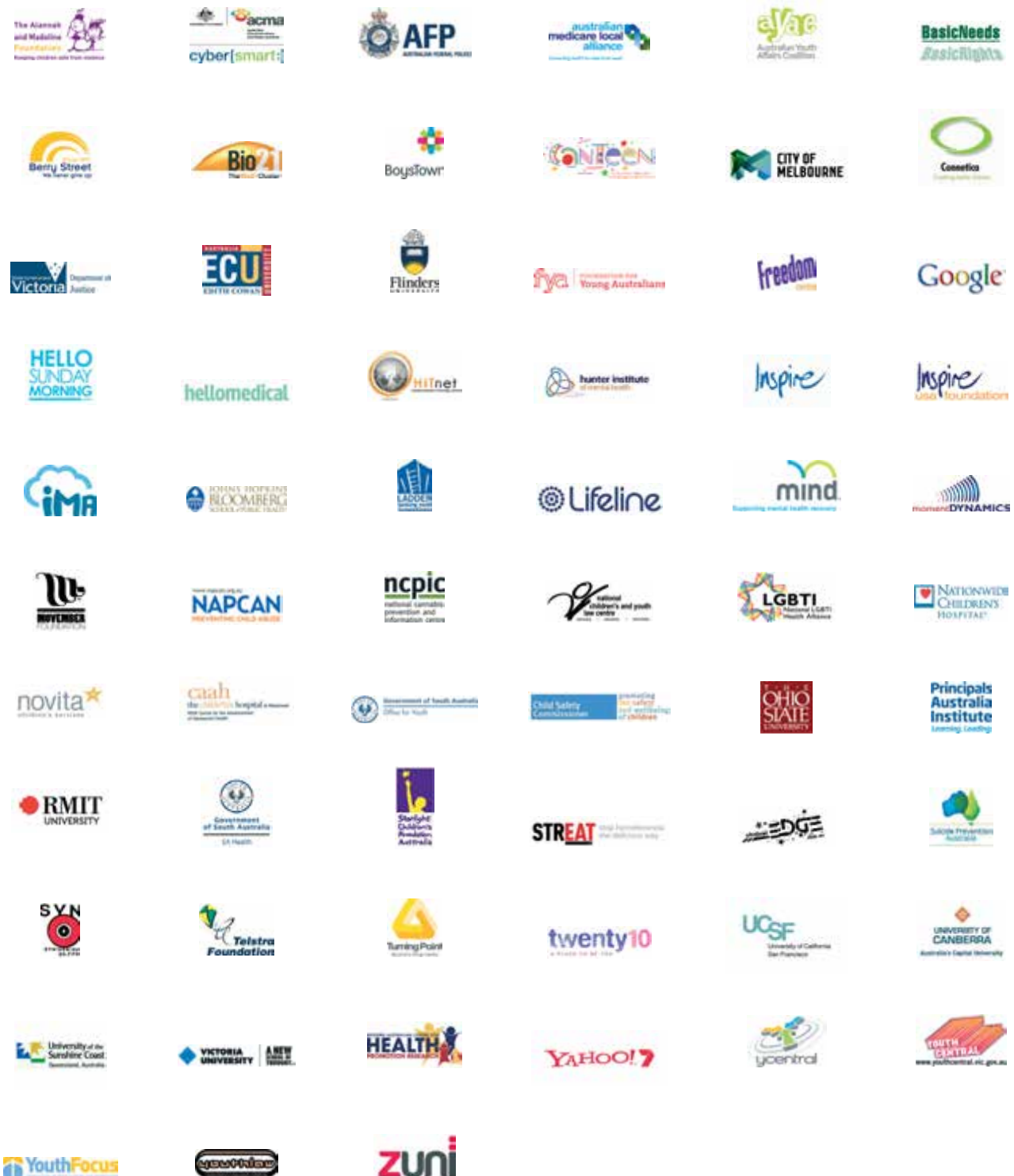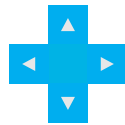
Our Partners

Lead Partner

Essential Participants

The Young and Well CRC is a multidisciplinary collaboration of 14 Essential and 63 Supporting Participants, each of which contributes specific expertise and infrastructure to our research projects.

Supporting Participants

"Young men face the greatest risk of onset of mental ill health across their lifespan yet receive a very raw deal from society. Most young men, their family and friends fail to recognise the need for care and if and when they do, access is extremely poor and the expertise and quality on offer falls well short of what is needed. The consequences are enormous. Premature death, drug and alcohol problems, offending behaviour and unfulfilled potential weaken our society and cost billions each year. It is time that young men were better understood and properly supported to contribute and flourish."

Professor Patrick McGorry AO
Executive Director, Orygen Youth Health
Professor, Centre for Youth Mental Health,
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Cooperative Research Centre