

National Male Health Policy Supporting Document

HEALTHY LIMITS

The National Male Health Policy has a focus on raising awareness about preventable health problems that affect males and targeting males with the poorest health outcomes. This document discusses some of the risky behaviour that males engage in and the impacts they have on male health. It does this by considering the evidence around male risky behaviour and risk-taking behaviour differences between groups of males.*

What's in this document?

This document first looks at various **issues** to do with healthy limits for males:

- Risk-taking behaviour
- Optimal health outcomes for males, and
- Equity between groups of males.

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

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

Risk-taking behaviour

There is no doubt that risk-taking is an important part of our culture which drives entrepreneurship, innovation and progress, and which is rewarded in many fields. However, there is also no doubt that some groups of Australian males, particularly young males, are engaging in levels of risk-taking which are harmful.

Concerns were raised during the Policy consultations about the risk-taking behaviour of young males, and participants and submissions highlighted the need to

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

take a broader, social-determinants approach to that behaviour. The discussion here focuses on harmful risk-taking in relation to motor vehicle accidents, unsafe sexual practices, and alcohol and other drugs.

Risky road use

Males are more likely than females to take risks on the road across all age groups, with peaks in the 20–24 age group.¹ Males in this age group are three times as likely to appear in court for exceeding legal speed limits and are more than seven times as likely to be convicted for dangerous or negligent driving than women in the same age group.²

They are also more than four times as likely than women in that age group to be convicted for driving a vehicle under the influence of alcohol and/or drugs, where driving was impaired, and similar age and sex patterns exist for convictions for exceeding the legal alcohol limit.³

Land transport accidents were the third highest cause of loss of potential years of life in males, and motor vehicle accidents were the second leading cause of death for males aged 15–24 years in 2007.^{4,5}

During 2004–2006, around a third of deaths of people aged 15–24 were due to transport accidents compared to 1 per cent of deaths of people aged 25 and over.⁶ For males aged 15–19 the rate was more than double the rate for females in that age group, and for males aged 20–24 it was more than triple the female rate in that group.

Males account for 73 per cent of injury due to road traffic accidents, and levels of injury for males are higher

than females across all ages, peaking in the 15–24 age group.^{7, 8} In 2005–06, males aged 15–24 years had a transport accident hospitalisation rate that was more than double that of young women.

Over the period 2002–2006, after adjusting for differences in the age structure of the two populations, Indigenous Australians died from transport accidents at three times the rate of non-Indigenous Australians. One of the leading causes of death for Indigenous Australians through injury is transport accidents (20%).⁹

In 2001–2005, 27 per cent of Aboriginal and Torres Strait Islander male deaths in Queensland, Western Australia, South Australia and the Northern Territory were due to transport accident injuries.

In Aboriginal and Torres Strait Islander communities, fatal injury rates are high through to middle adulthood in comparison to non-Indigenous communities, where male road trauma rates are high until 24 years and then decline.¹⁰

Serious injury and death as a result of motor vehicle accidents also increases significantly as the level of remoteness (outside major cities) increases, for both Aboriginal and Torres Strait Islander people and non-Indigenous people.¹¹

Aboriginal and Torres Strait Islander males are disproportionately represented among drink driving offenders, with the proportion of Aboriginal and Torres Strait Islander offenders increasing with the number and severity of offences.¹²

As a driver's blood alcohol level increases, so too does the probability of being involved in a motor vehicle accident, and the severity of the accident also increases as blood alcohol levels increase.¹³

Driving under the influence of illicit drugs such as cannabis has also been shown to compromise reaction time, attention, decision-making, time and distance perception, short-term memory, hand/eye coordination, and concentration.¹⁴ Approximately 32 per cent of all drivers and motorcyclists killed in 2008 were found to have drugs present in their system.¹⁵ As outlined below, in some Aboriginal and Torres Strait Islander communities, around 70 per cent of males are heavy, long-term cannabis users.

Risky sexual behaviour

In 2008, more than a quarter of Year 10 students (27 per cent of male students) and more than half of Year 12 students (44 per cent of male students) had experienced sexual intercourse. The proportion of students who had experienced sexual intercourse increased from 35 per cent in 2002 to 40 per cent in 2008, and the proportion of sexually active students reporting three or more sexual partners also increased in that period from 20 per cent to 30 per cent (36 per cent of male students in Year 10 and 38 per cent of students in Year 12).¹⁶

With the exception of gonorrhoea, rates of diagnosis of sexually transmissible infections (STIs) are rising in males:¹⁷

- Chlamydia is the most frequently reported STI in Australia, and rates of chlamydia in males doubled to 222 diagnoses per 100,000 population between 2003 and 2008, and
- Infectious syphilis diagnoses in males rose from approximately 5 per 100,000 population in 2004 to approximately 11 per 100,000 in 2008; this compares to the relatively stable rates of diagnoses in females, which remained below 2 per 100,000 from 2004 to 2008.

New HIV diagnoses in Australia have plateaued over the past three years at around 1000 cases per year, with males making up the majority of diagnoses.¹⁸ Transmission of HIV in Australia continues to occur primarily through sexual contact between men.¹⁹ In 2004–2008, men who have sex with men accounted for 68 per cent of cases of newly diagnosed HIV infection.

Aboriginal and Torres Strait Islander people

In 2008, Aboriginal and Torres Strait Islander people were diagnosed at higher rates than non-Indigenous populations for:

- *Chlamydia* – Over four times the rate of diagnosis of non-Indigenous people. Rates of chlamydia were slightly lower in Aboriginal and Torres Strait Islander males compared to females
- *Gonorrhoea* – 37 times the rate of non-Indigenous diagnosis. Rates are similar in Aboriginal and Torres Strait Islander males compared to females, in contrast to non-Indigenous people, where gonorrhoea occurs predominately in males
- *Infectious syphilis* – Five times the rate of non-Indigenous diagnosis; male and female rates are similar, in contrast to non-Indigenous people, where syphilis occurs predominately among men who have sex with men, and
- *Hepatitis C* – More than double the rate of non-Indigenous diagnosis.

HIV per capita rates are similar in Aboriginal and Torres Strait Islander people and non-Indigenous people; however, Aboriginal and Torres Strait Islander cases were attributed to injecting drug use (22 per cent of cases) at higher rates than the non-Indigenous people (3 per cent of cases).²⁰

People born overseas²¹

HIV diagnosis is more than eight times higher per capita among people born in countries in sub-Saharan Africa than among Australian-born people. People from a high-HIV-prevalence country, or whose sexual partner is from a high-prevalence country, accounted for 59 per cent of

cases of HIV infection from heterosexual contact in the past five years.

Men who have sex with men²²

Males who are gay and men who have sex with men are at a significantly higher risk of acquiring or living with HIV than other Australian men. Between 2004 and 2008, 86 per cent of newly acquired HIV and 68 per cent of newly diagnosed HIV cases were attributed to men who have sex with men. Men who have sex with men also have significantly higher rates of syphilis than other men, and made up approximately 72 per cent of men diagnosed with infectious syphilis in 2008.

Condom use

STIs are largely preventable through safe sexual practices. Condom use during sexual activities is an effective and important strategy for minimising transferral of STIs and HIV.²³ However, only 45 per cent of men always use condoms with casual partners for heterosexual intercourse.

Males in remote areas have been found to be less likely to use condoms in casual sexual relationships compared to males in major cities.²⁴

In 2008, more than a third of male secondary students (and more than half of female students) reported that they did not always use condoms in the previous 12 months, and students who had three or more sexual partners were significantly less likely than those with less sexual partners to report always using a condom (60 per cent of sexually active male students).²⁵

Risky drug use

According to Australian Social Trends 2008, drug-related health problems are wide ranging and include 'psychological and behavioural effects such as delusions, hallucinations, and aggressive or erratic behaviour, high blood pressure, respiratory problems and kidney, liver and brain damage'.²⁶

The 2007 National Drug Strategy Household Survey found that around twice as many people aged 14–24 (23 per cent) reported using illicit drugs during the past 12 months as people aged 25 years and over (11 per cent).²⁷ The most common drugs used in the past 12 months by people in the 14–24 age group were cannabis (18 per cent), ecstasy (9 per cent), methamphetamines and pharmaceuticals (both 4 per cent).

The survey found that 41 per cent of males, compared to 35 per cent of females, had used an illicit drug in their lifetime, and 16 per cent of males, compared to 11 per cent of females, had used an illicit drug in the previous 12 months. Males were more likely than females to have used marijuana, ecstasy and hallucinogens.

The survey also found that Aboriginal and Torres Strait Islander people were almost twice as likely to be recent

illicit drugs users as other Australians (24 per cent compared with 13 per cent), although this increase appears to be primarily about cannabis.

Other research has found that heavy cannabis use is common in some remote Aboriginal communities, and that in some areas of alcohol restriction over 70 per cent of males and 20 per cent of females are current users.²⁸ Regular heavy use was found in almost 90 per cent of users, around twice the consumption of regular cannabis users elsewhere in Australia. Around 90 per cent also reported symptoms of cannabis dependence and, after five years of follow-up, the majority of Aboriginal and Torres Strait Islander users reported continuing heavy use.

Cannabis use was linked to substantial health problems and social burdens in these communities, which are already disadvantaged by isolation and poverty.²⁹ Up to 10 per cent of the communities' total income and between 31 per cent and 62 per cent of a user's median weekly income was spent on cannabis. Cannabis users were less likely than non-users to participate in education or training and more likely to report auditory hallucinations, suicidal ideation, symptoms of depression, and having been imprisoned.

The survey also found that higher proportions of recent drug use were reported for people who were unemployed (23 per cent compared to 15 per cent of employed people), people from remote and very remote regions (21 per cent compared to 12 per cent of people in inner regional areas and 14 per cent in major cities), and people whose main language at home was English (14 per cent) compared to people whose main language at home was not English (6 per cent).

However, drug use in prison populations is relatively high compared to the wider Australian population, and 93 per cent of Australian prisoners in 2007 were male.³⁰ The *National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey Report 2004 & 2007* recorded that 55 per cent of prison entrants in 2007 had ever injected drugs and 60 per cent of these had injected in the past month.

Young males generally have lower rates of drug-related hospitalisation than young females, who have higher rates of intentional self-harm by drugs or medications. In 2005–06, the highest rate of hospitalisation relating to drug use for males occurred in the 20–24 age group (428 per 100,000 compared to 460 per 100,000 for young women).

As well as the physical and psychological impacts of drugs, the sharing of needles and syringes leads to transition of blood-borne viruses such as HIV/AIDS and hepatitis C.³¹ Eighty per cent of hepatitis C infections in Australia are due to sharing needles and syringes for injected drugs.³² Rates of hepatitis C infection decreased slightly between 2004 and 2008, with the most significant decreases in the 15–19 age group. Males are diagnosed with hepatitis C at a higher rate than women,

with 7129 diagnoses in males in 2008 compared to 4135 diagnoses in women.³³

Overall prevalence of hepatitis C in prison populations was also higher than the wider population, with 35 per cent of entrants in 2007 recording infection.³⁴ Ninety-three per cent of Australian prisoners in 2007 were male.³⁵

Risky alcohol use

The connection between alcohol and chronic disease and violence has been outlined in the *Healthy Routines* supporting document. The focus here is on risky alcohol use by young males.

In the 2007 National Drug Strategy Household Survey, 19 per cent of 18–24 year old males reported that they had engaged in risky or high-risk drinking at least once a week during the past 12 months, which was more than twice the rate of men aged 25 years and older (8 per cent).³⁶

The *State of Australia's Young People: A Report on the Social, Economic, Health and Family Lives of Young People* (2009) states that, according to the National Health and Medical Research Council (NHMRC) guidelines on alcohol consumption, 52 per cent of 18–24 year old males and 37 per cent of females in the same age group are drinking alcohol at levels that put them at increased risk of an alcohol-related harm. The report also cites research which found that more than a quarter of 18–24 year old males reported that their alcohol use had jeopardised their safety (nearly double that of women of the same age).³⁷

In 2005–06, males and females aged 15–19 had the highest hospitalisation rates for acute intoxication from alcohol among all age groups, and those aged 20–24 had the next highest rates.³⁸

In 2007, Aboriginal and Torres Strait Islander males aged 18–24 were more likely to consume alcohol at risky or high-risk levels than non-Indigenous males in the same age group (around 1 in 5 compared to 1 in 7).³⁹ Aboriginal and Torres Strait Islander males are disproportionately represented among drink driving offenders, with the proportion of Indigenous offenders increasing with the number and severity of offences.⁴⁰

Less alcohol is generally reported to be consumed by young people born outside of Australia, and those who do not speak English at home, than young people born in Australia.⁴¹

The 2007 National Drug Strategy Household Survey found that people in Australia who had higher levels of risky or high-risk alcohol consumption included unemployed people, those whose main language at home was English, and those living in remote or very remote areas. Aboriginal and Torres Strait Islander peoples are more likely than other Australians to abstain from alcohol but those who did drink were more likely

to drink at risky or high-risk levels, for short-term harm (9 per cent).⁴²

Optimal health outcomes for males

Harmful risk-taking behaviours are the result of a complex interaction of factors such as individual characteristics, biology, gender, age, mental health, and a range of social determinants.⁴³

According to Australian Social Trends (2008).⁴⁴

Youth is a period characterised by rapid psychological and physical transition, where young people progress from being dependent children to independent adults. This transition period has been made more complex by the social, economic and technological changes that have occurred in Australia over recent decades.

During this time young people 'may be inclined to experiment, push boundaries and take risks', and young men are known to have higher rates of risk-taking behaviour than women of the same age.⁴⁵

The Royal Australian College of Surgeons submission to the Senate Select Committee on Men's Health 2009 states that:⁴⁶

Evidence is emerging which indicates that the brain undergoes a maturation process where a person's risk management and decision making processes are not fully matured in males until aged 25 (23 years in females) and could affect a person's ability to drive, operate machinery etc.

Factors such as testosterone levels, feelings of invulnerability and addiction to an adrenalin 'rush' have been identified as contributing to risk-taking.^{47, 48} Other factors which may particularly impact on young males include the socialisation of boys to be risk takers, peer group pressure in relation to traditional notions of masculinity, alcohol and drug abuse, and the transition from school to employment and 'manhood'. Lower levels of help-seeking, which also contribute to risk-taking behaviour, will be discussed below.

Socialisation

The Men's Health Resource Centre submission to the Senate Select Committee on Men's Health discusses the cultural influences which 'socialise' males to be risk-takers.⁴⁹ For example, the submission notes the public praise and medals given to soldiers who have engaged in highly dangerous and risky behaviour of a 'heroic' nature. Further, it discusses the gendered nature of dangerous and risky occupations, such as construction work, fire fighting and the military, which are dominated by males.

Peer group pressure

Peer group pressure is a powerful influence at any time but particularly during youth. For example, the 2007 National Drug Strategy Household Survey revealed that

peer pressure was a factor influencing the use of an illicit drug for 43 per cent of both males and females.⁵⁰

Evidence suggests that for young males this pressure can relate to 'feats' of masculinity in relation to speeding while driving, sexual activity, and alcohol and drug abuse.⁵¹ A study quotes a number of the participants, including one who stated:

to take risks from a male point of view it's seen as macho and you're seen as great ... you get attention and you get praise ... women ... can get acknowledgement from friendships ... with men it's more from their actions and their deeds.

Alcohol in our culture is closely associated with masculinity, including in relation to high-profile male sports. Research has found that binge drinking and excessive alcohol consumption are 'often used as a very public display of allegiance to male peer groups'.⁵²

Alcohol and illicit drug use

As has been outlined, males have higher levels of risky alcohol and illicit drug use than young females, and this behaviour also increases the likelihood of other risky behaviours. It has been said that young men's sense of invincibility and indifference to risk is 'heightened in the presence of alcohol'.⁵³

Alcohol has been shown to weaken self-control, and reduce reasoning and judgment abilities.⁵⁴ It is one of the most important risk factors in injury as it reduces the perception of, and ability to respond to, hazards. Individuals who have been drinking are more likely to engage in risky behaviours that can lead to hazardous circumstances.⁵⁵

Young people are more likely to drive under the influence of alcohol and illicit drugs, and alcohol consumption in drivers has a dramatic effect on motor vehicle accidents.⁵⁶ As blood alcohol levels of the driver increase, so too does the probability of being involved in a motor vehicle accident, and the severity of the accident also increases as blood alcohol levels increase.⁵⁷

Some younger participants in the Policy consultations suggested that in order to get the message through to young males the consequences of dangerous driving need to be graphically portrayed in prevention initiatives, using real people who have been in accidents. Initiatives such as these are currently in place in some schools.

Condom use also decreases in males who consume alcohol in excess of the NHMRC guidelines.⁵⁸ There is research showing that 56 per cent of males agreed that alcohol had contributed to not using a condom during sex.⁵⁹

Transition from school to employment and 'manhood'

The key transition period from school to employment can involve significant change, uncertainty, and the assumption of far greater responsibility, which can impact on the mental health of young males. Not

obtaining employment can have particularly negative consequences for males, whose sense of identity may be closely associated with work, and who may have expectations of becoming a family provider. These sorts of pressures can lead to higher alcohol and drug abuse and other risk-taking behaviours as a means of coping and perhaps as a means of achieving some sort of peer group 'success'.

The importance of this period in terms of transitioning to 'manhood' was raised in a submission to the Policy.⁶⁰

We wonder why our young men run off the rails, but what sort of message do we send when the major rites of passage into adulthood are getting a licence to drive and the right to drink?

It has been suggested that 'initiation to manhood' programs, which have been run in some private schools and shown to improve boys' educational and behavioural outcomes, should be trialled more broadly.⁶¹

Ceremonial initiation to 'manhood' has particular relevance to some Aboriginal and Torres Strait Islander males. Restoring the roles and responsibilities of Aboriginal and Torres Strait Islander males is a key factor in improving health outcomes.

Awareness of risk

Risk-taking by young males may also be affected by a lack of knowledge and awareness (health literacy) of the level of risk and the consequences of risk-taking. For example:

- In one study, it was found that the majority of the participants significantly misjudged their level of alcohol consumption. Over 70 per cent of both binge and excessive drinkers reported their consumption as moderate, and 20 per cent of binge drinkers and 10 per cent of excessive drinkers considered themselves to be light drinkers
- The *State of Australia's Young People* (2009) cites research which found a low level of awareness among the young participants of the long-term health consequences of binge drinking and the belief that drug use would put them at more risk than alcohol, when both are harmful, and
- The *Secondary Students and Sexual Health 2008, Results of the 4th National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health* found that, while knowledge about HIV transmission was generally high, awareness of the most common STIs, such as chlamydia, was low. For example, only 47 per cent of students were aware that chlamydia affects both males and females.

Help-seeking

Higher levels of alcohol and drug abuse, substance use disorders, and other risky behaviours in young males may reflect their lower levels of help seeking for mental health problems.

As outlined in the *Healthy Minds* supporting document, Australian males are less likely to seek help for mental health problems than females, and this is magnified in younger males, who have high rates of mental health problems but the lowest use of mental health services. Risky behaviour such as alcohol and drug abuse may be a coping mechanism which then leads to further mental health problems and risk-taking behaviours.

As with mental health and reproductive issues, young males (particularly those from rural and remote communities) can be deterred from seeking help in relation to sexual health matters, such as sexually transmitted infections.⁶² As outlined in the *Access to Health Services* supporting document, factors include embarrassment around discussing 'private' issues with a health practitioner, and concerns about privacy and confidentiality. Males may also not wish to disclose same sex attraction to a medical practitioner for fear of discrimination, judgement and a lack of confidentiality. These issues are particularly relevant in smaller rural and remote communities, where GPs may be known on a social level.⁶³

Andrology Australia's *GP Summary Guide* suggests that doctors can help normalise these issues by routinely taking sexual and mental health histories within medical histories, and asking about sexual and mental health when risk factors are present.⁶⁴

Equity between groups of males

There are many factors associated with risky behaviours, including the adverse circumstances experienced by, for example, unemployed young males, Aboriginal and Torres Strait Islander males, young males living in rural and remote communities, and males from disadvantaged backgrounds.

Research indicates that males in rural and remote communities and from disadvantaged backgrounds may identify more strongly with notions of traditional masculinity, which may lead to higher levels of risk-taking and lower levels of use of services which are available.⁶⁵ Adherence to a more traditional male role in the family may be associated with the lower levels of control and power over other aspects of their lives that may be experienced by males from these backgrounds.

In addition, these groups of males also contend with issues such as discrimination, isolation, a lack of sense of purpose and inclusion in society, and barriers in accessing services. The College of Surgeons submission to the Senate Select Committee on Men's Health provides insight into the road toll for Aboriginal and Torres Strait Islander males:

The combination of alcohol, unlicensed incompetent driving, overcrowded cars, distance, poor roads and the absence of trauma systems and assets is disastrous for male health in rural and remote Indigenous communities.

Further insight is provided by the 2007 Mental Health and Wellbeing Survey, which revealed that Aboriginal and Torres Strait Islander people were twice as likely to report high or very high levels of psychological distress as the general population.⁶⁶

As outlined in the *Healthy Routines* supporting document, the World Health Organization (WHO) report *Closing the Gap in a Generation* emphasises the importance to good health of a sense of inclusion in society and control and power over life. A feeling of hope is also important. A lack of these factors can contribute to behaviour which takes no account of its possible or probable negative consequences.

Government action – policies and initiatives

National Strategy for Young Australians

In April 2010 the Government released the National Strategy for Young Australians to help young Australians take on new responsibilities and fully participate in all aspects of Australian life.

The National Strategy for Young Australians highlights eight priority areas for Government action to help young Australians:

- improve their health and wellbeing
- shape their own futures through education
- support them within their families
- empower them to take part and be active in their communities
- equip them with the skills and personal networks they need to get work
- enable them to participate online confidently and safely
- help them get their lives back on track through early intervention, and
- establish clear-cut legal consequences for behaviours that endanger the safety of others.

The National Strategy is an important part of realising the Government's vision for all young people to grow up safe, healthy, happy and resilient and to have the opportunities and skills they need to learn, work, engage in community life and influence decisions that affect them.

Investing in improving outcomes for all young people will not only help the individuals concerned but also deliver social, workforce and community benefits to the whole nation. The National Strategy will guide and direct government investment in young people to ensure it best addresses their needs.

HIV, STIs and blood-borne viruses initiatives

National STIs Prevention Program – In the 2007/08 Federal Budget, \$9.8 million was allocated for the National Sexually Transmissible Infections (STIs) Prevention Program, including an integrated national social marketing campaign to run over four years ending in 2011. The program aims to address increases in STIs by raising awareness of STIs (including HIV) and encourage behavioural change in target populations. The program is designed to inform Australians aged 15–29 about the transmission, symptoms, treatment and prevention of STIs. This audience includes men who have sex with men, heterosexual young people, and Aboriginal and Torres Strait Islander people. The program aims to contribute to a reduction in prevalence of STIs among the target audience. Its secondary audience is health care workers, including GPs, sexual health workers and staff of Aboriginal Medical Services. The program was launched in May 2009.

National Strategies review – A review of the 2005–2008 National Strategies for HIV/AIDS, Hepatitis C, STIs and Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Viruses commenced in 2008. Also, revised national strategies for 2009–2013 have been developed under the direction of the Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections. The new strategies will provide high-level guidance for the prevention, management and community impacts of STIs, HIV and hepatitis B and C. While the strategies will not be restricted to any population group, they will focus on populations that are highly impacted and burdened by one or more of these conditions, including men who have sex with men, people engaged in sex work, people from culturally and linguistically diverse backgrounds, people in custodial settings, people who inject drugs, and young people.

Key HIV/AIDS organisations – The two key Government-funded bodies working in HIV/AIDS education and prevention are the Australian Federation of AIDS Organisations and the National Association of People Living with HIV/AIDS. These organisations target gay men, men who have sex with men, and people living with HIV/AIDS in their programs.

Alcohol and illicit drug use initiatives

National Binge Drinking Strategy – The Australian Government is concerned that some young people are placing themselves at significant risk of misusing alcohol. It has therefore made a commitment to changing Australia's unhealthy drinking culture and to addressing the problems associated with binge drinking, especially among young people. In March 2008, the Prime Minister announced a National Binge Drinking Strategy which provides \$53.5 million over four years to address the problem of binge drinking. This includes:

- \$14.4 million for community-level initiatives to confront the culture of binge drinking, particularly in sporting organisations
- \$19.1 million to intervene earlier to assist young people and ensure that they assume personal responsibility for their binge drinking, and
- \$20 million for advertising that confronts young people with the costs and consequences of binge drinking.

An important component of the strategy is the increase in excise for ready-to-drink alcohol products (RTDs). RTDs are popular among underage drinkers and young people who drink at risky levels. Researchers have noted that some additives in RTDs can mask the presence of alcohol and this can make it difficult for underage drinkers to distinguish them from non-alcoholic drinks. Not being aware of the alcohol being consumed can significantly increase the risk of harm for young people. The increase in excise has resulted in a reduction in the consumption of these products and, although there has been some substitution to other alcohol products, overall there has been a reduction in alcohol consumption.

A further \$50 million is to be invested in the strategy following the passage of the 'alcopops' legislation.

The National Drug Strategy: Australia's Integrated Framework 2004–2009 – Australia's National Drug Strategy is a cooperative venture between Australian, state and territory governments and the non-government sector to reduce the harm caused by drug use in the Australian community. It guides government and non-government organisations in the development of strategies for a vast range of service delivery, policy development and research activity.

The current phase of Australia's drug strategy, *Australia's Integrated Framework 2004–2009*, aims to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in the Australian society. The strategy encompasses both legal and illegal drugs.

Another aspect of the National Drug Strategy is harm minimisation, which has been the cornerstone of the Australian approach from the outset. In the Australian context, harm minimisation encompasses:

- *Supply reduction* strategies to disrupt the production and supply of illicit drugs, and the control and regulation of legally available drugs
- *Demand reduction* strategies to prevent the uptake of harmful drug use, including abstinence-orientated strategies and treatment to reduce drug use, and
- *Harm reduction* strategies to reduce drug-related harm to individuals and communities.

Further elements of the National Drug Strategy include:

- Non-government treatment services (over \$167 million over four years)

- Capacity-building for services to support people with co-morbidity issues (approximately \$80 million over four years)
- National drug and alcohol research, in addition to research sponsored through the NHMRC (almost \$37 million over four years)
- A mass media campaign to educate young people about the dangers of methamphetamines, ecstasy and cannabis (\$17.9 million over four years), and
- Cannabis prevention and education programs (over \$18 million over four years).

Closing the Gap

The Australian Government is implementing a number of initiatives to address alcohol and other drug issues specifically for Aboriginal and Torres Strait Islander people. These include:

- \$98.6 million under the 2006 and 2007 COAG measures aimed at increasing drug and alcohol treatment and rehabilitation services in regional and remote Indigenous communities (each measure is \$49.3 million over four years, commencing in 2006/07 and 2008/09 respectively)
- \$30.2 million in 2009/10 for the Aboriginal and Torres Strait Islander Substance Use Program to support a range of Indigenous substance use services across Australia, including four men-specific residential treatment and rehabilitation services, and
- \$2.6 million in 2009/10 for drug and alcohol treatment and rehabilitation services in the Northern Territory as part of the Northern Territory Emergency Response.

Mental health initiatives

For Australian Government initiatives in male mental health see the *Healthy Minds* supporting document.

Community action – working together

Headspace

Headspace, the National Youth Mental Health Foundation, provides mental health and wellbeing support, information and services to young people (12 to 25 years) and their families across Australia. Headspace:

- Raises awareness about the need to seek help early if mental health and drug and alcohol issues emerge, and provides clear information about how and where to get help
- Has a youth-friendly website (www.headspace.org.au) which provides information about youth mental health and wellbeing issues and services in Australia
- Has 30 youth-friendly shopfronts, with a range of health professionals who provide mental health, education, employment, drug/alcohol and other services, and

- Provides up-to-date evidence-based treatments and early interventions for mental health and substance use disorders in young people (12–25) through its Centre of Excellence.

In April 2010, the Australian Government announced that it would invest \$78.3 million to double the number of headspace services from 30 to 60. This will provide early intervention and mental health support for an additional 20,000 young people each year.

Headspace is funded by the Australian Government under the Promoting Better Mental Health – Youth Mental Health Initiative.

Youthbeyondblue

Youthbeyondblue aims to promote awareness and reassure young people that it is okay to talk about depression and anxiety. It does this by encouraging youth, their families and friends to get help when needed.

The *youthbeyondblue* call to action is ‘look, listen, talk and seek help together’:

- *Look* for the signs of depression and anxiety
- *Listen* to your friends’ experience
- *Talk* about what’s going on, and
- *Seek help together*.

Youthbeyondblue includes a youth-specific website (www.youthbeyondblue.com), tailored resources, a targeted community awareness campaign, and a suite of youth-focused community-based events and programs. These include National Youth Week, the Rock Eisteddfod Challenge, the Good Sports Good Mental Health program, and a number of Indigenous festivals and events in rural and remote areas across Australia.

Personal action – what males themselves can do

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

- Talk to family, friends, a doctor or mental health professional if you feel stressed or have mental health problems. It is a sign of strength to take action to fix a problem.
- See the *Healthy Minds* supporting document for resources on mental health.

Alcohol and drug use

- Get information about safe alcohol use and its short- and long-term impacts – <http://au.reachout.org>
- Get information about drugs and drug use – www.drugs.health.gov.au

- Download a copy of *What You Need to Know: A Guide to Hepatitis C* (Hepatitis C Council of NSW) – www.hepc.org.au/documents/WYNTKweb-2MB.pdf
- Never share needles, syringes or other drug equipment.

Safe sex

- Get information about STIs (sexually transmitted infections) – www.sti.health.gov.au or www.shfpa.org.au
- Always wear a condom for any sexual contact with casual partners
- See your doctor, family planning clinic or sexual health clinic about STI testing if you have had unsafe sex or have symptoms such as pain, discharge or itching in your genital area
- Find your closest (sometimes free) sexual health clinic at:
 - ACT – www.health.act.gov.au/sexualhealth
 - NSW – www.health.nsw.gov.au/PublicHealth/sexualhealth/sexual_phus.asp
 - NT – <http://safesexnoregrets.nt.au/freetesting.html>
 - QLD – www.health.qld.gov.au/sexhealth/help/default.asp
 - SA – www.health.sa.gov.au/pehs/sexual-health.htm
 - TAS – www.dhhs.tas.gov.au/sexualhealth/sexual_health_service_tasmania
 - VIC – www.health.vic.gov.au/ideas/diseases/gr_sti/sti_furtherinfo
 - WA – www.public.health.wa.gov.au/2/421/2/where_can_i_go_for_help.pm

Safe driving

- Get youth-friendly driving information – www.ryda.org.au

Endnotes

1. Australian Bureau of Statistics (2008) *Australian Social Trends*, 4102.0
2. *ibid*
3. *ibid*
4. Royal Australasian College of Surgeons submission to the Senate Select Committee on Men's Health: www.aph.gov.au/Senate/committee/menshealth_ctte/submissions/submissions.htm, last accessed 15 February 2010.
5. Australian Bureau of Statistics (2008) *Causes of Death Australia, 2007*, 3303.0
6. Australian Bureau of Statistics (2008) *Australian Social Trends, 2007*, 4102.0
7. Begg S, Vos T, Barker B, Stevenson C, Stanley L & Lopez A (2007) *The Burden of Disease and Injury in Australia, 2003*, PHE 82, Australian Institute of Health and Welfare, Canberra
8. Australian Institute of Health and Welfare (2008) Serious injury due to Land transport accidents, Australia, 2005–06, Canberra, cat no INJCAT 113
9. Australian Health Ministers' Advisory Council 2008, *Aboriginal and Torres Strait Islander Performance Framework Report 2008*, AHMAC, Canberra
10. Royal Australasian College of Surgeons submission to The Senate Select Committee on Men's Health
11. *ibid*
12. Office for Road Safety (2006) 'Indigenous Unlicensed/Drink Driving Project: Project Brief', www.healthinfonet.ecu.edu.au/uploads/programs/263_iuddp_proj_brief.pdf
13. Australian Institute of Health and Welfare (2008) *Serious Injury Due to Land Transport Accidents, Australia, 2005–06*, , cat no INJCAT 113, Australian Institute of Health and Welfare, Canberra
14. National Cannabis Prevention and Information Centre (2009) 'Cannabis and Driving', <http://ncpic.org.au/ncpic/publications/factsheets/article/cannabis-and-driving>, last accessed 15 February 2010
15. Transport Accident Commission (2009) 'Drugs and Driving', www.tacsafety.com.au/jsp/content/NavigationController.do?arealD=13&tierID=1&navID=6E54AD9C7F000001013AD88B6352EB95&navLink=null&pageID=1373, last accessed 15 February 2010
16. Smith A, Agius P, Mitchell A, Barrett C & Pitts M (2009) *Secondary Students and Sexual Health 2008*, Melbourne: Australian Research Centre in Sex, Health & Society, La Trobe University, Monograph Series No. 70
17. National Centre in Clinical Epidemiology and Clinical Research (2009) *HIV/AIDS, Viral Hepatitis and Sexually Transmissible Infections in Australia Annual Surveillance Report 2009*
18. *ibid*
19. *ibid*

20. National Centre in Clinical Epidemiology and Clinical Research (2009) *HIV/AIDS, Viral Hepatitis and Sexually Transmissible Infections in Australia Annual Surveillance Report 2009*
21. *ibid*
22. *ibid*
23. De Visser, RO, Smith AMA, Rissel CE, Richters J & Grulich AE (2003) 'Sex in Australia: Safer sex and condom use among a representative sample of adults', *Australian and New Zealand Journal of Public Health*, 2003, vol.27, no.2
24. Holden CA, McLachlan RI, Pitts M, Cumming R, Wittert G, Agius P, Handelsman DJ & de Kretser DM (2005) 'Sexual activity, fertility and contraceptive use in middle-aged and older men: Men in Australia, Telephone Survey', *Human Reproduction*, 20, pp.3429–3434
25. Smith A, Agius P, Mitchell A, Barrett C & Pitts M (2009) *Secondary Students and Sexual Health 2008*, Monograph Series No.70, Melbourne: Australian Research Centre in Sex, Health & Society, La Trobe University
26. Australian Bureau of Statistics (2008) *Australian Social Trends* 4102.0
27. Australian Institute of Health and Welfare (2008) *2007 National Drug Strategy Household Survey: Detailed Findings*, Drug Statistics Series No.22, PHE 107
28. Kylie Lee K, Conigrave K, Patton G & Clough A (2009) 'Cannabis use in remote Indigenous communities in Australia: Endemic yet neglected', *Medical Journal of Australia*, Vol.190 No.5, 2 March
29. Kylie Lee K, Clough A, Jaragba M, Conigrave K & Patton G (2008) 'Heavy cannabis use and depressive symptoms in three Aboriginal communities in Arnhem Land, Northern Territory', *Medical Journal of Australia*, 188, pp.605–608
30. Australian Bureau of Statistics (2007) *Prisoners in Australia*, 4517.0
31. Australian Institute of Health and Welfare (2008) *Australia's Health 2008*, AUS 99
32. Hep C Information Booklet, www.hepc.org.au/documents/WYNTKweb-2MB.pdf, accessed 21 October 2009
33. National Centre in Clinical Epidemiology and Clinical Research (2009) *HIV/AIDS, Viral Hepatitis and Sexually Transmissible Infections in Australia Annual Surveillance Report 2009*
34. Butler T & Papanastasiou C (2008) *National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey Report 2004 & 2007*, National Drug Research Institute (Curtin University) & National Centre in HIV Epidemiology and Clinical Research (University of New South Wales)
35. Australian Bureau of Statistics (2007) *Prisoners in Australia*, 4517.0
36. Australian Bureau of Statistics (2008) *Australian Social Trends*, 2008, 4102.0
37. Office for Youth (2009) *State of Australia's Young People: A Report on the Social, Economic, Health and Family Lives of Young People*
38. *ibid*
39. Productivity Commission (2009) *Overcoming Indigenous Disadvantage Key Indicators 2009*
40. Office for Road Safety (2006) 'Indigenous Unlicensed/Drink Driving Project: Project Brief', www.healthinfonet.ecu.edu.au/uploads/programs/263_iuddp_proj_brief.pdf
41. Office for Youth (2009) *State of Australia's Young People: A Report on the Social, Economic, Health and Family Lives of Young People*, p.61
42. Australian Institute of Health and Welfare (2008) *National Drug Strategy Household Survey: Detailed Findings*, Drug Statistics Series, No.22, PHE 107
43. Australian Bureau of Statistics (2008) *Australian Social Trends*, 2008, 4102.0
44. *ibid*
45. *ibid*
46. Royal Australasian College of Surgeons Submission to The Senate Select Committee on Men's Health, www.aph.gov.au/Senate/committee/menshealth_ctte/submissions/submissions.htm, last accessed 15 February 2010
47. Richardson N (2004) *Getting Inside Men's Health*, South Eastern Health Board
48. Australian Broadcasting Commission, Catalyst: Risky Business www.abc.net.au/catalyst/stories/2525497.htm, last accessed 16 February 2010
49. Men's Health Information and Resource Centre (2009), submission to the Senate Select Committee on Men's Health, www.aph.gov.au/Senate/committee/menshealth_ctte/submissions/submissions.htm, last accessed 15 February 2010
50. Australian Institute of Health and Welfare (2008) *2007 National Drug Strategy Household Survey: Detailed Findings*, Drug Statistics Series, No.22, PHE 107
51. Richardson N (2004) *Getting Inside Men's Health*, South Eastern Health Board
52. *ibid*, p.109
53. *ibid*, p.119
54. National Public Health Partnership (2004) *The National Injury Prevention and Safety Promotion Plan: 2004–2014*, Canberra: NPHP, p.29
55. Australian Institute of Health and Welfare (2002) *Alcohol Related Injury in Males*, INJCAT 42, Research Centre for Injury Studies, p.6
56. *ibid*
57. Australian Institute of Health and Welfare (2002) *Alcohol Related Injury in Males*, INJCAT 42, Research Centre for Injury Studies, p.6
58. De Visser, RO, Smith AMA, Rissel CE, Richters J & Grulich AE (2003) 'Sex in Australia: Safer sex and condom use among a representative sample of adults', *Australian and New Zealand Journal of Public Health*, vol.27, no.2
59. Richardson N (2004) *Getting Inside Men's Health*, South Eastern Health Board, p.119

60. Malcher G (2009), submission to the Senate Select Committee on Men's Health, www.aph.gov.au/Senate/committee/menshealth_ctte/submissions/submissions.htm, last accessed 15 February 2010
61. *ibid*
62. Andrology Australia submission to the Senate Select Committee on Men's Health, www.aph.gov.au/Senate/committee/menshealth_ctte/submissions/submissions.htm, last accessed 15 February 2010
63. *ibid*
64. Andrology Australia, Engaging Men in Primary Care Settings GP Summary Guide, www.andrologyaustralia.org/docs/GPguide_11_EM.pdf, last accessed 16 February 2010
65. Richardson N (2004) *Getting Inside Men's Health*, South Eastern Health Board
66. Australian Bureau of Statistics (2008) *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, 4326.0

Note:

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