

Chapter 3

Depression and other mental illness

3.1 Mental health is a hugely significant contributor to the burden of disease in Australia. In chapter 1 the committee described the concept of 'disability adjusted life years' (DALYs) which seek to measure the impact of both fatal and chronic disease in Australia. DALYs measure both years of life lost through premature death and loss of quality of life through living with a chronic condition.

3.2 When these two measures are combined the full impact of mental health is clearly apparent. As a general disease category, mental health ranks third behind cancers and cardiovascular diseases as a contributor to the overall burden of disease.¹ When specific conditions are considered, anxiety and depression rank second behind coronary heart disease.² Mental disorders are the largest single component of the non-fatal burden of disease comprising 24.2% of that category.³

3.3 Mental health issues show distinct differences between the sexes. Generally men are less likely to experience a mental health problem than women.⁴ However, in specific areas and age groups men carry a greater share of the burden of disease. This is particularly clear in relation to substance abuse which is more common among men in all age groups. The incidence of suicide among men is four times that among women.

3.4 Anxiety and depression are less common in men than women but within the 35-44 age group both occur at significant levels. It is estimated that, in this age group, 8.3% of men experience depression or a related condition and 15% experience an anxiety disorder.⁵ Surveys suggest that 18% of men experience a mental health problem related to substance abuse or affective disorder (depression) or anxiety at any time.⁶

¹ AIHW, *Australia's Health 2008*, p.55, table 2.17. The respective proportions are 19%, 18% and 13.3% of total DALYs.

² *ibid.*, p.57, table 2.18. Coronary heart disease and anxiety and depression contribute 10% and 7.3% respectively of the total burden of disease.

³ *ibid.*, p.55, table 2.17

⁴ Crisis Support Services, submission 35, p.3. Men account for 47% of the mental illness burden in Australia but only 39% of all mental health-related general practice visits. In 2006-07, only 29% of men that had experienced a mental disorder in the past 12 months sought support services, compared to 46% of females.

⁵ *beyondblue*, submission 84, p.2.

⁶ *ibid.*, p.4, citing Australian Bureau of Statistics (2008), 2007 National Survey of Mental Health and Wellbeing: Summary of Results (4326.0). Canberra: ABS.

3.5 The identification and treatment of mental health problems, particularly in men, are made more difficult by a range of factors. Firstly, there is a widespread community perception that mental health is not an important issue and in conjunction with this is a level of ignorance about significant mental health problems. In each of the measures of knowledge of mental illness men were significantly less likely than women to see mental health as a serious issue or to be able to identify specific mental health problems, including depression.⁷ In conjunction with research which suggests that men access health services only when they consider it absolutely necessary, this low awareness of mental health inevitably results in failure to seek help.⁸

3.6 Men's attitudes to seeking help and treatment for all health problems are discussed in more detail in chapter 2. Specifically with regard to mental health, the recently published Irish Men's Health policy states that,

There is considerable evidence to suggest that mental health is highly gendered and requires a gendered focus at a policy and service delivery level. Mental health issues can pose a threat to a man's masculinity, as evidenced by the way many men conceal symptoms, reject help-seeking and rely on more 'acceptable' male outlets, such as alcohol abuse or aggression, to deal with a mental health issue.⁹

3.7 As *beyondblue* has described, men are particularly reticent about seeking help for mental health problems. Research,

...shows that over 70% of men with a mental disorder do not access services for their mental health problem and that lower rates of men (less than 20%) see their general practitioner for mental health issues than women (30%).

and that a high proportion of men "would feel embarrassed" to talk to their doctor.¹⁰

3.8 This is compounded by an apparently widely held perception that General Practitioners are not supportive in dealing with depression. Approximately 50% of respondents to a *beyondblue* survey did not feel that their GP would take depression seriously, and significant though smaller proportions held other negative views – that GPs are too busy; that they are likely to prescribe medication rather than engage in a thorough consideration of the problem and that GPs did not view depression as an issue of high importance.¹¹

⁷ *ibid.*, p.4

⁸ Freemason's Foundation for Men's Health, submission 38, p.6

⁹ Republic of Ireland, Department of Health & Children, *National Men's Health Policy 2008-2012*, (Dublin 2008), p. 72, paragraph 83

¹⁰ *beyondblue*, submission 84, p.8

¹¹ *ibid.*, p.8. The committee reports these as perceptions which may influence patient behaviour, not as fact. The limitations of, and pressures upon, general practice are discussed in chapter 2.

3.9 Male attitudes to health and seeking health care are exacerbated by the perceived stigma attaching to mental health problems. This is particularly important in regional and rural Australia. It was put to the committee that,

Both men and women in small communities often seek assistance from health professionals outside of their local community, especially for mental health issues, for fear of the reaction of others.¹²

This was supported by a number of witnesses to the inquiry.

3.10 Community perceptions of mental health also tend to reflect stereotypes, often driven by media representations, which are unrepresentative of the true situation:

...accounts of mental illness that instil fear have a greater influence on public opinion than direct contact with people who have mental illness. Mental illness is usually depicted through characters that are physically violent toward self or others or people who are simple, lacking in comprehension and appearing lost, unpredictable, unproductive, untrustworthy, and social outcasts.¹³

3.11 Inevitably this leads to a widespread perception that the community at large is unsympathetic to, or ignorant of, the realities of mental illness. The Royal Australian and New Zealand College of Psychiatry (RANZCP) reports that 80% hold these attitudes and that one-third of people "... are unsure how a friend or colleague would treat them after hearing they had a mental illness".¹⁴

3.12 In the context of men's health the College makes the important point that, "...employment status is a key social determinant in men's mental health and wellbeing", and that fears of "...job loss, being discriminated against at work and falling out with people they had close business and personal relationships with"¹⁵ are major disincentives to seeking early treatment or acknowledging a mental health problem.

3.13 In an area surrounded by so much misunderstanding and anxiety it is perhaps inevitable that confusion also exists about the role of mental health professionals and the treatments available. The RANZCP has commented that,

With the introduction of the Medicare items allowing access to psychologists, there has never been greater confusion within the wider community regarding the different practitioner roles and treatment options available to consumers.¹⁶

¹² Private Mental Health Consumer Carer Network, submission 33, p.1

¹³ Royal Australian & New Zealand College of Psychiatrists, submission 14, p.7

¹⁴ *ibid.*, p.9

¹⁵ *ibid.*, p.9

¹⁶ *ibid.*, p.7

The College went on to comment that psychiatry is particularly poorly understood by the community, carrying with it images of "...asylums and forced medication".

Funding and other support

3.14 Expenditure on the provision of mental health services is estimated to be 7.8% of total allocated health expenditure in Australia, which ranks third in terms of expenditure on broad disease categories.¹⁷ This is less than the proportion of the burden of disease which has led some submissions to suggest that funding should be increased to that proportion.¹⁸

3.15 However as table 8.9 in the AIHW report shows, none of the shares of allocated expenditure on broad disease categories matches the proportion of the burden of disease – the expenditure on cancer and cardiovascular diseases are similarly smaller than their share of the burden of disease, suggesting that such a comparison is not a useful guide to expenditure. To adopt this approach would imply an increase in expenditure on cardiovascular disease from its current 11.2% to 18% and on cancer from 7.2% to 19 %.

3.16 The split of expenditure on mental health per capita between men and women shows that whole of life expenditure on women is slightly higher than on men (\$209 compared with \$196) but expenditure by age group shows that at some ages expenditure on men exceeds that on women.¹⁹ As noted above, (paragraph 3.3), the incidence of mental health disorders in women is slightly higher than in men.

3.17 However as the College of Psychiatrists commented, "...the pattern of presentation and onset [with mental health disorders] does vary between males and females and there is a marked difference in accessing mental health services depending upon age and social factors".²⁰ Thus there is a clear need for a better understanding of these patterns and the factors that influence them so that services and interventions can be better targeted.

3.18 The committee received relatively little comment on research into men's mental health. The RANZCP noted that, with regard to depression,

It is also widely accepted that the understanding of gender specific symptomology of depression is not widely known or understood and could also be promoted in terms of improving men's health.

This conclusion would apply to mental illness generally. Thus providing funding for research into "...gender specific prevention, identification and appropriate treatments

¹⁷ AIHW, *Australia's Health 2008*, p.4111, table 8.9

¹⁸ E.g. Mental Health Council of Australia, submission 5, p. 3; *beyondblue*, submission 84, p.3

¹⁹ *ibid.*, p.413, table 8.10

²⁰ RANZCP, submission 14, p.4

of mental illness"²¹ should be seen as a priority and would, of course, be of benefit to both men and women.

3.19 A specific area of concern which impinges disproportionately on men's health is the use of alcohol and other drugs and the links to depression. It is now generally accepted that the male brain continues to mature until at least 25 years of age or even older and that the maturing brain can be adversely affected by alcohol. Research suggests that many of the behaviours identified in adolescent males – propensity for risk taking, lack of inhibition and judgement and heightened expression of emotion - which lead to significantly higher rates of accidents and fatalities reflect brain immaturity and that these characteristics are exacerbated by alcohol.

3.20 *beyondblue's* representatives emphasised the importance of recognising and responding to these issues in young people arguing that,

...the things that affect men most are alcohol and drug related issues, and relationship issues which are terribly profound...and the reason that *beyondblue* was founded was young men dealing with the break-up of relationships.

Drugs, alcohol and depression were described as the "axis of evil" in mental health which imposed "the greatest weight on the condition of men" and consequently needed to be accorded priority in the distribution of limited resources.²²

3.21 The RANZCP also commented on the need to address mental health issues in young people which "...if unresolved will manifest in adulthood and will become more difficult to manage" and,

...to ensure that boys learn more positive coping strategies and that aggressive, externalising coping mechanisms are not reinforced in the home or the community.²³

3.22 The committee considers the mental health of boys and young men to be a key area that must be addressed in the forthcoming national men's health policy. Elsewhere in this report it has recommended the introduction of health-related education programs for school age boys. These must include a component which monitors mental health and identifies emerging problems, permitting early intervention.

3.23 The committee received a large number of submissions about the specific issue of family breakdown and its impact on fathers, who are denied, or have only very limited, access to their children, particularly boys. Clearly, judging from both the individual submissions and those from organisations such as Dads in Distress and Dads4Kids Fatherhood Foundation, this has been a long running issue which, despite

²¹ *ibid.*, p.7

²² The Hon J. Kennett, *beyondblue*, committee transcript, 9 April 2009, p.3

²³ RANZCP, submission 14, p.7

reforms to the Family Law and to the procedures of the Family Court of Australia continues to cause immense distress.

3.24 With regard to the health of men in this situation, it is clearly important that they are provided with support after the finalisation of their matter before the court. Many men will need to rebuild their lives, to make new living arrangements, sometimes to find new employment and to adapt to the new relationships with their children, no matter how unsatisfactory they may consider their situation to be. These can be demanding and stressful undertakings. It is very important, therefore that they have access to advisory and counselling services that can help them through this period.

3.25 It is well understood that certain groups in society are at greater risk of developing mental health problems. In Australia, in addition to men who have experienced family break down and loss of contact with children, the incidence of mental health problems rises in rural and regional areas, particularly among Indigenous men, among men from low socio-economic backgrounds, and is also particularly prevalent among Defence force personnel who have served in conflict zones.²⁴

3.26 With the continuing impact of drought in south-eastern Australia, the impact of the global financial crises on employment, financial security and retirement income and the continuing involvement of Australian forces in conflict or peace-keeping roles in various theatres, the demands on mental health services are likely to rise.

3.27 At the same time service providers need to anticipate this growing demand by putting services in place in preparation. The impact of mental health problems can be significantly reduced through early identification and intervention thus it is vitally important that services are available when and where they are needed. Where at risk groups are readily identifiable, such as members of the forces or the unemployed it is incumbent on the appropriate agencies of government to ensure that at-risk people are monitored or, at the very least, advised as to the availability of mental health support services should they need them.

Education and Awareness

3.28 Improving the community's understanding of mental health is central to making progress in this area. As noted above, men are generally perceived as being unwilling to access medical services and seek help for mental health problems. A

²⁴ Crisis Support Services, submission 35, p.3. For example, among Korean War veterans studied in 2004, anxiety was present in 31% and depression in 24%, while 59% drank hazardous amounts of alcohol. In 2005, there were 9.5 suicides per 100,000 people in capital cities compared with 12.5 suicides per 100,000 people in rural areas. Indigenous Australians experience rates of self-harm and suicide that are higher; and substance abuse, domestic violence and disadvantage contributed additional risk factors.

significant component of this unwillingness is the stigma attaching to those suffering from such problems.

3.29 Changing community attitudes is extremely difficult as demonstrated by the long term efforts in relation to tobacco use. However the work of *beyondblue* with regard to depression does demonstrate that remarkable progress can be made with well-designed programs. A key aspect of *beyondblue's* success appears to be its ability to get highly visible public figures from a range of backgrounds – politics, business, the theatre, sport - to talk publicly about their problem, to demonstrate that a significant mental health issue can be managed and that it is not a barrier to living a full, productive and rewarding life.

3.30 The Director of Communications for the Mental Health Council of Australia looked forward to the day,

...where, when we look at a football park and we say, 'He recovered from two broken arms and has got back on the field,' we can also say 'Well, that person has had a history of depression or anxiety,' without a stigma being attached to that, and we do it in the same laudatory way of: 'Isn't that great; recovery and resilience.'²⁵

3.31 A second component of *beyondblue's* success has been to take its message directly to people where they work, live and relax. It has numerous programs that target rural communities, sporting clubs, organisations and workplaces where a combination of meetings, distribution of educational material and training in how to identify and respond to depression has had considerable success.

3.32 The success of these activities suggests that the generally accepted view that men are not willing to talk about, or seek help for, health problems, specifically mental health issues, needs to be modified. Mr Kennett described to the committee participating in meetings of several hundred people in small communities in rural Australia where there was considerable willingness to talk publicly about problems.²⁶ Clearly well designed programs which approach men in a manner with which they are comfortable and provide information which they find useful will overcome reticence.

3.33 While progress is being made in encouraging men to acknowledge that they have a mental health problem and to seek treatment, advances in identifying and addressing causes are more difficult. As noted above, the interaction of alcohol, drug use and depression is a major problem, particularly among young people. There is also evidence that drug and alcohol use is related to a high level of 'self-medication' by those experiencing mental health problems.

3.34 Despite recent publicity surrounding alcopops and binge drinking among young women, men remain significantly higher consumers of alcohol than women and alcohol consumption is strongly linked to ideas of masculinity:

²⁵ Mr C. Tatz, committee transcript, 26 March 2009, p.90

²⁶ The Hon J. Kennett, committee transcript, 9 April 2009, p. 5

It is considered a masculine behaviour. I do not think I have to provide a number of citations for you to realise this. Holding your drink is considered to be a masculine accomplishment...it certainly is embedded in Australian culture...men definitely have a cultural background, an impulse, to drink more, to show that they can drink: to show themselves, not only their friends.²⁷

3.35 Research increasingly supports the position that alcohol has a significant negative impact on the immature human brain, leading to recommendations that no alcohol should be consumed before the age of eighteen or even older. However, as has been the experience with changing behaviour with regard to tobacco smoking and drink driving for example, it is extremely difficult to compete with entrenched social and cultural attitudes to the consumption of alcohol, (particularly where they intersect with attitudes to typically 'masculine' behaviour) and the commercial interests that promote it.

3.36 As Dr James Lemon told the committee, attempts to change attitudes that ignore the reality that in the short term drug or alcohol use can make the user feel better will fail and that young people will respond much more strongly to behaviours they see modelled by adults than to messages that are contradicted by people's own experience.

As long as young men see an advertisement on television telling them that getting drunk is not cool and their experience of getting drunk is that it is cool...they simply say, 'This is a load of codswallop and I'm not going to listen to any of it,' even if the entire remainder of the content is quite sound and would be helpful.²⁸

3.37 Alcohol consumption is an area where conflicting messages undermine efforts to educate users about safe behaviour. The known protective effects of regular moderate alcohol consumption tend to confuse the debate about the dangers of alcohol. This emphasises the point that, unless education campaigns are carefully designed they will fail and in failing may discredit the worthwhile messages that they are trying to promote.

3.38 Related to this, the committee heard much comment on the need for thorough evaluation of health-related education and awareness campaigns in general and specifically in the area of mental health. Dr Lemon commented, with regard to advertising campaigns, that,

...the government does fund a lot of these efforts...It funds the research that devises these interventions, it funds the interventions themselves and it funds people like me. A lot of my job is looking at evaluating these interventions. Very often I end up being a sort of coroner who has to

²⁷ Dr J. Lemon, National Drug & Alcohol Research Centre, UNSW, committee transcript, 7 April 2009, p.78

²⁸ *ibid.*, p.77. It should be noted that, while there have been small variations in patterns of drinking, alcohol consumption in Australia is actually declining overall.

determine the reason the intervention died and explain this to the bereaved therapist whose intervention has not worked ...²⁹

The committee has commented further on this in chapter 2.

3.39 The final area of awareness that the committee wishes to emphasise is the link between family breakdown and mental health issues. *beyondblue* identified relationship breakdown as a major contributor to mental health problems. The College of Psychiatrists similarly identified family circumstances as one of the most important social factors affecting men's mental health.³⁰

3.40 The committee also received a number of submissions from individuals and organisations specifically concerned with the impact of family breakdown on men and on the children of a relationship who found themselves without regular contact with their father. These submissions referred to both the damage to men's mental health and the impact on boys of growing up without a father providing a male role model. The committee has commented on the need to provide support to men experiencing this process at paragraphs 3.23-3.24 above.

3.41 In terms of addressing the causes of depression and other mental health problems, some effort needs to be put into educating young men (and women) about the responsibilities that they will take on when entering into long-term relationships, particularly where they become parents, with the object of reducing the incidence of relationship breakdown. A second group that should be targeted is parents whose relationship has failed, to assist them in minimizing the adverse impacts on children of behaviours which inappropriately limit contact between the child and both parents, or worse, involve the children in a conflict with the estranged partner.

3.42 In terms of reducing the incidence of family breakdown and addressing a source of depression in both men and boys the committee supports the proposals put forward in the submission from the Family Action Centre at the University of Newcastle on the need to increase awareness among fathers of the issue of post-natal depression and also the related issue of the incidence of depression in new fathers, which can have damaging effects on the whole family.³¹

3.43 The committee notes that the Commonwealth Government has announced the National Perinatal Depression Plan³² which "...aims to improve prevention and early detection of antenatal and postnatal depression and provide better support and

²⁹ *ibid.*, p.76

³⁰ RANZCP, submission 14, p.4

³¹ Submission 7

³² Approximately 16% of mothers experience problems related to perinatal depression. See *beyondblue* Media Release, 26 November 2008

treatment for expectant and new mothers experiencing depression".³³ The program will involve screening of all pregnant women for depression prior to and two months after the birth of a child. The program will also include some information and advice for men as to how they can help their partner and also where they can get advice.

3.44 While the incidence of depression in new fathers may not be high enough to justify a universal testing program, the committee suggests that the screening program for mothers could be extended to include contact with the father to ensure that he is fully aware of the issue and that he is given an opportunity to raise any problems he may be having.

Improving the quality and accessibility of services

3.45 Removing the stigma attached to mental health, promoting open discussion and encouraging men to seek help for mental health problems will not have significant impact on morbidity if the services cannot respond appropriately to demand.

Improving health professionals' capacity and willingness to recognise and manage depression and anxiety may be a key factor in improving the help seeking behaviours of both Australian men and women.³⁴

3.46 General practice is the first point of contact for the majority of men seeking help for a mental health problem,³⁵ despite the perception noted above in paragraph 3.8 that it is not a sympathetic environment in which to discuss depression. The committee is aware of the demands on general practitioners and does not wish to criticise them but there do appear to be structural problems which militate against the men concerned about their mental health seeking treatment from a GP.

3.47 The standard short consultation is not appropriate to the identification of depression or anxiety. Yet reliance on the short consultation is largely driven by demand (the doctor's waiting room is full) and cost (the gap between the Medicare rebate and the GP's fee is obviously greater for longer consultations).

3.48 There are also training issues in relation to general practice because GPs may not be particularly well-equipped to identify a mental health problem, especially where the patient presents with another complaint and does not volunteer the information that they have an additional problem. Here again we see the interaction of men's behaviour, a reticence to talk about mental health and a preference for practical advice in relation to a visible problem, with the realities of general practice. Research suggests that most GPs deal with only one problem at a time.³⁶

³³ Department of Health and Ageing;
<http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/perinatal-depression-3>
 (accessed 25 May 2009)

³⁴ *beyondblue*, submission 84, p.8

³⁵ *ibid.*, p.8

³⁶ Freemasons Foundation, submission 38, p.7

3.49 In recognition of this problem *beyondblue* is supporting research to "...enhance general practice's capacity to identify depression and suicidal risk factors".³⁷ The committee has also considered this matter in chapter 2 and made recommendations to improve the situation.

3.50 An important aspect of the incidence of depression is co-morbidity, where depression occurs in conjunction with, and as a result of, a physical disease such as prostate cancer. The committee has discussed this at some length in chapter 4. There is a clear need for general practitioners and specialists to consider the mental health implications of major physical diseases or trauma. The committee notes that the Prostate Cancer Foundation of Australia (PCFA) and *beyondblue* have collaborated in a number of activities to increase awareness of this problem, particularly the successful Movember campaign which acts as both a fund- and awareness raiser.³⁸

3.51 A more general problem exists as a result of the rigid division between services which are, in practice, often closely related. This is most apparent in the areas of drug and alcohol problems which are often associated with mental illness, particularly among men, given the incidence of self-medication. *beyondblue* explained to the committee that there is a need for much better integration of services to ensure that people are not turned away if they approach the 'wrong' service.

...if you have a drug problem and an alcohol problem you may not even get into the one service. If you have mental illness as well, you will not; you will be turned away because 'we do drugs here' or 'we do alcohol here' or 'we do mental illness'.³⁹

and concluded,

...there is an absolute need for identifying issues and working together in an integrated way across drug, alcohol and mental health services. Regardless of the point at which you come in, you should not to be turned away...There is a strategy for everything, but they are not integrated. In fact, the person is often excluded from services because of that.⁴⁰

3.52 The College of Psychiatrists also commented on two aspects of service provision:

- The variable standards of care across the various jurisdictions in Australia, and
- the range of services which are often required in the treatment of mental illness and the need to bring them together,

There is also a need to better coordinate and connect other relevant community supported services needed by patients with severe mental

³⁷ *beyondblue*, op cit, p.3

³⁸ *ibid.*, p.5

³⁹ Ms L. Young, CEO, *beyondblue*, committee transcript, p.7

⁴⁰ *ibid.*, p.7

illness and complex needs with their clinical care (e.g. general health care, financial support, housing, substance abuse, rehabilitation etc).⁴¹

3.53 This can be particularly true for patients from rural or regional Australia who have had to move 'out of area' to receive treatment.

3.54 The importance of recognising the range of services that a person with a mental health diagnosis may need cannot be over-emphasised. It is a common occurrence, particularly for a person being released from institutional care to be left without adequate support. The pressure on acute care beds is such that many mental health units have to discharge patients somewhat earlier than is ideal:

Adequate discharge planning and follow-up of patients should become mandatory for all patients discharged into the community from hospital settings. Acute inpatient units increasingly discharge people with severe illness into crisis accommodation or "no fixed address". In communities that do not have the service structures and operating systems to support people with mental illness to live safely or rehabilitate in the broader community, people with mental illness will not receive adequate follow-up treatment and often end up being readmitted following a worsening of their condition.⁴²

3.55 There is overwhelming evidence of the interconnectedness of men's physical and mental health issues. It is important that this be recognised in the provision and conduct of treatment services. Therefore,

The committee recommends that the integration of health service provision to recognise the interconnectedness of men's health issues be made a central part of the forthcoming national men's health policy.

The committee recommends that the Commonwealth Government investigate standardised service models for mental health to facilitate a uniform standard of care throughout Australia.

3.56 Given men's attitudes to seeking help for mental health problems and its higher incidence in rural and remote areas, and the lower level of trained and specialist services in those areas, telephone counselling services play an important part in providing initial contact and advice on mental health and in providing crisis support.

3.57 The Commonwealth must ensure that services such as Mensline Australia, SuicideLine Victoria and the *beyondblue* Information Line are adequately funded and that the services they provide are widely publicised, particularly to known at-risk groups. These services also have specific advantages for men particularly in:

⁴¹ RANZCP, submission 14, p.9

⁴² *ibid.*, p.8

Providing services that allow men to access help without have to confront perceived social obstacles; [and]

Devising gender-specific information and disseminating it through media that are appropriate for men;...⁴³

and the potential to expand them should be investigated.

Suicide

3.58 Men are four times more likely to commit suicide than women. It is the tenth most common cause of death for men, ranking above such things as melanoma and land transport accidents.⁴⁴ Suicide is highest in the 30-45 age group but is high, above 20 per 100 000, in every age group from the late teens through to late middle age. It also increases in older men above the age of 75.⁴⁵

3.59 The reasons why men commit suicide are, perhaps inevitably, unclear and there is no clear linear progression from a 'negative life event' to suicide. It is known that having a diagnosed mental illness is an increased risk factor for suicide and that relationship breakdown leading to anxiety and depression is correlated with attempted suicide in men.⁴⁶ The increasing incidence of suicide in rural Australia has been linked to economic and social stresses related to the extended drought. It is also conjectured that men are particularly ill-equipped to cope with the sense of failure that may come from the loss of a property or job.

⁴³ Crisis Support Services, submission 35, p.4

⁴⁴ AIHW, *Australia's Health 2008*, p. 43, table 2.12. The comparable rates are: men 16.6 per 100 000; women 4.4 per 100 000

⁴⁵ *beyondblue*, submission, p.3

⁴⁶ *ibid.*

