The Health of the Male Population in Hume Region, Victoria

Introduction - Overview of men and their behavior towards health

Men's views regarding health and healthcare services are not as similar as those of women due to biological and gender actors (Australian Bureau of Statistics, 2011). They have less possibility to look after their own heath, visit health-care providers and usually skip their recommended diagnostic tests for their diseases as Murray-Law (2011). In accordance with the Australian Department of Health and Aging (2010) as it has stated that more often that the image males have of themselves is the reason for the lower use of health services. DHA (2010) also added that men avoid seeking medical help even when unwell due to the fear of being seen as fragile men rather than the conventional label of strong and independent.

This predicament comes about to all men in Australia whether they are urban or rurally situated (Australian Institute of Health and Welfare, 2010). AIWH (2010) revealed there is a possibility of twofold disadvantage for men that reside in regional and remote areas in Australia to suffer more health problems due to socioeconomic disadvantages compared to men situated in urban areas. These factors can be more evident for men living in countries due to their location, work and lifestyle (AIWH, 2010). AIWH (2010) also reported that barriers to health service access could make their situation more intricate, such as lack of health care services, longer working hours and lack of health education. More than half of the population in regional, remote and very remote areas is socioeconomic disadvantaged, in contrast to the one fourth of the population in major cities (AIWH, 2010). Aboriginal and Torres Strait Islander people, who are a great part of the population in remote populations are socioeconomically disadvantaged as well (AIWH, 2010). Moreover, the Australian

Psychological Society Ltd ([APS], 2009) has identified that there are factors related to living in rural areas that may contribute to the outcome of a person with a mental health condition. Significant adversities, which include geographical isolation, distance from health services, environmental hazards (such as bush fires and drought), lack of public infrastructures, and social and economic difficulties, could be experienced by men residing in rural and remote Australia (APS, 2009). If not given attention to and if immediate access to support services is lacking in an area, rural men could turn to means of suicide (LIFE Communications, 2007).

I. Hume Region, Victoria and its Male Population

Hume Region is a 40,000 square kilometer, multi-cultured area located in northeast of Victoria (Regional Development Victoria [RDV], 2011). According to the Victorian Government Department of Health (VGDH), the region's ARIA remoteness category is highly accessible and nut it remains to be predominantly rural (VGDH, 2011a). It also stated that Hume is a home to a population of 270,530 in 2009 (VGDH, 2011a). Statistics also shown that the male population is almost the same of the female population in the area, 135,539 men and 134,991 women (VGDH, 2011a). The number of people living in districts that have Index of Relative Socio-economic Disadvantage scores under the Regional Victorian average in 2008 is 146,201, which is 36% of the entire population in Hume and is 5% higher than the rate of entire Victoria (VGDH, 2011b). In 2008, the Victorian Government Department of Human Services (VGDHS) suggested that there were 3,361 Aboriginal residents in the Hume, which ranks the region as the 2nd largest Aboriginal population in Victoria (VGDH, 2010b). The average life expectancy of males in as of 2007 is 79.3 years which is almost 5% lower than the females and that of whole Victoria with 80.3 years (VGDH, 2010a). There is a larger proportion of unemployed people in this region

during 2010 compared to Victoria; 7% of the whole population was unemployed, Victoria with 5.5% (VGDH, 2010a). As part of Hume's healthcare system, it has 14 hospitals that can offer a comprehensive range of services from primary health, emergency, mental, and community services, health programs, age care and as well as drug and alcohol treatments for the optimal health of Hume's community (Hospitals Located in the Hume Region NorthEast Victoria, Australia, 2008).

II. Suicide in Rural Men

As reported in Avoidable Mortality study in Victoria by the Victorian Department of Human Services (VGDHS), suicide ranked as the 4th leading cause of avoidable death in whole Victoria from 1997 to 2003 (VGDHS, 2008). In addition to this, in all seven years, suicide mortality rate trends were significantly higher in males compared to females by about 154 to 328% (VGDHS, 2008). Moreover, it is the number one cause of death in Victoria with high proportion in men in 2008; about 78% of all cases were reported to be of the male gender (ABS, 2010b). It is evident that male deaths caused by suicide are more common outside major cities (AIHW, 2010). The suicide mortality rates of males from rural LGAs in Victoria were 19 to 56% higher than of those of men who live in metropolitan LGAs from 1997 to 2003 (VGDHS, 2008). In the positive side, male suicide rates from 1997 to 2003 in both rural and metropolitan areas Victoria decreased gradually VGDHS, 2008). In metropolitan LGAs, from 19 to 16 out of 100,000 male suicide deaths from 1997 to 2003 and 26 to 20 out of 100,000 in rural LGAs (VGDHS, 2008) Suicide rates in the female gender from metropolitan and rural Victoria had no significant differences from 1997 to 2003 and remained relatively low (VGDHS, 2008). In relation to socio-economic status by Index of Relative Socio-economic disadvantage scoring (SEIFA-RCD), suicide rates in men are higher in most

disadvantaged LGAs compared to least disadvantaged ones; 3 out of 100,000 death difference were recorded (VGDHS, 2008) In terms of accessibility to services by ARIA category, in accordance male suicide deaths in least accessible areas of Victoria remained slightly higher than most accessible areas from 1997 to 2003; with a difference 4 out of 100,000 deaths (VGDHS, 2008). For Aboriginal and Indigenous males of all Australia, intentional self-harm was the leading cause of death in 1999–2003; the rate of suicide was more than twofold that for non-Indigenous males, almost 250 per 100,000 deaths in ages 25 to 34, and these rates remain relatively high until 44 years of age (AIWH, 2005). These age-specific rates were three times the greater than the age-specific rates for non-Indigenous males (AIWH, 2005). Hume region alone made up 5.09% of all male suicide incidents that were committed in Victoria in 2001 according to the Victorian Health Information Surveillance System [VHISS] (VGDH, 2011c). These deaths peaked at men of 15 to 24 years of age and remained significantly high in the ages 25 to 54 and decreased after (VGDH, 2011c).

III. Health Determinants in Relation to Suicide

A. Physiological

There is a high risk of suicide in people diagnosed with psychiatric disorder compared to the general population and between 60-90% of people that tried to commit suicide are depressed. Common mental illnesses associated to suicide are schizophrenia, bipolar disorder and personality disorders. No treatment is given to such because the illness is unrecognized and is mistakenly to be assumed as ‘acting out’ behavior (VGDHS, 2006).

B. Behavioral

Alcoholics and substance abusers have higher rates of suicide with substance abuse often immediately preceding suicidal behavior (VGDHS, 2006). Although substance abuse is not directly linked to suicide, there is a increased risk for people with this behavior (VGDHS, 2006). A research by the Office of the Victorian State Coroner proved that in 2000, 26.9% of all Victorian suicide fatalities the victim had alcohol present in their blood and 61.3% of suicide victims had more than just alcohol, but also carbon monoxide and other drugs in their blood (VGDHS, 2006).

C. Psychosocial

One of the common reasons for deaths of men in rural areas is living at work' which offers farming families little opportunity for time away for themselves (NRHA, 2009). The image of masculinity and a rural ideology discourages men to seek help (NRHA, 2009). Another reason is less or no access to support services; it is not common for rural and remote communities to have easy access to community support and mental health services. There maybe but, only a few services are available. Not so many people in rural areas have internet access and most of the time, traditional methods of support cannot be obtained (LIFE, 2007).

D. Socioeconomic

Unemployment and economic change leading to financial insecurity and vulnerability can also push men to committing suicide (NRHA, 2009). The Victorian coronial data reported a strong correlation between unemployment and suicide (VGDHS, 2006). Men ages 30 to 34 years, are among the population that commit suicide due to unemployment (VGDHS, 2006). The same research has proved that unemployment is also a reason of increased rates in attempted suicide (VGDHS, 2006). There is also an increased rate of suicide in Aboriginal people (VGDHS, 2006). This presents that suicide as a significant social issue in Aboriginal communities which links to both the cycle of ongoing chronic socioeconomic disadvantages, family and substance abuse and injustice experienced by Aboriginal people (VGDHS, 2006).

E. Environmental

Suicide rates are also high in specific areas of Victoria after climate changes. The vulnerability to climate and economic change appears to be common in rural and regional areas and there is a causal relationship between trauma after droughts in people living in agricultural communities, such as farmers and micro-business people (NRHA, 2009).

IV. The Effect of Suicide on Families

A death of a love one is always painful, but the grief experience by the family and friends of a person who died in the means of suicide is greater (Better Health Channel [BHC], 2011). Even if the truth is that it's not the family's fault the person died, guilt still reigns and there is a feeling of responsibility for the incident (SANE Australia [SANE], 2010). According to the American Association of Suicidology (AAS), grief in this case does not follow a linear path and doesn't always move in a forward direction (AAS, 2008). Although this situation is truly

difficult, survivors must aim to adjust without the presence of the person who passed on (AAS, 2008). Some of the usual reactions in relation to the suicide of a significant other may include: remorseful over the opportunities that were lost, guilt due to responsibilities that were failed, shock and trauma caused the sudden death, and difficulty accepting that the death was by suicide (BHC, 2011). There is a possibility for developing mental health problems as after-effects in people who have experienced suicide encounters such as depression and post-traumatic stress disorder, particularly in the person who discovered the body. A risk of suicide is also likely to a certain extent caused by one's negative reactions and partly due to the realization of possibility of taking one's life is true (Suicide Prevention Resource Center [SPRC], 2005). It would be of great help to allow people to give time to cope with the loss and seek support from other people and professional counseling (BHC, 2011).

V. Interventions in Addressing Health Determinants

A. Upstream

National Suicide Prevention Strategy - Due to the alarming increase of suicide all over the nation, the Australian Government created an program called the National Suicide Prevention Strategy (NSPS) (Australian Government Department of Health and Aging [DoHA], 2011). The aims of NSPS is to develop research and more understanding in preventing suicide, lift individual spirits and enable them to seek help when needed, improve community ties and networks in suicide prevention, provide suicide prevention activities for affected individuals and families, and implement standards and quality in preventing suicide (DoHA, 2011). This strategy has major components: the Living Is For Everyone or LIFE Framework, which

provides the public with a tactical evidenced based framework for suicide prevention; the National Suicide Prevention Strategy Action Framework, which is focused on giving time limited workplans for empowering and venturing suicide prevention forward; The National Suicide Prevention Program or NSPP which is the funding program delegated by the Australian Government to fund for suicide prevention programs and activities(DoHA, 2011). Since 1999, the Australian Governments has been allocating $10 million yearly under the NSPS for the development of national and local suicide prevention models. In the past years, the government has funded more than 25 national suicide prevention projects and roughly 170 in the community (Leo, Herrman, Ueda, & Takeshima, 2006).

World Suicide Prevention Day - The World Health Organization (WHO) in cooperation with the International Association for Suicide Prevention, and other partners have officially declared every 10th of September World Suicide Prevention Day (WHO, 2011) That day of the year promotes worldwide commitment and action to prevent suicides. It increases awareness that suicide is a main preventable cause of premature death at a global level, and encourages localities to create policies and research to lead in creation of suicide prevention programmes and activities in communities (WHO, 2011).

Because mental health matters: Victorian mental health reform strategy 2009–2019 – Because Mental Health Matters is a mental health reform agenda by the Victorian Government to change and improve mental health service provision and response in Victoria, Australia (VGDH, 2010a). The aim is to make sure that all citizens of Victoria, with are given equal changes to obtain optimal mental health, while those who are currently experiencing health problems have access to the best quality of care and support services to live successfully in society (VGDH, 2010a). One of the goals of the Mental Health Reform

Strategy is to focus on reforming the delivery of mental health care service for Aboriginal people in Victoria (VGDH, 2010a).

B. Midstream

Hume Region Closing the Health Gap Plan - Closing the Health Gap in the Hume Region have priorities to increase the service system's cultural capability throughout Hume Region, identify and develop service models for Aboriginal communities' health needs and provide access to mental health services for Aboriginal people and reduce intentional self-harm and suicide, which is comparatively high in the Aboriginal community (VGDH, 2010b).

Alcohol, Tobacco and Other Drugs Strategic Plan - The objectives of Alcohol, Tobacco and Other Drugs (ATOD) strategic plan is to ensure strong, receptive and sustainable way of approaching problems to address and prevent the injuries and deaths due to alcohol, tobacco and other drugs misuse in the Hume Region (VGDH, 2010c).

Non-government Suicide Prevention Organizations - There are non-government organization with the purpose of suicide prevention, these organizations can be reached by telephone and are available for counseling 24 hours a day. Some of the mentioned are Lifeline, Mens Line Australia, Salvo Counselling Line, SANE Australia Helpline , beyondblue, and Just Ask, which is a particular lifeline for rural mental health service (National Rural Health Alliance [NRHA], 2009).

C. Downstream

There are many ways one could do in times of crisis when one is feeling suicidal (LIFE, 2007). First is to seek help early by talking to a family member or friend, postpone all decisions in ending one's life until one has found support needed, developing a safety plan one can put into action at any time when the person is feeling overwhelmed or upset, avoiding drugs and alcohol, staying healthy and trying to get enough exercise and seeing a mental health professional that are trained to deal with issues relating to suicide, mental illness and wellbeing (LIFE, 2007).

VI. Role of Nurses in Suicide Prevention

According to the Joint Commission Services ([JCS], 2007), suicide prevention is a very important part of the nursing profession. The role of the nurse in preventing suicide in regional areas of Australia is to cooperate with other disciplines and the government in delvering clinical support and services in the community (JCS, 2007). By doing such, nurses can help improve care levels and reduce the chance of avoidable hospital admissions and readmissions of people with suicidal attempts, and assist in keeping people with severe mental disorders well (JCS, 2007).

VII. Conclusions and Recommendations

Men from regional and rural areas may seem to be the least people to get affected with disease and mental problems, but the factors that lead the said population to suicide in increased rates is a proof that health of these men should taken into more consideration.

Education programs should be made in order to keep the population in rural areas of Australia updated and informed of the what the health care system can offer, in order for them to make good health decisions.

In conclusion, the government should promote further actions to bring health care system nearer to the regional population's reach. More importantly, tie ups with different suicide prevention organizations could maximize the potential to lessen if not eradicate fully the incidences of suicide in men of rural Australia.

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