

# Men's Mental Health

## What Helps or Hinders Men's Access to a Community Mental Health Team

By

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## **PREFACE**

This research seeks to identify what helps or hinders men's access to a community mental health team. Chapter one introduces the topic of mental health, providing a Global, National, and Regional overview of the current New Zealand context, in which this study is placed.

Chapter two provides a current review of the literature both nationally and internationally that explains current health care problems for men. It describes the theoretical positioning of the research and outlines the perspectives used in the research. Also discussed is the impact and importance of gender in researching men and men's interests. It outlines the impact of a gendered approach to men's health and discusses how a repositioning is needed at the Macro, Meso, and Micro levels to assist in developing a useful context at these levels for men's health. It also examines and describes the impact that current and historical power relations (at the micro, meso, and macro level) have on men's health, and possible ways of developing a new power relation for men's health.

Chapter three describes the Methodology outlining the tools used in this qualitative research project these include Action Research and Narrative Inquiry. It describes the design of the research and how the data was collected. It also tests the validity and reliability of the research by identifying dilemmas and rigorous ethical standards and processes gone through for the research to be initiated. It finishes by identifying approaches needed to be able to successfully research men's health.

Chapter four presents the findings from the Client Data elicited from interviews with male participants. These are centred on seven meta-themes that arose out of the literature review they include; Access, Barriers, Community Mental Health Team, Legitimate Others, Masculinity, Power Differentials, and Sites of Risk. It finishes with information about the men's focus group.

Chapter five outlines finding from the Clinician Data that was elicited from both the interviews and focus groups. Similarly, it centres on the same seven meta-themes identified in the literature review and includes data from focus groups of both male and female clinicians. It finishes with a comparison between data collected from both clients and clinicians.

Chapter six provides an analysis of the findings from the data. It identifies and outlines the tools used in this analysis and applies these tools to the findings. It also identifies and explores the types of power relations that currently exist in health and their impact on men's health. It finishes by identifying what is needed and the types of power relations needed in men's health.

Chapter seven provides a conclusion and summary of the research project. It discusses the results of the research and what is needed at the macro and policy level in New Zealand, the meso and Service level, and lastly what needs to occur at the micro and client - clinician level for successful men's mental health initiatives in New Zealand. It also discusses the implications of these findings for men's health services in general.

## **Chapter 1 – INTRODUCTION**

### **1.1 The Historical Context**

Much has been written on the history of mental health, predominantly focusing on the genesis of the institution that began and became later known as the asylum (Shorter 1997). Prior to the sixteenth century societal interaction with those that were seen as different was more naturalistic. This difference saw them set apart from community life, at times viewed as possessed, or evil, they were the mad men and women who lived on the edge of the village. Mythologized as the simpleton, the mad man or the witch who lived deep in the woods, they were tolerated by some in the community, but avoided by most. Always blamed when life was difficult, they were the ones whose tragic narratives were woven into village folklore and early traditions (Brookes 2001).

The only system of established support for these men and women was either the kindness or care of their family, or the mercy and compassion shown by the community within which they lived. Life revolved around communities and families ability to work and to the rhythm of the seasons. Having a family member who was different (mad, possessed, or evil), was a break away from the norm of an inherited and traditional seasonal and social order. They were easily stigmatised and viewed as a potential economic burden (Shorter 1997). These themes still resonate today for those experiencing mental illness and those who work with them.

The beginning of the eighteenth century saw society's interactions with those deemed as different take on a new form, that of containment. As the industrialisation of Europe began and society grew, villages inevitably transformed into towns, the towns into cities, and the development of larger urban populations. Those seen as mad, sad, or bad, became increasingly more visible, at the same time as societal viewings of difference became more intolerant. As their numbers and visibility grew they were seen as a threat to the emerging social order whose foundations were the growth and development of industry and commerce. There was no room for those who could not participate in such a society. Indeed, it was seen as being in society's best interest that these 'dangerous' mad men and women be contained and confined (Foucault 2003).

In the nineteenth century this was consolidated with the development and formation of separate institutions of confinement, that of the asylums (mental hospital), the almshouses (poor houses), and the goal. The growth of the asylums was further offset by the handing over of responsibility of the mentally ill individual by the family and almshouse, to the asylum and goal (Shorter 1997).

## **1.2 The New Zealand Context**

The history of the asylum in New Zealand began circa 1850 and soon adopted similar approaches to its European counterpart, that of confinement and containment. As New Zealand's colonial population grew, so to did the number of people needing to be confined to the asylum. New Zealand's early colonial government needed to find a

way to manage the burgeoning number of those seen as mad, sad, and bad in this newly established and fast growing antipodean isle (Bloomfield 1979).

The nineteenth century colonisation of New Zealand brought new ideas of scientific enlightenment and positivism and with them, ideas of curability and therapeutic process (Brookes and Thomson 2001). In this, all mental illness was viewed as disease and therefore as a disease that could be cured. Matters pertaining to curability were seen to be the domain of the sciences, the ever growing medical establishment; who were also becoming powerful politically (Bloomfield 1979). The good willed layperson, that up until this time ran the asylum, was seen not to be knowledgeable enough to provide a cure (Brookes and Thomson 2001).

Medicalisation of mental illness as a disease coupled with the beginning of a global era of Scientific Positivism from the mid nineteenth century, lead to the establishment and entrenchment of a medical positioning within the mental health institution that encompassed what we know today as the field of Psychiatry (Shorter 1997). Though this medical positioning in New Zealand is historically young, its roots are reflected in a European dominance of treatment modality that still retains a dominant position within mental health services to date. It must be remembered that,

Before the end of the 18<sup>th</sup> Century, there was no such thing as psychiatry... [it] did not exist as a discipline... the advent of medical specialism was a phenomenon of the 19<sup>th</sup> century.  
(Shorter 1997)

### 1.3 The Otago/ Dunedin Context

As the population of New Zealand grew so did the need for its treatment of the insane. Dunedin's early asylum soon filled with a large number of predominantly male colonial settlers who had little or no family connection (Bloomfield 1979).

Disconnected from family and community, the men and women in these overcrowded institutions (themselves increasingly dependent on the relatively new provincial and central governments of an establishing colony), were subjected to a regime that initially showed little difference from early European asylums, that of the containment and removal of the insane individual in order to keep the rest of society safe (Brookes and Thomson 2001) (Shorter 1997).

Attempts to treat the mentally ill didn't occur until some time after the first asylums in Dunedin opened and even then they were underpinned by the idea of removal and containment. The later part of the nineteenth century saw the asylum in Dunedin focus on both the physical and moral health of the individual (Brookes 2001). Early medical practitioners saw managing insanity as managing both a medical illness and to a greater extent its perceived resultant moral illness. This type of treatment was strictly authoritarian and regime focused, the emphasis being on the mental hygiene of the patient (Bloomfield 1979) (Blake 1956). The asylum was viewed as,

The setting itself with its orderly routines and communal spirit, and the doctor-patient relationship... a particular form of this relationship was often called 'moral therapy' (Shorter 1997, 18).

The asylum in Dunedin in the 1890's was focused on providing humane treatment for the 'moral' management of patients (Brunton 2001).

The beginning of the twentieth century saw the ongoing recognition and adoption of medical practices and therapeutic processes that were proving successful in Europe. A shift was occurring in how individuals affected with a mental disorder were viewed. They were recognised as needing a different form of treatment than those with medical problems. The result was a change in patient management, service provision, and a shift to a more hospital focussed culture and language (Brunton 2001). Changes, that also meant an increase in guidance and assistance from local and regional governments. More and more control over the newly named mental hospital now lay with the Medical Superintendent and the Department of Health (Brunton 2001). This is a distinct and historical power relation that has existed since the earliest of European asylums and is still found in today's mental health services.

The early 1970's brought yet another shift in mental health service delivery with the Health Department handing over the management, administration, and delivery of mental health services to local hospital boards (Brunton 2001). The following two decades began a process of de-institutionalisation and the shifting of mental health services into the community. The development of Community Mental Health Teams to work with clients in the community in order to keep them out of hospital, coupled with the eventual closure of the institutions began an era of specialism.

## 1.4 The Individual Context

The historical inmate turned patient, now became a client of a specialist service. A service that developed specific entry and exit criteria where the client was regularly examined and monitored by the specialist to see if they were eligible to receive such a service.

The examination is central to determining each individual client in her or his particular specificity. Through the examination the individual is given a status and then linked to any number of markers and measurements meant to characterise each individual client. Finally the individual is reconstituted as a case. The individual case is the result as well as the object of power (Moffat 1999, 223).

Today the viewing of the client as a case is reflective of a power relationship within the mental health service that focuses on the client's eligibility to participate in the service. It has become the client's and family's responsibility to prove eligibility in order to access the service. Proof comes via the specialist's examination of the case to ascertain eligibility in order to access further specialist care.

Within mental health the mental health social worker spends much of their time making assessments and evaluating the cases they work with. As a specialist the mental health social worker (in this process) has become what Foucault identifies as a power technician of discipline (Moffat 1999). The economy in this social interaction is an economy of power expressed through the social work discipline by assessment, monitoring, evaluation, and examination.

The examination [social work assessment] implies an entire domain of knowledge related to the specific exercise of power... A surveillance that makes it possible to qualify, to classify, and to punish. It establishes over the individuals a visibility through which one differentiates them and judges them. The effect of the examination is the subjection of interrogated people so that they become objects of measurement and study. (Moffat 1999, 222)

Historically social work has its roots as a disciplinary power and was a political necessity used to distinguish the suspect poor from the respectable citizen (Moffat 1999). Its aim was to ascertain the difference between the demands of those in legitimate need from those whose needs were seen by those in power as deviant.

A primary function of the social worker historically has been to distinguish the deserving from the non-deserving poor. The worker makes the judgement in order to determine who is worthy of being designated as a beneficiary of charitable or public assistance. Implicit in such judgements is that the non-deserving poor are morally suspect. In fact, the lack of moral fibre characteristic of the non-deserving poor has been perceived as a threat to the moral character of the entire social body. (Moffat 1999, 231)

Ironically this research could be seen as perpetuating this economy of power by assisting the specialist (or non-marginalised) in creating more knowledge and understanding of those identified as the client (the marginalised). Questions within the research need to ask, who does this or any other social work research actually assist? Or, does the discourse of social work research contribute to the pathology of social work research as only another form of disciplinary power?

## **CHAPTER 2 – Literature Review**

### **2.1 Introduction:**

The great commonality within our humanity is that of our ‘experience’. Though varied and unique to us all, it is this experience that shapes our viewing of the world, producing a multitude of views, perspectives, and stories. The narrative of these experiences as told in our stories shape our many varied and unique practices including that of being men. Our ability as men to explore the practices of men has only arisen from the feminist critique of issues such as gender and health (Sabo 1999, 3). Authors such as Connell (1995), Courtney (2000), Addis and Cohane (2005) and Pease (2000), identify the need to look beyond the gendered debate, to ask what lies beyond the current rhetoric and discourse of a Post Feminist response to those issues.

In researching men and their many and varied practices, we need to firstly identify which men and which practices we are seeking to understand. If this becomes our starting point, then which male experience do we attempt to articulate? Men with severe health problems, men with moderate health problems, men with mental illness, men without mental illness, men in poverty, men who are rich, men who are unemployed, men who are unemployable, men with disabilities, men on government benefits, men of different ethnicities, men of different sexual orientation, men who are trans-gendered, or men who are marginalised? If we are to research men, then identifying whose male experience we are attempting to describe becomes pertinent.

Secondly, in the research of men, a huge chasm exists in the current literature for men to articulate their *own* subject positions in relation to issues such as health, disability, and gender (Pease 1997). Addis and Cohane (2005) and Connell (1995) identified gaps in the literature even though,

Men's gendered experience is increasingly visible in our day to day lives... men's gendered experience itself has not been the focus in theory or method (Addis and Cohane 2005, 633-634)

Much of the research and theory on gender and health revolves around women's health (Sabo 1999). This gap in the research and theory of men's health means that men have not been able to actively participate in the development of their own gender identity (Sabo 1999), what Connell identifies as 'doing gender' (Connell 1995). Historically gender research and theory has largely been the domain of women. This research project seeks to add to the gendered debate of men by attempting to identify the many varied practices and experiences of men's health and their access to health services. It seeks to validate men by asking men to articulate their health and illness experiences. Rather than developing a theory and method for men's research, I am hoping to add to the discussion of men's health and ultimately to assist in men 'doing gender' (Connell 1995).

## **2.2 Theoretical Positioning**

### ***2.2-1 Introduction:***

For the social work practitioner, there is a need to have an understanding of their own practice, as well as what has or continues to inform that practice. This also applies to the research practitioner, who must also have an understanding of what it is that informs their own subject position in relation to their research. This involves identifying those theoretical frameworks that underpin the research practitioner's research and methodology. This research project has drawn on predominantly qualitative approaches and perspectives that are more reflective of the overall research aims.

### ***2.2-2 Critical Feminist Perspective:***

Within the Feminist paradigm there is a discourse of men and masculinity that has enabled a critique to be made of men (Pease 1997). The initial critique has been made predominantly by the feminist fraternity in response to significant power differentials between the sexes. Shifts have occurred in the last ten to fifteen years, with a new critique of men being done 'by men for men'. The legitimacy of this shift has been questioned and some debate has centred on men's ability to offer a critique from a distinctly feminist perspective. Yet, if men are seen from a health perspective as being marginalised, then from a feminist perspective it is,

Important that those [who are] marginalised are able to determine whether the research meets their needs, interests and resolves their problems (Pease 1997, 147).

The emphasis of the feminist perspective has been an analysis and critique of the power relations between men and women (Pease 1997). Yet, even with the attempt to shift the dialogue to a gendered debate, much of health research has tended to focus on the biological differences and the reproductive factors of women's health with,

A huge amount of research attention has been paid to the hypothesized relationship between reproductive related events such as menstruation, pregnancy, miscarriage, childbirth, premature delivery, infertility, abortion, [and] menopause... This individualising focus on reproductive and intra-psychic factors has long detracted attention and investigation of social and structural determinants of women's mental health (Astbury 1999, 5).

Bio-medical focused research has to a large extent remained focused on the 'sexual difference' between men and women and its resultant inequities rather than acknowledging that men and women have totally 'divergent' or different gendered health needs. It is less an emphasis on comparing the health needs of the sexes and more one of identifying the unique and divergent health needs of each gender. To solely focus on sexual difference,

As an organizing framework is severely limiting when it comes to understanding men's (or women's) experiences of problems in living... understanding the social context of masculinity (and gender more broadly) is similar to the social context of race and ethnicity... Approaching important questions only from a perspective of difference is a bit like assuming we can understand

one racial, cultural, or ethnic group by comparing it with another (Addis and Cohane 2005, 635).

This focus on 'difference' in health research has tended towards a biological or solely physical viewing (Pease 1997), and has neglected a differential viewing of 'power'. This one-dimensional viewing of health lends itself towards a medicalisation and disease-focused model of health. It doesn't take into account,

The interwoven social formations involving historic, economic, political, linguistic, interpersonal, and psychological threads. (Addis and Cohane 2005, 635)

For example; within a New Zealand context this would mean that a meaningful understanding of the needs of Maori health is only arrived at, by comparison with Pakeha people on a variety of measures. This is similar to comparisons between the health needs of women and men. Rather, we need to look at the differentials in power relations between Maori and Pakeha, or men and women, and understand their effects on health. In the process, acknowledging that different populations have different health needs. Foucault (Foucault 1982) sees the need to redirect our attention to understand how this difference in power operates, and how this power has come to be, either knowingly or unknowingly.

Bunch (Bunch 1983) provides a model from a feminist perspective that assists in understanding the theory of such a power differential between men and women.

Bunch developed a feminist model for understanding theory that she uses in her work

as a feminist educator. She identifies four interconnected parts of theoretical analysis that include,

- The Description – describing what exists
- The Analysis – why that reality exists
- The Vision – determining what should exist
- The Strategy – hypothesising how to change what is to what should be.

(Bunch 1983, 251-252)

The discourse surrounding masculinity studies has provided a theoretical understanding of what Bunch identifies as the ‘description’ and the ‘analysis’. Yet after this, the literature and data become less comprehensive, lacking what Bunch describes as ‘the vision’ and the ‘strategy’. Bunch identifies that vision,

Requires the establishing principles (or values) and setting goals. In taking action to bring about change, we operate consciously or unconsciously out of certain assumptions about what is right or what we value (principles), and out of our sense of what society ought to be (goals). This aspect of theory involves making a conscious choice about those principles in order to make our vision and goals concrete... Visions, principles and goals will change with experience, but the more explicit we make them, the more our actions can be directed toward creating the society we want, as well as reacting to what we don't like (Bunch 1983, 252).

Within men's health this means asking men what they see of value for men's health. It also involves asking men how they think men's health ought to be and how it should be shaped. Within mental health this may mean comparing how different men with mental health problems navigate the ‘demands of traditional masculine norms and ideologies’ (Addis and Cohane 2005, 640).

From here the development of what Bunch (Bunch 1983) identifies as the ‘strategy’ or how to change from what is to what should be can begin. This is viewed as a process by which,

We draw out the consequences of theory and suggest the general directions for change. Like the other aspects of theory, this involves a combination of information gathering and creative speculation. It entails making judgements about what will lead to change – judgements that are based both on description and analysis of reality, and on visions, principles, and goals. Developing a strategy also involves examining various tools of change... determining which are most effective in what situations... And in working out which strategies will be most effective, the interaction between developing theory and actively experimenting with it becomes most clear. For in all aspects of theory development, theory and activism continually inform and alter each other (Bunch 1983, 253).

Contextually, Bunch’s use of activism was a response developed during the second wave of feminism. From a social work practitioner’s perspective activism is, and continues to be, intrinsically linked to our New Zealand social work practice as one of the practitioner’s ethical responsibilities, part of their ‘responsibilities to the wider community’ (ANZASW 1993, 11). Bunch identified theory and activism as a key to informing understanding and knowledge. Similarly, the social work practitioner mirrors this in the social work process by combining theory and action. The result is praxis or reflective practice which informs and develops new knowledge’s.

From a men’s health perspective, the creation of a strategy implies making concrete decisions, what Bunch terms as ‘judgments’ (Bunch, 1983), based on what she already identified via the analysis and description (of men’s health; that which we already know) so as to identify what tools are needed to make change.

Much of the description and analysis of masculinity in literature has been embedded in the roots and rhetoric of an educative feminist perspective. This perspective has adequately described the 'what' and 'why'; the description and the analysis. What hadn't occurred within this educative feminist perspective for men is 'determining what should exist and how to change what is to what should be' (Bunch 1983).

Feminist perspectives provide a starting point for men to begin to reposition themselves. As it has been for the journey of women within the feminist movement, change for men can only occur for men, by men. Only men can assist men in creating a new discourse about what lies beyond the gendered debate for men.

### ***2.2-3 Social Constructionist Perspectives:***

Social Constructionist Perspectives are a post-modern response to a previously dominant positivist paradigm, which says that all knowledge has an 'essential unity' and that knowledge can only be found, discovered, or at the very least acquired (Irving, Chambron et al. 1999). The social constructionist perspective is based on the belief that no one view (or individual's experience) of reality can adequately claim to have the answer to a particular and specific understanding of that reality (Payne 1997).

A Constructivist perspective decries the notion of truth as something that lies somewhere out there, just waiting to be found (Irving, Chambron et al. 1999). Rather, that,

Reality instead is contingent and historical, constructed out of language and cultural codes. There is no knowledge that is true in itself, that is independent of languages, and institutions that we create and invent. Empirical reality does not exist as a universal

truth but as an unending collection of stories that we tell. The truth is made not found. Meaning is acquired through culturally conditioned paradigms (Irving, Chambron et al. 1999, 32).

Within men's health, if truth is not objective but something that is created, then the question of whose truth men's health is aligning itself too, is raised. If truth is seen to be continually constructed, reworked, and re-constructed then the truth of last century is not necessarily the truth of this century. This does not mean that we disregard the truths of last century, but, rather, that these truths are continually being added too, reworked, and constructed.

If health is part of this process of continual construction, reworking, and re-construction, then it is imperative that we, in our knowledge making, have an understanding of the language, cultural codes, and culturally conditioned paradigms that shape men's experience (Irving, Chambron et al. 1999). A social constructivist approach provides a framework for this to occur. Within mental health research a social constructionist discourse means that,

Qualitative approaches to research on men's characterisations of mental health problems are well equipped to deal with the complex and shifting constructions of meaning in ways that traditional empirical and quantitative methodologies are not. (Addis and Cohane 2005, 641)

#### ***2.2-4 Social Learning Theory***

The core tenet of Social Learning Theory acknowledges that behaviours, beliefs, and attitudes, are all learned via our individual social environments. As we are all socially constructed beings (Payne 1997), we are shaped, directed, or neglected via this process of social construction. For males, it means that though we are born a male, it is via our cultural context that we do (or do not) become men (Addis and Cohane 2005). The empirical positivist and predominantly psychological approaches of Social Learning Theory tend to default to a focus on social learning via the context of role, namely our sex role or gendered role.

Unfortunately this is largely reductionist in approach, as the focus shifts toward a biological viewing of sex roles. Though useful in highlighting what a possible negative hegemonic masculinity may look like and how it has come to be, it does little more than create an analysis paralysis. This is a perpetuation of that which we already know, what Bunch (1983) identified as the description and the analysis. It does not assist in identifying what lies beyond the gendered debate for males, or men with mental illness, that of vision (determining what should exist) and a strategy (hypothesising how to change what is to what should be) (Bunch 1983).

#### ***2.2-5 Grounded Theory***

Grounded Theory as a qualitative approach allows for the interaction of both ‘theory’ and ‘data’ (Neuman 2000). Unlike a more positivist and empirical based approach that

seeks to fit the research data into a specific theory; grounded theory differs significantly in that it follows a more inductive process (Neuman 2000). It begins by asking an initial question, through which a theory (or theories) are hypothesised and developed during the data collection process. Here the data and theory are not mutually exclusive, but interact (or inform) each other. Therefore, the raw data may change the perspective or theoretical approach of the research. Likewise the theoretical perspective may produce different or specific lines of questioning that may follow on from the original research question. Rather than the theory informing and justifying the data, instead theory is developed out of the data (Neuman 2000).

Grounded theory tells us what is going on... [it] tells us how to account for the participant's main concerns, and reveals access variables that allow for incremental change. Grounded theory is what is, not what should, could, or ought to be (Denscombe 2003, 110).

This research process asks the initial question; 'what helps or hinders men's access to a community mental health team'. This fits well with a grounded theory approach, as this research is primarily interested in discovering the male respondent's position and viewing of this issue. It is an attempt to discover what their experience of access is, rather than a hypothesising of how their access might or could be.

Analysis is central to grounded theory approaches, with data being analysed and theoretical perspective being developed 'out of' the data. It is the data or research that informs the theory. A second layer of analysis occurs within this research process via focus groups, with the primary data (collected, collated, and coded from the interviews) being further analysed, added to, and checked for the accuracy of the themes elicited from the interviews.

## **2.3 Gender**

### ***2.3-1 Introduction:***

This section on Gender will identify how the methodology of ‘Gender Relational Analysis’ can be used to assist in developing health services by identifying the gaps in health service delivery in New Zealand for both men and women. It will discuss the impact of ‘Multiple Masculinities’ and how current service delivery perpetuates the cycle of non-attendance of men to health services. This section will highlight the need to understand the relationship between ‘Patriarchy’ and ‘Masculinity’ and how the former impacts our viewing of men, in turn shaping our understanding of the later. This section will investigate the concept of ‘Gender Equity’ and discuss how equitable we are in our delivery of healthcare services for men. Finally, it will introduce the idea and impact of ‘Misandry’, and how this further entrenches attitudes (both personal and societal) about men, that are reflected in their non-involvement in health services in New Zealand.

### ***2.3-2 Gender Relational Analysis:***

Feminist thinking and critique has had a major influence in understanding masculinity as a social and global phenomenon. It has been central to transferring masculinity onto the gender map for ‘gender analysis’ (Pease and Pringle 2001). Gender analysis as a methodology encompasses those differences in women’s and men’s opportunities, needs, incentives, circumstances, health status, and quality of life (Sabo 1999). It is

used to redress gender biases in policies, programme design, management, implementation, and review process (NSW Health Department 2000).

In the field of Health, gender analysis can highlight the differences in the 'determinants' of health and ill health, identify services used, and 'explain differences' in women's and men's 'choice and use' of services. It seeks to identify and remove 'barriers' to achieve gender equity (NSW Health Department 2000)

Health is not viewed from a men or women's perspective, but rather from a local, regional, and global context. This avoids an adversarial and insular approach to women's and men's health. Gender analysis acknowledges that the impact of gender in health occurs within a social context and not solely a medical one. These social factors contribute significantly to a positive or negative health status (Pease and Pringle 2001). Gender Relational Analysis aims to,

Identify, analyse, and act upon inequalities that arise from belonging to one sex or the other, or from unequal power relations between the sexes... proponents of gender equity call for more 'gender aware' policies (Sabo 1999, 16).

In applying a gender analysis to mental health services in New Zealand, we see significant gaps. Reports on the future direction of Health in New Zealand from the Ministry of Health highlight these gaps in their 'failure' to address men's health by neglecting to talk of men's health (Ministry of Health 1999, Ministry of Health 2000, Ministry of Health 2003, Ministry of Health 2004).

The majority of services for men in New Zealand are 'reactive' in nature, and tend to focus on 'reactive' service provision (i.e. forensic services, anger management, stopping violence programmes, programmes in prisons, treatment programmes for sex offenders, probation services, etc). These types of service, though needed, reinforce that which we already know, those negative and dominant discourses for men, whereby men are seen as not okay (MacDonald and Crawford 2002). The 'limited' rhetoric of men's health in New Zealand is reflective of a pathologising approach to health (MacDonald, McDermott et al. 2000) that ends up highlighting the deficits of being male (Goodyear-Smith 2003), that somehow being male with a health problem is not okay.

In contrast with this are the 'protective' services for men (i.e. fathering, mentoring programmes, positive parenting programmes, etc). Though smaller in number, they none-the-less focus on the positive aspects of masculinity and seek to introduce a new rhetoric within health service delivery that it is okay to be male. MacDonald et al (2000) term this as a Salutogenic (versus a Pathogenic) approach to health, which invests itself in identifying and promoting health and health enhancing behaviours in boys, male adolescents, young men, and men (MacDonald, McDermott et al. 2000) (King, Sweeney et al. 2004).

In terms of specific services for men within the mental health sector there appears to be a shortfall which reflect not only a deficit model in terms of approach to health, but also reflects a distinct lack of models and frameworks for provision of men's health care (King, Sweeney et al. 2004). From a gender analysis perspective, current health services for men follow a pathogenic and disease model of health. They do not reflect

a model that is gendered, or one that is inclusive of men. Sabo (Sabo 1999) cautions focusing dialogue around an increase in health resources for women in view of men's greater mortality as a,

Type of thinking [that] however reveals a tendency to see issues of gender inequity in categorical and binary terms; i.e., men versus women. Moreover, it places more importance on biological health outcomes independent of social processes that influence health and wellbeing (Sabo 1999, 17).

The use of a gendered relational framework (Pease and Pringle 2001) would ensure a greater gender equity in health, introducing a framework for promoting both women's and men's health. It recognises the significance of gender on the health of both men and women (Cheyne, O'Brien et al. 1999). This significance is experienced in different ways which means that addressing the impacts of gender on health require 'different' strategies for women and men. Positive health outcomes that include men may mean the development of new services that are easily accessed by men and inclusive of them (King, Sweeney et al. 2004), (Adams 1997). The current absence of services for men reflects and reinforces the current discourse of hegemonic masculinity, and a rhetoric that speaks punitively and negatively of men and their health. All of which ensure the continued lack of men accessing health services. Within the New Zealand context strategies for women's health have been developed. These are reflected within policy and specific health policy for women (Ministry of Health 2004), (Ministry of Health 2000). What we do not see and have not yet developed in New Zealand is a strategy for men's health.

### **2.3-3 *Multiple Masculinities***

The discourse of feminism has a multiplicity of frameworks, practices, and perspectives, that include liberal feminist, radical feminist, socialist feminist, critical feminist, cultural feminist, women centred, and gender specific perspectives (Payne 1997). A multiplicity of perspectives that enable women to capture the experiences and varying perspectives of other women. Each perspective adds to, and informs the discourse of feminist perspective and practice for women and men. Within the discourse of Masculinity there exists what Connell (1995) and his contemporaries (Addis and Cohane 2005, Stanistreet 2005, Pease 2000, Sabo 1999) acknowledge as 'Multiple Masculinities'. This idea of multiplicity stems from a social constructionist paradigm whereby all:

'Reality' is knowledge, which guides our behaviour, but we all have different views on it. We arrive at shared views of reality by sharing our knowledge through various social processes, which organise it and make it objective... individuals contribute through institutionalisation and legitimation to the creation of social meaning, within the social structure of societies. We see a spiral of constantly shifting influence, creating and recreating structures and these changing structures re-creating the conventions by which people live in them (Payne, 1997, 14).

Understanding the dynamic process of the social constructionist paradigm, that informs Connell's (1995) idea of 'multiple masculinities', assists in developing an important context in which to explore the many varied subject positions of men, their multiple masculinities.

Without exploring this question we are left with a discourse of thought, that Pease (Pease 2000) terms 'binary thinking', the us versus them. This binary creates a duality, a dyadatic power relationship that positions the discourse of masculinity around what Foucault (1982) identified as being 'subject to' by 'the other'.

There are two meanings of the word 'subject': subject to someone else by control and dependence, and tied to his own identity by a conscience or self-knowledge. Both meanings suggest a form of power that subjugates and makes subject to...this form of power that applies itself to immediate everyday life categorizes the individual, marks him by his own individuality, attaches to him to his own identity, imposes a law of truth in him that he must recognise and the other have to recognise in him. It is a form of power that makes individuals subjects (Foucault 1982, 331)

Smith & Blanc (1997) refer to it as a social transaction that is binary, where each participant in the transaction desires a sense of 'legitimacy or expertise' (Smith and Blanc 1997, 297). This being legitimated is outworked and displayed in the form of a power relationship that is predominantly inequitable. Likewise Kelly & Sewell (1996) identify this as a 'binary logic' (Kelly and Sewell 1996, 15) which creates a viewing between two parties that all things are 'separate, mutually inconsistent, or contradictory' (Kelly and Sewell 1996, 15). Here the outworking of power in the relationship reinforces what Pease (2000) identified as a binary power relation.

Likewise men with mental illness who are involved with the mental health service in particular a community mental health team are viewed as being 'subject to' by the health professional. This 'being subject to' forms a binary power relationship that reinforces the binary of the 'subject' and the 'other'. The result is the 'polarising' of viewpoints rather than recognition of an interconnected and diverse spectrum of views

within a body of discourse such as masculinity. The binary power relationship inadvertently creates what Foucault calls ‘the other [or] an opposite’ (Foucault 1982, 329). This is reflected in,

The power of men over women, of parents over children, of psychiatry over the mentally ill, of medicine over the population, of administration over the way people live... [power is] not limited to one country, not confined to a particular political or economic form of government (Foucault 1982, 329).

This polarising of views has historically paralysed the debate and reinforced a negative dominant hegemonic discourse of masculinity. Stanistreet (2005) describes this hegemonic discourse as the result of the ‘form’ that masculinity takes.

While hegemonic masculinity significantly benefits dominant male groups, it also results in incredibly high death rates of young men as they seek to make the transition out of adolescents and into adulthood, adopting hazardous lifestyle often resulting in violent death, drug abuse, and suicide. It is the form of masculinity that is as dangerous to men as it is to women (Stanistreet 2005, 246).

The end result of this is what Stanistreet (2005) identifies as a continual ‘constructing and sustaining [of] risk taking and self destructive masculinities’ (Stanistreet 2005, 243). Addis and Cohane (2005), Stanistreet (2005), and Adams (1997) say a good place to begin in understanding men’s masculinity and its impact on health is to ‘examine the ways different men talk about the experience of mental health problems while negotiating the demands of traditional masculine norms and ideologies’ (Addis and Cohane 2005, 640).

Undoubtedly the demands of men to arbitrate their personal experiences in accessing health services like a community mental health team, juxtaposed with societal expectations of what it means to be a man (Adams 1997) produces for men both an internal and external tension. The expectations (external tension) of traditional and societal norms of what it means to be masculine coupled with men who may already be marginalised by mental illness (an internal tension) further entrenches and oppresses these marginalised men in their masculinity. These ‘marginalised masculinities’ (Stanistreet 2005) are not only oppressed but are also oppressive. Similar to the discourse and rhetoric in what Freire (1996) describes as the oppressed who then becomes the oppressor (Freire 1996).

Freire (1996) and his work with oppressed peasants and their oppressive overseers and landowners discuss this type of power relationship being continually perpetuated because the ‘societal context’ of the relationship doesn’t change (Freire, 1993, 28). Similarly for marginalised men with mental illness, their oppression remains and they continue to be oppressed because their societal context does not change. The context of the external tension (the societal) reinforces the context of the internal tension (the personal) and vice versa. Like the peasant, marginalised men’s oppression remains and is perpetuated because their oppressive context remains unchanged.

Freire (1996) identified that the peasants who want their freedom, seek to become overseers in order to someday afford to buy their own land, to become landowners, the new landowners – the new oppressors. They in turn need peasant workers and overseers to ensure that their new position of ‘freedom’ as landowners is maintained (Freire, 1993, 28). Even though they move from a place of being oppressed to the

place of landowner, it can be said that they are still 'contextually oppressed', locked into and paralysed by the unhealthy power relationship of the 'other' (Foucault 1982), in this case the peasants and overseers.

Likewise for men with mental illness their 'context' has struggled to change. Being men coupled with a negative societal perception of what it means to be masculine has meant that marginalised men (like men with mental illness) have historically been unable to look at the specific issues affected by masculinity. Particularly issues in which men figure disproportionately higher; such as drink driving, accidental deaths, suicide, HIV/ AIDS, drug and alcohol abuse (Broom 2000). Instead, marginalised men have been paralysed, remaining stuck in a contextual relationship that views them as being homogenously oppressive and not as oppressed. Adherence to a solely feminist analysis and understanding of masculinity appears only to reinforce this old context that views all men as oppressors (Pease 2002). The need exists for men to occupy a new context and to be able to reposition themselves accordingly (Courtney and Keeling 2000).

What has the context been for women? Historically via feminist perspectives, women have been able to develop a context for themselves from which to subvert a negative hegemonic masculinity. Cheyne et al (1999) identify the notion of 'sameness versus difference', similar rhetoric to the idea of gender equity versus gender equality. Here women are not seeking to be 'the same as men' (Cheyne, O'Brien et al. 1999, 110) but rather to challenge and legislate those areas in society which are not unbiased for women as they are for men (Enloe 2000).

How does this highly visible feminist context translate for men? Is it transferable and if so, for which men? As for women, is there a context whereby areas like health can be more equitable for marginalised men? Or does the feminist context that has been useful for women actually reinforce for men the dyadic relationship, producing and adding to rhetoric that places all men (including marginalised men) into the negative homogenous category of oppressors? The reinforcing of a context similar to Freire's (1996) idea of the new landowners becoming the new oppressors. The creation of a binary-based relationship that is for men embedded and entrenched in the female and male, us versus them polarising and paralysing debate. Likened to the paralysis that Tollich (2002) identifies in Pakeha's reluctance to engage in research involving any aspect of Maori where,

As Pakeha they had learned that they had no place researching Maori. At no time had they been taught how to consider cross-cultural research... What are the ethical considerations of this exclusion of Maori... The ethical principle that they violated was harm (Tollich 2002, 165).

The paralysis of the gendered debate means that men have been unable to cross the 'cross cultural' divide of gender and research men's health. In particular men have been reluctant or felt unable to look beyond the gendered debate (Pease 1997, Connell 1995) for fear of being solely viewed as the progenitor of patriarchal power relations rather than its protagonist.

Within the health and mental health field men are placed contextually within a predominantly negative hegemonic masculinity as both clients and clinicians. Though they may personally view themselves as protagonists or what Smith & Blanc (1997)

identify as the 'smuggler', they are viewed societally as progenitors of patriarchal power relations. The messages that are given to men at this societal level are reflected at the personal level; that men don't have health problems, and that men don't need to access health services. Much of the quantitative and qualitative analysis and description on men's health adequately describes that which we already know; that men have a poor record of accessing health services, and make up an alarmingly and disproportionately high percentage of health statistics (Ministry of Health 2004).

A gap exists in New Zealand literature that explores the experiences of men, particularly in what they identify as being helpful or a hindrance to them developing a positive hegemonic discourse in health. What King et al (2004) and MacDonald et al (2000) term as a 'non-deficit model' of health. A focus not on what is not happening for men, but on what needs to happen for men. A gap in the discourse that could assist in the useful development or provision of health services for men in New Zealand.

#### ***2.3-4 Differentiating between Patriarchy and Masculinity:***

When looking at the study of Masculinities one invariably must come to terms with understanding and identifying the differences between 'patriarchy' and 'masculinity'. Patriarchy has been primarily used as a 'historical and contextual explanatory tool of how things have come to be' (Pease 2000, 13).

Contextually and historically both patriarchy and masculinity have been used to describe the predominant negative discourses surrounded in being male. This rhetoric

has acted as a re-enforcer, placing all men into a negative homogenous category. This further creates a binary-based relationship that is embedded and entrenched in the female and male, us versus them, debate.

Pease (2000) suggest that men must be continually aware of the effect that patriarchy has. I agree that it is important for men to have an understanding of patriarchy as a historical and contextual explanatory tool in understanding how things have come to be, as a starting point. Yet, I am unsure about what the continual revisiting of a negative hegemonic discourse (and the hegemonic shaming, blaming, guilt, that accompanies it), does to create a positive hegemony for men. If the context of a negative hegemonic discourse remains via a continual re-visitation, how then is a new context to be created. Similarly to Freire (1996), if the negative hegemonic discourse for men (the oppression) remains unchanged, the old context (the peasant turned landowner) continues to reinforce a binary power relationship (remaining oppressive in order to keep his job and land).

A continual re-focussing on the context of patriarchy can have the tendency to create a broad viewing of men that sees all men as bad. It is crucial that we identify whose context we are attempting to define, or explore, or understand. For Maori and Pacific Island men, masculinity is arrived at via a context unique to them. How they 'do gender' (Connell 1995) is unique and specific compared with how Pakeha or Asian men 'do gender'. If we position the debate solely around a broad viewing of masculinity in terms of patriarchal relations then we need to be specific in identifying which masculinity we are describing. If we fail to do this then the premise for the gendered debate is that 'all men' actively and continually seek to oppress 'all women'

‘all of the time’. For men who are already marginalised (via mental illness) and oppressed by patriarchal relations, the allocation of blame of the male gender does little to assist those who are already marginalised to change. The focus on the discourse and rhetoric of patriarchy appears to reinforce what the feminist critique has sought to break down, the discourse of ‘us versus them’. Pease argues,

That patriarchy is best understood as an historical structure with changing dynamics, allowing... for opportunities of intervention. By contrast some, feminist version of the concept of patriarchy allow no position from which men can change the gender order (Pease 2000, 13).

The need exists to shift the rhetoric away from patriarchy toward masculinities, ensuring that we are clear to identify ‘whose’ masculinity we are seeking to extrapolate. If we do not do this, then we simply reinforce a gender bias perpetuated by a binary relationship that reinforces the role of the ‘subject’ and ‘other’; a viewing of ‘all’ men as oppressors (perpetrators) and ‘all’ women as oppressed (victims). It would be incorrect to suggest that women have not been victimized and that men have not been oppressive, though is it an issue of gender or one of ‘power’ and ‘power relations’. The power relations that result in some women becoming victims and some men being oppressors and increasingly vice versa.

### **2.3-5 Gender Equity:**

As Goodyear-Smith (2003) states, it would appear naive to suspect that because resources have been going into servicing a population, yet that population does not appear to access those services, that one would simply infer that this population now does not need services. Reflective of a neo-liberal approach to the delivery of health services that focuses on the needs of the market, (in this case men not accessing health services) means there is no market for men's health, and no need for delivery of health services to men. Surely one would ask questions of why that population doesn't access services? Or what needs to change in order for improved usage by that population? Or whether the services currently provided are helpful, or in and of themselves a hindrance? Current approaches in men's health policy yet again reflect a deficit model and approach to health that implies,

The problem lies with men themselves, some form of internal deficiency... yet if I throw a party and no one comes, should I blame the no shows? Health services could gain from a change of focus – away from a blame to a search for how to make [services]... more attractive to men. (MacDonald, McDermott et al. 2000, 4)

In New Zealand, much of the focus of health policy has focussed on instigating a gendered approach to health, resulting in the development of services and initiatives for women. This has been much needed with many good services for women having been developed. Currently, the need exists for more service development and research within women's health. What has not occurred in light of a gendered approach to health is addressing the inevitable inequity that the gendered approach has since

created within health research and health service development. The health pendulum appears to be swinging from one gender's agenda to the other, which is anything but a gendered approach.

A key tenet within the gendered approach is that of equity. Though men have historically designed services for women and children, health services have never really been developed specifically for men. Yes, services existed designed 'by' men – yet historically services were not designed 'for' men. Current 'service design' reflects well for women, but not for men. Gendered approaches are working well for women, but appear to be excluding men's health (MacDonald, McDermott et al. 2000).

Tice (1998) identified a historical connection that reflects men's exclusion from health, and women's inclusion predominantly as the result of what she terms as 'professional power' (Tice 1998, 55). Historically this 'professional power' has lain within the male practices of science, rationality, and empiricism. Tice (1998) identified that the premise of helping those in need (the early social worker) was enclaved in values of 'charity', 'goodwill', and 'helping' those in need. This was largely seen as the practice of the feminine, a practice that initially did not need to legitimise what it was doing.

Tice (Tice 1998) identified a fundamental shift in this largely feminine practice of 'working with people' that resulted in it becoming an industry. To work in and develop the industry of working with people meant a need to develop a 'legitimacy' of the work being done (Tice 1998, 52). Those who legitimated the work being done were part of the established professional domain (the practitioners of the masculine).

It was they who questioned the methods and approaches of what was being done by these largely feminine practitioners (early social workers). Their questioning came from their own professional position (or practices of being masculine), which were legitimated via the domain of science, empirical evidence, and quantitative approaches. Tice (1998) identified that it was,

About how professional power shaped the interpretation, narration, and representation of social reality and constructed particular elements as factual and significant. Yet many social workers believed they could put an end to their vagrant professional status by emulating the science of sociology and later throughout the 1920's, the science of psychology. (Tice 1998, 54)

This 'emulation' that Tice (1998) identifies is reflected within our current provision of health services that sees those 'professionals' or 'experts' of scientific practice (the masculine) working predominantly with those seen as unprofessional, un-expert, and unscientific (the feminine).

The rhetoric around gendered perspectives has meant that gendered approaches have now become synonymous with 'women's health'. Yet little attention has been given to men's gendered health concerns (Courtney and Keeling 2000). If we were serious about gender equity within health then we need to ask what an equitable approach to health research and service development would look like? One that ensures inclusivity of the diversity of both women and men's different health needs.

### **2.3-6 *Misogyny versus Misandry: The Teaching of Contempt for Men***

The literature clearly identifies tensions that lie in the dominant popular culture in which a variety of medias continually and systematically represent men as incompetent, idiotic, and infantile (MacDonald and Crawford 2002, Nathanson and Young 2002). The term ‘misandry’ coined by Nathanson & Young (2002) has been referred to as the ‘hatred and vilification of men’. Its counterpart, misogyny, is known as the ‘hatred and denigration of women’ (MacDonald and Crawford 2002). Similar to misogyny, which has sought to denigrate women, the spread of misandry has been seen to not only silence men but to also denigrate and ‘dehumanise men’ (Nathanson and Young 2002, 18).

Dehumanization [also] marks not only those whose humanity has been stolen, but also... those who have stolen it... The struggle for humanization, for the emancipation of labour, for the overcoming of alienation, for the affirmation of men and women as persons would be meaningless. This struggle is possible only because of dehumanisation, although a concrete historical fact, is not a given destiny but the result of and unjust order that engenders violence in the oppressors, which in turn dehumanizes the oppressed (Freire 1996, 26).

Freire (1996), in his work on oppression, identified the process of dehumanization as a double-edged sword. One where,

The situation of the oppression is a dehumanized and dehumanizing totality affecting both the oppressors and those whom they oppress, it is the latter who must, from their stifled humanity, wage for both the struggle of a fuller humanity; the oppressor, who is himself dehumanized because he dehumanizes other’s, is unable to lead this struggle (Freire 1996, 29).

If men in our current context are continually being portrayed in misandric ways by the media, then under a feminist critique or the feminist academic 'le gaze' (Foucault 1982), it could be argued that men are in fact being dehumanized. Who then is the oppressor of men? Has the feminist gaze become that which it originally sought to liberate and free itself from? Has it become 'the oppressor'?

This 'Cultural Pathologising' that contextually dehumanises, both boys and men (MacDonald and Crawford 2002), their identity and needs, lends itself to perpetuating an already established rhetoric that is reflected in the lack of health policy and health practices for men. If men are seen as less than human, and not needing health care because they are too incompetent, idiotic, and too infantile to access it (Nathanson and Young 2002), then this only perpetuates a rhetoric within the cultural pathology that reinforces the messages that it is not okay for men to have health problems; more so that men do not have health problems.

## 2.4 Explaining Health Care Problems for Men

This section will identify four major theoretical explanations of society and their viewing of health care and men's health. They include,

- *Social Democratic (Industrial Society) Theory*
- *Neo-Liberal (Classical Liberal) Theory*
- *Constructionist (Alternative) Theory*
- *The Third Way*

I will also explore an 'ecological systems perspective' (Payne 1997). This perspective accommodates a broad approach, encapsulating the different levels of why it is problematic for men to access health services like a community mental health team.

The ecological system perspective is best applied by exploring this research question of what helps or hinders men's access from the micro, meso, and macro levels.

In order to explain problems surrounding health care for men and what contributes to helping or hindering their access to health services like a community mental health teams, it is necessary to develop a framework for comparison and contrast. I have chosen to expand on the ecological systems perspective (Payne 1997) and identify what the four major theories identify as being problematic for men in accessing health care, or more specifically in accessing a community mental health team.

### **2.4-1 Social Democratic Theory:**

Social Democratic Theory (or Industrial Societal Theory) is based on the premise that the state rather than the individual or family needs to intervene and provide services such as health and welfare for the populous. Responsibility for provision and delivery of health and welfare services lies with government, not with the individual. The states role is to 'adjust' or 'engineer' the social system in order to ensure that it runs efficiently and well (Shannon and Young 2004, 127).

From this perspective, the provision and delivery of health care is seen as 'infinite' (Shannon and Young 2004, 167). The provision of health services is the mandate of the state, with service provision being matched up with client need. The focus is not on the client and their ill health but rather on ensuring adequate health services are provided for by the state. Ill health is seen to be the result of a lack of services by the state whose mandate is to provide policy and structures that provide an array of options of health services for the client (Shannon and Young 2004).

Under this theory illness is not defined by the role of the medical practitioner or specialist (Opie 2000) (Foucault 1982) but rather by 'societal and cultural attitudes' (Shannon and Young 2004, 167). Unlike a classical liberal theory approach that places responsibility for health on the patient, social democratic theory places responsibility for health on the societal context.

In this societal context illness is seen as 'normal' (Shannon and Young 2004, 167) or okay. Men with mental health problems are not seen as patients who need to be cured, but rather as clients who need to be cared for. Health programmes are designed to

treat populations (i.e. men with mental illness) rather than the individual. Health promotion strategies are seen as key in changing the health behaviours of whole populations (like men), rather than targeting the individual male. From this perspective, society is seen as having a distinct role alongside the recipients and participants of health care in promoting positive messages about healthy lifestyle (Shannon and Young 2004, 167), (Turner 2000).

In this context health becomes the business of all members of society rather than the sole domain of the health professional. Society has the responsibility to remain healthy, with the state's mandate being to provide a proficient level of care. Problems in health are seen as problems with societal behaviours. The treatment of these health problems is focused on the whole population rather than the individual with the individuals responsibility being to remain healthy and follow the health messages from the state (Shannon and Young 2004, 167).

#### **2.4-2 Neo-Liberal Theory**

Neo-Liberal Theory is based on the premise of 'free market economics' (Jones and May 1995), that comprises of the individual and the market. Identified as a 'market perspective' (Jones and May 1995, 52) whereby the individuals sole responsibility is to participate in the market. Participation is viewed solely in terms of the individual's ability (or inability) to perform economic transactions (Jones and May 1995). The more individuals that participate in the market, the more competition there is, and more competition means more economic transactions. Competition promotes the

concept of the self interested individual (Jones and May 1995) who chooses to purchase in the market. This in turn reinforces competition which is seen as good and needed to grow the economy. Competition within the market creates an array of choices in which those with differing knowledge, skills, and expertise to compete to sell their services and products in the market (in this case health care). This is said to make health services more efficient as only those that can compete successfully succeed (Shannon and Young 2004).

Health from this perspective is viewed as a solely biological phenomenon with a focus on ill health or disease (Shannon and Young 2004). Within this pathogenic approach (MacDonald, McDermott et al. 2000), the implication is that ill health is something that the recipient can be cured of, with those seen as having the 'ability' or knowledge to cure as the experts with medical specific knowledge. (Opie 2000), (Foucault 1982). Health from this perspective is about illness and illness is about cure, the emphasis being on 'curability. Health systems and services are established with a disease, sick, or pathology focus (Illich 1975) rather than a health focus. (MacDonald, McDermott et al. 2000). From this perspective clinicians interest is in working with the individual (Cheyne, O'Brien et al. 1999) who is seen as diseased or sick and is defined by a role; that of 'the patient'. The role of the health professional is seen as the one who provides a cure with their specific medical knowledge, something exclusive to the health professional (Lupton 1997), (Germov 2000).

In the treatment and care of the patient, if the health professional is unsure about the 'cure', they have the option to refer the patient to the 'specialist' (Foucault 1982). The role of the specialist, like that of the medical practitioner is defined by their use of

specific knowledge's that the patient does not have (Opie 2000). The specialist provides the means to cure the patient, and the responsibility of the patient is to adhere to the treatment regime of the specialist. Non-adherence to treatment is seen as the problem of the patient, not that of the treatment or health service that has been purchased for them.

The Neo Liberal perspective views the problem of men not adhering or attending treatment at a community mental health team as the male patient's problem. The specialists have provided a means for cure or treatment (the community mental health team and its practitioners), and the male patient by choice is ignoring to follow the specific medical knowledge offered by the specialist (Lupton 1997). The problem of treatment lies with the patient (or men) resisting accessing the specialist (the community mental health team). The delivery of health services and treatment is viewed as 'finite' with a focus on the patient taking equal responsibility in the treatment process.

Here the focus is on illness rather than health. The state's mandate is to provide (or purchase) a cure for the individual, not care for the individual. Illness is seen as the result of a disease affecting an individual, rather than a health behaviour that follows a societal trend. The individual with the disease has a right to treatment that is determined by those who provide the treatment, namely the medical professional (Shannon and Young 2004, 165).

### **2.4-3 Constructivist Theory**

Constructivist Theory is viewed as an alternative theory to the other grand theories in that it purports the idea of 'bottom up decision making' (Shannon and Young 2004, 173). Here power, its control, and its exercise do not sit with an individual authority, or a state authority, but with a collective. The community has the collective authority to make decisions and exercise power. From this perspective it is the community that has the power to assess and decide on how to meet their own needs (Payne 2005).

Health from this perspective is viewed as being intrinsically linked within the context of power and control (Shannon and Young 2004) (McHoul and Grace 1993) (Opie 2000). Outside constructivist theory the structures and systems of health services and their provision are,

Characterized by hierarchical and authoritarian institutions of the state, business corporations, the professions, science, work, and the family, which allow some groups to dominate other (Shannon and Young 2004, 172).

Within constructivist theory the provision and delivery of health care services comes from the community rather than from the state, the institution or the individual.

Constructivist theory purports that health care is viewed holistically both in a community and a global context (Shannon and Young 2004). The participants of health are not viewed as patients who have no power to make decision, nor are they viewed as clients who abdicate responsibility for their health needs to the state. They are viewed as consumers who are involved, participate, and act as decision makers in the provision and delivery of health care (Kelly and Sewell 1996) (Linthicum 1996).

Alternative theory views the consumer of health services as the 'expert' (Opie 2000), the holder of specific knowledge's crucial to knowing what the form and function of the health service for men should look like. Developing the collectivity of the consumer community rather than the individual consumer is the focus. The aim is to create,

A model that stresses the need to strengthen community development, develop personal skills, create supportive environments, and reorient health services. These are the dynamic, co-existent, and independent strategies, driven by principles of enablement, mediation, and advocacy towards the clear goal of building health public policy (Knight 2000).

From this perspective men with mental health problems are viewed as the holders of power. They are the ones who decide on the shape and form the provision and delivery of health services for men should take.

#### **2.4-4 The Third Way**

The adoption of the 'Third Way' is viewed as a follow on from the 'Second Way' (Giddens 2001) of neo-liberalism, which many agree did,

Little to help alleviate the extreme inequalities that exist between the poorest and richest countries. Within the developed societies, the electorate has recoiled from neo-liberal policies, which suggest it is up to the individuals to fend for themselves in a world marked by high levels of technological change and insecurity. The return of left of centre parties to government in so many countries sends a clear signal that people don't want to be left unprotected in the face of the global marketplace (Giddens 2001, 2).

The result of the failure of neo-liberalism to deliver what it promised, ‘higher relative economic growth, lower poverty, and reduced unemployment’ (Dalziel, 2001, 87) combined with dramatic changes in how we view ‘globalisation, the emergence of a knowledge economy, and profound changes in peoples everyday lives’ (Giddens 2001, 3) has meant the need to look for another way. As the ‘core principals of socialism are viewed as no longer applicable’ (Giddens 2001, 2), the Third Way was seen as the ‘renewal of social democracy in contemporary social conditions’ (Giddens 2001, 2).

This renewal of ‘social democracy’ has seen industry moving away from the traditional ‘blue collar’ (Giddens 2001, 4) arena into a burgeoning industry of technologically advanced, high skilled workers. Both technology and globalisation have meant significant changes in the lives of the individual, the family, and the community (Giddens 2001) including a dramatic increase in their ability to ‘participate’ at different levels within society. Participation has meant an increase in ‘partner-shiping’, individually, regionally, nationally, and globally.

The *Blueprint for Mental Health* (Mental Health Commission 1998) identified gaps in health services and service delivery. It identifies how things need to be, yet not how to get there; the rhetoric and the reality did not match. Similarly the Third Way endorses a rhetoric of participation, yet how the reality of this matches up is not yet known. Health from this perspective of participation is viewed through the lens of increasing partnerships. Seen most visibly in New Zealand health with the establishment of partnerships between government (the DHB), the primary health provider (the PHO) and the non-governmental agency (the NGO) (Ministry of Health 2006).

The creation of partnerships in health service delivery is further reflected in the 'team-based' approach to health delivery, the development of the 'multi-disciplinary team' (Opie 2000), and the increased involvement of families in the planning and choosing of options for health treatment. For men who are marginalised by ill health, the Third Way invites men into the process of treatment, asking for their choice and options. Central to the delivery of health services is the invitation to partner with the health worker or health service like a community mental health team.

## **2.5 Men's Repositioning:**

### ***2.5-1 Introduction***

This section on 'Men's Repositioning' will discuss the current position that men 'occupy' in relation to accessing health services in New Zealand and how this is a reflection of a larger need for men to 'reposition' themselves at the micro, meso, and macro levels within society. It will outline ways in which men can do this at the micro (or personal) level as well as identify at the meso level (the health systems context) if men are able to reposition themselves or what might need to change in order for them to do so. And finally at the macro level I will discuss what needs to change in order to develop a societal context from which men are able to reposition themselves.

Pease (2000) talks of the idea of 'occupancy', whereby men occupy the position of men, yet all men do not occupy the position in the same way. The current discourse of a negative homogenous masculinity does little to assist us in understanding the many varied experiences of men, and does little to assist men to 'reposition' themselves (Pease 2000). It does little to enable men to take part in discovering or developing a positive hegemonic masculinity, or understand men's negative hegemony. If men are to be assisted to reposition themselves, then what Bunch (1983) identifies as the 'strategy – the changing what is, to what should be' is needed.

Only if men are able to reposition themselves to a positive hegemonic masculinity, are their interests reconstructed (Pease 1997, 155).

This piece of research broadly seeks to question men and ask,

- What marginalises them?
- What inhibits them from being able to reposition themselves individually and societally?
- Is it safe to do so?

I have not been able to find these questions or answers to these questions in the current literature. It seems that these questions have not been asked of men and there is limited research that tells us, of men's experiences and views of what they need, to be able to reposition themselves. Instead we have a plethora of information that focuses solely on a negative hegemonic masculinity, a negative discourse or 'deficit' viewing of men. There is limited research that looks at a positive discourse or 'non deficit' viewing of men (King, Sweeney et al. 2004, MacDonald, McDermott et al. 2000).

### ***2.5-2 Macro Perspectives: Developing a Societal Context for Men's Health***

What are societal viewings of men's health? What is society doing to assist in 'men letting go' of dominant forms of hegemonic masculinity, or not? Feminist perspectives contend that due to contextual and historical patriarchal power relations, women not men are more marginalised and so a more gendered approach to health policy is needed. It has been viewed historically that in health studies women have a propensity to be excluded (Lumb 2003, Goodyear-Smith 2003). Historically this was so, yet this has changed significantly in the last fifteen years.

A retrospective examination of 441 original clinical studies published in the JAMA, Lancet, and New England Medical Journal... found that only 3% excluded women from the subject population in 1991 (compared with 11% in 1971). In 1991 12% of the studies were specific to women's health but only 0.7% were specific to men's health... a Medline search for the year 1980 to 2002 found 7,991 articles using the keyword 'women's health', compared to 179 using the keyword 'men's health', with 28% (51) of the latter related to HIV infection in homosexual men... while male subjects may have been assumed to be 'generic' for human beings, there has been little research specifically on the health of men. (Goodyear-Smith 2003, 23-24)

Men currently figure disproportionately in areas of health such as drug and alcohol addiction. They have a high propensity to violence, high rates of accidental death and suicide, high mortality rates for testicular, prostate cancer, and cardio-vascular disease, and high rates of risk taking behaviour (Ministry of Health 2004, Goodyear-Smith 2003, Adams 1997). Even though men figure highly in these areas of health, in our current climate of gender specific policies men's health appears to be excluded. The '*New Zealand Health Strategy*' (Ministry of Health 2000), makes numerous references to the work of continually developing strategies for women's health, identifying key stakeholders and those involved in inter-sectorial collaboration. It appears that the New Zealand National Health Strategy reinforces a rhetoric long associated with men's health, that men do not have health problems. This appears problematic as it is something that the statistics do not reflect (Ministry of Health 2004). So where does this discrepancy come from, this reinforcing of a dominant hegemonic discourse for men and their health, that at the coal face helps to ensure men do not access, or need to access health services. It portrays men as not having problems with health and reinforces a viewing of health that sees it as the sole business of women (Pease 1997), (Connell 1995).

The *'New Zealand Health Strategy Discussion Document: Summary of Submissions'* (Ministry of Health 2000), reinforces the idea again that men have no need for health services. The document makes one reference to 'men' (Ministry of Health 2000, 19) compared with eight specific references to women, women's health, women's groups, and women's health initiatives. The sole mention of men is in the context of identifying 'men' as a homogenous grouping being able to pay their GP's for health care costs. Again, reinforcing a negative hegemonic viewing of men, it fails to identify which men they are meaning, those men on Unemployment Benefits, those on Sickness Benefits, or those on Invalids Benefits.

It does raise the question of whether men are being marginalised by a lack of attendance to men's health needs, as shown in the 'absence of rhetoric' surrounding men's health. New Zealand has a successful and vibrant National Women's Health Strategy actively promoted by the Ministry of Women's Affairs - *Minitanga Mo Nga Wahine*. Yet, the absence of a National Health Strategy for Men appears to reflect the absence of rhetoric and discourse around men's health. This absence of a 'men's language for men's health', is in part the result of a societal viewing that places no 'value' on men's health. It also calls into question the 'value' that society places on being male (as children, adolescents, young men, and men) in general.

Is the focus on women's health issues inadvertently excluding men, and adding to the already increasing marginality of men's health within New Zealand society? This raises the question of where else men in New Zealand are, or have been marginalised? Or is it simply, men's turn to be marginalised?

In their document 'The Health of Women', aimed at improving the health of women throughout their lives, and Auckland health authority asserted that women 'are pivotal to the health of families' and advocated health service improvement to 'better meet the needs and wishes of women'. In contrast the equivalent document 'The Health of Men' identified the primary cause of male ill health as 'the social construct of masculinity' with the chief message that male health gains require men to be less 'masculinist' (Goodyear-Smith 2003, 24).

The gendered approach appears to be having the opposite effect for men, highlighting deficits in male health, yet doing nothing to address those deficits. Instead, it seems to perpetuate and reinforce a culture of 'blame' of men and men's health. Men are being viewed as solely 'culpable' for their health problems. The gendered approach to health reflects a one sided agenda rather a truly gendered viewing of health.

A similar gendered approach can be found in a comprehensive Ministry of Health report on Mental Health. The chapter on women offers a sympathetic approach to their mental health problems, whereas the chapter on men describes attitudes critical of men or is blind to there needs...that being a man is 'bad' for one's health. (Goodyear-Smith 2003, 24)

The marginalisation of men's issues is also reflected in other areas such as men's sexuality, men's ethnicity, and men's gender (Pease 2002). Rather than being addressed these marginalities end up becoming key indicators or key determinants effecting men's health and wellbeing (Refer Table 2.5). Little is done to address the individual and specific marginalities of men that inform, produce and add to these key determinants of men's health.

**(Table 2.5) (Courtney 2003)**

**‘Thirty Key Determinants of the Health and Well-Being of U.S. Men and Boys’.**

**Behaviours of men and boys**

1. Health-promoting behaviour
2. Risk-taking behaviour
3. Physical abuse and violence
4. Social support
5. Behavioural responses to stress
6. Health care use

**Health-related beliefs and the expression of emotions and physical distress**

7. Self-rated health status and behaviour
8. Perceived susceptibility to risk
9. Body image
10. Personal control
11. Readiness to change unhealthy behaviours
12. Masculinity
13. Expression of emotions and physical distress

**Biological, socioeconomic, cultural, and environmental factors**

14. Biology and genetics
15. Psychophysiology
16. Ethnicity
17. Socioeconomic status
18. Age
19. Marital status
20. Occupational hazards
21. Unemployment
22. Imprisonment
23. Societal beliefs about masculinity and the social treatment of boys and men
24. Media and advertisements
25. Health knowledge

**Health care**

26. Insurance coverage and health care costs
27. Health care access
28. Institutional influences and research methodology
29. Clinician-patient interaction and communication
30. Clinicians' gender biases

This may be due in part due to the tensions between dominant social constructions of 'perceived' masculinity and those 'actual' circumstances that marginalised men find themselves in. Men with disabilities, whose masculinities are marginalised in a variety of ways by hegemonic masculinity, battle in attempting to recreate their gender identity. Within this social constructionist paradigm, masculinity has shifted,

To be an aspect of not only what one is, but more fundamentally it is something that one does in interaction with others (West & Zimmerman, 1987)... Murphy (1990) observes that men with disabilities experience 'embattled identities' because of the conflicting expectations placed upon them as men and as people with disabilities (Gerschick and Miller 1994).

Marginalised men live in a great tension of feeling the pressures of hegemonic masculinity that calls for all men to be strong, self reliant, aggressive, independent and healthy; the 'perception' of what it is to be masculine. Set against this are the 'actual' circumstances that many marginalised men find is their reality, that of weakness and vulnerability, and ill health (Gerschick and Miller 1994). For marginalised men,

Gender identity and practice are maintained as the crossroads of the demands of contemporary masculinity and the stigmatization associated with disability... being recognized as masculine by others is especially difficult... Yet not being recognised as masculine is untenable because, in our culture, everyone is expected to display an appropriate gender identity. (West & Zimmerman) (Gerschick and Miller 1994, 314)

Set amongst this marginality, the need exists for men to redefine their own perceptions or forms of masculinity, of what it means to be male. The understanding

what men's needs are and what men's experiences have been, is essential in assisting men with redefining and stepping away from a disturbing hegemonic masculinity. Understanding men's experiences and needs is crucial in assisting men to reconstruct hegemonic masculinity and develop a new practice and viewing of masculinity. (Gerschick and Miller 1994).

### ***2.5-3 Meso Perspectives: Developing a Health Systems Context for Men's Health***

From the meso or health service perspective, if men are to be encouraged to 'let go' so as to be able to participate in health services, the question then becomes 'what are we asking marginalised men to let themselves go into? This research seeks to find out if our current model of service delivery is encouraging men to actively participate in health services and if not, why not. Building on from the micro perspective of 'letting men go' to our health services, do health services and systems in New Zealand 'let men in'?

Health services in New Zealand are not sites of praxis or change, as they do not actively allow men to 'let go' neither do they 'let men in' (Mental Health and General Practice Investigation 2005, Goodyear-Smith 2003). Adams (1997) says that health services in New Zealand are 'blind to men', and that we have a 'male sex invisibility' (Adams 1997, 214). Adams identifies several reasons for this invisibility. They include,

- Men have had more attention than they deserve
- It is unmanly to have problems
- Men are the Norm
- Men are 'just like that'

(Adams 1997, 216).

Health Services in New Zealand tend to adhere to a scripted dominant hegemonic masculinity that only pathologises and reinforces these assumptions and health problems. This is reflected in poor attendance rates for men with General Practitioners (Adams 1997, 226) and men's disproportionate representation in health statistics (Ministry of Health 2004).

If, as Adams (1997) highlights, men are seen as having had more attention than they deserve within health, then encouraging men to attend their General Practitioners (GP) seems a contradiction. Also if it is 'unmanly' (Adams 1997, 215) to have health problems then attending a general practitioner also seems a contradiction. And if men's viewing is seen as the 'norm' then the,

Traditional values of competitiveness, self-sufficiency and control... [and] the omnipresence of these values allows then to be mistake for universal standards. The way men see the world is the way the world is, they believe (Adams 1997, 216).

All of which is encompassed in what Adams identifies as a common understanding and an inevitable message that 'men are just like that' (Adams 1997, 216). Again all of which reinforces a dominant hegemony surrounding ideas of how, why, and if men access health services. With the current shift in the New Zealand health system from District Health Boards back to the GP as the primary health provider for the client,

this raises the question of how men's health needs are expected be met? More so when statistics highlight that health issues are disproportionately higher for men (Adams 1997, 214).

It appears that the lack of acknowledgment around ideas such as the okay-ness of men displaying weakness and vulnerability cuts to the core of our medical institutions and health practices. Both weakness and vulnerability are viewed biologically, psychologically, and socially as 'deficits' (King, Sweeney et al. 2004, MacDonald, McDermott et al. 2000). This deficit model of health is similar to the pathogenic approach that re-enforces the hegemonic practice of men's health that we currently see today, based on the premise that men in fact do not have health problems.

If effective health delivery of services for men is to occur, King et al (2004) suggests that four key areas of change within service delivery for men need to be addressed in order to assist in 'letting men in'. Seen as a non-deficit model of health, it includes changes to the:

- The Services Environment
- The Language of the Service
- The Initial Contact and Marketing by the Service
- Service Provision by the Service'

(King, Sweeney et al. 2004, 2)

### ***The Services Environment:***

King et al (2004) found that men were willing to engage with services, if ‘they’ saw that the service was,

Supportive, respectful, non-judgemental, and validated their experience (King, Sweeney et al. 2004, 8).

King et al (2004) also found that there were high rates of initial contact by men if someone they ‘trusted’ recommended the service to them. Assisting men to move from a space of ‘suspicion’ to a place of ‘trust’ appeared pivotal in encouraging men to access services. Men’s ‘viewing’ or ‘perception’ of services appeared key in ensuring whether men would access a particular service or not.

King et al (2004) identified that the two components of ‘trust’ and ‘perception’ were important for men in identifying with a particular service provider. The perception of how they thought others viewed them in light of their accessing services was also important for men (King, Sweeney et al. 2004). This suggests that how others view them is important for men, especially when they access health services. And, how men perceive how others view them is intrinsically linked with how they view themselves. This is similar to Gerschick and Millers (Gerschick and Miller 1994) concept of ‘reliance’, where men became reliant on and internalize dominant societal viewings of masculinity. King et al (2004) found that men saw a certain amount of risk associated with identifying with a particular service provider. The amount of

'personal risk' involved appears in direct proportion with the amount of identification with a particular provider (King, Sweeney et al. 2004).

### *The Language of the Service:*

King et al (2004) also identified language as having a big impact on influencing whether men accessed health services. For example, language in the context of working with fathers was seen to be either 'deficit' or 'non-deficit' (King, Sweeney et al. 2004;3 , MacDonald, McDermott et al. 2000). Deficit based language was found to hold a variety of assumptions that increased the 'suspicion' (King, Sweeney et al. 2004, 3) of the male user. This added to their individual sense of personal risk, which in turn effected whether they accessed health services. Deficit language included,

- Abusing fathers
- Emotionally challenged fathers
- Under involved in household activities
- Having little interest in professional feedback about their children

(King, Sweeney et al. 2004, 3)

King et al (2004) divided non-deficit or 'effective language' (King, Sweeney et al. 2004, 3) into three parts, all of which were written into the occupational health and safety policies of the organisation and became part of the process of 'how' they worked with their male clients. They included,

- Relevance – the discussion needs to be relevant to the service users needs

- Faith Building – the worker needs to convey the belief that the male service user has the ability to commit, choose, care, change, create, connect, and communicate.
- Honest/ Direct – male service users respect people who honestly and respectfully discuss with them the important issues in their life.

(King, Sweeney et al. 2004, 3)

***The Initial Contact and Marketing by the Service:***

King et al (2004) also found that men preferred to have ‘options’ and ‘choice’ (King, Sweeney et al. 2004, 5) about the type of programme or service they wish to access. Some preferred a group context and others an individual one. They identified ‘word of mouth’ (King, Sweeney et al. 2004, 5) as the most effective marketing tool for health services. Men were seen to access the service in two distinct ways,

When in a current life crisis... and the crescendo has reached its crisis... [or] when the crisis has not reached its crescendo... men respond best to the recommendation of a programme by someone they trust (King, Sweeney et al. 2004, 5).

King et al (2004) identified that ‘gatekeepers’ (King, Sweeney et al. 2004, 5) were important people in determining how well men accessed services like a health service. Gatekeepers were those seen as someone that the men could trust and included,

Friends, family members, partners, colleagues, human resource workers, doctors, other professionals, and mates (King, Sweeney et al. 2004, 5).

Similar to Smith & Blanc (1997) and Kelly & Sewell's (1996) idea of the 'tripartite' relationship, (i.e. the 'smuggler' or the 'I-You-We'), the gatekeeper acts in a quasi-brokerage role for men in their accessing of health services.

***Service Provision by the Service:***

King et al (2004) identified that male service users preferred,

- having knowledge of the structure of the service
- clearly identify service user needs
- clearly identify what is expected from them
- regularly review what is achieved
- obtain feedback from male clients

(King, Sweeney et al. 2004, 6)

King et al (2004) also found that men preferred a service environment that left them feeling valued, and one in which they could contribute, and where they could be involved in decision making processes. Without this it was identified that men,

Quickly identify how to play the game and may use programs briefly to get what they want while holding themselves back from true involvement and commitment. (King, Sweeney et al. 2004, 6)

In comparing some of the international and national research of men's access to health services, several notable comparisons can be made. Dyall et al (1999) in his research with Maori men identified that what they saw as important to them utilising services was,

- having others involved, on their terms
- having control
- feeling respected
- others to have more understanding, awareness of their positioning
- others to be tolerant of where they are at
- involve those seen as helpful

(Dyall, Bridgman et al. 1999, 71)

King et al (2004) research on Australian European men identified that men identified strongly with a service provider if they were,

- feeling supported
- being respected
- feeling non-judged
- feeling validated in their experience

(King, Sweeney et al. 2004, 8)

And similarly Gerschick and Miller (1994) research of American European men identified that what was important for them was,

- relying on others
- trusting others
- being able to share with others

(Gerschick and Miller 1994, 325)

This shows that irrespective of ethnicity, both Maori and Non-Maori men identified similar needs in assisting them to better access health services. Having people involved that they trusted, feeling respected, having a sense of control in decision-making processes, and being able to share with others were seen by men as important.

Themes of 'trust', 'control', and 'risk' appear consistent for both Maori and European men, and their ability or inability to access health services.

#### ***2.5-4 Micro Perspectives: Developing an Individual Context for Men's Health***

In developing a new context or a new hegemony for men, Freire (1996) identifies areas of reflected change (or praxis) from the micro perspective that provides a useful strategy for enabling men to 'let go'. In his work, Freire says that the oppressed (or marginalised) wish to exist authentically (to exhibit vulnerability), and to be free from oppression (from marginalisation) (Freire, 1993, 28). Freire identified this 'freedom' as problematic for landowners and overseers, as freedom was a threat to their autonomy and independence, which was maintained only by being oppressive. They are dominated by what Freire calls the 'fear of freedom' (Freire, 1993, 31).

It is interesting to note that in the study by Gerschick & Miller (1994) that a change of men's hegemonic masculine practice did not occur until the men were disabled in accidents. That it took a significant event, such as becoming permanently disabled, to catalyse a transformation of men's practice, itself a possible reflection of men and the rhetoric and discourse of a negative hegemony. Change proceeded only when a catalyst preceded the hegemonic behaviour (King 2005). With Gerschick & Miller (1994), the catalyst, in this case a permanent physical disability, acted as a trigger for initiating the beginning of an 'internal transformation process'. The process of shifting away from a 'negative' viewing of hegemonic masculine practice toward a 'newer' viewing of masculine practice.

Understanding the experiences of an oppressed group does not appear to be sufficient, unless it involves some kind of transformation experience, particularly of the sort that results in the unsettling of the persons self and position (Pease 2000)

Men, who are oppressed or marginalised by health at the micro or ‘personal level’ are caught in the tension of the dominant masculine discourse (being oppressed) and the desire to be free from marginalisation that places them in a dominant hegemony (the oppressive position). In Gerschick and Millers (1994) study, the participants with severe physical disabilities talked of the practice of ‘letting go’, and a moving away from the,

Common reaction to coping with disability... [the] attempting to overcome... [rather than] the metaphor of giving up or letting go of behavioural expectations and gender practices as a way to gain greater strength and control over one’s life... this requires a cognitive shift and a change in reference group as well as a source of social support (Gerschick and Miller 1994, 325).

This process of ‘praxis’ (Linthicum 1996) for men with disabilities involves tension between the duality of adhering to hegemonic masculine practices, and the alternative masculine practice of ‘letting go’. This follows a familiar theme in Freire’s work on the pedagogy of the oppressed. Freire identified that oppressed peasants suffered with the tension of both desiring freedom (the letting go of) and the fearing of that freedom resulting in a continued oppression (the adhering to a dominant hegemonic practice) (Freire 1996). Gerschick and Miller (1994) identified that those men with disabilities who discovered freedom in letting go of their pedagogy (or hegemonic practice) via this process of praxis were better able to reinterpret their masculinity and not,

Rely on dominant conceptions of masculinity... [they weren't]... likely to internalise their feelings of inadequacy and seek to compensate or overcompensate for them. Because the problem is perceived to be located within oneself rather than within the social structure, this model does not challenge, but rather perpetuates the current [negative] gender order (Gerschick and Miller 1994, 325)

Some of individual men were able to 'let go' of those culturally developed internal drivers that pushed toward a negative hegemonic viewing of men. Gerschick and Miller (1994) identified that it was not until the men were in a position of being vulnerable, honest, and trusting, acknowledging what they saw as their 'weakness', that they acknowledged having fuller, richer, stronger, and more intimate relationships with their partners, families, and friends. That it was not until the men 'let go' and took on a new practice of 'vulnerability' (Gerschick and Miller 1994), that a new process or 'transformation' occurred. A shifting from a perceived hegemonic weakness into a new strength. Similarly, Freire (1996) says the beginning of this transformation process out of oppression begins when,

People [men] ...first critically recognize its [oppressions] causes, so that through transforming action they [men] can create a new situation, one which makes possible the pursuit of a fuller humanity [masculinity] (Freire, 1993, 29).

Here within an individual context the men were not throwing away their masculinity, but only those parts that are negatively geared toward the dominant hegemonic discourse (Gerschick and Miller 1994). For these men, it was the taking on of a new set of 'values' (relying on others, trusting others, sharing with others, etc), and a shift in focus away from the interests of the self. This enabled the men to shed the

dominant negative hegemony of what it meant to be a man. In this process of praxis, the adoption of these new 'values' can be seen as necessary in creating a 'new context', a new positive hegemonic discourse of masculinity for men.

This new context at the micro level for men does not mean a 'disregarding' of, but a 're-evaluating' of men's values. It does not mean that all men's displays of strength, power, prowess, assertiveness and independence are negative, or similarly that displays of affection and care are either. Rather, it is the value placed on these as reflected in men's practice; that of either serving solely the interests of the self, or the shifting of men's interests that becomes inclusive of what Foucault (1982) terms as 'the other'. At this micro level, the shift in what men value assists in the development of a new men's practice, what Connell (1995) and others identify as 'men doing gender'. For example one man said,

I've found a whole different side to having sex with a partner and looking at satisfying the partner rather than satisfying myself; and that has taken the focus off satisfying myself, being the manly stud, and concentrating more on my partner. And that has become just as satisfying. (Gerschick and Miller 1994, 317)

For men with disabilities, a repositioning towards a positive hegemonic masculinity involved a new or re-viewing of one-self. It was only when the men came to terms with and 'liked' or what Freire (1996) identifies as, 'loved' oneself, [or the exhibiting of 'vulnerability'], that an 'acceptance' of the new self occurred. Resulting in a new viewing of oneself. This new or re-viewing of the new self assisted men in developing an okay-ness about their individual context (i.e. being male and having a disability). The process of developing a sense of 'okay-ness' or acceptance about oneself requires

the acknowledgment of, and need for a degree of ‘trust’, ‘honesty’, ‘reflective-ness’, and ‘transparency’ with another; a higher degree of ‘vulnerability’. Terms and value positions not seen to be readily associated with men within a dominant negative hegemonic viewing of men and masculinity. Similarly, Freire saw,

Oppression not as a closed world from which there is no exit, but as a limiting situation which they [men] can transform. ...[To] stop regarding the oppressed [men] as an abstract category, and see them [men] as persons who have been unjustly dealt with, deprived of their voice, cheated in the sale of their labour – when he [men] stops making pious, sentimental, and individualistic gestures and risks an act of love [vulnerability] (Freire, 1993, 31-32).

Freire (1996) identified love [or vulnerability] in this sense, as the stepping beyond and outside of ones own suffering, pain, and/ or oppression. The moving beyond the interests of the self, [or negative hegemonic masculinity], and adapting ideas of ‘trust’, ‘honesty’, ‘vulnerability’, and the development of ‘empathy’. This was key for men, in their repositioning to a positive discourse of hegemonic masculinity. Pease (2000) identified this process as the catalyst that begins for men part of the ‘internal transformation process’, from negative to positive hegemonic discourse; that the,

Reconstruction of men’s interest [occurs] first through the encouragement of social empathy in men by increasing their understanding of the consequences of men’s structural power and privilege; and, second, through the re-conceptualisation of men’s pain based on a new conception of need (Pease 2000, 134).

Within the context of mental health, men’s viewings of self, how they see and value themselves (i.e. self esteem, self worth, etc), and their perceptions of how others view and value them (i.e. judgements, biases, etc), are reflected within their health. If the

individual view of themselves is positive, then by default there is an increase in the desire to look after and manage their health. This raises the question of to what extent current health services are sites that foster men in ways in which they feel accepted, valued, and are given the opportunity to trust, to be honest, to show vulnerability. Or, is the lack of services for men a reflection of societal viewings of men; in which men don't have health needs (they should be strong, stoic, and independent, etc) and are therefore not encouraged to look after their own health.

Gerschick and Miller (1994) identified three specific frameworks that their male participants accessed to assist in managing their severe physical disability and their masculinity. They included,

- 1 Reformulation
- 2 Reliance
- 3 Rejection

(Gerschick and Miller 1994, 315)

(1) Reformulation of masculinity involved men with disabilities realigning a pre-existing view of masculinity with a current viewing of masculinity. This realigning and reformulating of masculinity was via the lens of disability. Gerschick & Miller (1994) identified that these men,

Recognised in their own condition an inability to meet these ideals as they were culturally conceived (Gerschick and Miller 1994,315-316).

Gerschick and Miller (1994) identified that the men who attempted to 'reformulate' their viewing of masculinity found difficulty in challenging and changing the status they placed on occupation. Previous to their being disabled their 'identity' was intrinsically linked with what they 'did'. Their viewing of being masculine was derived from 'occupational accomplishments' and being both 'economically and physically independent' (Gerschick and Miller 1994, 318).

(2) Reliance on masculinity was the result of men with disabilities who juggled the matching of hegemonic masculinity with how others viewed masculinity. Their viewing of being both men and men with disability was to 'rely' on dominant masculinity (Gerschick and Miller 1994). This,

Involved the internalisation of many more of the ideals of predominant masculinity, including physical strength, athleticism, independence, and sexual prowess. Just as some men depended on reformulation for much of their masculine definition, others, despite their inability to meet many of these ideals 'relied' on them heavily (Gerschick and Miller 1994, 318).

This resulted in leaving the disabled men conflicted and feeling 'incomplete' (Gerschick and Miller 1994). They were continually aware that they were different from others and struggled to 'develop an identity and masculinity free of others perceptions and expectations' (Gerschick and Miller 1994, 318). Gerschick and Miller (1994) reported that these men struggled within hegemonic masculinity and its underlying notions of independence, as they were to varying degrees dependent on other people for assistance. The restriction in choices, of choosing the type of

assistance, or controlling when you wanted assistance was identified by the men as both frustrating and demoralising.

This distinct lack of choice (of having control) meant that they in wanting to gain acceptance for themselves and from others at times reverted to dominant conceptions of masculinity to regain a sense of control. Gerschick & Miller (Gerschick and Miller 1994) identified that it was the threat to men's independence and autonomy that increased their avoidance in obtaining help, and in actively pursuing risk-taking behaviours. For the men, it was an ongoing process of reconciling their severe physical disability and developing new conceptions of masculinity, a new hegemony and discourse of masculinity. As one participant stated,

Manhood no longer simply meant independence and sexual conquest... it also meant... being responsible for ones actions; being considerate of another's feelings; being sensitive to individuals who are more vulnerable than yourself, to what there needs would be; standing up on behalf and fighting for those who cannot speak out for themselves, fight for themselves. It means being willing to take a position and be committed to a position, even when its inconvenient or costly to take that point of view, and you do it only because of the principle involved (Gerschick and Miller 1994, 322).

(3) Rejection was seen as the process men with disabilities took in creating 'alternative masculine identities and subcultures' (Gerschick and Miller 1994, 323). Rejecting meant 'reacting' to societal norms of what being masculine means. This took the form of rejecting male roles such as procreator and provider as purported within hegemonic masculinity, through to realigning oneself with distinctly un-

masculine hegemonic movements such as the women's movement or the disability movement (Gerschick and Miller 1994).

Here, men with disabilities understood that it was the broader misconceptions of what it meant to be masculine that were 'problematic' not themselves (Gerschick and Miller 1994, 325). Like Freire and his description of the oppressed, it was only when they,

Discovered themselves to be the 'hosts' of the oppressor [could] they contribute to... their liberating pedagogy. As long as they live[d] in the duality in which to be is to be like, and to be like is to be like the oppressor, this contribution is impossible. The pedagogy of the oppressed is an instrument for their critical discovery that both they and their oppressors are manifestations of dehumanization. (Freire, 1993, 30).

They had the self-knowledge pertinent to their 'liberating pedagogy' (Freire 1996), a new viewing of self.

## **2.6 Power Relations**

### ***2.6-1 Introduction:***

Embedded in this study of what helps or hinders men's access to health services like a community mental health team, is an inescapable discourse of power relations. This section will analyse macro power relations and practices of power and their impact on the health service user, in this case 'marginalised men'. This section will also look at meso power relations within the delivery of current health services; and micro power relations between clients and clinicians.

### ***2.6-2 Macro Power Relations:***

The current direction of health initiatives and health policy in New Zealand reflects a Third Way approach to policy (Giddens 2001). This approach has sought to create partnerships in the provision and delivery of healthcare services in New Zealand. Globalisation and the boom of technology (Giddens 2001), (including increased access to vast amounts of health information and knowledge) has resulted in the increased ability of the health consumer to participate in the direction and delivery of health services.

This participatory approach has also resulted in a shift in discourse, to one of a power relation that fosters participation by 'creating partnerships' (Shannon and Young

2004). How equitable these partnerships are is debateable, and the type of power relation that exists in these partnerships has been largely unexplored. The rhetoric talks of the desire of government to create and work in partnership. Reflected within health in New Zealand by the establishment of partnerships between government (the DHB), the primary health provider (the PHO) and the non-governmental agency (the NGO) (Ministry of Health 2006).

The equity of these partnerships is reflective of a paradigm of political economy that promotes a 'partner-shiping'; individually, regionally, nationally, and globally that operates within a clear legal, contractual, fiscal, and authoritative 'top down' discourse. A rhetoric of partnership that speaks of a 'Binary' transaction (Refer figure 2.5c, page 80), yet whose reality reflects of a 'Uni-polar' transaction (Refer figure 2.5d, page 81).

The rhetoric of 'partnership' limits itself to a type of social transaction that encapsulates the rhetoric of our current political economy; of legal, contractual, transactional, and economic obligations. Unlike a 'bottom up' (Shannon and Young 2004) approach that mirrors less of a 'partnership of', and more of a 'marriage to', the rhetoric and discourse of a partnership doesn't embody the 'interconnectedness' that the rhetoric of marriage does. A 'bottom up' (Shannon and Young 2004) discourse of partnership would tend to reflect multiple tripartite social and power relations. Our current system of health service and delivery from the macro perspective is viewed through the lens of increased participation leading to increased partnerships. Seen within mental health with the involvement, inclusion, and partnering by clinicians

with families. These partnerships are viewed as an integral part in the provision and treatment and healthcare of clients.

### ***2.6-3 Meso Power Relations:***

The maintenance of an equitable tension within partnerships proves difficult, when the subject and the other are operating within a larger systems context that does not acknowledge the differences of ‘self knowledge’, of multiple experts (Opie 2000).

For example, within the larger systems context of a District Health Board, the board decides and provides specific services for the ‘other’. This reinforces a discourse and rhetoric of the deliverer of services as the ‘legitimate’ expert, entrenching an inequity in power relations. The result is a reverting to, or a reinforcing of a uni-polar power relation in which (despite the rhetoric of partnerships), the service provider holds the power in decision making (see Figure 2.5d, page 81).

Opie (2000), in her discussions on the narrative of medical teams and the impact of this narrative on the clients they worked with, identified a power relation of knowledge and illustrated how this was reflected in the teams practice with the client. Like Foucault (1982), Opie (2000) was interested in the ‘practice of power’ and, how within a dominant medical model, the ‘transmission’ of this knowledge (Opie 2000), or the practice of power occurred between the clients and the health team. Foucault and his critique of power did,

Not ask: who is in power? He asks how power installs itself and produces material effects... Foucault does not turn to the ‘authors’

of power but to the field [practices] of power. (McHoul and Grace 1993, 21)

In mental health, these mechanisms of power are clearly seen within the medical institution. In this context the subjects of power (the health practitioner), themselves have become part of the mechanism and process by which power is subjected. The end result is the individual (the client/ patient) being made a subject of and to by the other (the health practitioner), and in the process becoming 'subjugated' by this other (the health practitioner). A dichotomy is created, a didactic power relationship established, and another type of binary relationship is formed. This is seen within the mental health systems use of specifically prescribed 'knowledge's' held by the experts, such as the use of 'complex language'. The health practitioner uses this to describe symptoms of, and diagnosis of mental disorders, as part of the health practitioners 'assessment'. Again, reflective of Foucault's (1982) 'micro practice' or 'micro tactic' of the disciplinary institution (Fraser 1995, 138).

Foucault claims that the modern power/ knowledge regime was not imposed from the top down, but developed only gradually in local, piecemeal fashion largely in what he calls 'disciplinary institutions' beginning in the late 18<sup>th</sup> Century. A variety of 'micro techniques' were perfected by obscure doctors, wardens, and schoolmasters in obscure hospitals, prisons, and schools; far removed from the 'ancien reime'. Only later were these techniques and practices taken up and integrated into what Foucault calls 'global or micro-strategies of domination' (Fraser 1995, 137).

Foucault's interest was in identifying the power relationship between the subject and the other, and how power was allowed to operate within such a setting. Within the

setting of psychiatry, he identified the process of assessment as the result of the medical 'gaze'.

The gaze was a technique of power/ knowledge used by administrators to manage the institutions populations by means of visibility. They organised these populations so that they could be seen, known, surveilled, and thus controlled. This new visibility was of two kinds according to Foucault: synoptic and individualizing (Fraser 1995, 138).

According to Foucault, the 'synoptic' gaze was that which occurred within prisons, hospitals, and institutions; structures where populations could be surveilled. It is this 'individualizing' gaze that is currently used within health and mental health services today. It is,

Aimed at exhaustive, detailed, observation of individuals, their habits and histories. Foucault claims that this visibility succeeded in constituting the individual for the first time as a case, simultaneously a new object of inquiry and a new target of power (Fraser 1995, 138).

How then does one work within such a health context and maintain an equitable tension, and equal power relation? It requires a shift away from a binary power relation and the introduction of a trialectic, or tripartite power relation. This assists in moving away from a discourse and rhetoric of 'us' versus 'them', the 'subject' and the 'other'; and introduces a 'third party' (see Figure 2.5a, page 76).

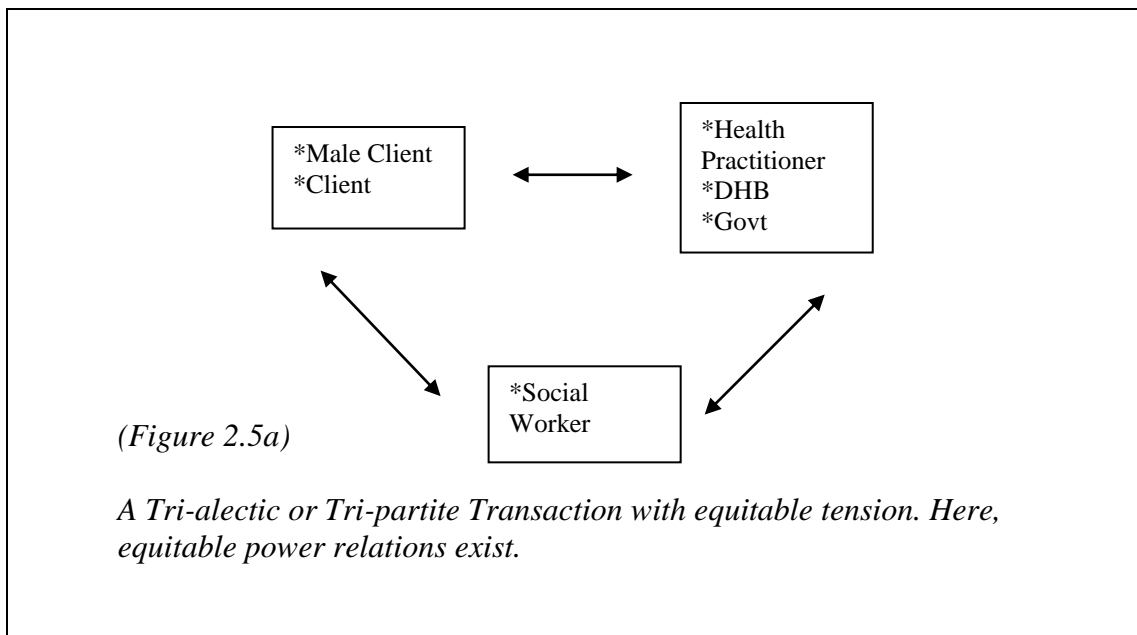
Remy (1992) adds to this idea of the game of threes. Transactions produce unstable compromises. Therefore they frequently involve

the activity of the intermediary, who moves between the opposing forces, seeking a tenable compromise (Smith and Blanc 1997, 295).

This intermediary or third party assists in the creation of discourse and rhetoric that focuses on the 'common'. What Kelly and Sewell (1996) identifies in the Trialectic logic as the 'we'. The moving from 'you' & 'I', to the 'you, I & we' (Kelly and Sewell 1996, 24). The commonality of the process and the power relation's assist in developing a transparent and open process; a 'collaborative and collective' process. This collaborative process of the trialectic,

Adds to and expands a context in which we make judgements. Rather than posing a problem to be solved, it can change the way a problem is perceived. In providing an expanded context, the trialectic liberates us from the belief that truth is what I say it is – or what you say it is. Both of us separately and together, must at least take account of what the other persons says (Kelly and Sewell 1996, 29).

This collaborative process requires a high degree of honesty, transparency, and a seeking by all parties to understand what Gerschick & Miller identified as the 'others position' (Gerschick and Miller 1994). As a collaborative approach it suggests that all parties bring certain and specific knowledge's, producing 'multiple' experts rather than 'an' expert (Opie 2000).

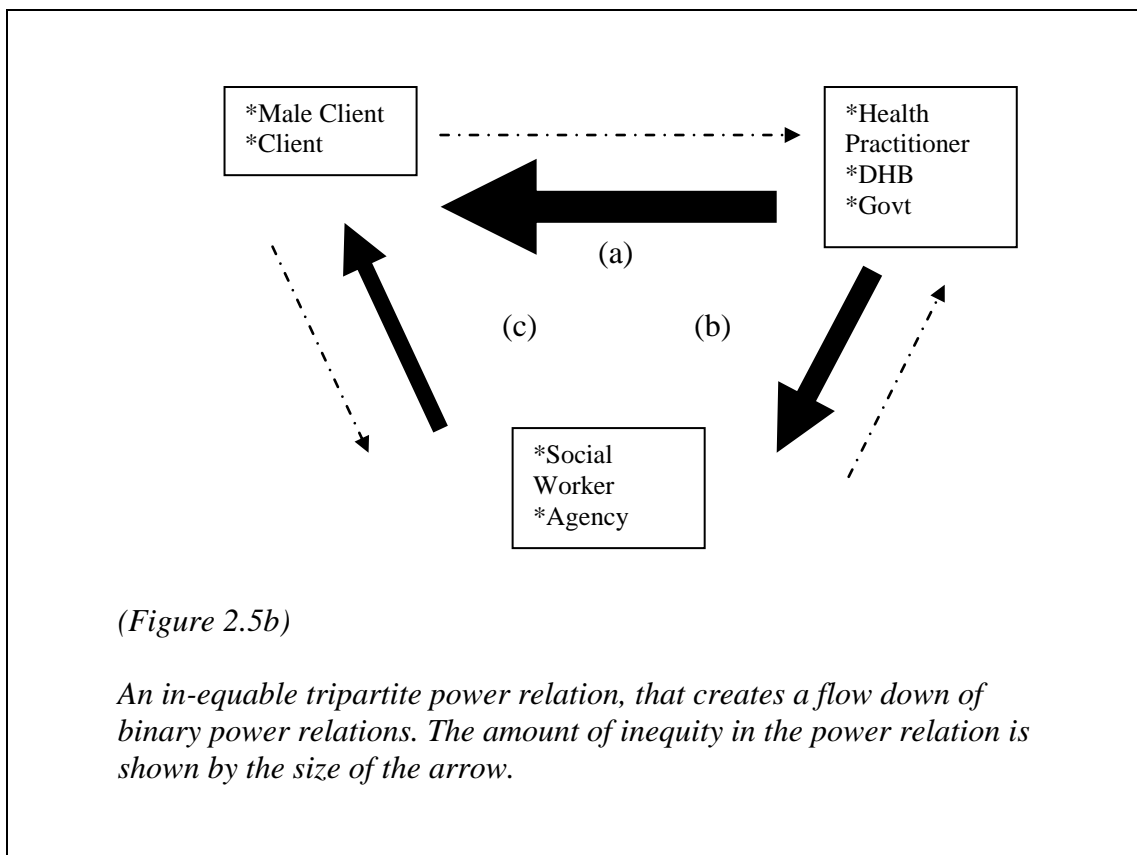


Within this tri-partite social transaction, attempts can be made to usurp power, or avoid an equitable tension. The result is a new social transaction and a new power relation between the Client and/or Practitioner, and the Agency, Government and the Social Worker. A reverting back to a collection of ‘Uni-polar’ power relationships between the health practitioner and the ‘other’ (i.e. the client of the social worker). If left unchecked this creates a ‘flow down’ and mirroring of further uni-polar power relationships between all parties (Refer Figure 2.5b, page 77).

Smith and Blanc (1997) identifies the ‘Smuggler’ as the social intermediary and the one,

Who asks socially deprived groups and others who need help in expressing themselves in order to be heard and to make known their rights. The smuggler does not have to identify with them totally but must act in their interests with competence and efficiency. The smuggler is a kind of public defender, acting for the defenceless whether or not the issues spontaneously appeal to him or her personally (Smith and Blanc 1997, 229).

Here the role of the smuggler lies in assisting with challenging the polarisation within society. Similarly the social and/ or community worker in his or her role assists in highlighting, challenging, bridging, or recreating those discrepancies that have resulted from polarisation within society. In this case the discrepancy created in men not accessing health services like Community Mental Health Teams.



#### **2.6-4 Micro Power Relations:**

McHoul & Grace (1993) agree with Foucault (1976) and his idea for the need to dissect the power relationship of the oppressor and oppressed in order to understand how to change the power relationship.

Oppressive forces of domination do not hold the monopoly in the capacity to invent tactics. If resistance is to be effective, it requires the active interrogation of the tactics employed in a struggle. But this means that one must acknowledge in the first place that tactics are being used. In other words, the ethical relationship of the protagonist to the 'power' being opposed and the historical position of the relationship must be explicit. (McHoul and Grace 1993, 87).

Freire (1996) also identifies the need for the power dynamic to be exposed to allow those who identify as being oppressed, liberate not only themselves but in the process their oppressors. McHoul & Grace identify that,

Power is not to be read, therefore in terms of ones individual domination over another or others; or even as that of one class over another or others; for the subjects which power has constituted becomes part of the mechanisms of power (McHoul and Grace 1993, 22).

Central to the discourse of power relations within this research project is the interplay and relationship between the subject and the object; between the male client and the health practitioner, the male client and the health team, the male client with other men, the male client and the health service, the male clinician and the health service, and the male client and the male researcher. Foucault (1982) in his analysis of power relations within the medical establishments focussed attention on the practices or micro practices that the individual was subjected to. Power was viewed,

As a relationship which was localised, dispersed, diffused, and typically disguised through the social systems, operating at a micro, local, and covert level through sets of specific practices. Power is embodied in the day-to-day practices of the medical profession within the clinic, through the activities of social workers, through

the mundane decision-making of legal officers, and through the religious practices of the church as they operate through such rituals as confessionals (Turner 1997, xi-xii).

These 'practices of power', what Foucault termed as 'micro practices' (Foucault 1982), are those clinical interactions between the client and the practitioner that result in displays of adverse or conducive power. Both Opie (2000) and Foucault's (1976) interests are in the 'productive' nature of power (Opie 2000) and how it is that the power came to be. Within the current mental health paradigm, this practice of power is viewed to be working towards a more equitable paradigm as reflected in the growth of the consumer and advocacy movement, as well as attempts to involve family.

Within the context of mental health, its rhetoric is the promotion of, and inclusion of working with family and consumer groups. The rhetoric of,

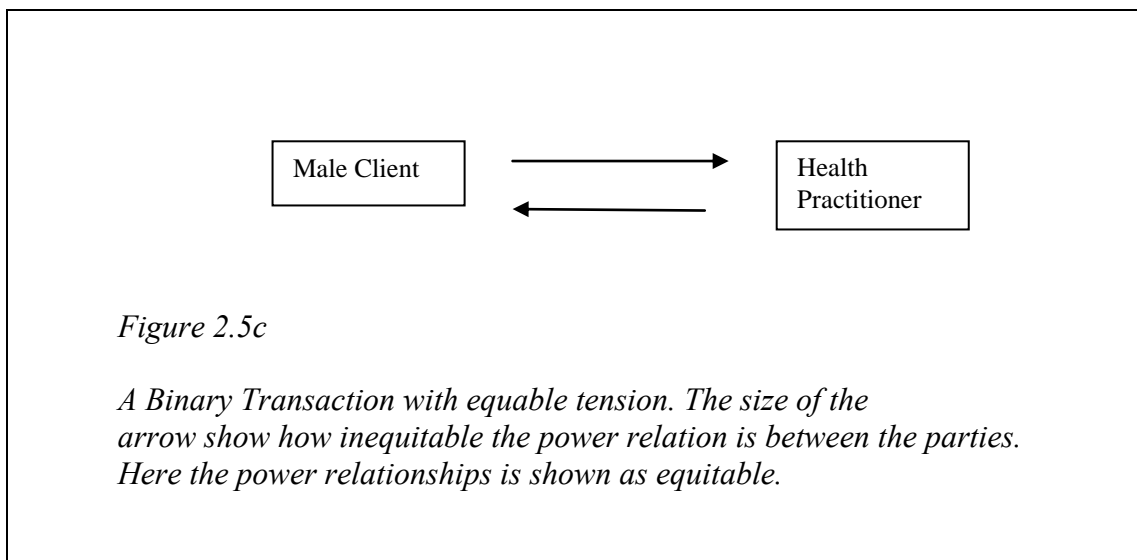
Realigning the power relations away from the more established model of care, which defined patients as passive and grateful for services received (Opie 2000, 225).

How equitable this 'inclusion' is from the client's perspective, is in part, what this research touches briefly on. These movements towards equity have not involved the clinician's giving away their practices of power, but rather an increase in the knowledge of the impact that their practices of power can, and do have on the client. Though there is an increase in the knowledge and understanding of the impact that their practices of power have on the client, they (the client) are still viewed not as expert, but as subject (Opie 2000). This viewing of the client as 'subject' by default creates an, 'other'; a viewing that inadvertently leads into a divisive context, a

dichotomy, what Foucault (Foucault 1976) and Freire (Freire 1996) identify as the ‘us’ versus ‘them’.

The social transactions that occur between the ‘subject’ and the ‘other’ (Foucault 1982) have the potential to create several types of power relations. Smith (Smith and Blanc 1997) identified that interpersonal transactions have historically revolved around ‘decision making’ creating what Smith termed as a ‘binary transaction’ (Refer Figure 2.5c) This is seen as a social transaction that occurs,

Between two conflicting principles of legitimacy; representation and expertise... these experts need not agree with each other but can legitimately offer diametrically opposed opinions [and positions]. (Smith and Blanc 1997, 297)



Ideally the power relation between the health professional and the client is one where equity in ‘tension’ exists, such that the power relation is equitable (Figure 2.5c). The equitability here is the difference between both the subject and the others degree of

‘knowledge’s’ (Foucault 1982, 331), or what Freire calls ‘their liberating pedagogy’ (Freire 1996, 30). Gerschick & Miller (1994) identified it as that knowledge that enabled for the shifting of the focus away from the self and onto the other. Opie (2000) identified it as the repositioning of power and the acknowledging that both the subject and the other have different knowledge’s, which in and of themselves produce both as ‘experts’.

The current reality is a discourse whose rhetoric identifies the individual not as a unique person, but rather as a ‘case’. An echoing of rhetoric that tends to de-humanize the individual client or patient, via a repositioning of power between the individual and the health professional. A new power relation is formed, one that is ‘Uni-Polar’ that exhibits an in-equable tension, and positions power with the Health Professional (Figure 2.5d). Unlike the binary transaction where both are viewed as experts, the uni-polar transaction imbues the idea of ‘the expert’ and a ‘the non-expert’ which produces an in equable power relation.



*Figure 2.5d*

*Uni- polar Transaction with in-equable tension resulting in The power relation of the expert and the non-expert’. The amount of inequity in the power relation is shown by the size of the arrow.*

## **2.7 What Helps or Hinders Men's Access to a Community Mental Health Team.**

In examining the literature and noting the various gaps in relation to men's health this body of research asks the question of 'what helps or hinders men's access to a community mental health team'. To do this research takes a qualitative approach that seeks to explore the experiences of current male clients of a Community Mental Health Team in Dunedin to identify what they see as either 'helping' or 'hindering' access for them to their Community Mental Health Team. This study will also investigate what male clinicians working within a Community Mental Health Team also see as helping and/ or hindering their male client's access to their team. The study will consider the perspectives of the client and the clinicians to understand what is currently working for Men's access, and what issues can be identified to assist in making access to Community Mental Health Teams for Men more useful.

## Chapter 3 – METHODOLOGY

### 3.1 Introduction:

In describing the methods and methodology of this research project I am firstly aware of the multiple 'subject' positions that I find myself in. These include a new position as researcher, and other historical positions such as social work practitioner, heterosexual, Pakeha, male, and husband. A multiplicity of subject positions is something that we all find ourselves in irrespective of culture, gender, ethnicity, social class, and economic status. These things add to, and make up this multiplicity of subject positions.

This research seeks to capture the subject positions of a specific population, which in itself produces some tensions. Firstly, acknowledging that it would be impossible to capture the totality of the participant's perspectives, perspectives themselves that change with time. Secondly, acknowledging that participants own viewing of illness and their experiences with illness are continually shaped and reshaped in the telling of their narrative. In their participation, the viewing of illness itself is reworked and changed.

Realistically this research can only capture a snippet of the totality of men's experiences in accessing a community mental health team. The establishment of methodology is used to give a context for the research, to order the research, and to give meaning to it. As a social work practitioner, the use of a qualitative methodology is more a reflection of how 'I' am positioned (my subject position) and how I operate

within the multiple subject positions that I find myself in. Even as I have written up this research my positioning has shifted as my knowledge's have changed. As a participant of this research process, my viewing of illness and masculinity too has been reworked and changed.

## 3.2 Qualitative Research:

### 3.2-1 *Introduction:*

I have chosen a qualitative approach to this research project, primarily because the aim of the research is to identify male client's experience of health service access and provision. Within research paradigms, the research of experience (Qualitative Research) tends to steer away from an objective viewing or a positivist discourse (Payne 1997) and align itself with a constructivist or phenomenological discourse (Denscombe 2003). This type of discourse emphasises:

- Subjectivity (rather than objectivity)
- Description (more than analysis)
- Interpretation (rather than measurement)
- Agency (rather than structure)

(Denscombe, 2003, 96)

Qualitative research acknowledges that knowledge and its understanding does not necessarily occur in a linear or positivist approach, from one point or one understanding, to the next new point or new understanding, and so on (Irving, 1999). Rather, that the understanding of knowledge can be non-linear or constructivist in approach (Bunch 1983). That it can be interconnected at various matrixes or sites of new knowledge and new understanding, and adapted accordingly (Laragy 1996). Within qualitative approaches, research is seen to have multiple strands (or multiple disciplines), each with their own method of measuring truth (Irving 1999).

Within such a discourse, the aim is to take an account of the subject's truths, identify their subject position, analyse these positions or accounts, identify and elicit common and new themes, and order these to broaden an understanding of the subject's positional discourse. In this case, that of men's health, particularly men's *access* to community mental health services, the phenomenological perspective fits well with this research project as it is interested more so in the 'how life is experienced' (Denscombe, 2003, 97) by men who access a community mental health team. This phenomenological perspective in research is interested in:

- Experience
- The Everyday World
- Seeing things through the eyes of others
- The Social Construction of reality
- Multiple Realities
- Description
- The suspension of common-sense beliefs
- Members Accounts
- Acknowledging types of phenomenology; [the] underlying essences or actual accounts

(Denscombe, 2003, 97-103)

This research seeks to understand men's viewing in accessing a community mental health team, and the subsequent positions that men find themselves in. It is this identification of the subject's position via their own experience in accessing health services (either as helpful or a hindrance) that marks the distinction between a qualitative and quantitative approach.

### **3.2-2 Action Research:**

As this research project is seeking to elicit 'men's' experiences in accessing a community mental health team, the use of an action method is most appropriate. The action method aims to identify 'practical' issues and focus on the 'change' process of those issues, similar to the reflective process of 'praxis'. Denscombe (2003) identifies the four specific functions of action research. They include,

- Practical – It is aimed at dealing with real-world problems and issues typically at work and in organisational settings.
- Change – Both as a way of dealing with practical problems and as a means of discovering more about phenomena, change is regarded as an integral part of research.
- Cyclical Process – Research involves a feedback loop in which initial findings generate possibilities for change which are then implemented and evaluated as a prelude to further investigation
- Participation – Practitioners [the respondents] are the crucial people in the research process. Their participation is active, not passive

(Denscombe, 2003, 73-73)

This project follows an Action Research process. The respondents are viewed as insiders in the research process (Laragy 1996). They are seen as the practitioners or experts and it is their perspectives, experiences, and narratives that provide the raw data that in turn informs the content of the follow up focus groups. The experts or practitioners who make up the focus groups then provide a further layer of analysis of

the primary data collected from their peers (the primary experts). As a model, action research encourages a responsiveness to change where,

The research, in this sense, is practitioner-driven, with the practitioner not just an equal partner but a sponsor and director of the research process... Control is transferred away from the professional researcher towards the practitioner. Power shifts towards the insider who is the practitioner... the outside expert has the role of facilitator of the practitioner's own project, a resource to be drawn upon as and when the practitioner see fits (Denscombe, 2003, 77).

As the researcher in this project I see myself as an outsider, a non-expert in knowing what helps or hinders men's access to a mental health service. It is the client and the clinician, as 'insiders' who hold this knowledge. It is their account or narrative that we are attempting to elicit and explore. Action research mirrors the process of praxis and as a cyclical process is interested in ensuring that the 'research' is fed back directly into the practice. This reflection is also continual (Denscombe 2003). The continuity of this process of,

Action and reflection feed upon each other, with each action leading to a deeper and more insightful reflection which, in turn, leads to a more courageous action. Thus, a spiral is created, with action pushing towards reflection which results in a more decisive action which in turn causes deeper and more analytical reflection which leads to further action, and thus to reflection (Linthicum, 1996, 61).

Within the research, a pedagogy of action and reflection (Linthicum 1996) is developed, whereby the action of the respondent giving an account or telling their

narrative at the same time produces an effect on the way the respondent thinks about that action.

### **3.2-3 *Narrative Inquiry:***

Narrative research fits well within a Feminist Paradigm and this research process as by definition narrative research,

Refers to any study that uses or analyzes narrative material. The data can be collected as a story... or in a different manner... It can be the object of the research or a means for the study of another question. It may be used for comparison among groups, to learn about a social phenomenon or historical period, or to explore a personality (Lieblich, 1998, 2).

If we are to elicit an understanding of the lived experiences of men with mental illness, and their interactions with a community mental health team, the requirement then becomes how to best capture an understanding of those resultant interactions. How do we capture men with mental illness, and their perspectives of interactions with a community mental health team? Also, how do we capture the interactions of the male clinicians with male clients?

When we acknowledge a multiplicity of perspectives and experiences within a specific population, then it is important to explore as many different perspectives as possible to ensure the legitimacy of the research and research processes. If it is the

individual account we are attempting to elicit, then this account or 'narrative' is what needs to be collected, coded, and analysed.

Narrative analysis in medical sociology focuses upon individual's experiences of ill health as expressed in stories they tell or the accounts they give. Telling 'a story' or providing 'an account' each has very different, multiple connotations of course, but both can be said to produce 'narratives'... Whether self authored or co-authored, narratives are seemingly authentic representations of the ontology of experience. In other words, if life is lived as a narrative, then the representation of that life in narrative will contain sharp truths about the life of the person (Williams, 2004).

This process of Narrative Inquiry (Chase 2005) allows for the individual to produce an account or story that when told is mirrored by a conscious or unconscious, yet parallel process of self-analysis or self-reflection. As the account or story is told, the narrators' own self-awareness is increased. Knowledge and understanding about their own subject position is clarified in their narrative via what the individual has experienced. Narrative inquiry can therefore be seen as very much an enabling process of praxis for both the individual and the researcher.

Narratives provide a link between experience and structure and in doing so provide some understanding of what to do in difficult situations (Williams 2004).

For the respondent, an increase in their knowledge and understanding occurs via their narrative. For the researcher the respondent's narrative provides an insight and understanding that assists the researcher in understanding the respondent's own subject position, in relation to their specific experience. Through this process of

inquiry these various subject positions and resultant accounts can be identified, explored, compared, and contrasted. The researcher can then identify and draw out comparisons, discrepancies, commonalities and themes, which can be further analysed, in this case within a second layer of analysis, that of the focus groups.

Chase (2005) says that the narrative researcher is informed by enabling them to identify the individual's subject position, and each resultant narrative. Narrative is seen as discourse, with a verbal action that both enables and constrains (Chase 2005).

### ***3.2-4 Qualitative versus Quantitative:***

Qualitative research as a research style attempts to 'do the same things differently' (Denzin 2005), compared with quantitative research. Their points of 'difference' (Denzin 2005) produce dilemmas in the research, especially qualitative research.

These points of difference... all involve different ways of addressing the same set of issues. They return always to the politics of research, and to who has the power to legislate correct solutions to social problems (Denzin 2005).

These points of difference include,

- Use of Positivism and Post-Positivism
- Acceptance of Post-modern sensibilities
- Capturing the individuals point of view
- Examining the constraints of everyday life
- Securing rich descriptions

(Denzin 2005)

The dilemmas faced in using Qualitative approaches are like those for Quantitative research, that of the ‘methods and conclusions being justified’ (Denscombe, 2003, 273). Justification is essential in ensuring validity of the research and for Qualitative research ‘the issues of objectivity, reliability, and validity’ (Denscombe, 2003, 273) are just as important as for quantitative research processes.

The potential dilemmas of qualitative research are found in its disadvantages that include,

- The data may be less representative (*Generalisations*)
- Interpretation is bound up with the ‘self’ of the researcher (*Subjective vs. Objective*)
- There is a possibility of de-contextualizing the meaning (*Taking out of Context*)
- There is the danger of oversimplifying the explanation (*Making the research fit*)

(Denscombe, 2003, 281)

For this research project, the use of a small sample of participants and the amount of data the researcher can extrapolate from it could be seen as being ‘less representative’ and be seen to create ‘generalisations’ (Denscombe, 2003, 281) about the research subject. Generalising and making broad statements extrapolated from the small amount of data could be seen to decrease the validity of the research. I suggest that the ‘amount’ of participants involved in the study produces a ‘better’ quality of data. The amount of data obtained was not only comprehensive (from a small number of participants) but most importantly it was in depth.

Interpretation of data (or the subjective nature of the research) can be viewed as a possible disadvantage in the qualitative approach. The premise in the quantitative research process is that the self (or researcher) is always objective (Denscombe, 2003, 281). The less they bring of themselves to the research process, the more accurate and valid the data. Paramount is the need to remain 'objective'. The active use of self in the research process is seen as disrupting this objectivity. Where as qualitative approaches acknowledge the subjectivity of the researcher in the process.

This research process is clearly qualitative. I am aware and fully acknowledge that I bring with me a whole variety of experiences, beliefs, attitudes, and values that are inherent to me. As a male, heterosexual, Pakeha, social work practitioner, and researcher, it means that I bring my own biases and filters, my own ways of viewing the world around me. I am as Denscombe states, 'self-aware' (Denscombe, 2003, 218). I personally don't see this as hindering the research process, but rather it has helped me to create a context from which to attempt to understand the views and perspectives of the participants better. This can also be seen as one of the strengths of qualitative research. The researcher and participant can explore the topic in depth and are not constrained by standardised and limited questions (such as a survey), that the objectivity of the quantitative research demands.

One of the possible weaknesses of quantitative research is the propensity to 'decontextualiz[e] the meaning' (Denscombe, 2003, 282) of the data. In the latter stages of both analysis and coding the raw data can 'get literally taken out of context' (Denscombe, 2003, 281). Quantitative researchers argue that the data can be misread, misunderstood, and misinterpreted by the qualitative researcher. Within this research

project, checks and balances were established to ensure that what the participants said was accurately reflected in the analysed results of the project. This took the form of a focus group where the initial data that was transcribed and thematically analysed by the researcher, was then 'rechecked' by the participants to ensure that it was reflective of what the participants stated.

Another possible dilemma in a qualitative approach exists in the 'danger of oversimplifying the explanation' (Denscombe, 2003, 281) in order to make the 'data fit' (Denscombe, 2003, 282). Qualitative research is more likely to highlight those things that are inconsistent and/ or ambiguous (Denscombe 2003). This can result in the researcher leaving out or ordering the data to fit the question or conform to preconceived ideas about possible results. Ensuring the efficacy of the data lies for the most part with the researcher. With all valid research (both qualitative and quantitative), utilising rigorous ethical processes, as well as any professional association standards, and supervision, to ensure that the researcher is held accountable in their research process, including analysis and interpretation.

### **3.3 Research Design:**

#### ***3.3-1 Client Participants:***

All potential respondents were initially approached by their respective case manager. Case managers had received a presentation of the proposed research project at a North Community Mental Health Team staff meeting. Client respondents were elicited via their case manager, who identified and made initial contact with the potential respondents. Clients were given the opportunity to decide if they wished to take part in the interviews and/ or focus groups. Information and consent sheets were given to the client respondents via their case managers. Client respondents were given three weeks to decide if they wished to take part in the research process, at a time, place, and location convenient to them.

I choose to utilise the case managers as an initial point of contact as I believed that the case manager, who is a insider, had a better working knowledge and understanding of their clients, and a current awareness of their ability to participate in the study. I initially talked with clinicians at a staff meeting, presenting an outline of the study, informing them of the purpose and intent of the research. An opportunity was also given to ask questions and respond to the proposal. The specified criteria for potential respondents was kept to a minimum to ensure the inclusion of a wide range of potential respondents. Criteria for client respondents included:

- Male
- Current client of the North Community Mental Health Team
- Have an identified Case Manager

### **3.3-2 *Clinician Participants:***

In eliciting male clinicians, I initially spoke with the Unit Manager of the North Community Mental Health Team. I then asked the Manager if I could speak at a staff meeting to inform and invite potential clinical participants of the research to take part. At the staff meeting I undertook a brief presentation that outlined the purpose and intent of the research. Interested clinicians were identified and followed up the next week with the establishment of interview days and times at a time, place, and date convenient to them. Again, to ensure a wide range of clinician participation the criteria for clinicians was kept to a minimum. Criteria included,

- Male or Female
- Identified as a current Case Manager
- Currently working with Male Clients
- Clinicians belonged to a Professional Body

### **3.4 Data Collection:**

#### ***3.4-1 The Interview Schedule:***

The interview schedule was designed in discussion with my research supervisor, and drew on the findings of the literature review. The aim was to ensure that the breadth of discussion and resultant information was kept wide, with participants given opportunity to talk specifically about their experiences in accessing a community mental health team.

The interview schedule followed some meta-themes that were identified in the preliminary literature review. They included:

- Community Mental Health Teams
- Power Differentials
- Masculinity
- Barriers
- Access
- Sites of Risk
- Legitimate Others

#### ***3.4-2 The Interviews:***

The researcher conducted a total of 8 interviews. They consisted of,

- 4 interviews with male clinicians
- 4 interviews with male clients

Interviews ranged from 60 minutes to 120 minutes. All interviews were at sites chosen by the respective respondent. All respondents were given opportunity to have a support person present who was subject to the same consent and privacy conditions as the respondents and the researcher (Refer Appendix). All interviews were audio taped and transcribed. All respondents were given access to a draft copy of their own transcript to comment on and make amendments.

Male clinicians interviewed were made up of four people:

- 1 Crisis Nurse
- 3 Psychiatric District Nurses

Male clients interviewed were made up of four clients of the North Community Mental Health Team. Interviews were categorized into Clients and Clinicians. Both sets of Interviews followed a set format (refer appendix). Questions centred round the seven themes from the literature review. The raw data from the initial interviews was then transcribed and thematically analysed by identifying keywords pertinent to the particular meta-theme.

Keywords for the Clinicians included;

- Community Mental Health Team
  - **Impressions, Contact, Visit, Friendly**
- Power Differential
  - **Power, Control**
- Masculinity
  - **Role, Masculine, Masculinity, Change**

- Barriers
  - **Barrier, Hinder, Stigma, Reluctance, Resistance**
- Access
  - **Access, Equity/ Inequity, Useful, View**
- Sites of Risk
  - **Risk/ Safe, Visible, Emotion, Trust, Weakness, Vulnerable**
- Legitimate Others
  - **Family/ Whanau, Partner/ Wife, Sibling/ Children, Mate/ Friend/ Peer**

Keywords for Clients included;

- Community Mental Health Team
  - **Attitude, Clinician, Impression, Change, Visit**
- Power Differential
  - **Power, Control**
- Masculinity
  - **Role, Masculine, Masculinity**
- Barriers
  - **Barrier, Hinder, Stigma**
- Access
  - **Access, Equal, Change, Useful, Approach**
- Sites of Risk
  - **Risk, Visible, Emotion, Vulnerable**
- Legitimate Others
  - **Family/ Whanau, Partner/ Wife, Sibling/ Children, Mate/ Friend/ Peer, Subject**

Identifying and using keywords as part of thematic analysis ensured that the data from the participants (as experts) remained in a raw form and was subject to the least

amount of bias from the researcher. This was to ensure that the ‘voice’ of the ‘expert’ (in this case, the participants) was captured. Using participant’s keywords also assisted in managing the data when categorized under headings from the literature review (the meta-themes).

The sentences in which the keywords were found were taken, and placed as raw data under each meta-theme. The collection of raw data was then edited to ensure that the keywords and sentences identified were in the context of the particular meta-theme. Identifying common themes in the data within each meta-theme then condensed the data further. This new condensed set of data formed the themes and basis of discussion for the focus groups.

### ***3.4-3 The Focus Groups:***

Focus groups were incorporated into the methodology of the research to check the legitimacy of the analysed themes that had been elicited from the raw data of both client and clinician participants. This second layer of analysis was to ensure that the analysed data was reflective of the participant’s viewings of men accessing a community mental health team. As a qualitative tool the focus group is useful in capturing the subjective viewings of the participants (Edmunds 1999).

Rather than providing quantifiable responses to a specific question obtained from a large sampling of the population, focus group participants provide a flow of input and interaction related to the topic or group of topics that the group is centred around (Edmunds 1999).

Three focus groups were to be conducted to capture this second layer of data. They included,

- 5 Male Clinicians
- 7 Female Clinicians
- 0 Male Clients

Focus Groups ranged from 60 minutes to 90 minutes in duration. They were conducted at sites that were chosen and agreed to by the respondents. A transcriber was present during the focus group and was subject to the same consent and privacy conditions as the participants and researcher (Refer Appendix).

The two Clinicians focus groups were conducted in available rooms at the North Community Mental Health Team. The Client focus group was to be conducted in available rooms at the Department of Social-Work and Community Development, Otago University. The Focus Groups were made up of;

- Male Clinicians Focus Group:
  - 1 Crisis Nurse
  - 1 Psychiatric District Nurse
  - 2 Consultant Psychiatrists
  - 1 Community Support Worker
  - 1 Transcriber
  - 1 Facilitator
  
- Female Clinicians Focus Group:
  - 1 Crisis Nurse
  - 1 Social Worker
  - 1 Occupational Therapists
  - 1 Clinical Psychologist
  - 3 Psychiatric District Nurses
  - 1 Transcriber
  - 1 Facilitator

- Male Clients Focus Group:
  - 0 Male Clients

Data collected in the focus group was two fold; firstly in the form of direct participant feedback whereby the participants recorded their own immediate responses on large sheets of paper. This was to ensure that the responses from the individuals in the group were elicited, ensuring accuracy and legitimacy of collated data, and to reduce researcher bias. Secondly, data was obtained from a transcriber (who was not the researcher), who was present during the focus groups. As the researcher was also the facilitator of the focus groups, this limited the researcher's ability to pick up on the entirety of the participants expressed views in the focus group. The role of the transcriber ensured that as much of the participants viewing was collected as possible.

Data collected from the focus group was then thematically analysed as had been done in the interviews. These themes were then compared and contrasted with the meta-themes established from the Literature Review, and the themes from the initial interview. This process was used primarily to highlight any inconsistencies, inaccuracies and highlight any discrepancies between what the participants said and what the researcher recorded. All of which ensured that the analysed data was an accurate reflection of the raw data given by the participants in the interviews.

#### ***3.4-4 Male Client's Non-Involvement in the Focus Groups:***

None of the participants were willing to participate in the proposed focus group for male clients of the North Community Mental Health Team. Letters were originally sent to the participants outlining the content and plan of the proposed focus group. Follow-up phone calls were made to participants, of whom none expressed an interest in attending the planned focus group. After discussion with my research supervisor, it was decided to identify any parallels between the men's reluctance to participate in the focus group and the research topic; of what helps or hinders men's access to health services like a community mental health team. It raised the question about what had contributed to their disinterest; such as was it reflective of men's general avoidance of issues surrounding healthcare.

For men exhibiting vulnerability does not generally come easily or naturally. If you are a man who is already marginalised, exposed, and made vulnerable by mental illness, then the re-marginalising (or re-stigmatising) of one-self will be avoided (Gerschick and Miller 1994). It is possible that meeting together to discuss issues around mental health and men's mental health was seen as 're-marginalising' for them. Particularly for men who already view themselves as highly different and highly visible.

### **3.5 Validity and Reliability**

#### **3.5-1 *Dilemmas:***

Within this research project I expected to encounter a myriad of dilemmas that would arise out of my interactions with both clients and clinicians, yet surprisingly I did not. Instead I encountered an overarching dilemma that resonated to the core of my social work practice, challenging me in my roles as both a social work practitioner and social work researcher. The dilemma I faced was the insidious way our health and mental health sectors have, and are, continually being eroded. And, how they are imbued in the rhetoric and discourse of the political. As a social work practitioner I am inherently aware of the political. Politics shows itself in all research and research processes whereby,

All research is political, imbued with power and engaged in a moral struggle about what is 'normal', what is 'truth', what is legitimate 'knowledge' and who can be validated as the 'knower'...In that case the [social work] profession is obliged to strive for a research practice that takes account of its moral purpose to engage with oppressive structures and political and social action to change them (Humphries 2005).

This is reflective of government mandates and initiatives that follow a distinctive historical pattern of shifting accountability and delivery of mental health services from the state onto the community. The community's response to this over time has been the formation, establishment, and entrenchment of the NGO. This continual restructuring of mental health services by District Health Boards as a result of

defining and redefining their 'core business' has inevitably led to the 'culling' of services not related to this business.

Governmental approaches to health and health care have seen a change to a population based funding approach. This is being outworked within District Health Boards in the re-defining of their core business; and the reduction of mental health, drug and alcohol, and intellectual disabilities services. Set alongside this, is the realignment (or devolution) of community mental health services with NGO's and GP's.

The Implementation Plan for the National Mental Health Information Strategy outlines the future of actions needed to address information gaps and move the mental health sector closer to the ideal of an integrated network of service providers, especially in the non-governmental organisations (NGO) sector (Ministry of Health, 2006, 1).

The assumption and expectation is that both the NGO and the GP have the *same* resources needed to provide the level of care that the District Health Boards are now unable to provide. It appears farcical that the Ministry of Health by devolving services back onto the community to reduce costs, expects the community to then have the *fiscal* resources to provide the same level of care; resources that the Government themselves don't have. The juxtaposition of the community not having the resources, and the government being unable to provide resources, reiterates for me, a huge dilemma for the future of health services in New Zealand.

### 3.5-2 *Ethics Committees*

Before starting the research project and eliciting potential respondents, I first had to go through several rigorous ethical, cultural, and health committees. This process helps to ensure the efficacy and clarity of the research, the ethical and safety imperatives of the research process, and most importantly the safety of the potential respondents.

Initial application was made to the Lower South Island Ethics Committee that forms part of the National Ethics Committee for New Zealand. This rigorous process proved invaluable, and resulted in the resubmitting of parts of the original application. The ethics committee had no issue with the ethical standards of the proposed research project. Resubmitting the original application was as a result of ensuring a consistency in format of the application. Most of the committee's attention was drawn to the layout and presentation of the original application document. Amendments to layout and presentation were subsequently made, and approval to begin the study given (Study was approved until 1<sup>st</sup> December 2006).

As part of the research process, consultation with local Iwi occurred in the form of application to the Ngai Tahu Research Consultation Committee (*Te Komiti Rakahau ki Kai Tahu*). The committee gave approval as they saw that as a population based study (with Maori making up a significant proportion of the working population) that the research project had the potential to make positive contributions to Maori health. The committee also recommended that the results of the study be distributed to Maori Health Organisations.

Approval from the Otago University Ethics Committee was automatically granted as a result of approval from the Lower South Island Ethics Committee. As the information I was eliciting would be from both users and employees of health services I needed to also get approval from the Otago District Health Board and its Health Research Office.

### **3.5-3 ANZASW (*Aotearoa New Zealand Association of Social Workers*)**

As a current member of the Aotearoa New Zealand Association of Social Workers (ANZASW) I am obliged to abide by a code of ethics that ensures my social work practice is of a standard that is also safe and ethical. The code of conduct also applies to social work research with clear expectations surrounding the social work researcher's ethical responsibility for research and/ or publications (ANZASW, 1993, 14-15). I am also bound by a set of ethical standards pertaining to research ensuring responsibility of research and publications (ANZASW 1993).

A social worker would have to justify to an appropriate ethics committee any methodological requirement of a study...to demonstrate that other non-deceptive procedures could not be used... ensuring that all participants are given full explanations as soon as practicable (ANZASW, 1993, 14).

This meant that I had a process of supervision in place to provide checks and balances within the research process. This is to ensure that I adhere to the standards, recommendations, and outcomes of the ethics research bodies, and that at all times in the research process, I as researcher inform the participants of the research and its processes, and that I do no harm, and protect participants from harm. It also ensures

that I provide objective and accurate information acknowledging all sources of information and ideas (ANZASW 1993).

### **3.6 Approaches to Researching Men's Health: A Salutogenic versus Pathogenic Approach**

In researching men's health, there is a tension in the debate surrounding how to research men's experience and who is best able to research this experience. From a feminist perspective men are seen to be inherently and continually located within a wider context of patriarchal relations. This is combined with what Haywood (Haywood 2003) describes as 'cultural institutionalisation', similar to Foucault's (Foucault 1982) description of 'the gaze', in this instance the male gaze. This can create discrepancies for men attempting to research from a feminist perspective.

Implications arise around men's ability to replicate 'feminist knowledge making' (Haywood 2003) and to apply such methodology to the male experience. Can the male researcher in men's research validate the authenticity of the male subject's oppressive experience from a feminist or feminine perspective? Or, is there the need to develop like the feminist perspective, a masculine or male approach and perspective, something 'pro masculine rather than anti feminist' (Bly 1990), something that replicates for men, a masculine knowledge making.

To understand the male experience of health and men's health issues in research, it is important that we explore the different experiences of different men within health services, such as mental health. The male researcher is at an advantage as both he and the participants have access to the shared experiences of being men, from both a positive and negative hegemonic discourse and a shared knowledge that is found only through other male relationships. So why research men's issues? With a continuing

growth in statistics reflecting negative trends in male mental health and well-being MacDonald et al identify a need to pursue initiatives in research that promote ‘in boys and men a positive sense of self’ (MacDonald 2000). MacDonald identified the need for a ‘salutogenic’ approach to men’s health versus the current ‘pathogenic’ approach (MacDonald 2000).

Similar to Foucault’s ‘Gaze’ (Foucault 1982), the Pathogenic approach to health focuses solely on the pathology of the problem, compared with the Salutogenic approach to health research, that focuses on men’s health and health enhancing behaviours. This is what Illich (Illich 1975) describes as a ‘health services’ focus rather than a ‘disease services’ focus, a moving on from what Bunch (Bunch 1983) identifies as the ‘description’ and ‘analysis’ to strategised interventions, the ‘changing what is to what should be’, and to the development of a vision and a strategy within men’s health (Bunch 1983).

The Salutogenic approach is of particular relevance to men’s health research, more so when current health research of men pathologies the multitude of problems facing men, reinforcing negative and hegemonic discourses of masculinity. This type of research shows up in the ‘health pathologies’; of men’s cancer (testicular, prostate, cardiovascular), of men not accessing health services (GP, outpatient appointments); and the ‘social pathologies’; of men’s violence, men’s emotional inadequacies, and men’s abuse of others. This type of research produces what has been called a ‘deficiency syndrome’ and a ‘deficit model’ of research in health (MacDonald, 2000, 2).

Current pathogenic approaches to men’s health research, focus on the pathology and pathological path of men’s health research. This creates a tendency to follow a cyclic pattern of only ever ‘describing’ and ‘analysing’ men’s health (Bunch, 1983).

Current health research for men also tends to focus on a deficit model identifying what we already know, that men don't have health problems and that admission of any health problems is not permitted, all of which reinforce the invalidation of the male who does not conform to societal norms. A need exists for men's research to focus on the positives for men and build on them,

Asking questions of what fosters men's health? What is good for men? How can we make services more men friendly? A salutogenic approach to research of men's health mean's introducing a 'men's language' into health and health care (MacDonald, 2000, 3).

This salutogenic approach to research is needed to help develop a positive way of seeing maleness and male culture that includes finding a positive language around maleness and being male that says that it is okay to be male. The salutogenic approach to men's research assists in this by,

The building of a new language of men's health. In this way we can build a language of 'men's business' in health, a language which, is respectful of women's business but claims, without any need for aggression, the right to talk of men's health as something complimentary to, [yet different from] women's health. A talk, or discourse, which is ready to address contradictions but from the outset, and throughout, is based on the foundation that being male is what we [as men] are and it is good (MacDonald, 2000, 5).

## **Chapter 4 – CLIENT DATA**

### **4.1 Introduction:**

The raw data collected was from 4 interviews with 4 male clients from the North Community Mental Health Team. The raw data collected in the interviews was collated according to the seven meta-themes that were identified in the Literature Review. The format of the interview was structured around these seven meta-themes.

They included:

- Access
- Barriers
- Community Mental Health Teams
- Legitimate Others
- Masculinity
- Power Differentials
- Sites of Risk

Within each meta-theme a series of questions was developed in which the client was given opportunity to respond (refer appendix).

## **4.2 Interviews: Views of Male Clients**

### ***4.2-1 Access***

Health services were seen as equally available for men but not equally accessed, with women seen as being more familiar with health services and therefore more likely to access health services.

Right... ummm... I wrote down...that...they equally available...but not accessed equally...like with men.

I think that... ummm...just... I think that...its... equal... there are probably differences that are related to it... ummm... women as child bearers... quite early on in life...they're... more frequent in using health services...they're more... comfortable... know more about... health... health issues.

### ***4.2-2 Barriers***

Not knowing what would happen as a result of attending a community mental health team was difficult for men.

I guess... some guys...might find it difficult to approach the north team... I think the most... is how... not knowing how it is going to be.

Ummm... no nothing springs to mind... its just... in... in a meeting...like that... you're trying to get to grips with...its you're first contact...with community mental health team... your trying to get to grips with practical things like... your medications...how often you should take them...where you should pick them up...and how often you should pick them up...you know... is the prescription fortnightly...or monthly... or is it a monthly prescription on fortnightly...pick up... what am I allowed to do... what am I not allowed to do?

The stigma of mental illness had a large impact on them as men.

Ummm... I wrote down the first that just came to my mind... was the stigma of being psycho... and so...its just that when you are there... you are a person with a problem... and you feel people are going to label you as being... whatever that problem may be... and I know that on TV they have the ads... know me before you judge me...and stuff like that...etc... but you feel that people are going to judge you as being psycho.

Its because of all we've spoken about... well... I was thinking about my GP... ummm... as far as mental health services... again... its that thing... that terrible stigma...of being a person with a mental health problem.

For sure... stigma... no... its always there... its always there in the background.

Oh yeah...yeah... its hugely less and less and less now...ummm... and... one of the reasons why is because of the ahhh... Mental health commission... who have come up with this brilliant series of ads which we've not had for a fair while now... in fact you still see them...but they are ... they are as much a gift to mentally ill...or people with mental illnesses as they are to the public at large.

Being visible, being seen, or being known as having a mental illness, was something men avoided.

“But you do feel... but I have felt...during my illness that... ummm... there is a danger that people I know from my past... who know me when... I became unwell... will see me on the street...and they’ll know that I’m psycho...or... and yeah... they might well react negatively...they might abuse me... or call me a psycho...or take to me...”

“Yeah... I have a... I have a thing about being visible... I ummm... prefer...blend into the background... I... ummm...hang back...”

“Yeah... I feel exposed and I feel as though I've got a neon sign... attached to me...flashing...that people can actually see it... sort of thing... see something wrong with you... something different...or something you’re ashamed of...”

#### **4.2-3 Community Mental Health Teams (CMHT)**

The waiting area of the community mental health team was viewed by male clients as ‘unhelpful’

Yeah... yep... it’s a small waiting room... it doesn’t take much to fill... but it was full... well that was my impression anyway...and there was a couple of loud people there...ummm... couple of clients that were a bit... quite loud and sort of... and so... ummmm... so that sort of... freaked me out a wee bit as well.

The waiting room was full... Ohhh... I don't know... maybe just...probably because...I was ummm...quite sensitive about that.

I guess... it was the physical space...the waiting room...the corridor... it was...Yeah... it is an exposed sort of place...yeah yeah...there are lots of people coming and going...through...the waiting area.

Car magazines... [laughter] I think from... my memory... even my most recent... visit to the north team... they're all women's magazines... I didn't see a single man's magazine.

I wrote that on one of the questions... how about a few more men's mag's...like boating... and tramping.

Opportunity was not given for the male clients to ask questions at the initial stages of involvement with the community mental health team.

My impressions... looking back now was... that there was no opportunity to get offered to ask any questions

And none of those questions were addressed...really... and I felt probably... a bit silly asking those sort of questions...so I didn't ask... and a lot of the questions... sort of...only occurred to me afterwards...anyway

So I didn't ask... and a lot of the questions... sort of...only occurred to me afterwards...anyway...So... yeah... so I remember my comment to my wife...she came with me...I try to involve her in most of things...where I can... that I'm doing with the mental health team...and where there's a meeting about something... you know...I try to get her involved...and my comment to her was... I felt that we had been steam rolled

Not being given enough 'time' was also identified as unhelpful for the male clients.

They don't have more time... that they could give... I find it difficult to... to kind of...ummm... its six weeks or two months... between... I just have a quarter of an hour appointment.

Because I think... because I think he was under time pressure... ummm... only had a half hour window... or whatever... for me...probably behind time as it was...plus he had made time before...and seeing he didn't get to know me at another time...and I failed to show up...by that...so when I got to see him this time round he was just going...like machine gun... questions...questions... questions... questions...How are you about this... how are you about this... how are you about this... how are you about this...how are you about this... how are you about this...My impressions... looking back now was... that there was no opportunity to get offered to ask any questions...There may well have been at the end... perhaps... do you have any questions... but I was so...sort of...freaked out and blown away by it... that I didn't... I wouldn't... I didn't know what to ask...if I had a question to ask...anyway...if I had a question to ask.

The telling or retelling of their life history for different and/or new clinicians was not helpful for men, and this made them more likely to choose not to disclose how they were.

Yeah... ummmm... it was bad apart from the usual... anxiety about seeing a new person... and having to regurgitate my life history again... Ummm...it was...really nerve racking... just not knowing who I was going to see...Utterly terrifying...having to talk.

Get your meds signed off and get away...again...yep... that's basically my attitude to it.

After subsequent visits and the advent of 'time', male clients felt better in attending the community mental health team.

Yeah, because... because the community is tolerant of it... and certain... I don't know about the south team...but the north teams a great team...and... and the standard... the attitude towards people in mental health... is ... tolerant...and professional

Yeah... naturally...I think things...always progress as you become more used to them... you have a changing attitude to them...ummm... I'm much more comfortable with the north team in general.

Once I started knowing where they were and that... and that when I rang the hospital for some reason like... because I needed... I needed to see my psychiatrist or I needed to do something about my medication or... I needed to see them because I had this fantastic new idea happening inside me... ahhh.... And I knew that if I rang... and asked for the community mental health north... id get somebody that I knew... so it was a sort of... it was an identity thing that that was the first time I appreciated them was because I knew that's who they were.

Use of humour was important, assisting in delaying anxiety, and in building a trusting relationship, between the client and clinicians.

From a physical point of view... I've got used to the doctor... [laughter]...a bit more... I realise he's a bit of a... one off... and a bit of a character... ummm.... and he likes to sort of... kid you along... and joke you along...a bit... so...I kid along and joke along with him a bit...in return... it helped me... put me at ease.

Well... we'd... we might have a few arguments... I don't know...[laughter]... see its... I try to joke him along a bit about it... and any disagreement we might have you try... to joke him along...a bit...and see if he's got any bend in him... ummm... and soon find out whether he has or

hasn't... I'm not sure... with regards to my PDN... ummm... and our relationship is a bit more... fluid... I guess you might say... and a bit more... interactive... ummm...because he's not in the role of the doctor... ummm... so... we tend to get on a bit easier... yeah.

I think it is something that... ummm... something I find useful...ummm... and I think the doctor finds it useful... and I... I find it useful... I can relate to it...ummm... yeah I think that guys in general... actually tend to use humour a wee bit I think...to try an temper the... seriousness of a situation.

The clinicians at the community mental health team were viewed positively by male clients.

No... the people themselves were all... were all... quite friendly...and involved...the receptionist was good.

Well, yes...it is... yes... because there are no fuck wits to come and spoil things for you...you might be unwell...but... the chances of there being a fuckwit... is very very small.

Ummm, they were good...because I never had one before...they come around and checked on yah...ummm... at that stage it was... [Identified nurse]...who came around and checked on me...yeah she was good.

Yeah, it went away.... I just got used to it...and that... it was... you were treated like human beings...and that's what amazed me...you weren't just a number on a piece of paper... you were treated like a human being.

Oh yeah... I think they are...yeah... because I'll tell you one reason why... because usually I get the impression that the people that work in the mental health team...regarded it as a promotion...and ...and... they're regarded with some envy...its like a teacher in a school...being... being... given the job of full time outdoor education person...

and... with all the perks that it includes...so the other people are always respectful of that person...that person is a previous colleague, so in case...ummm... these people are talking about people who were colleagues of theirs anyway... and who have been chosen or lucky enough...to have been accepted into the... the community north team... and therefore... they're good people...and they're well worth... ummm... respecting and so on.

It was good, because...she came out and seen me, when I went into a house...I spent a bit of time in hospital...in 6C and then I went out to Hume House...and she took me down to the beach... had a chat to me... come back and said I would be coming here... and that she would see me every week for a start... then every fortnight...and that ... and then go from there.

#### ***4.2-4 Legitimate Others***

Talking with female staff was seen as easier for men.

I say that women are more intuitive... particularly because I've had... a couple of experiences during 1A that seemed to bear that out in practice...that a women was... a female nurse... had a particular empathy... and ability to listen...and there was a particular male nurse that I particularly thought was very off hand and rude...didn't care less... what I ... ummm... yeah... was particularly offhand in that he would listen to certain extent and then turn off... and so I thought that they...both bought out the female and male stereotype to a large extent...about talking about... listening to deeper things.

Yeah... well... I would find it easier to talk to a female health professional... ummmm...well I think I'm saying that because my present PDN is... an extraordinary pleasant women...which is not a good reason because my doctor... my GP is great and my psychiatrist is a very excellent fellow...I think...its because there is a gender

difference and a women's ability to listen, focus, and respond.

In general I find...it easier to talk to women... about how I am...and my private parts... No... generally I find it easier... to talk to females.

The 'Sex Role' was associated with gender when identifying the preference of which gender to talk to.

I've written down female... because they are less... because they have the role of being a listening type person... they are less confrontational.

Yeah... I think so... I think so... I think again... the person is in the role... to talk about these things...I don't... I wouldn't have any difficulty talking to a women or a man... if I had the need to speak about it.

Participants felt that what having a mental illness meant for them, was not fully understood by their family and they felt 'inferior' as a result.

Well in general it makes me feel inferior...ummm... to members of my family and friends... Yeah... ummm... yeah... inferior compared to how I used to be and feel...and...yeah... so... and I guess I'm expecting them to criticise me or be critical of me at some stage...although they've been the supportive so far... ummm... but to a certain extent I feel...that they want to say to me... you know... snap out of it... get it together... ummm... and... certainly I want to say that to myself as well...but... its proving more difficult... than that... I can't just snap out of it...for some reason or another.

In general... I... just a general feeling that I'm a little bit inferior and inadequate... and if there was a family issue to be discussed then I would... feel...that I would pretty well go along with what was decided by the others... rather than have much input myself...yeah.

Peers, colleagues, and friends were identified as 'significant others' that men with mental illness had talked too.

I don't really think I've got friends that I could talk to about issues...I must say... when I first became ill... and the second time I became ill... both times... that my wife's cousin and partner were very much... we actually called them and said please come over... I really need to talk to someone...about my feeling of hopelessness and wanting to end my life...so we did reach out to them... and they'd be the one couple that we'd reach out to...to talk to about in depth things.

I've got some... a friend whose a teacher... he's been my sort of boss in one of the schools I go to... ahhh... and I would talk to him about anything at all... so what sort of things do I talk to him about... well... [laughter] I probably wouldn't talk to him about... he's a catholic and he's married...faithfully... so I wouldn't talk to him about sexual dysfunction... It's a kinship, mate ship...we... yeah... there are some things he says...oh [name] please... and I joke with him.

#### **4.2-5 Masculinity**

The perceived loss of a traditional masculine role was identified as having a large impact. This included feelings associated with not providing, not working, and not having responsibilities.

Yeah... I wrote down here... my role as a provider is gone...that's the thing that sprung into mind...when you said what I find most difficult...about having a mental health problem... yeah... it's the contrast where I was... and what I was doing.. .to where I am now.

Not being able to work... not being well enough... not being well enough to hold down a job... is an issue for me.

Yeah... I certainly feel that way myself... and the really big thing I feel about being sick is... that... that's been stolen from me...and I now... I don't have roles or responsibilities...or things to do...and it's very difficult to grasp that back.

Having a 'role' was seen as inherently important for men. The fulfilling of a role, more so for men with mental illness.

Yeah... yeah... your survey prompted me to... think about... what... what is important to men...and also... as opposed to women... in what ways are we different... and I ummm... I sort of think its a lot to do with men... its to do with your roles and responsibilities...in society... not to say that that's not important to women as well... I mean it is... but men's roles... and responsibilities are different to women's... and in particular to me... it centres around being a provider... working... bringing the money in... ummm... money issues therefore.

Yeah... I think its largely that... again that's another of the roles... for men... the role that society has placed on men...or that men have perceived to be... their role in society... and ummm... yeah... you know... its... still... even though I say it's a role... placed on men and it's a role that they've learnt from society... to a certain extent... its also nature... its part of mans nature... to be like that... I think.

Ummmm... doing... doing things... being active...  
ummm... yeah... rather than just being...doing and  
acting... on things... making plans... making a plan... and  
bringing a plan to fruition...rather than sitting around  
talking about it...which I perceive is more a women's  
thing... talking about our emotions... and touchy feeling...  
lets have a party... that's how women go about... their  
roles and responsibilities... men are much more... doing  
orientated... and plan orientated...achievement.

It was not okay to ask for help or admit weakness. Both were seen as failure and for  
men with mental illness, as reinforcing failure.

I don't know...something about... something  
about...about... masculinity that it's not okay to put up  
your hand and say I need help.

Yeah I think...some... some men... would kind of see it as  
an admission of weakness...or failure on their part.

And in the past... after my first round... ahhh... in  
hospital... and with community team... I sort of came  
right... by doing things and getting out and being... and...  
ummm... actually doing wee jobs around the  
house...painting... and... the back deck...it seemed to put  
me on an even keel and put me right and I was away.

Having contact with other men with similar experiences was seen as helpful for men.

Ummmm... no I guess sometimes... its useful...I think its  
just reassurance...that... that I'm not alone...that there are  
other people...in similar circumstances.

Yeah... a wee bit in going through to day hospital...and  
OPG...ummm... I'm actually at the moment with OPG...  
and ummm... there's out of about a dozen clients there's...

I think three of us... that are male...ummm... and its... I think its helpful... to see other guys... have similar problems to yourself... and see them coping and dealing with them.

When asked what would be useful for men, they identified more NGO's that worked with men, more direct feedback about how they were doing (to monitor progress), more time with the clinician (bloke to bloke), and more male friendly services.

Well...I reckon that the [identified NGO] was a great health service...it was run by people with a mental illness...who...and there is no... there is no... there is nothing better than having people with an illness to understand how another person.. ummm. Maybe... even... even... their thinking maybe very different their priorities may be very different but the fact...even though... that they know that they got the same illness as them.

Well not particularly... because the sort of things that might make it more useful are the sort of things that the [identified NGO] would probably do even better.

Ahhh... its been useful in terms of... having regular contact... and having feedback about...how I am... my perceptions and how I... ummmm... kind of reality checking.

Maybe more time... yeah...I think that... you know... that...ideally from... you need to be able to go in sit down... and have a good... coffee... and talk about... rugby... spend some time...talking first.

No...ummm... to make it more community...I was think... you know... we talked before of making it like MacDonald's... but then that tends to make it more a women's health... service... because it's the kids that the women are involved with... what would make it a man's health service... what would put a man at ease... or

stimulate his interest... I'm thinking of something like a video game... or a pin ball machine... ummm... big screen TV with sports...running 24-7... that sort of thing would make it more community for a man... ummm... a big double door... leading out to a park...that would make it more community.

Since their illness what the participants valued and saw as important changed.

Well one thing I have to say is that I cant think of anything that is specifically would be... as a man... you know...I would just be as a person...doing those things...but...ummm... well you know before I first presented with illness...I was going to be the worlds most famous career person...ahhh.... My brilliant career as it were...and...so I was very very ambitious... I was lined up to... succeed... I was short listed for... through a queens council grant to study conducting in Baltimore, USA... stuff like that you know... id been on volunteer service abroad...I conducted a lovely little orchestra... I did five concerts a year...yeah I could just have easily been a women doing great things I reckon...but... it... I suppose one thing you could say is that I was ambitious and this ambition was just flattened...absolutely flattened...so that could be a male thing I suppose...couldn't it... because... because I wanted these things to be a life long career type thing...I also wanted to be...a... a father and a... stuff like that.

Ahhhh... I do see myself as...different... just... because...I'm frail and... have health issues...and so my awareness...of myself...now is... I tend to react to...things... how I see myself has changed...or... I sense that I should... but I need to give myself permission to feel...the things...yeah.

#### ***4.2-6 Power Differentials***

Power was seen to lie with the health professional because of their role.

Yeah... ummm... my first reaction to that question is to say that...that my PDN and the doctor and the health professionals have...the power...and I have very limited or little power.

So... ummm... I don't mean that they're physically over bearing or attitudinally... you know... aggressive...or anything like that...but... but... I certainly feel that their roles and responsibilities...give them... give them a control... a position of control.

Ummm... power... by the right of office... and... ummm... yeah the power that there office gives them...their role and their responsibility.

Power showed up in the relationship with the clinician in the form of having to take medication.

Just by one pill... out of about four...but... he wont reduce that one...he's quite adamant... so I've got to take it...ummm... but to me that illustrates... a probably what would happen... in any difference of opinion that I had... with the doctor...and ummm... you know... he would...he would...ummm... have the power of veto... and say you're to have it... ummm... which is probably natural enough...so I'm just glad that I mostly don't disagree with him.

Ummm... I guess I see the clinician... as having... as having more power... than I do...I suppose...in regard to... medications.

I don't...trust them... ummm... I don't believe what they saying... might be totally true... particularly... I'm thinking of the doctor... he's a great one to...well he seems to be a great one to...give you plenty of pills... and ummm... I'm trying to sort of minimize the pills... not take as many... ummm... but he's got the opinion that they're doing me good.

Power was seen as non-abusive by the male clients.

Well... I don't think... it could...but a lot of them are that...ummm... trained up and that...they...they... don't think they'd.... Really abuse it...I don't think they abuse it...they're ummmm... there to help them.

Because when you're unwell, the parameters change entirely...ummm... but I would feel far safer... ahhh... presenting myself unwell to the north team than any.. any other department at the time...I've had some very bad experiences with ... ahhh... emergency... psych... down in public...and...I can still remember... but... and as far as the hospitals concerned... I've had some very... ahhh... disenchanting experiences.

Powerlessness was felt when they were in an acute ward setting and when they were unable to see a clinician,

No... no it doesn't... it's a difficult position to be in...very difficult position to be in... ummm... its... its... scary being amongst other people who have... serious problems... different degrees... of seriousness of their problems...but you're amongst them...and you're an equal with them...you know... talking about roles again... and powers... who has the power and who doesn't have the power... you're just one of the mass...you're just one of the many that has a problem...ummm... that's quite scary...I find it difficult to... feel trapped with other people... in that situation... in the ward situation... ward 1A... very... very difficult.

No... its not... you're just totally... vulnerable and at the mercy of... circumstances really... I mean there are people there... people controlling the place... ummm... the nurses and whatever... and I guess if you loud hard enough someone would come and help you... but ummm... yeah you just feel like you're going to be worked over at any minute.

Ummm... I suppose the other thing is that I cant... I can't get an appointment...to see my doctor... ummm... I guess I

could with some... but in general terms... it so systematic... it dictates how often and when I see him... you kind of have to fit in to that sort of system... and if you don't fit in to that system.

#### **4.2-7 Sites of Risk**

In comparison with other hospital based services, the community mental health team was seen as a safe and familiar service.

A safe place...one of the things about the north team is that its not complicated...in a hospital you've got all these bloody engines...and all these fire workers... and all these insurance keepers and all these... ahhh... people who look after the books...the people who tell everyone else what to do...oh my godfather.

Ummm... just that I have become more familiar with... everything there... more familiar with the doctor... when I first seen him there was a big risk about who you were going to see as a doctor... what would he be like...ummm... and now that risk is gone.

Initially I thought... and felt... that it was actually risky being involved with other patients... with other clients... that my issues might rub up against their issues... rub each other the wrong way...ummm... and that was sort of... brought up with my first interaction with the north team...it felt fairly unsafe for me... since then I haven't found it like that... but I definitely feel that when... you're on the ward situation, 1A or 9B... that is a very real fear... of rubbing the other inmates up the wrong way...it feels unsafe... but...for the north team I don't feel that anymore... in a physical sense... ummm... I'm there for an appointment... I have a clear focus on what I'm doing there... and ummm... those who are waiting are in the same view... there for an appointment... we're not rubbing each other up the wrong way.

The community mental health team was not seen as a place where men could be 'vulnerable'.

That is a real... that's a real problem there... ummm...I just noted down that it wasn't a place where I could be vulnerable as such... but again...because of that idea that it's a public place...to some extent...and ummm... you're there to achieve a goal... to see the doctor... to have a meeting... and get out again.

Okay...yep... when you go in to the building there...ahhh... the receptionist is behind a glass door... she's on the other side the island so to speak...and she says hello, takes details, go have a seat.... If you're unwell... they would have to call somebody... now I don't know who they would call... but you're left to sit in the waiting room there... but I don't know how... whether they could work that.. because... ummm... the thing is... ok... when you're unwell... you're vulnerable no matter what...if you're unwell you're...you're... in the shit...and somebody has to step into it...to get you out of it...I think... so the simplicity of the organisation is its... is one of its redeeming features, but it can at the same time be a type of fragility.

#### ***4.2-8 Summary of Clients Themes:***

Male clients believed that although services were there for men, they were not accessed by men. They did not elaborate on specific services for men, and referred only to their General Practitioner, and the Community Mental Health Team. Feeling visible, being unsure what would happen once they accessed a mental health service and the stigma of mental illness were identified as inhibiting their access to a community mental health team.

The waiting area was seen as unhelpful adding to an already established and vulnerable sense of feeling visible. Clients said that clinicians did not give them enough time and that they initially felt unable to ask questions. After subsequent visits to a community mental health team the men acknowledged that they felt more relaxed with the clinician. The retelling of their life history to different clinicians was viewed as unhelpful. Humour was identified as key in their relating to the clinician.

Male clients felt that females were easier to talk to, though this was viewed in terms of the traditional 'sex roles' of the genders. They acknowledged that they felt inferior when they contrasted themselves with their immediate and extended family. Peers, colleagues, and friends were seen as legitimate and significant others to talk with.

Male clients identified the loss and change in their role as having a huge impact. The view of themselves as being unable to provide, unable to work, and unable to take on responsibility was seen as devastating. This inevitably led to the need to ask for help which was viewed as further failure. They did acknowledge finding some use in having contact with other men in a similar circumstance.

Male clients had a high degree of awareness of the part that power played in the relationship with their clinician. Power was seen to reside with the clinician in the form of compulsory treatment and the prescription of medication. They said that they felt most powerless when in an acute ward setting and when they were unable to see a clinician. The community mental health team was seen as a safe place when compared with other mental health services, both in and outpatient. Lastly they said, the community mental health team was not a place where men could be vulnerable.

### **4.3 Client's Focus Group**

#### ***4.3-1 Introduction***

It was planned that male participants would take part in a focus group following a similar process as for the male and female clinician participants. All of the participants were previously given summarized information of the meta-themes from the thematically analysed interviews with the male clients. The focus group was to provide a second layer of analysis, as well as a platform to check the legitimacy of extrapolated themes from the raw data of the clients by the researcher.

Data was to be collected from the focus groups by recording on large sheets of paper the client participant's responses and reactions to the initial analysed data provided by the researcher. This was to ensure that the elicited responses from the individuals in the group would be an accurate and legitimate reflection of the already collated data and reduce any researcher bias. Data would also be obtained from a transcriber (who was not the researcher), and who would be present during the focus groups. As the researcher was also the facilitator of the focus groups, this limited the researcher's ability to pick up on the entirety of the participant's expressed views in the focus group. The role of the transcriber was to ensure that as much of the participant's viewing was collected as possible.

The data collected from the focus group would then be compared and contrasted with the data from the already thematically analysed data from the interviews. The aim

being to highlight any discrepancies, similarities, or inaccuracies to ensure the accuracy and legitimacy of what clinicians had identified in their interviews.

#### ***4.3-2 View of the Male Clients***

The male clients did not wish to participate in a focus group. Exhibiting vulnerability for men in general does not come easily or naturally. If you are a man who is already marginalised, exposed, and made vulnerable by mental illness, then the re-marginalising (or re-stigmatising) of one-self will be avoided. It is possible that the meeting together to discuss issues around mental health and men's mental health may be seen as a form of 're-stigmatizing' (or re-marginalisation) of them. For men who already view themselves as highly different and highly visible, meeting together to further highlight that difference may prove to be too difficult, reflective of both the personal and the societal hegemony around masculinity, where it is not okay for men to talk about health with other men.

## **Chapter 5 – CLINICIAN DATA**

### **5.1 Introduction**

The raw data collected was from 4 interviews with 4 male clinicians from the North Community Mental Health Team. The raw data collected in the interviews was collated according to the seven meta-themes that were identified in the Literature Review. The format of the interview was structured around these seven meta-themes.

They included:

- Access
- Barriers
- Community Mental Health Teams
- Legitimate Others
- Masculinity
- Power Differentials
- Sites of Risk

Within each meta-theme a series of questions was developed in which the clinician was given opportunity to respond (refer appendix).

## 5.2 Interviews with Male Clinicians

### 5.2-1 Access

Participants believed that while health services were ‘their’ for men, men themselves ‘struggled’ to attend these services. Men were seen to ‘choose’ not to access health services like a community mental health team. Motivating and encouraging men was seen as helpful in assisting men to access health services like a community mental health team.

I think... possibly... motivational stuff... I think getting people to see... that there’s stuff out there that they can take part in... trying to... to get them motivated to do something...with their day...sometimes its about what you do... and what ever you’ve got to do to get... to move along... like going for a walk... that helps sometimes.

Historical contact with the mental health service was also seen as having a dramatic effect on how men accessed services, like a community mental health team.

[Their past MHS experience]... Definitely... huge amount of influence on... how they access the health services now... and... I guess... probably...the ones that I can work with a bit more proactively are the ones that have only recently come into the health system.

A focus towards specific services that targeted men was seen a potentially helpful in assisting men to access health related services. This included work based health care, occupation focused rehabilitation, increased community health education directed at men, and men's groups, etc.

So its probably the people with more sort of ... low grade disorders... that tend to fall through the cracks... because they... don't go and see their GP... they do go... and see their workplace... ummm... workplace health person... and they just tend to try and deal with it on their own... so maybe... a bit more education in the work place... a bit more education in the community...that kind of thing would be beneficial for helping people...to feel comfortable with accessing... the health care services... with regards to us I suppose... yeah...actually looking into...ummm... us clinician developing more of an awareness... of gender issues... and ahhh... and how they can impact on people... ummm... incorporate more with our work with clients... ummm... a men's group or whatever... but having said that I don't think there's a women's group around... so you know... I guess you can't argue about gender bias in that respect... and it seems... that all services seem pretty well equally well used by males and females... so... you wouldn't look around and say males must be scared off... they don't seem to be...I guess the only other thing would be more occupational stuff... ummm.

### **5.2-2 Barriers**

Barriers identified included the limited time clients got with clinicians at the community mental health team; the expectation on the male client to exhibit vulnerability; and the lack of acknowledgment that males communicate in a different way, a way that is masculine.

A couple of people that I've worked with in the past... have said that... that the time they got was limited.

Yep... in some ways its quite a professional...place like and office like a GP practice... ummm... and often that can be a barrier... to them being able to come in and...its very clinical...psychology may be a bit different the... a different sort of mindset...but they've got half an hour...to see the doctor... go over medication with them... its not a place where they can be vulnerable.

A lot of them... don't express in that way... you know... a majority of people would not say... ohhh... you know I feel... a lot of them will have difficulty in expressing their emotion... but they wont be able to say its because I'm a bloke... they're just...no I don't want to talk about that... I'm not interested... or...I haven't got that... it's not my illness... so... it's more... it would be more of a denial than an active... resistance to the idea.

Participants believed that the community mental health team can acts as a barrier in and of itself. It was seen to foster its own inherent cultural attitudes that included, not viewing 'life beyond illness'; a continual focus on clients 'past/ historical' events; and a type of 'community institutionalism' where chronic mental health service users mixed only with other chronic mental health service users.

Yeah... its extremely important to remember that... like people aren't at home... when you go see them...for sure...ummm... barriers that stop them... I guess its what we talked about with...ummm... men want to get on with their lives... and whatever they see as being a point...whether it be... getting back into their career... or...establishing social links... or... getting partners... ummm... they start wanting to focus on that... rather than...than mental health services...

Ummm... yeah... again I sometimes think that... we can be a service that's... a little bit too focussed on... the here and

now and the past rather than... moving on... that creates perhaps... a bit of... a tussle with... fellows... even sometimes it's a bit too early... and you need to recognise that but... as a service we can be a bit... looking at what's happening now and the past... even though that's important... but it creates a bit of a barrier... and a bit of a... coming from two different ends.

so sometimes that can be... ahhhh...a barrier because...they're so busy looking at this other stuff... they'll...sort of...think that if I just keep taking my meds I'll be okay...but not look at the help the mental health services can give them...ummm... barriers I think...it's a bit of pride as well... you know...like ummm...its just loosing that independence...especially...the fellows on the mental health act...its... its...effects their pride.

But not quite the pressure of a full work place...that might be beneficial...ummm... yeah... my of my big bug bears about this area... and its not just a gender thing but... in general... is the fact that... although we're working towards recovery and getting back into the community...and being active in their own community... all the services we provide are almost encapsulated in them... so that anyone... with a chronic mental issue, the services they can access are only for mental health service users... and it makes it very hard for people then to move out... its almost impossible for them to form a support in the community... because the people they're mixing with are other people who are service users.

Non-acceptance of illness was seen as a big barrier for males with mental illness. This stemmed from fears associated with having a mental illness including being stigmatized, and labelled, and being reliant on medication.

Ummm... I'd say the... the biggest factor would be non-acceptance of illness... just generally not wanting to accept that they've got a mental illness... not wanting to accept that they need treating for it... I mean that's the biggest thing which I find... for most of the blokes...they just don't want to accept it...when they're unwell

Partly... but partly I think its just... still the stigmatising of metal illness... you know... a lot of people... that we deal with... either don't want to accept that they have a mental illness... or... ummm...even if they have a mental illness... they don't necessarily want to be treated... it may be because... ummm... they don't like the medication or side affects...maybe that they have secondary gains from their illness... you know... a reluctance to be treated because they feel good.

Ummm... partly I think its just... a general stigmatisation of society... about a having a mental illness full stop...I mean a lot of people feel that stigmatization...I think partly its also... seeing as a weakness... you know... if you've got a mental illness... you know you can go to your mates and say I've got a broken leg and that's fine... but if you go to them and say I'm a bit depressed or a bit tearful today... you probably going to get a bit of a ribbing... I mean its...you know its just not an accepted part of culture still... but... there are people with mental illness who are accepted for what they are... so I think its a lot of the culture of being a bloke...being strong... being a provider... umm.

Distinct gender differences were identified, in how men and women access and utilise health services like a community mental health team.

Ummmm...oh yeah... I think so... I do think so... yeah... but again its...so often about... showing how it would work...and outcomes...another thing that I thought about...is... often men's reluctance to ask for help means they...get pushed aside a little bit... when... you have women with axis two disorders and they're... always in your face... always asking for help.... More so than they actually need... but they get so much of it... we've had guys with serious mental illness who want to get off... you actually end up putting them to the side a little bit... to help these people in your face... and that's a real disadvantage... for some of the serious illnesses.

A 'preventative' and 'normalising' health approach to men's mental health was thought to be most useful for men.

I guess... I'm probably thinking of it to grandly here... but... I think... for males to be more comfortable in dealing with health services full stop... there needs to be more of a... a prophylactic type approach...it needs to be something that's addressed before people get unwell... so that... in the same way you do...if problems in the work place... you know... like how do you stop yourself getting back pain...like... how do you deal with it if you get a bit stressed or tired...anxious... whatever... so I think...the primary work with males more involved with services would be to... to get rid some of the stigmatisation by including it in normal... kind of day to day working practices.

### ***5.2-3 Community Mental Health Teams (CMHT)***

Men's involvement with a community mental health team began for the most part with referrals from other inpatient mental health services. It was usually after they had been admitted to hospital or had been in some type of mental health crisis that a referral to the community mental health team was initiated. General Practitioners referred a smaller portion of male clients.

Some are referred by GP... most of the ones that I've picked up... extra since I started...have been... have come through the inpatient unit... have been people that have come in... and then been referred on.

Definitely the acute or inpatient service...ummm... some of my clients do have ongoing contact with their GP...a semi close relationship with their GP...I

guess...ummm...yeah... day programmes...work with a few of my clients...ummm...a lot of the NGO's as well.

Men had minimal regular and ongoing contact with a General Practitioner, and as such were much less likely to be referred to the community mental health team from a General Practitioner. Attending a General Practitioner was not seen as important.

I would say... the majority would be pretty sporadic...but then I would say that for both sexes...its not specifically a male thing...and its also... dictated by other factors such as finance... or... particularly with some of the more paranoid... psychotic type illnesses... those with those types of illnesses are wary about who they access full stop... the GP... us ... whoever... they try to keep the contact down to a minimum... but mostly its sporadic...I mean there's very few that actually would regularly access a GP or take any notice of what they say either.

Yep... predominately... even the ones with physical problems... don't attend [a GP]...yeah...not seen as important... their focus is on other things.

Men who were actively involved with the community mental health team also accessed other mental health service providers, from both inside the mental health services and from non-governmental organisations.

Other men...with mental illness... Yeap...signpost... like bi polar support network...one of my clients had... ummm...really good contact...with their worker there...and... there was another bloke that sort of... mentored him a little bit... and... on his sort of ...recovery journey.

The community mental health team was seen as an 'unfriendly' place for men, and a more 'user friendly' place for women. This was seen to hinder men's access.

I would say... they would probably... just walk in through the front door... they would think it a very female dominated area... because you've got the office there...with all the clerical staff... they're all female... the triage nurse in the office next door...female...so that initial... first glimpse... would just be females... it would be interesting I suppose.

Ummm... there's one fishing magazine I think... [laughter]... the rest...are all women's world...so there's certainly not much for men to read out there.

The waiting area of the community mental health team was seen as unhelpful for men, in that it was positioned in a highly visible area and was not seen as private.

Waiting in the waiting room... yeah... they would probably see a good mix of people coming in and out... I mean the waiting room is not particularly private place... and ummm... yeah... I guess you could look at it two ways... I go down to the south team for my supervision... and down there they've actually... walled off their waiting room...to make it a more private area...cause their clients complained that the didn't like... people walking past and looking at them.

Which I hadn't really sort of considered...about a waiting room...since then I've thought... well maybe it is a bit of an open area... but then I... think... it would be quite uncomfortable...to wall it off... and then as happen to me...I went down to see my supervisor... she walked passed and deliberately looked the other way... and didn't realise that I wasn't sat in the waiting room... because that's their policy now... not to look in and upset people...and I thought if I was a client... I would... actually find that quite rude...and... not very welcoming...cause people are just actively ignoring you...so... I'm not sure... I've sort of got ambivalent feelings about our waiting area... it could be quite

intrusive... it could be... quite sort of intimidating... having lots of people walking past and staring at you...but at the same time...particularly for a new... a new user to the service... but at the same for someone that already uses the service...and knows some of the staff... I think it would probably be less welcoming...if we boxed them in and shut them away from everyone.

Clinicians at the community mental health team believed that even though the service was not 'male friendly' or 'male specific', they saw that both genders were treated equally.

So you're saying how do you think they would see the service when they first had contact with it...I would think that ummm... I mean... I think they would find it okay...you know... find it fairly welcoming...ummm... fairly gender balanced...maybe more so in the way of males... there are more male doctors.

Ummm... in the north north side, there's more... you know... there's three male PDN... and one female PDN... but there's of course the social workers...and the OT are female... but...I guess putting myself in their shoes... I mean its highly daunting having a mental illness...first contact with us... you know...but...I wouldn't find it too bad I think...I guess mostly... maybe coming from that...that perspective of having known blokes around here.

Yeah... that's a difficult question...ummm... I think it is... Well... I mean from what I've seen...in my eighteen months here is...no... blokes haven't really been treated differently...when they come in...for an appointment...ummm... you know at different times... again...that gender balance... there are more clients... in the clozapine clinic... they're mostly men...and stuff like that... yeah.

#### 5.2-4 *Legitimate Others*

Male clinicians were aware of boundaries around working with males as a professional and working with male's, 'bloke' to 'bloke'.

And I... think sometimes... that can help... but then... I've had experience of a young bloke I started working with... last year... when I started...and when we...swung to far that way...we were too much buddy buddy... you know... and I learnt from that because...we're too buddy buddy... and then...I went on holiday for a couple of weeks...he came in stressed out...hadn't been able to talk to me about...what had been happening...ummm... because he sort of wanted...it was all sort of hey mate this and hey mate that...ummm... and that had to relate to someone else that he wasn't doing very well at all...so it was...ummm... I sort of learnt from that as well... so...its definitely important to keep that...professional boundary... but as well as that it can be helpful having that...sort of...that male... male interaction...sort of way...yeah.

I guess I can see a down side about that... that you might get over involved with people... you might suddenly get to the stage where you think... hang on... why am I doing this with this person... this is outside the scope of where I'm supposed to be at...but... yeah... its vital that you build some sort of relationship...and...it may just be on a matey kind of level...maybe just... a pat on the back... did you watch the rugby last night... its that the level you need to build it at... then that's where you aim for... just to get your foot in the door and then work on it... build it up...I guess one thing we probably don't do very well actually... is... check who our clients want to work with... we take it for granted that they all... accept whoever they're forced to work with... I don't think its ever offered to males when they come into the service... would you like to work with male or female... in the same way its probably a bit more focussed on the females... I mean... if a female come in with abuse issues... would you like to talk to a female or male about that...sort of thing.

Family support for the men with chronic long-term mental illness was minimal. The lack of family support was seen by clinicians as the result of the behaviour that resulted from chronic mental illness, or deliberate choices made by either the client or their family.

I mean that one thing certainly about most of... the longer term chronic guys that I deal with... is that they don't really have a lot of family support... they don't have a lot of social support...they don't have... circles of friends... or... the circle of friends they have are... limited to people with the same sort of issues and problems that they've got... so... that is something that is a major issue... no normal family life... no normal friends... no social relationships.

Ummm... I guess... it's hard to say... well some have certainly alienated their families... I mean one guy I'm thinking of... in particular he's alienated his family through the behaviour when he's unwell.

“So he's definitely pushed his family away... he's not really formed another support system at all... the one support system he's formed is an abusive relationship with a female where...ummm... I think a lot if its just...people being unwell... and unable to function in society... they've developed their illness... in their late teens or early twenties and... they drop out of work... and drop out of social life... they drop out of family life and then... they get to their 40's and 50's... you don't expect your parents to be supporting you...at 40... there's supported accommodation and tapestry...so... families do their natural moving on and moving away... but... the children do keep out... they just get stuck at the stage that they were, at the age of 17.

Other chronic long-term clients of the mental health service were identified as an unhealthy peer group, and participants believed they had a significant influence on the male client.

No... no I don't believe so... not that I've seen... because they often get those role models from other clients in the service... ahhhh... and... they're often sort of isolated from family and others.

They hang out... at places like 420 drop in centre... together, live in boarding houses together... drink together... its pretty unhealthy I think

### **5.2-5 Masculinity**

Changes in the male clients 'role' as a result of having mental illness, was seen as highly 'disruptive'. It impacted on how the men viewed themselves and their identity, and led them to question their masculinity.

Ummm...I think definitely... an interruption of their role...where you know...there's that sort of ...and I feel it too...as a bloke...there's that expectation... that ...you'll keep stepping up as you get older...and as you move on...and become more experienced...in your profession...you'll sort of keep stepping up and stepping up...ummm... and some of these guys...young guys and old... there's a huge interruption in that...that... in forming that role...in forming that identity...so... they... you know... cant continue to practice law...or they can't work...at the poly-tech like they used to...yeah I think...ahhh...yeah I think it just leaves them a bit lost sometimes...what they should be...and...doing... and sort of... society's expectations of them...it's a bit skewed really.

Yeap... yeah... ummm... its certainly difficult... for clients to have role... male role models... yeah... if you can't work... can't provide...a change in role.

Men who had a historical involvement with mental health services were seen to be resistant or reluctant to involve themselves with a community mental health team, a reluctance or resistance that stemmed from their past negative experiences as clients.

A lot of the contact they would have had with the health services over the years... and this a historic thing... is that it would have been them becoming unwell... them being coerced or... legally made to accept treatment... the treatment probably being quite... heavy handed... severe side effects... detrimental to their health all in all... and then them being back out on the street...and getting back to their own lives... no real sort of opportunities to move forward...improve themselves... go back to work...whatever... so that becomes their cycle... so... even if the service now has changed... its hard to make people see that...that's changed... because... they've got that traditional view of how a service has been... over so many years... particularly if they're sort of long term clients... they're going to see that... and they're not going to see that now...some might be able to get support... get a job out it... could go to the day programme... learn a few social skills... what they see is...a going and being carted off to 9B... locked in seclusion... injected with something's that's going to give them side effects.

Participants said that it is a 'myth' that men don't talk about 'deep stuff'. They found that it took men 'time' to develop a trusting relationship with the clinician, but when this trust was established, they were better able to share.

Yeah... yep... definitely... and... I think it's a bit of a myth that they sometimes say that men...wont talk about in depth stuff...because with the clients that I've become...that you do get to know... you do go into that stuff a little bit because you know its important...and... that's how I feel...sometimes you can change that masculinity a little bit...that idea of being tough... of getting through it.

Most definitely...I guess part of that comes with...I'm meant to know about that its part of my role... but... definitely think...that's only a small part of it... its that trust...and yeah I think it would come into it...that... with... ummmm... a partner or parent... the fact that they can trust them... and ummmm... yeah I think you know... a lot of those people...have seen the men in that emotional state...often that's what ... ends up creating that trust...I reckon because... you know when you see... the clients that I don't have... that do have a wall up... I don't have that... you can't sort of get in there...and that trusting relationship...you...you often never see...the breakdown...or never see them...really at their most vulnerable.

Yeah... it's very important...yeah it's definitely important... it's just... I think it ... fit with some blokes...and would take years... you've got to have a relationship... but once it's established... yeah... very important.

Clinicians said that a large part of their job description involved the 'role-modelling' of positive and healthy masculine behaviours.

Sometimes...what I think some of my clients have an idea of how they are meant to be... and I can sometimes change their thinking a little bit...about how they should be... like I mean... as in saying its okay to ask for help... its okay to be... depressed or express your emotions...and not being do so well all the time...you can change their ideas a little about that...like... I guess... trying to change their stereotypical role...a little bit.

Yeah... I do...I do... its just having that ummm...sometimes its... I find it a wee bit difficult because often I'm younger than my clients...but...we're... all mental health workers...full all clients are role models...to some degree... you know... you sort of...you're trying to...you're being a role model... about ... expressing yourself properly...emotionally...

looking after your mental and physical health...ummm... interactions with people...in some ways... we are often role models for that...the same goes for the...male clinicians to male clients...being male clients definitely.

I find being a clinician... you can be in that role as well... you can sort of say... oh no this is... give this stuff a try... its bloody good... I've seen it help...people before...such as anti depressants or whatever.

Set up as supports...and... able to give them role models... you know...its okay to be a bloke and go to work...and still come and see me and talk about the voices and stuff

Male clinicians identified that their own understandings and viewings of masculinity were challenged. This affected them both personally and in their work with male clients.

I wouldn't like to generalise... a lot of males would feel threatened by talking to a male... and may prefer to talk to a women... I guess... from our perspective...but we've got to look at it from the other way round... they may see us in a certain sort of role... they may think...that guys doing nursing... he's a poof.

I mean I don't know if it's necessarily a guy thing... because it's something you encounter in everyday society... I mean if I go and talk to ummm...a section of... the people... the male people that I know around me... in my community... 90 percent of them probably wouldn't have a clue what I did... and even if I told them they probably still wouldn't really understand what it meant... You know... electricians and farmers... and... they're not really interested in that... and they'd probably... at there own level express their own emotions... delved into their own psyche... and...whatever... but its not... a major part of their life... I guess we focus on it more because...its what we deal with.

Oh there'd have to be... there'd definitely have to be... I mean speaking as a male clinician... I find the tension... because sometimes I think... what am I doing this job for... you know... I should be out there working... making something with my hands... [laughter]... you know... that man's work... what am I doing talking to all these blokes about their emotions.

Participants believed that men, who were able to exhibit a degree of vulnerability, were able to re-evaluate and readjust to the disruption of their role that their mental illness caused.

Yeah... if you can't work... can't provide...a change in role... ummm... they had all this status...once upon a time ago... and now... they don't... its huge... their value may not have changed... their relationships have changed...they're more...focussed about now.

Yeah... I think so... yeah... definitely...with all the changes...and like...having a relationship or someone... they can share their life with... becomes... more important again.

There's not a lot...that... a few... well... a couple were successful business men...and they worked... made money... talks now about his kids... his family... more... views things differently I think.

### ***5.2-6 Power Differentials***

Power in the relationship was seen to lie predominantly with the clinician, more so when the male client was unwell and/ or admitted to an acute inpatient environment.

Yeah... we've had a bit of a chat about this...the other day... and it doesn't sound very nice...but I think that unfortunately that we are the holders of power really...well... we... in a power balance...each person has power...and...in the community I believe clients have a hell of a lot more power than they do in an inpatient ward...because when you're seeing someone in their own home...that shifts the power imbalance significantly...ummm... and they get to choose when they're going to see us...if they're going to see us...ummm...but unfortunately I think that the power imbalance is...is tilted the other way a little bit.

Ummm...I suppose that the power base... is very much with... the whole power thing sits with the professional...though ... it is based on what they do... whether they decide to come in... and how we meet... how its going to be...them setting the goals.

Control was also seen to lie with the clinician particularly when the male client was unwell. This resulted in the clinician either directly or indirectly stepping in and making decisions for the client.

They're not in control... of the situation...anymore... they're...even if they're not being forced into...into accepting help... there's sort of... like you say they lose control... of the whole situation... and that...I mean... that's just a hard thing to deal with anyway... I mean we do have that control...and... like I said before...there's this whole thing about...ummm... us as a service being responsible for peoples' illness and recovery... as opposed to them being responsible for their illness and recovery...and...on the one hand...you say to someone...its your illness you need to think about what you're doing about it... but on the other hand... if you get out of control we're going to take over.

Clinicians identified that issues of power and control for men were more acute within an inpatient setting, compared with an outpatient service like a community mental health team. Yet, they acknowledged that they still held a higher degree of power and control than their clients.

You know... this the best thing for you...and... you know... luckily most of the guys I work with... have not too much of a problem... in relationship to the power issues...but I can see it would become a problem... certainly...working on the inpatient units... it's a major problem... that whole fronting up and... what are you going to do about it... getting a big aggro... and actually fighting... physically fighting against... the system... against the treatment...just asserting... so yeah... there's... definitely a lot of elements impact on males...and... in regards to the power balance... I mean... it's not necessarily a bad thing either.

“Yeah...its quite significant the power that they don't have...I guess it's quite focussed to...something that they might not know of... or...don't understand... or don't ask about...”

Ohhh... definitely... well it's a triple whammy almost because... and then on top of that... you've got someone else telling you what to do... so going back to the power relationship... you know... you come in... you've got an illness... you're trying to cope with the fact that you've got an illness and the fact that...your illness is not acceptable to society... and then you've got some guy coming along saying... well you should be doing this and doing that.

Power showed up in the clinician's ability to choose who could or could not access the community mental health team, and when it was or wasn't time to be discharged from mental health services.

We provide the service...we... we sort of say yay or nay...if people get the service, or when they get the service... unfortunately... and... then incorporating that into the...is of course...people that have to receive the service...under the mental health act...so... unfortunately I still see...the power imbalance being in our favour... because...we hold... we have the power to give or take that service away...and I think its... definitely been ummm... been balanced up a bit more...with... you know... ummm... consumer rights...and... ummm... advocacy services...informed consent...ummm... and then something different again would be how each clinician...would work with people.

How power was 'used' in the working relationship with the male client was seen as important by the clinician, and was believed to be dependent on the wellness of the client. Clinicians acknowledged that at times power (in terms of decision-making), was dictated to the male clients.

Its up to each individual... I mean there are people that...I would promote total independence of choice...and they make their choice as they do... what they want... they get the consequences...but there are other people that... are a lot more damaged or... a lot more... more institutionalised... and... you have to assess that you use your power... in a different way... you use it to actually get that person doing something... because... at that point... wherever they are in their illness... their recovery... they aren't able to do it themselves...they cant make that choice... so you have to use your power to push them along... and hope that at some stage that they will... be able to take over and drive the relationship.

I mean there are... I guess the way you have to do this... is... you have to assess how you use your power...certainly...you've got to decide which way you're going to go.

Yeah... yeah... for example... the guy I went to pick up this morning...I mean...you could look at that as a very

abusive power... relationship... because I dictate to this guy what he's got to do... I say right... you're going to tapestry club today... quite often he'd be a bit... ohhh I don't want to go today... and I mean... I could be very liberal and say... well alright that's your choice...you have to live with the consequences... but if I did that... he would never go anywhere... he would just lay in bed all day every day... and that's his life for the moment and has been for several years now... So he just... really deteriorated... doesn't do anything... he's got very little in the way of ... ummm...ADL'S, skills, he just... he just exists basically... so I use the power in that relationship to actually drive him forward... to get him out...to see that there are things out there that you can do...that can participate in... and I'm hoping... you know... the end product will one day be...that he says I want to go there...not me having to say you have to go there...or if he says I don't want to go... it would be because I want to go and do that instead... And that's fine... but its just taking that... first step to actually... to moving on to a position where he can look at the options... so...I don't see that as an abuse of power... he might moan about it [laugh]... probably...but... you know its using it in a therapeutic way isn't it.

Power has historically been invested in the institution and its clinicians. Participants believed that this meant the responsibility for illness tends to be placed on the mental health service. This was seen by clinicians as fostering a culture of dependence within mental health services resulting in clients taking less responsibility.

That's a real hard attitude to shift in people... in the same way that... its almost impossible to...for a lot of the clients we deal with at the moment... to get them to actually take responsibility for their... illness... because for so many years... the responsibility and this goes back to the power base...the responsibility has been with the clinician... with the mental health service...to actually get someone to turn around and say... well we're not going to be responsible for your behaviour... you need to be responsible for... and if things go wrong...its because of what you're doing... its not because of us.

Men who had a long history of using mental health services were viewed as having less power and control in their ability to manage their illness.

And give you medication...and you know it... it does make them feel pretty powerless... ummm... and... the... a lot of the guys I've worked with as well have got this sort of... they got this residual need to... to go to work... and be part of society... they just haven't got the... the capability to... or after years of instutionalisation or... medication... or whatever it is... they sort of see their role...as being a certain thing... but where they're at and where they want to be are just poles apart... and that.

### ***5.2-7 Sites of Risk***

Sites of Risk are those things that added to male client's resistance and/or reluctance in accessing a health service like a community mental health team. Risk included the 'unknowns' about having mental illness, how 'others' viewed you as a man with mental illness, and 'admitting' having mental illness.

And its that more than often they are restrained... I guess that can have that fear or that risk that it's going to happen here.

Yeah... exactly... ohhh definitely... the how people see you... I think its hugely important... to ... many men... and...coming from my own experience... yeah... and how people see you and their expectations... like dropping the ball sort of thing.

Oh yeah... its definitely...a... its something that a lot of them don't want to entertain... just actually admitting that because... it is...its...accepting that all this stuff isn't something that they can deal with themselves... its something that they need help with... having accepted that you have to have input from someone else.

Having the ability to express emotion in a healthy and masculine way was something men were seen to be unfamiliar with. This, coupled with the expectation that men would express emotions to health workers (whom you don't know and don't yet trust) adds to 'risk' for men.

Ummm.... yeah I'm, not sure... yeah you know its hard to say...exactly why...but it can be... it can be just embarrassing for guys...to really... really break down... but... easier for them when you... when you can get that trust...and that sort of... that more deeper relationship I guess... with clients... for sure.

It just wouldn't be there... it wouldn't be counted...and I guess...you know... I mean I don't even... in a lot of the people that I work with... I guess I don't even... really delve into it too much... there are some people that... it's very easy to work with because they're more in touch with their emotions... ummm... I've got a guy...and he's really aware of himself and what happens for him... he's really keen on learning about himself...and that kind of side of it... And then there are other guys... that... you know... chronic schizophrenic...that have been in and out of the system... for years and years and years and... I don't even think to talk with them about their emotions you know... I just go in a give them their depot... how you're going?... you going to work?...what you're doing?... how much dope you smoking this week? [laugh]...yeah... I guess its probably a neglected area...from both sides... that the clients don't really...a lot of clients don't address it themselves... maybe I as a practitioner sometimes... don't really address it either.

I think it does to some degree...you know... I think it has...some positives and negatives...ummm...it does get in the way... in that... men are more reluctant to ask for

help...ummm... more focussed on ... their independence... and moving forward... ummm.. and not being held back by mental illness... or the services...for sure... its that whole...being able to express themselves... emotionally... does get in the way sometimes.

Sharing with clinicians from a community mental health team is a mixture of both 'perceived risk' and 'actual risk'. Both are based on the male's historical/ past experience of health services and in sharing with others. Both affect men's ability to 'trust' others.

Sometimes it's only a perceived risk... I think... Sometimes its like... shit something bad is going to happen...but it doesn't... When these guys open up to me... with the clients that have... and they're like shit what's going to happen next... and... all I do is respond appropriately... ummm... and they're like... well that wasn't so bad after all... so it develops that degree of trust.

Yeah... I think it's a big thing for all clients...ummm... but yeah... I'd almost say that its... takes longer for a man to be able to...to trust another guy... yes... I would say that... and often... its because... they have been... they've lost trust in males before... such as ... father figures... peers at school like... so many people I talk to you know... they got a real shit of a time from other blokes at school...ummm... and that counts a bit for when... I meet up with guys that are my age... because they're sort of like... well... you know... are you gonna to take the piss out of me... or...ummm... and then of course the older fellows...are... yeah... its harder for their pride as well because...I'm younger...and...I think that trust does a little bit longer to establish...for sure...and that maybe again... that difficulty in being able to relate emotionally... which females have an easier...to do a bit easier.

Ummm... I think it is a low risk... but for them...perception wise... probably... it's a place of high risk... and definitely... high risk with some of those guys who have had bad experiences... where they've been

admitted and restrained... they think its going to happen here again... and unfortunately... ummm.... many blokes.. there are more blokes that are admitted to hospital that way... because they've got the propensity to be a bit more violent... they're bigger... make a bit more noise... there's that risk...where more blokes have had that happen to them...unfortunately... and is that going to happen again.

For male clients, exhibiting any form of 'weakness' or 'vulnerability' is viewed as a deficit, and is to be avoided.

Ummm... partly I think its just... a general stigmatisation of society... about a having a mental illness full stop...I mean a lot of people feel that stigmatization...I think partly its also... seen as a weakness... you know... if you've got a mental illness... you know you can go to your mates and say I've got a broken leg and that's fine... but if you go to them and say I'm a bit depressed or a bit tearful today... you probably going to get a bit of a ribbing... I mean its...you know its just not an accepted part of culture still... but... there are people with mental illness who are accepted for what they are... so I think its a lot of the culture of being a bloke...being strong... being a provider... ummm.

Yeah... I think it takes a little bit longer with blokes... and some blokes never quite get there... Yeah... I guess its sort of...the stuff we've talked about... its just... wanting to get on with things...working... worried about loosing that independence...worry about being... vulnerable... unhappy to open up... because... I think they find that a bit harder... ummm.

I think...its... I thinks its societal and developmental... its...you know... in basic terms its... probably shows weakness... it probably shows that... coming from my perspective as being a bloke as well... and seeing what I see... ummmm... I think... when guys really break down...and you know that's...often it feels like the end of the world... you know... you think shit things aren't going to get better...and I think guys are afraid of that feeling...sometimes...Sort of going back to that... are you

weak by coming in to see the psychiatrist... to... or having support from a PDN.

Men with mental illness are imbued with a perception that they are inherently violent, aggressive, and dangerous. Being a male is seen as a 'risk', being a male with a mental illness is seen as 'high risk'.

I would guess... that... I think it boils down to... basically... going back to what I said about the intensive care units... seem to be more males... I think it because males probably present as a lot more aggressive intimidating dangerous unsafe when they're unwell... there are very few... I mean there are... certain individuals that can be quite nasty when they're unwell... but compared to the men... there seems to be a lot less in the way of actually physical violence... or... threatened violence... or aggression towards others... so... I'm guessing that what's happening... is the systems... picking up the males... sort of... a large proportion of males that are aggressive... putting them through places like 9B, acute wards and then finding that... they're the ones... of the ones that have got chronic enduring illnesses they're the one that need that support because they've got that perceived risk or threat... whatever... so they're... getting placed in places like... Hulme House... because they're obviously... or supposed to need more intensive support... so then you end up with a larger proportion of those in that type of environment... I mean I'm thinking about two clients that I've got in... Hulme House... they're both males, they're both on risk management, they're both got long risk and safety histories.

Yeah risk is a funny thing... its strange how the majority of people that are seen as dangerous... or under risk management... most of them are probably blokes... I don't know if that's because of the perception that... guys are more dangerous... or just the fact that they are... I mean... certainly... from working up on 9B... you'd be a lot more aware of some of the 6 foot 7 Maori guys... that's totally psychotic and unstable... whose coming in today.

### *5.2-8 Summary of Clinicians*

Both male and female clinicians identified meaningful activity for men with mental illness as crucial for them re-establishing a role. Clinicians acknowledged that this fell outside their role in working with clients with acute mental illness. It was believed that there was a general lack of service provision (for clients with sub-acute illness), that assisted men in developing a role via purposeful activity. Health and mental health education with employers was seen as necessary to assist men with mental illness in the workplace. The cultural differences in health between the genders meant that women had more established points of contact with health services compared with men. These cultural differences reinforced reluctance in men accessing health services like a community mental health team.

Time constraints were identified by the clinician as a major barrier in working with men. A male client's negative historical experience of a mental health service impacted on their current viewing (and attendance) of mental health services. Clinicians believed that male clients were more likely to adopt a 'sick role', that of the mental health consumer. This re-establishing of a role (even a sick role) was in part understandable, but overall was seen to entrench them in their position of illness and was largely identified as having a largely negative impact. The mental health service created the expectation that the male client would attend an appointment at the community mental health team. The expectation was that the male client fitted in with the clinician and the community mental health team.

Both groups of clinicians saw that family involvement was reflected in the acuity of the male client. The higher and longer the acuity, the less likely there was any ongoing family involvement. An identifiable gang mentality existed in the Dunedin context between an older more institutionalised service user and the newer service user. The new service user was seen to at times be absorbed into the deviant scene of the older service user. Clinicians believed that male clients were happy to talk about specific events, and physical health issues but reluctant to talk about feelings and emotions. Building trust was seen as crucial in building rapport between the client and the clinician. This was seen to take longer with the male client.

The role modelling of healthy behaviour by male clinicians was seen as important for male clients. Male clients were more reluctant to accept their mental illness and therefore tended to avoid taking responsibility for their illness. Acceptance of mental illness was seen as a huge part of men's recovery. Both clinician groups identified gendered differences in accessing mental health services, with men accessing a service when in crisis, compared with women who would be more likely to have contact with the service as the crisis was escalating.

Clinicians had different viewings on who they saw as holding the most power in the clinician-client relationship. The male clinicians saw themselves as holding most of the power at the start of the relationship. While gender differences in viewings of power meant that the female clinicians viewed themselves as *not* holding most of the power at the start of the relationship. Their viewing was one of alliance building, and building rapport. Male clients were seen to exhibit control by missing appointments, not returning phone calls, and refusing to take medication.

## **5.3 Clinicians Focus Groups**

### ***5.3-1 Introduction***

The focus groups were incorporated into the research to check the legitimacy of the analysed themes that had been elicited from the raw data from both participants. Data collected from the focus group was then thematically analysed as had been done in the interviews. These themes were then compared and contrasted with the meta-themes established from the Literature Review, and the themes from the initial interview. This process was used primarily to highlight any inconsistencies, inaccuracies and highlight any discrepancies between what the participants said and what the researcher recorded. This second layer of analysis ensured that the analysed data was reflective of the participant's viewings of men accessing a community mental health team.

### ***5.3-2 View of the Male Clinicians***

*Access:*

- Meaningful activity for men with mental illness as crucial. Meaningful activity included occupation, work, and routine. This would encompass a more 'recovery' based perspective and approach.
- The mandate of the Mental Health Service is focused on working with people at the acute stage of illness.

- Employers give good support but have little understanding about mental illness. Men were not able to talk about their illness with their boss or colleagues.
- Men were reluctant to talk to their GP about illness.

*Barriers:*

- Time constraints were a major barrier in their working with both men and women.
- Chronic mentally ill male clients had little or limited thoughts about life beyond their illness.
- Role adaptation occurred with men where they adopted the 'role' of mental health consumer. This impacted negatively on them.
- The perception of being male was a barrier and a risk. 'Being male' was seen in relation to physical size, strength and perceived aggression. This resulted in men more than often being given larger doses of sedating medication, because they were perceived to be a risk.
- Clients who were either long-term users of mental health services were reluctant to access mental health services.

*Community Mental Health Teams:*

- The client having the first option of where they would meet the clinician is not considered realistic. Clients are sent an appointment card and an 'expectation' is created that they 'will' attend.
- There was a distinct lack of privacy in the waiting area and it was not male friendly. The waiting areas in general are set up for females, as they tend to be maintained by reception staffs that are predominantly female.

### *Legitimate Others:*

- The relationships between men and their families tends to become strained and men become isolated from their families either by choice, by illness, or by behaviour.
- There was a gang type of mentality between a large 'sub-group' of older and historical anti-psychiatry users and newer, younger males to the service. The younger service users were seen to be victimized by this older population of service user.
- This sub-culture participated in deviant culture, including the buying, selling, and stealing of medication; using high levels of alcohol and illicit drugs; and exhibiting high levels of violence. This was seen as a result of 'community institutionalism'.
- The clients 'age' was seen as influencing family involvement, with younger male clients being more willing and able to maintain, and use family connections. The older population of service user remained fragmented and isolated from family and extended family.
- The older males were reluctant to talk about emotions and feelings, compared with younger males who were more able to share.
- Building trust was seen as important in developing relationships with men. It took men longer to build those connections, and to be able to trust.
- There were noticeable gender differences in managing illness, with men presenting when in crisis compared with women who would present whilst the crisis was building.
- It was believed that there was a general lack of health services for men in the community.

### *Masculinity:*

- Male clients were seen to avoid acceptance of their illness, which led to avoidance in taking responsibility for their circumstance.
- Being a man with mental illness resulted in large inner tensions that added to an already fragile construction of masculinity.

*Power Differentials:*

- Men with mental illness who adopted the role of their illness tended to abdicate from taking on any form of personal, familial, or societal responsibility. Their focus and new role was on the illness, and life beyond illness was difficult to see.
- Long-term users of the mental health service were happy to give over power and control to the mental health worker.
- Tensions for the clinician arose between assisting with acute mental illness rather than assisting with or aiding personal growth and change.

**5.3-3 *View of Female Clinicians***

*Access:*

- Employment for men was viewed as a positive thing. It was believed that employers now had more understanding and knowledge about mental illness, but participants saw big challenges in how male employees with mental illness and employers communicated about illness.

- The majority of male referrals to the community mental health team were via GP and medical practices.
- There is a lack of services for people with sub acute mental illness, as well as those identified as non-acute but still experiencing distressful life events (loss, grief, separation, etc).
- Approaching health services is viewed as showing or admitting weakness.
- Men exhibited high levels of reluctance to be seen in waiting rooms of health services.
- Females have more points of contact with health services (menstruation, pre and post pregnancy, child birth, children, menopause, etc) compared with men. The culture of women attending health services was different for men.

*Barriers:*

- Limited time with clients was seen as a barrier. Time was determined by discipline and was reflective of the models, approaches, and systems that clinicians work within. An expectation was established in clients, that clinicians 'don't have time' or 'have limited time'.
- The waiting area of the community mental health team is unhelpful for men, its not discrete and has no space for privacy.
- Client's historical experiences contribute to a negative viewing of current mental health services.

### *Community Mental Health Teams:*

- The type of initial contact with clients was discipline specific.
- Clinicians identified two types of male clients in CMHT; the older more institutionalised client with a history of service use, and the younger, newer client to the services.
- There was an identifiable change in the language used in mental health services over past 15 years; from patient, to client, to consumer. This is a reflection of the shift in power and control from the clinician to the client.

### *Legitimate Others:*

- The level of family involvement is reflective of the acuity of the illness. Male clients who experienced high and ongoing levels of psychosis (chronic) were alienated from family. Those who experienced more anxiety and depressive disorders were more dependent on family.
- An identifiable 'gang mentality' existed between the older, chronic, and more institutionalised males and the newer, younger males to the mental health service. This young age group (21-30 years) are absorbed into a negative sub-culture and mirror the negative patterns of behaviour of the older age group. This older group were men who lived in doss houses, boarding houses, and on benefits, and were likely to be drug and alcohol dependent.
- Male clients have difficulty and are not educated in talking about emotions and feelings. Male clients were happy to talk about physical health issues but not mental health issues. Talking around the subject was prevalent amongst male clients.

### *Masculinity:*

- The male clinician's role in modelling healthy behaviours was unique to men, in the unique knowing of what it means to be a bloke.
- Male clients adopted a 'sick role' in response to personal fear about failing at work; failure to get work, having an illness is a failure, etc. They identified a 'lowering' of male client's self esteem and a sense of 'opting' out.
- 'Trust' was a big part of working with male clients. They identified that it took older males longer to build trust in the client – clinician relationship.
- Male clients are more focussed on independence, and on moving forward. Expressing emotion and having illness is seen to get in the way of this goal.

### *Power Differentials*

- Female clinicians did not agree that they held most of the power at the start of the client – clinician relationship. They saw the focus of the relationship on engagement and alliance building.
- There is a societal viewing of the perceived power that the mental health service has. A mentality that sees the 'men in white coats' who 'lock you up'. This is a reflection of a historical versus a current mental health service model.
- It is the clinician's responsibility to balance power in client – clinician relationship.
- Power imbalances exist between male and female clinicians. Issues of gender contributed to the power dynamic producing this imbalance.
- Power was a tool, used to assist and motivate male clients in their recovery.

- Male clients exerted control by missing appointments, and not returning phone calls, etc.
- Clients were seen to have more power via mechanisms like Health and Disability Commission, Mental Health Foundation, etc.
- Female clinicians acknowledged that male clients would contact the service when in crisis compared with female clients who would make contact as the crisis was building.

## **5.4 Comparison between Clients and Clinicians**

### **5.4-1 *Introduction***

This section will compare and contrast the data received from male and female clinicians and the data between clients and clinicians. It will identify similarities and differences between both clients and clinicians. A breakdown of the data (Refer Table 6.5, pg 173) highlights the factors that contribute to hindering men's access to a community mental health team.

### **5.4-2 *Macro Factors***

Data collated from both clients and clinicians identified the following macro factors that contributed towards hindering men's access to a community mental health team.

They included,

- Community Institutionalism
- Societal Misconceptions
- Being Male
- Historical Institutionalism

Both 'Societal Misconceptions' and 'Being Male' were identified by clients, and clinicians as hindering men's access to a community mental health team. 'Community

Institutionalism’ and ‘Historical Institutionalism’ were identified only by male and female clinicians as hindering men’s access (Refer Table 5.5, pg 173).

### ***5.4-3 Meso Factors***

Data from both clients and clinicians identified the following factors at the Meso level that hinder men’s access to a community mental health team. They include,

- Service Design
- Limited Points of Reference
- Limited Options
- Increasing reliance on GP
- Increasing reliance on NGO
- Negative Historical Experiences
- Positive Male Role Modelling
- Exhibiting Control
- Empowerment
- Clinicians Gender

‘Service Design’, ‘Limited Options’, ‘Negative Historical Experiences’, Positive Male Role Modelling’, ‘Exhibiting Control’, and the ‘Clinicians Gender’ were identified by both the clients and the clinicians as factors at the meso level that hinder men’s access to a community mental health team. The remaining factors contributing to hindering men’s access to a community mental health team were only identified by the male and female clinicians (Refer Table 5.5, pg 173).

#### **5.4-4 *Micro Factors***

- Meaningful Activity
- Workplace Healthcare
- Types of Male Service User
- Building Trust
- Limited Time
- Weakness and Vulnerability
- The Healthy Peer Group
- The Unhealthy Peer Group
- Acuity
- Men's Reluctance
- Men's Role
- Avoidance
- Expressing Emotion
- Family
- Age
- Power usage in Relationship

The micro factors of, 'Meaningful Activity', 'Workplace Healthcare', 'Building Trust', 'Limited Time', 'Weakness and Vulnerability', 'The Unhealthy Peer Group', 'Men's Reluctance', 'Men's Role', 'Avoidance', 'Expressing Emotion', and 'Family' were identified by both clients and clinicians as hindering men's access to a community mental health team. The 'Use of Power' in the relationship was identified by male clients and male clinicians, but not by female clinicians. The remaining factors at this macro level were identified only by the male and female clinicians as hindering men's access to a community mental health team (Refer Table 5.5, pg 173).

**Table 5.5**

**Comparison between Clients and Clinicians of Contributing Factors Hindering Men’s access to a Community Mental Health Team**

	<b>CLIENT (Male)</b>	<b>CLINICIAN (Male)</b>	<b>CLINICIAN (Female)</b>
<b>MACRO FACTORS</b>			
Community Institutionalism	o	x	x
<b>Societal Misconceptions</b>	<b>x</b>	<b>x</b>	<b>x</b>
<b>Being Male</b>	<b>x</b>	<b>x</b>	<b>x</b>
Historical Institutionalism	o	x	x
<b>MESO FACTORS</b>			
<b>Service Design</b>	<b>x</b>	<b>x</b>	<b>x</b>
Limited Points of Reference	o	x	x
<b>Limited Options</b>	<b>x</b>	<b>x</b>	<b>x</b>
Increasing reliance on GP	o	x	x
Increasing reliance on NGO	o	x	x
<b>Negative Historical Experiences</b>	<b>x</b>	<b>x</b>	<b>x</b>
<b>Positive Male Role Modelling</b>	<b>x</b>	<b>x</b>	<b>x</b>
<b>Exhibiting Control</b>	<b>x</b>	<b>x</b>	<b>x</b>
Empowerment	o	x	x
<b>Clinicians Gender</b>	<b>x</b>	<b>x</b>	<b>x</b>
<b>MICRO FACTORS</b>			
<b>Meaningful Activity</b>	<b>x</b>	<b>x</b>	<b>x</b>
<b>Workplace Healthcare</b>	<b>x</b>	<b>x</b>	<b>x</b>
Types of Male Service User	o	x	x
<b>Building Trust</b>	<b>x</b>	<b>x</b>	<b>x</b>
<b>Limited Time</b>	<b>x</b>	<b>x</b>	<b>x</b>
<b>Weakness and Vulnerability</b>	<b>x</b>	<b>x</b>	<b>x</b>
The Healthy Peer Group	o	x	x
<b>The Unhealthy/ Unhelpful Peer Group</b>	<b>x</b>	<b>x</b>	<b>x</b>
Acuity	o	x	x
<b>Men's Reluctance</b>	<b>x</b>	<b>x</b>	<b>x</b>
<b>Men's Role</b>	<b>x</b>	<b>x</b>	<b>x</b>
<b>Avoidance</b>	<b>x</b>	<b>x</b>	<b>x</b>
<b>Expressing Emotion</b>	<b>x</b>	<b>x</b>	<b>x</b>
<b>Family</b>	<b>x</b>	<b>x</b>	<b>x</b>
Age	o	x	x
Use of Power	x	x	o

**Key:**

- x – Identified as hindering men’s access to a community mental health team.
- o – Not identified as hindering men’s access to a community mental health team.
- x – Both Clients and Clinicians identified as hindering men’s access to a community mental health team.

#### **5.4-5 Conclusion**

Both clients and clinicians identified societal misconceptions about being a male with a mental illness inhibited them from accessing a community mental health team. Also identified were negative historical experiences in accessing mental health services, including a community mental health team. It was viewed that men had limited options available as to the types of specific services available to men. Current services and their design were seen to hinder their access.

Both clients and clinicians saw the need for men to have positive male role models. They could be influenced by an unhealthy or unhelpful peer group that followed the current societal viewing, that men don't have health problems. This added to men's reluctance to access services, with them seeking to avoid accessing a health service like a community mental health team. It was identified that men needed a lengthier timeframe to build a trusting relationship with clinicians. Expressing emotion was not seen as important for men as they felt it contributed to their pre-existing feelings of weakness and vulnerability. Rather male clients were interested in having a having a role and being involved in meaningful activity.

## **Chapter 6 – ANALYSIS**

### **6.1 Introduction:**

This chapter will provide analysis of men's health (at the macro, meso, and micro levels), in relation to what helps or hinders their access to mental health services. I will use Bunch's (Bunch 1983) model of analysis to describe and analyze problems that hinder men's access to community mental health teams and identify possible strategies and a vision for men's health.

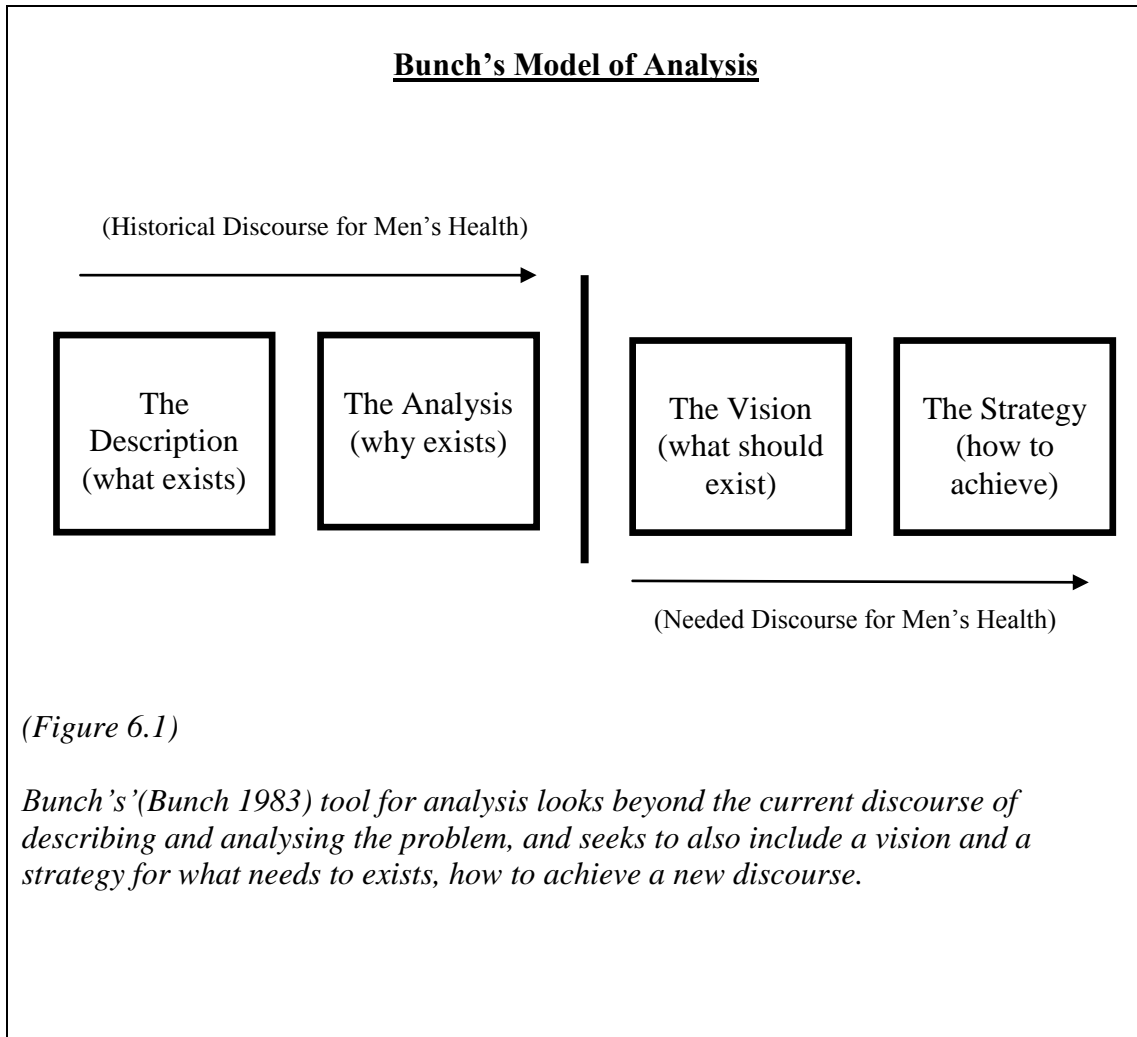
I will also use a model developed by Kelly and Sewell (1996) and Smith and Blanc (1997) to explore issues surrounding imbalances in social transactions and power relationships that currently exist. This includes addressing questions such as why these imbalances exist, the type of power relations that need to exist; and how we might change current power relationships to enhance and encourage men's access to health services, like a community mental health team.

## 6.2 Analysis Tools:

Bunch says that it is important that social debate (such as men's limited access to health services) does not stop at the 'description and analysis' stage of a problem solving, such as men's limited access of health services. These only explain how we have arrived (via a historical context) at our current hegemonic viewing of health and masculinity. Much of the current literature is orientated towards a 'description' of this problem but has limited perspectives on what a 'new context' for a positive hegemonic discourse of men's health might look like, 'what is and needs to be, rather than what isn't' (Bunch 1983, 253) (Refer figure 6.1, pg 177).

Kelly and Sewell (1996) and Smith and Blanc (1997) provide a framework that addresses the need for a strategy and vision alongside the description and analysis. They explore the type of power relations that exist and how they contribute to the power dynamic of social transactions that currently exist in men's health (Refer figure 6.4c). They also identify possible ways to redress this imbalance in power relationships by developing 'tripartite' (Smith and Blanc 1997) or 'trialectic' (Kelly and Sewell 1996) social and power relations. They provide a vision and a strategy for how we might provide planning, provision, and delivery of health services for men in more equitable ways. In analysing the power relations that contribute to either helping or hindering men's access to a community mental health team, we need to identify,

- Current power relationships
- Historical power relationships
- A new type of power relationship that might exist
- How to shift into these new power relations



## **6.3 Application of Bunch's Model**

### **6.3-1 *Introduction***

In applying Bunch's (Bunch 1983) model to the discourse of what helps or hinders men's access to a health service like a community mental health team, we need to,

- Describe what currently exists?
- Analyse why that exists?
- En-Vision what should exist?
- Strategise how to achieve what needs to exist?

(Bunch 1983)

### **6.3-2 *What currently exists:***

In the New Zealand context we have no language or rhetoric when it comes to 'men and health'; both are mutually exclusive. This 'absence of rhetoric' is reflected at different levels, and to varying degrees within New Zealand. At the macro (societal) level, it is seen in the absence of health policy, health strategies, and male specific health programmes (Lumb 2003, Ministry of Health 2000). At the macro level we have no 'health culture' for men's health. Men are viewed societally and personally as 'not' having health problems. This was reflected by both client and clinician respondents who identified that there was a lack of specific health services for men including men with mental illness. This contributes to a cultural viewing of men's health that says that men do not have health problems.

(Clinician) Ummm... partly I think its just... a general stigmatisation of society... about a having a mental illness full stop...I mean a lot of people feel that stigmatization...I think partly its also... seeing as a weakness... you know... if you've got a mental illness... you know you can go to your mates and say I've got a broken leg and that's fine... but if you go to them and say I'm a bit depressed or a bit tearful today... you probably going to get a bit of a ribbing... I mean it's... you know it's just not an accepted part of culture still... so I think it's a lot of the culture of being a bloke...being strong... being a provider... ummm.

Our current provision of health services is not gendered (it does not address men and women's health). We currently have a variety of general and specific health services, initiatives, programs, and campaigns that specifically target women's health in New Zealand (Goodyear-Smith 2003; Ministry of Health 2003). For men in New Zealand we have no specific health services, no preventative health programmes specific to men, and limited campaigns that specifically target men's health. Those campaigns that do appear on television, though piece meal are seen by men as effective.

(Client) Oh yeah...yeah... it's hugely less and less and less now...ummm... and... one of the reasons why is because of the ahhh.... Mental health commission... who have come up with this brilliant series of ads which we've not had for a fair while now... in fact you still see them...but they are ... they are as much a gift to mentally ill...or people with mental illnesses as they are to the public at large.

We also have no cohesive strategy for men's health in New Zealand and no strategic plan that specifically and methodically outlines a strategy for *male* health in New

Zealand. We have successfully developed and integrated into the New Zealand Health Strategy specific policies for the implementation and delivery of women's health services, yet men appear to be excluded (Ministry of Health 2000). An exclusion that feeds into an already established discourse and in turn becomes a self fulfilling prophecy, that men do not have health problems. If societally *men* are viewed as not having health problems then to be viewed as having a health related problem is to instil a viewing that one is not a *man*. Issues such as this cut to the core of men and how they define their masculinity. This was illustrated when male respondents identified masculinity as being defined by their role and saw health problems as a threat to this role, and therefore their identity, and their masculinity.

(Client) Yeah... I think its largely that... again that's another of the roles... for men... the role that society has placed on men...or that men have perceived to be... their role in society... and ummm... yeah... you know... its... still... even though I say it's a role... placed on men and it's a role that they've learnt from society... to a certain extent... its also nature... its part of mans nature... to be like that... I think.

(Client) Ummmm... doing... doing things... being active... ummm... yeah... rather than just being...doing and acting... on things... making plans... making a plan... and bringing a plan to fruition...rather than sitting around talking about it...which I perceive is more a women's thing... talking about our emotions... and touchy feeling... lets have a party... that's how women go about... their roles and responsibilities... men are much more... doing orientated... and plan orientated...achievement.

(Clinician) Ummm...I think definitely... an interruption of there role...where you know...there's that sort of ...and I feel it too...as a bloke...there's that expectation... that ...you'll keep stepping up as you get older...and as you move on...and become more experienced...in your profession...you'll sort of keep stepping up and stepping up...ummm... and some of these guys...young guys and

old... there's a huge interruption in that...that... in forming that role...in forming that identity...so... they... you know... cant continue to practice law...or they cant work...at the poly-tech like they used to...yeah I think...ahhh...yeah I think it just leaves them a bit lost sometimes...what they should be...and...doing... and sort of... societies expectations of them...it's a bit skewed really.

The absence of a rhetoric for men's health is further reflected at the meso (agency) level in our current provision of health services (King, Sweeney et al. 2004). Here the rhetoric reflects a historical paradigm in which health services have been designed by men for women and children. The only response to health services for men in New Zealand has followed a pathogenic (MacDonald, McDermott et al. 2000), and diseased focused (Illich 1975) approach. It views men's health in terms of 'illness' and 'deficit' (MacDonald, McDermott et al. 2000), rather than 'health' and 'wellness'. This is seen in the multitude of 'reactive' based services provided for men (anger management, probation services, etc) that reinforce a deficit viewing of men's hegemony. We have an insufficient number of services for men such as male mentoring, positive fathering, parenting programmes, male role modelling, etc. Male clinicians said that a very important part of their working with men involved modelling healthy and positive behaviours. Female clinicians agreed also acknowledging that male clinicians had the unique understanding of what it meant to be male, in being able to do this.

(Clinician) You know... you sort of...you're trying to...you're being a role model... about ... expressing yourself properly...emotionally... looking after your mental and physical health...ummm.... interactions with people...in some ways... we are often role models for

that...the same goes for the...male clinicians to male clients...being male clients definitely.

(Clinician) I find being a clinician... you can be in that role as well... you can sort of say... oh no this is... give this stuff a try... its bloody good... I've seen it help...people before...such as anti depressants or whatever....and... able to give them role models... you know...its okay to be a bloke and go to work...and still and come and see me and talk about the voices and stuff

At the micro (personal) level men in New Zealand are seen to 'present at', rather than 'access' health services. Men currently 'present at' health services when in crisis; as for them to 'access' a health service is viewed societally as un-masculine, and personally as emasculating.

(Client) I don't know...something about... something about...about... masculinity that it's not okay to put up your hand and say I need help.

(Clinician) Ummm... I don't know if it... it's maybe not a question that the services aren't there for males...I think it's just the choice of not accessing them.

(Clinician) I think its equal... I think it's about men... accessing... and using it...I think its all there for them... but...they struggle to do that... whether that makes the... health service inequable... I don't know... I think... I feel that the health service... is there for both genders... but it's about how men use it.

We know that men have a disproportionate number of preventable health problems such as, high rates of accidental death and suicide, high mortality rates for testicular cancer, prostate cancer, cardio-vascular disease, associated cancers, and they have

higher rates of risk taking behaviour (Adams 1997), (Goodyear-Smith 2003), (Ministry of Health 2004). The very areas of health where a primarily a preventative health focus would benefit men's health most. Clinicians identified the need for a preventative approach for men's mental health by normalising and incorporating men's health messages into daily work practices.

(Clinician) I guess... I'm probably thinking of it too grandly here... but... I think... for males to be more comfortable in dealing with health services full stop... there needs to be more of a... a prophylactic type approach...it needs to be something that addressed before people get unwell... so that... in the same way you do...if problems in the work place... you know... like how do you stop yourself getting back pain...like... how do you deal with it if you get a bit stressed or tired...anxious... whatever... so I think...the primary work with males more involved with services would be to... to get rid some of the stigmatisation by including it in normal... kind of day to day working practices.

This current viewing of men's health is reflective of a historical patriarchal power relation. What Tice (1998) identified as a historical connection that reflects men's exclusion from health, and women's inclusion predominantly as the result of what she termed as 'professional power' (Tice 1998). This power has historically lain within the male practices of science, rationality, and empiricism. Developing knowledge and understanding of health and health problems is viewed through this historical lens as a 'masculine practice'. The recipients of this masculine practice are those who are not masculine, namely women and children. Health then becomes the sole business of women and children (Pease 1997, Connell 1995). The 'accessing' of the health practitioner or health service for assistance with a health problem is viewed through this historical lens as a 'feminine practice'. This discourse resonates today, with

men's current viewing, that accessing health services and/or admission of health problems is seen as 'un-masculine', the practice of the feminine. Respondents identified it as both weakness and failure.

(Client) Yeah I think...some... some men... would kind of see it as an admission of weakness...or failure on their part.

### **6.3-3 *Why that exists:***

Historically 'professional power' (Tice 1998) in health services has been exercised via a predominantly masculine practice of medicine. Feminist and Post Feminist perspectives have created an opportunity to critique this historical power relation by creating comparisons between the genders. From a feminist perspective, this comparative context has meant an exploration of the power imbalances created by historical practices of power, such as the masculine practice of medicine. From a post-feminist perspective it has been a further exploration of the gendered debate and ideas of gender equity. How equitable the results of this exploration have been, is debatable.

It appears that the pendulum of gendered health is anything but equal in health. Instead we have continued to perpetuate a didactic power relationship that further entrenches the viewing that women have health problems and men do not. A viewing that equates women with the 'sick role' promoting ideas of fragility and vulnerability, and reinforcing ideas counter to a post feminist response. It views men as those who

are not sick, not weak, and not vulnerable, the wielders of professional power.

Because they are not sick, weak, or vulnerable then they are better able to assist those who are, namely women and children. It appears that the lack of acknowledgment for men's health needs and strategising a response to specifically meet these health needs reinforces a post feminist critique of health. The result is the reduced need for males to access health services and an increase in their reluctance to access general and specific health services like a community mental health team.

(Clinician) Ummm... I'd say the... the biggest factor would be non-acceptance of illness... just generally not wanting to accept that they've got a mental illness... not wanting to accept that they need treating for it... I mean that's the biggest thing which I find... for most of the blokes...they just don't want to accept it...when they're unwell

Our current rhetoric at the macro level in health policy speaks of perspectives and approaches that promote 'gender equity' (Sabo 1999). The reality is that our current health policy does not reflect an approach that is any way 'gendered'. Rather, the rhetoric around gendered perspectives has meant that gendered approaches have become synonymous with 'women's health' (Sabo 1999). Limited attention is given to men's gendered health concerns (Courtney 2000), (Sabo 1999), as reflected in the lack of models and frameworks for providing men's health care (King, Sweeney et al. 2004). Men have not been 'assisted' to shift into a positive discourse of health and wellbeing.

At the meso (agency) level, health services in New Zealand are not designed to foster men's health and wellbeing. Simply, because this is not their focus, nor what they

were designed to do. Like being in a foreign country we have no knowledge or understanding of the 'language' or 'culture' of men's health and wellbeing. Unlike women there are no historical or current reference points in men's health to guide men into an understanding of health and wellbeing.

(Client) I think that... ummm...just... I think that...it's... equal... there are probably differences that are related to it... ummm... women as child bearers... quite early on in life...they're... more frequent in using health services...they're more... comfortable... know more about... health... health issues.

The only reference point for men in mental health has been an historical one. A context that has reinforced for men a negative viewing of mental health services.

(Clinician) A lot of the contact they would have had with the health services over the years... and this a historic thing... is that it would have been them becoming unwell... them being coerced or... legally made to accept treatment... the treatment probably being quite... heavy handed... severe side effects... detrimental to there health all in all... and then them being back out on the street...and getting back to there own lives... no real sort of opportunities to move forward...improve themselves... go back to work...whatever... so that becomes there cycle... so... even if the service now has changed... its hard to make people see that...that's changed... because... they've got that traditional view of how a service has been... over so many years... particularly if they're sort of long term clients... they're going to see that... and they're not going to see that now...some might be able to get support... get a job out it... could go to the day programme... learn a few social skills... what they see is...a going and being carted off to 9B... locked in seclusion... injected with something's that's going to give them side effects.

At the micro level in health, men are placed contextually within a predominantly negative hegemonic masculinity. A viewing that sees 'all men' as the progenitors and contributors of 'all' patriarchal power relations. Societally all men are viewed in terms of 'deficit'. Male clinicians saw that the perception of being male was a barrier and a risk to accessing mental health services. Maleness was seen in relation to physical size, strength and perceived aggression. The result was men often being given larger doses of sedating medication, because they were perceived to be a risk.

(Clinician) Ummm... I think it is a low risk... but for them... perception wise... probably... it's a place of high risk... and definitely... high risk with some of those guys who have had bad experiences... where they been admitted and restrained... they think its going to happen here again... and unfortunately... ummm.... many blokes.. there are more blokes that are admitted to hospital that way... because they've got the propensity to be a bit more violent... they're bigger... make a bit more noise... there's that risk...where more blokes have had that happen to them...unfortunately... and is that going to happen again.

Within popular culture this deficit viewing, or 'Misandric' (Nathanson and Young 2002) portrayal of men is seen in a variety of medias, that societally represent men as 'incompetent, idiotic, and infantile' (MacDonald, McDermott et al. 2000), (Nathanson and Young 2002). Little has been asked 'of what lies beyond the gendered debate for men' (Pease 1997), of envisioning what should exist for men's health.

#### **6.3-4 *Envision What Should Exist:***

A gap exists in the New Zealand literature that explores the health experiences of men, especially in what they identify as helping or hindering the development of a positive hegemonic discourse in men's health. There needs to be a focussing not on what 'isn't happening for men', but a strategic plan of what 'needs to happen for men'. This is a gap in the discourse that could assist in the useful development and/ or provision of health services for men in New Zealand.

At the strategic planning level, what King et al (2004) and MacDonald et al (2000), term as a 'non-deficit' approach and model to men's health is needed. A plan for health that reflects the ethos of health and wellbeing rather than illness and deficit. At the macro (societal) level, this means the need to develop specific health policy that is measured and tested against a 'gendered equity' that identifies the health needs of 'both men and women'. Underlying this is the knowledge that the health needs of men and women are different and will require different strategies, resources, approaches, and the need to ask those who will access the service.

(Client) No...ummm... to make it more community...I was think... you know... we talked before of making it like MacDonald's... but then that tends to make it more a women's health... service... because it's the kids that the women are involved with... what would make it a man's health service... what would put a man at ease... or stimulate his interest... I'm thinking of something like a video game... or a pin ball machine... ummm... big screen TV with sports...running 24-7... that sort of thing would make it more community for a man... ummm... a big double door... leading out to a park...that would make it more community.

At the meso level, this means the delivery and provision of some health services that are specific to men. This includes a shift from a 'reactive' based approach to a 'proactive' based approach and necessitates the need for service development that focuses on preventative solutions to health problems for men. This preventative perspective must also include developing 'normalising' points of contact in men's 'health life spectrum'.

(Clinician) I guess... I'm probably thinking of it to grandly here... but... I think... for males to be more comfortable in dealing with health services full stop... there needs to be more of a... a prophylactic type approach...it needs to be something that addressed before people get unwell... so that... in the same way you do...if problems in the work place... you know... like how do you stop yourself getting back pain...like... how do you deal with it if you get a bit stressed or tired...anxious... whatever... so I think...the primary work with males more involved with services would be to... to get rid some of the stigmatisation by including it in normal... kind of day to day working practices.

A viewing of 'male' health that is 'spectrum' based, that identifies points of contact in men's 'health life' and seeks to legitimize those points of contact for males.

Developing 'normalising points of contact' within health services would assist men to better access health services. Currently it is normal for male infants, male children, and male adolescents to attend health services; yet for young male adults onwards, men's points of contact with health services decline (Refer figure 6.3, pg 191). At a certain point, it is no longer legitimate for males to access health services. To create and maintain legitimacy for males to access health services would mean a 'Life Focus Approach' to male's health.

At the micro level, this would entail a new discourse for men's health, a 'Life-Focus Approach' to men's health and wellbeing versus the current 'Crisis-Based Approach'. To assist in the development of a culture of health amongst young boys, adolescent boys, and young men, middle aged and older men; with the message that health is for life, and life is looking after your health. A shift of paradigm whereby, health is not viewed as episodic and relevant only when acuity is high, but rather, health is ongoing, and the individuals for life; a life-health approach. The 'Normalising' of health by creating from a young age through to older adults legitimate sites of contact for male health.

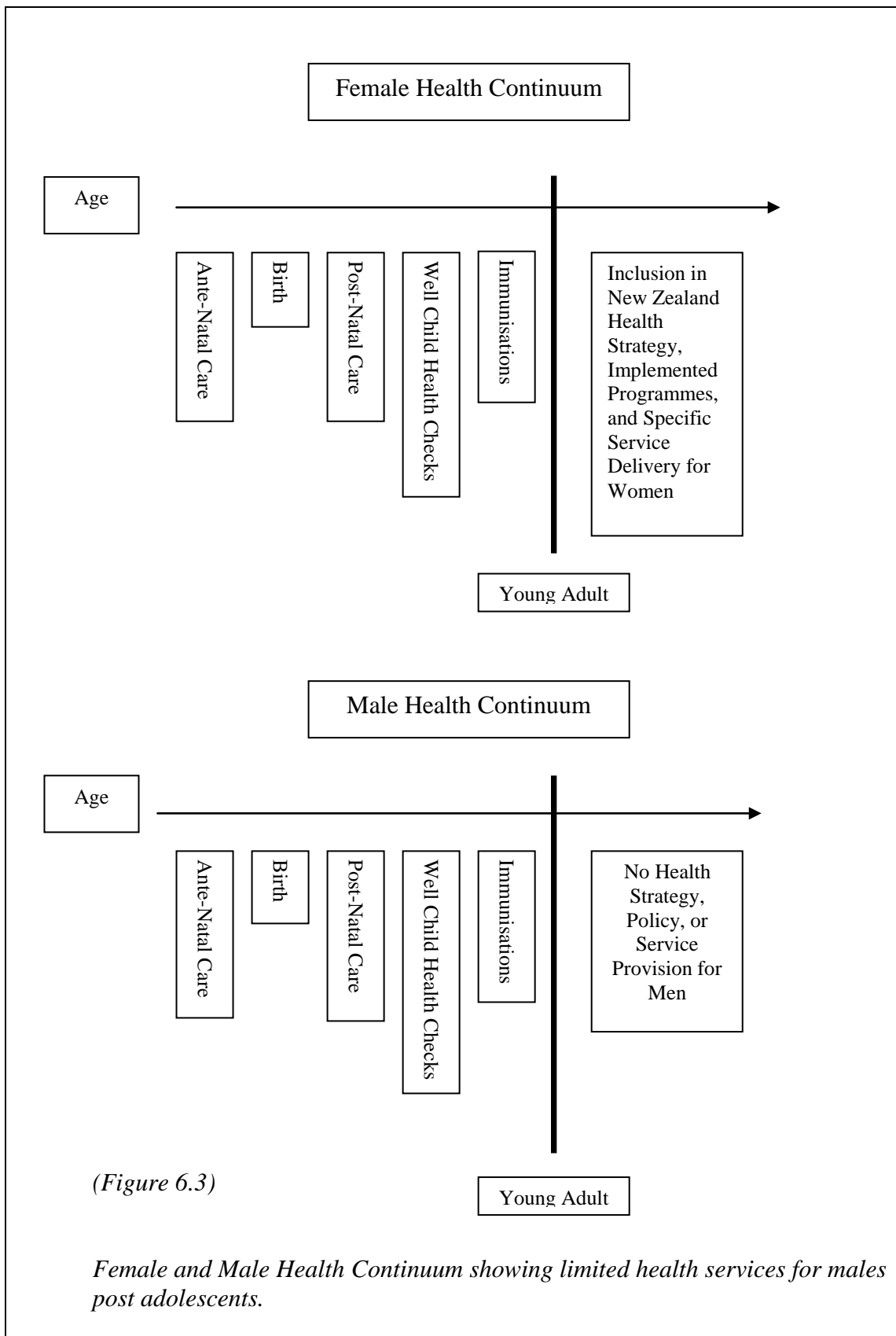
The power relationship that has existed historically is one that Smith & Blanc (1997) identifies as 'uni-polar', or what Kelly & Sewell (1996) identify as 'top down'.

Within the New Zealand health context, the exercising of power in relation to health is not equitable. This is reflected in the social transactions (Smith and Blanc 1997) that occur between the client and the health practitioner (at the micro level), the health agency (at the meso level), and the ministry of health (at the macro level) (see Figure 6.4a, pg 192). All of which reflect a series of uni-polar social transactions with inequitable power relations. Male respondents identified the imbalance of power between client and clinician.

(Clinician) Ummm...I suppose that the power base... is very much with... the whole power thing sits with the professional...though ... it is based on what they do... whether they decide to come in... and how we meet... how its going to be...them setting the goals.

(Client) Yeah... ummm... my first reaction to that question is to say that...that my PDN and the doctor and the health

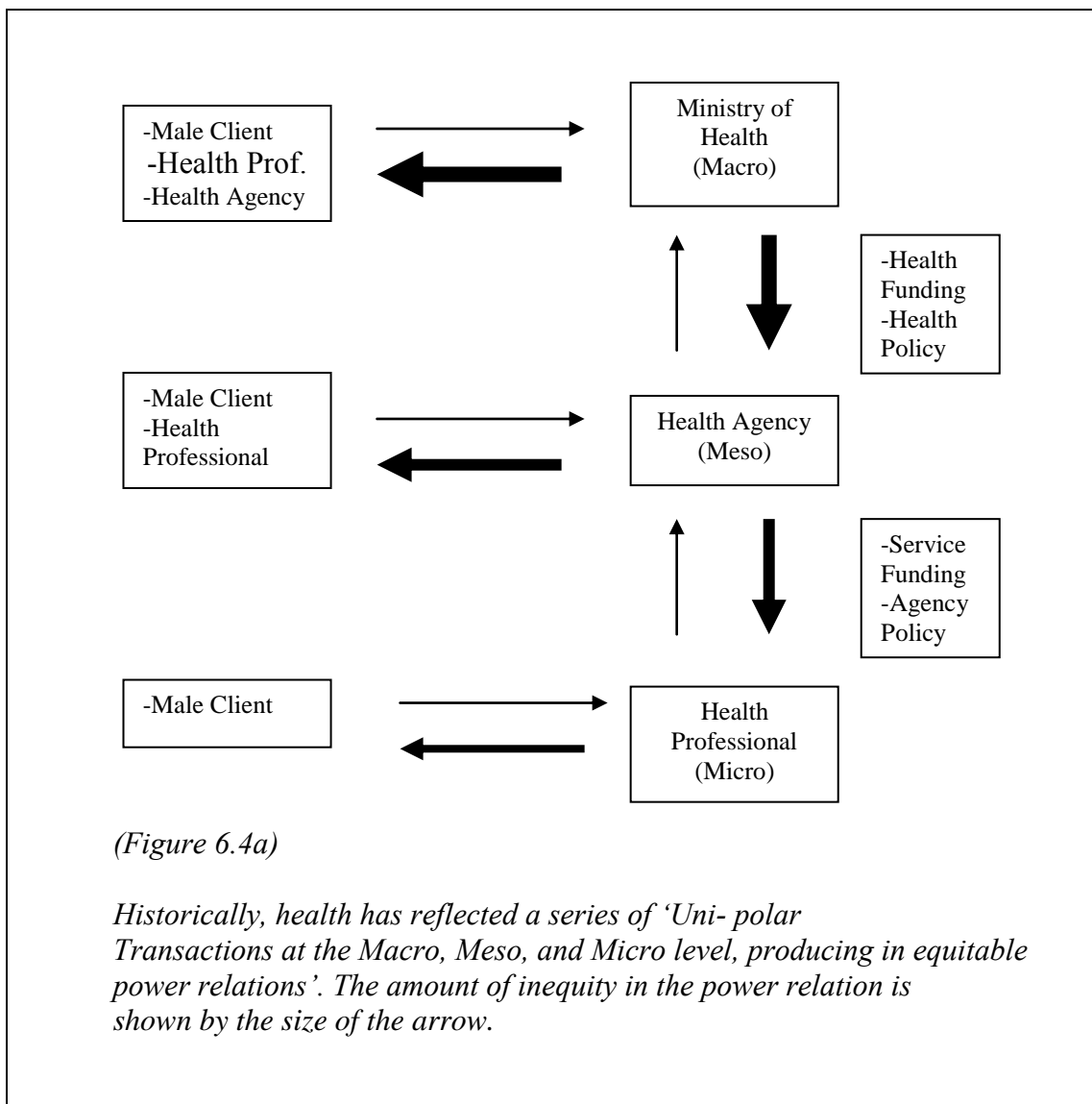
professionals have...the power...and I have very limited or little power.



(Figure 6.3)

*Female and Male Health Continuum showing limited health services for males post adolescents.*

Female clinicians unlike their male colleagues did not see themselves as ‘holding’ the most power at the start of the client – clinician relationship. They believed they had more of a focus on engagement and alliance building in the relationship. They did acknowledge that there is a distinct power imbalance between male and female clinicians and that gender contributed to this power dynamic. For male clients their viewing of power and its associated constructs of control played a large part in their access of a health service such as a community mental health team



Historical inequitable power relations have resulted in a 'hierarchy of power', a top down approach (Shannon and Young 2004), (Kelly and Sewell 1996) to health policy, and the provision and delivery of health services. This hierarchy of power is reflected in today's health context (see Figure 6.4b, pg 194). Both clients and clinicians also identified this hierarchy of power as being outworked in their working relationship.

(Clinician) They're not in control... of the situation...anymore... they're...even if they're not being forced into...into accepting help... there's sort of... like you say they loose control... of the whole situation... and that...I mean... that's just a hard thing to deal with anyway... I mean we do have that control...and... like I said before...there's this whole thing about...ummm... us as a service being responsible for peoples illness and recovery... as opposed to them being responsible for there illness and recovery...and...on the one hand...you say to someone...its your illness you need to think about what you're doing about it... but on the other hand... if you get out of control were going to take over.

(Client) No... no it doesn't... it's a difficult position to be in...very difficult position to be in... ummm... its... its... scary being amongst other people who have... serious problems... different degrees... of seriousness of there problems...but you're amongst them...and you're an equal with them...you know... talking about roles again... and powers... who has the power and who doesn't have the power... you're just one of the mass...your just one of the many that has a problem...ummm... that's quite scary...I find it difficult to... feel trapped with other people... in that situation... in the ward situation... ward 1A... very... very difficult.

This power hierarchy reinforces 'uni-polar social transactions' (Smith and Blanc 1997) (see Figure 6.4b, pg 194), at the macro, meso, and micro levels. This in turn reinforces and perpetuates further power imbalances at the macro, meso, and micro level's.

(Clinician) Ohhh... definitely... well it's a triple whammy almost because... an then on top of that... you've got someone else telling you what to do... so going back to the power relationship... you know... you come in... you've got an illness... you trying to cope with the fact that you've got an illness and the fact that...your illness is not acceptable to society... and then you've got some guy coming along saying... well you should be doing this and doing that.

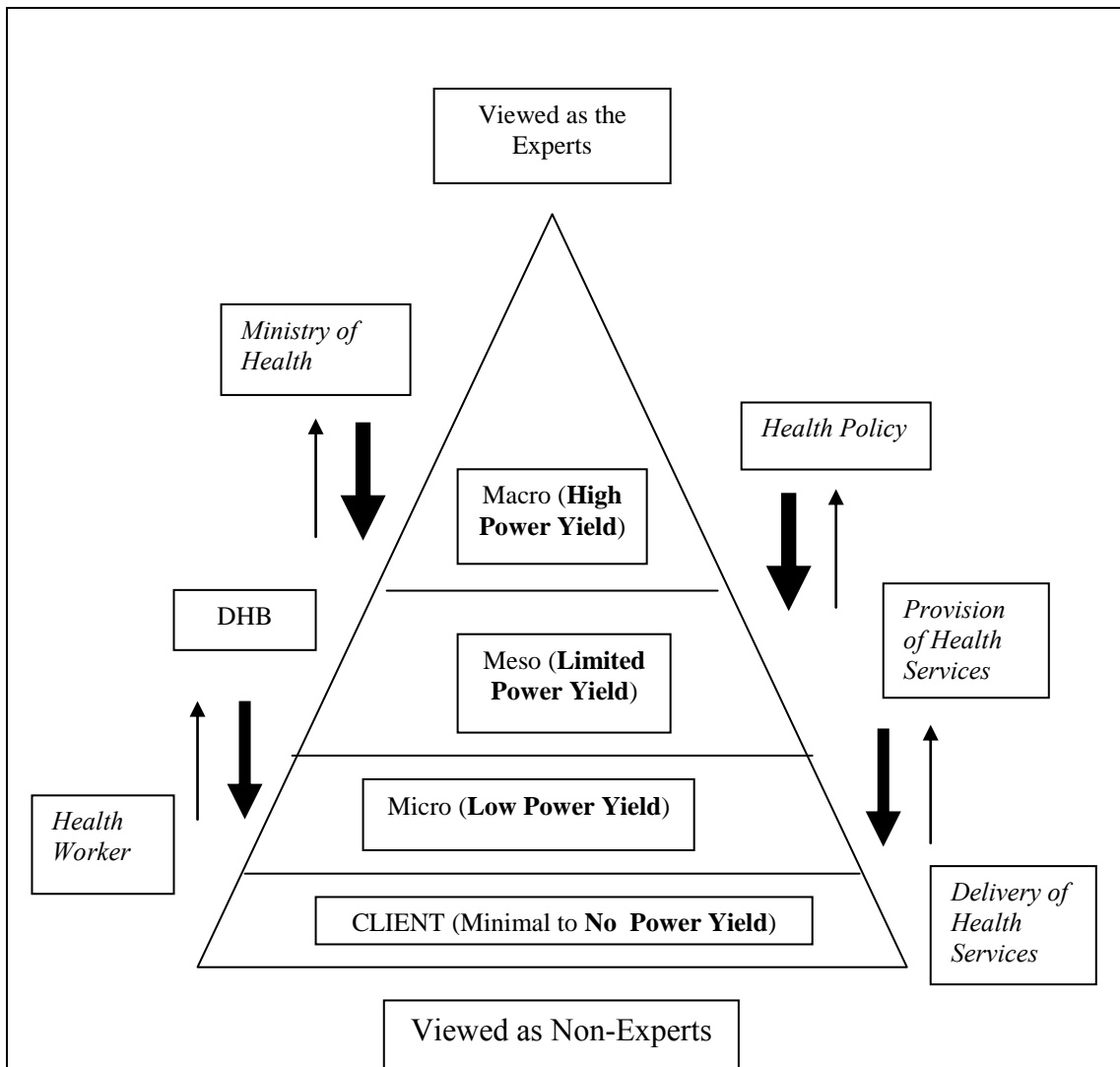


Figure 6.4b

*Our current health context reflects a 'Hierarchy of Power and a 'Top down Approach'. The result is 'inequitable' planning of health policies and the provision and delivery of Health Services. The amount of inequity in the power relation is shown by the size of the arrow.*

### ***6.3-5 How to Achieve What Needs to Exist:***

At the macro (societal) level we have no strategy for men's health, no strategic plan that offers a legitimate starting point to direct us from here. Within the New Zealand context a starting point may be the legitimating of further research of men, by men, into the health needs for men. For our Tane, our men, the current health statistics reflect the pressing need to simply 'begin'. From a ministerial perspective this may mean a paper exercise into the development of a strategic plan for male health, backed up by a collective of current research into current male health needs in New Zealand. From here, we may begin to accurately encapsulate the 'primary' health needs of males, and begin to develop robust health policy for males, all the while acknowledging the different and specific health needs of both men and women.

Here, 'the smuggler or third party' (Smith and Blanc 1997) (Refer figure 6.4c, pg 198) is able to act as an agent for creating change, operating at the macro (political), meso (agency), and micro (individual) level. Assisting in the development of a strategy and direction for men's health. Assisting with men's health research, men's health policy development, service planning, and eventual delivery of health services for men. At the meso and micro level, this may mean investing in the development of health-based initiatives that work for men. This would mean developing legitimate sites of contact for young adult male health service users. It may also involve re-orientating healthcare for males around more 'male friendly' sites such as employment, sports, or education, rather than the traditional site of the medical practice.

The shift from current power relations based on a 'you & I' relationship, to a new power relationship based on 'you, I, & we' (Kelly and Sewell 1996), initially means a recognition and acknowledgment primarily at the macro (political) level of the problems surrounding male health issues in New Zealand. This initiation by the 'smuggler or third party' (Smith and Blanc 1997), maybe from the male health consumer, the health practitioner, the men's health researcher, or men's health collaboratives. The male clients themselves likened the NGO mental health consumer and advocate to the smuggler or third party.

(Client) Well...I reckon that the [identified NGO] was a great health service...it was run by people with a mental illness...who...and there is no... there is no... there is nothing better than having people with an illness to understand how another person.. ummm... Maybe... even... even... there thinking maybe very different there priorities may be very different but the fact...even though... that they know that they got the same illness as them.

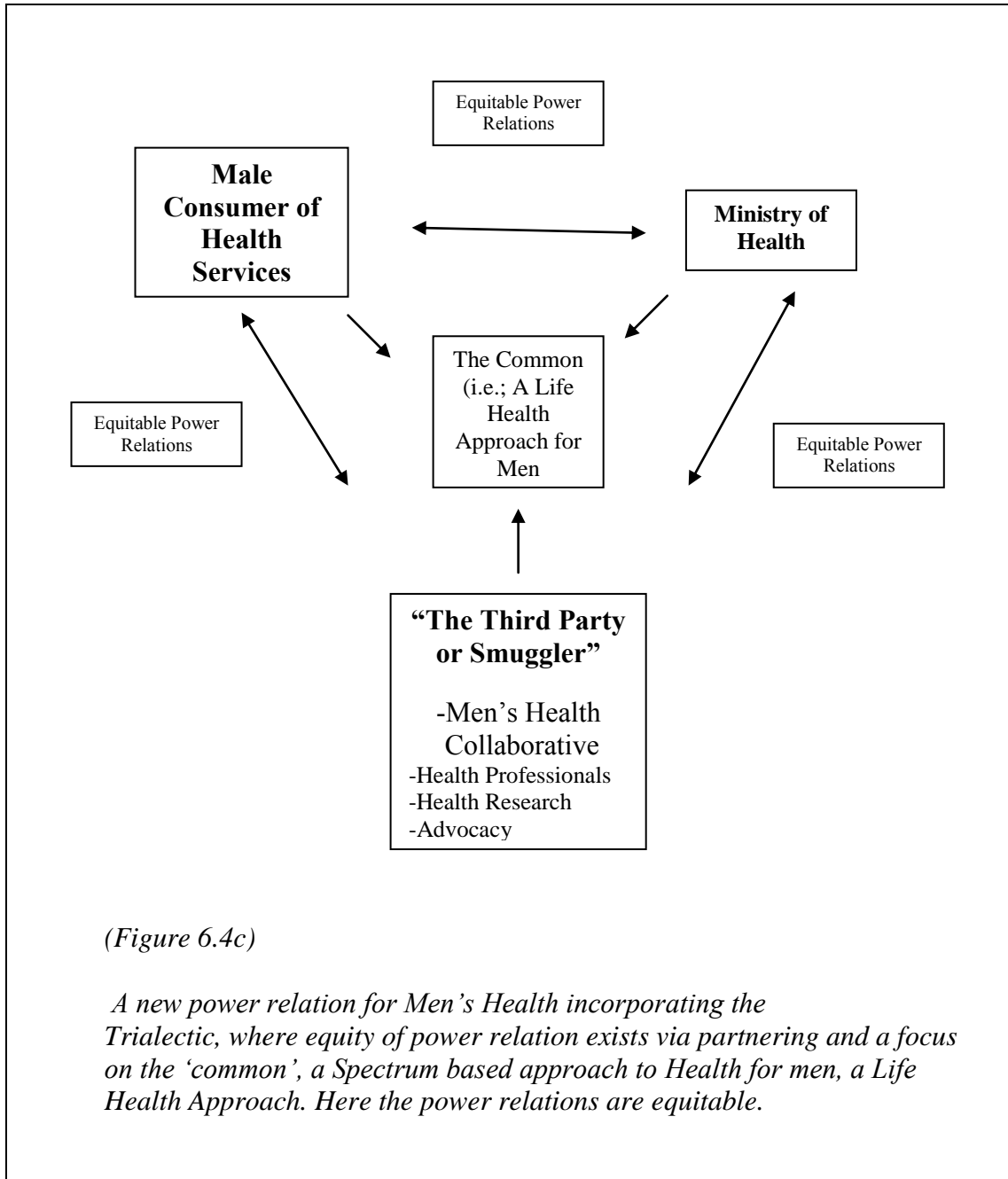
The raising of awareness of male health initiates its own development and crucially alongside this the development, of a language for male health. The current language of men's health in New Zealand is limited and finite, so the need exists to develop contexts at each of the micro, meso, and macro levels where male health can be further discussed, debated, and researched, and where the latent language of male health can develop. This raising of awareness and development of a language surrounding men's health and male health issues at macro, meso, and micro levels assists in developing a 'culture' of male health in New Zealand. This in turn will create new power relations and result in a positive change concerning men's health in

contexts at the macro, meso, and micro levels, thereby assisting in creating a new paradigm for men's health in New Zealand.

Both Kelly and Sewell (1996) and Smith and Blanc (1997) identify a new type of power relation that builds on existing social transactions and developing power relations. Smith and Blanc (1997) incorporate the concept of the 'smuggler' (Smith and Blanc 1997), the introduction and incorporation of a third party. Kelly and Sewell (1996) identify it as the development of 'trialectic' or 'tripartite' power relationship. The moving of the discourse away from the polarising rhetoric of 'us' versus 'them', the you & I; to the inclusive rhetoric of 'you, I, & we' (Kelly and Sewell 1996). The focus shifts from the individual's knowledge's, 'the expert versus the non-expert' (Opie 2000), to identifying that which is 'common' (Kelly and Sewell 1996). The common, becomes the focus of the process and power relation, assisting to develop a transparent and open therapeutic process, which is both a collaborative and a collective process (Shannon and Young 2004) (Refer Figure 6.4c, pg 198)

The 'you, I, & we' (Kelly and Sewell 1996) approach in the development of health policy, and the delivery and provision of health services is a 'bottom up approach' (Shannon and Young 2004), incorporating equitable 'bi-polar' (Smith and Blanc 1997) social transactions. The role of the 'smuggler' (Smith and Blanc 1997), or third party is to assist in challenging the polarisation that may occur (refer Figure 2.5b, pg77). The third party may be a health collaborative, further bodies of research, or a health professional. These people and groups may assist in highlighting, challenging, bridging, or recreating new relationships that mitigate against polarisation. In this

case highlighting the discrepancies in men's health both as a result of and caused by men not accessing services like a community mental health team.



(Figure 6.4c)

*A new power relation for Men's Health incorporating the Trialectic, where equity of power relation exists via partnering and a focus on the 'common', a Spectrum based approach to Health for men, a Life Health Approach. Here the power relations are equitable.*

Within men's health, this new power relation means a 'partnering' (Giddens 2001) between males users of health services, the Ministry of Health, and the 'third party or smuggler' (Smith and Blanc 1997), to further research, develop relevant health policy, and add to current health services to ensure men's inclusivity (refer Figure 6.4c). An inclusivity of men in health means adopting a gendered perspective which recognises women and men's different, yet specific health needs.

## **Chapter 7: CONCLUSION AND SUMMARY**

### ***7.1 Introduction***

This research set out to identify what helps or hinders men's access to health services, in particular a community mental health team. I interviewed both male clients and male and female clinicians, asking them what they saw as assisting or inhibiting male clients access to a community mental health team. I have identified what helped or hindered men's access at the Macro, Meso, and Micro levels.

### ***7.2 The Macro Level***

In New Zealand, we currently lack male specific health services. Historically our health services have been designed by men for women and children. This historical paradigm has contributed to an absence of services for males in New Zealand, as well as contributing to a lack of rhetoric for men's health generally. This absence of rhetoric has created our current default position within men's health; one where men are viewed societally and personally as *not* having health problems. This was reflected by both client and clinician respondents who identified that there was a lack of general and mental health services that catered for the needs of men with mental illness.

This lack of rhetoric is further reflected in the *lack* of health specific policies and strategies that are inclusive of men in New Zealand. We currently have no strategic plan for men's or male health in New Zealand. There is a need at a policy level to develop (with relevant stakeholders) a gendered strategy that acknowledges the differences between men and women's health needs, yet is inclusive of both men and women's health. Our current 'gendered' health strategy in New Zealand is *not inclusive of men*.

This lack of men's health rhetoric highlights significant gaps in men's health that are currently not being addressed at this macro, health policy level. There have historically been some isolated and piecemeal health promotion messages for men, but these have not been part of an overall strategic health plan that is inclusive of male health. At the policy and political level, these gaps in men's health policy are made visible by various reports on the future direction of Health in New Zealand from the Ministry of Health that *fail* to make mention of, or address men's health (Ministry of Health 2004, Ministry of Health 2003, Ministry of Health 2000, Ministry of Health 1999). This *omission* of men's health from current health policy is reflective of a pathologising approach to health (MacDonald, McDermott et al. 2000). An approach that ends up highlighting the deficits of being male (Goodyear-Smith 2003), and reinforces that being a male with a health problem is *not okay*.

Both clients and clinicians identified current *societal perceptions* about being a male with health problems as hindering men's access to health services like a community mental health team. They identified the tensions created by being a man with a mental illness, in a society that promoted men as *not* having health problems. This was seen

to perpetuate the current negative societal misconception of being a man with a mental illness.

### 7.3 *The Meso Level*

At the meso or service level both clients and clinicians identified that the current health service design, format, and delivery was *not* male friendly. This combined with men's different health needs compared with women (as well as the gender's different expression of health needs), meant the need to develop services that are *gender specific*. There are currently no male specific health services in New Zealand. Both clients and clinicians saw the need to change the way community mental health teams delivered their services to men to assist in improving men's access to health services.

Both male and female clinicians identified the effects of *historical institutionalism* on chronic long term male mental health service users as inhibiting their access to the community mental health team. Clients, who experienced the negative effects of institutionalism within a mental health service, had high levels of distrust of all mental health service, including outpatient services like a community mental health team. This resulted in these men avoiding contact with *all* health services. The chronic and complicated nature of co-morbidity and mental illness saw these distrustful male clients become entrenched in a new type of *community institutionalism*. Though they were not in institutions, they were isolated in lower socio-economic parts of the community and known as 'ex-psychiatric' patients. This resulted in them being further stigmatised and further isolated from general and mental health services and

the community at large. The minimal contact they did have was with community based Non-Governmental Organisations and groups.

Clinicians acknowledged that the current service design of the community mental health team did not cater for men, and that there was a need to be creative in terms of community mental health service delivery. Male clinicians identified the need to move the delivery of general health and community mental health services away from the traditional realms of the hospital or GP practice, towards a safer site (a place of less risk) for men. Clients identified that the community mental health team and GP practice were unsafe places for men, compared with work and home which were identified as safe sites for men. Clinicians mooted the idea of employment based health and mental health programmes and clinics with a preventative focus.

Both clients and clinicians identified that males had limited sites of legitimate contact with health services post adolescence. Unlike females who had legitimate points of contact with health services well into adulthood, men's legitimacy in accessing a health service (like a community mental health team) occurred only when in their health was in crisis. This reflects the reactive nature of current men's health practices and the tendency to focus on 'reactive' service provision. These types of services, though needed, reinforce that which we already know, those negative and dominant discourses for men, whereby men [who have health problems] are seen as not okay (MacDonald and Crawford 2002).

In general, males in New Zealand do not have a culture of prevention when it comes to their own health. There are minimal 'protective' services for men that focus on the

*positive* aspects of male health, or seek to introduce a new rhetoric within health service delivery that it is okay to be male with a health problem. A Salutogenic (MacDonald, McDermott et al. 2000) approach to health (versus a Pathogenic approach to health), has its focus in identifying and promoting health and health enhancing behaviours in boys, male adolescents, young men, and adult males (King, Sweeney et al. 2004, MacDonald, McDermott et al. 2000). This salutogenic approach to men's health is not happening in New Zealand.

#### **7.4    *The Micro Level***

Clinicians identified that a different set of knowledges was required when working with men with mental illness. They said that the advantage of male clinicians working with male clients is that they have the unique understanding of what it means to be a man and the ability to role model positive healthy male behaviours. Clinicians acknowledged that men required a large amount of time to build a *trusting* client-clinician relationship. This produced a tension within the current service framework of the community mental health team that often left the client seeing a different doctor, for a short period of time, between even longer periods of time. All of which did not assist men in the building of a trusting client-clinician relationship.

Male clients identified *mistrust* as hindering their access to the community mental health team. A mistrust that was reflective of previous negative experience with mental health services and clinicians within the mental health services. Clinicians found that men were more like to access a community mental health team, when they

had a clear understanding of the service they were attending, why they needed to attend, and what was expected from them. They also found that male clients needed to receive regular feedback as to how their treatment was progressing. Male clients identified that they wanted others involved in their treatment, but on their terms. Having some semblance of control in the decision making process, left them feeling respected and validated. They also identified the need for others to have an understanding of their position in light of being a man with mental illness.

Clinicians identified the need for male clients to have positive male role models, who modelled healthy behaviours and lifestyles. Clients identified the usefulness of having other men with whom they could connect with and feel supported, non-judged, and validated. Being able to rely, trust, and share with others was important for men in assisting them to further access an outpatient service such as a community mental health team. Both clients and clinicians identified the use of humour as key (or the oil in the mechanism) that helped men build relationships.

This research set out to ask what helps or hinders men's access to a health service like a Community Mental Health Team. Much of the literature repeats that which we already know; that men do not access health services. This research has suggested a number of strategies that would assist men in accessing health services such as a Community Mental Health Team. More broadly, it illustrates the need for a collaborative approach to men's health. This includes the need for more research in this area and the development of relevant men's health policy as part of the broader New Zealand health strategy. Meso and micro strategies are unlikely to be effective without this broad approach, as this research illustrates the major impact that societal

perceptions of men's health has on their ability to access services. Therefore change needs to happen at a macro policy level from which relevant stakeholders can be identified and specific services developed. More importantly this research highlights the need for this development to be driven from the bottom, with men's voices central in the development and implementation of both policy and services. Otherwise we risk adding to and reinforcing the very rhetoric that hinders men's access to health services; the idea that men do not have health problems.

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## APPENDICES

## **INTERVIEW GUIDE -Clients**

### ***Community Mental Health Teams:***

1. How long have you been a client of the North Community Mental Health Team?
2. How were you first referred to the North Community Mental Health Team?
3. What were your first impressions when you arrived at the North Team?
4. What were your impressions after subsequent visits? Did anything change? If so, what?
5. What were your impressions of the first health professional you had contact with at the North Team? What about now?

### ***Power/ Control Differentials:***

6. In your view, who has the power/ control in your interactions with the community mental health team? Why do you think this?
7. How does this power/ control show itself?
8. As a man, what effect does this have on you?
9. Where else have you seen this type of power/ control used?
10. As a male who uses a health services, what sort of power/ control do you see yourself having?

### ***Masculinity:***

11. As a male, what do you find most difficult about having a mental illness?
12. Do you have contact with other men with mental illness? Why? Why not? Is it useful? Or not?
13. Do you have contact with other health services that work with men? Were they useful?
14. What other types of health services would be useful for you?
15. Explain what dilemmas you have experienced in being a man with a mental illness?

16. As a man, how does masculinity help or hinder you in managing your mental illness?
17. Some people with health problems talk of how it was before ill health. What did you value? Or, what was important to you at the beginning of your ill health? And now? What has changed? Why?

***Barriers:***

18. What are the barriers that stop you from accessing a mental health service like a community mental health team?
19. As a male, what makes it difficult in approaching a health service like a community mental health team?
20. As a male, what makes it difficult in using a health service like a community mental health team?
21. As a man, what do you find most difficult about the community mental health team you're involved with?
22. What effect does the stigma of mental illness have on you?
23. As a male how do you respond to this stigma? How do men react to this?
24. As a man what effect does 'being seen' to have a mental illness have on you? How do you manage this?

***Access:***

25. How equal are health services for men compared with women?
26. What have you found useful about the community mental health team you're involved with?
27. What would you change about the community mental health team you're involved to make it more useful for you?
28. What do you think a community mental health team could do to make it more approachable/ and or useful for men?
29. What in your view should a men's health service look like?
30. Are clinicians helpful in breaking down stereotypes? How? How not?
31. Are health workers helpful in assisting you make the move to a community mental health team? How? How not?

***Sites of Risk:***

32. What are the risks for you in using a health service like a community mental health team?
33. Is a community mental health team a safe place for you? Why? Why not?
34. What would make you reluctant or resistant in accessing a health services like a community mental health team?
35. Is a health service like a community mental health team, a place you trust? Why? Why not?
36. Is it a place where you can be vulnerable? Why/ Why not?
37. What have you found most risky about your community mental health team?
38. People talk about experiencing a health problem and it being a catalyst for change. Has this been your experience? How was it before? After? What has changed?

***Legitimate Others:***

39. What type of health professional have you found it easier to talk too? Why them?
40. Who would you find it easier to talk to, a male or female health professional?
41. What sort of things would it be easier to talk to a male professional about?
42. What sort of things would it be easier to talk to a female professional about?
43. As a male, whom else would you talk to about how your health issues? Why them? What sort of things do you talk to them about?
44. As a man with mental illness, what impact does your health have on your relationships with others like your Whanau? Family? Siblings? Wife? Partner? Children?

**-Many Thanks for your Valued Participation-**

## **INTERVIEW GUIDE -Clinicians**

### ***Community Mental Health Teams:***

1. What percentage of clients would you see that are men?
2. What other health services would the majority of your male client's access?
3. What would be your male client's first impression of the community mental health team?
4. Is it a male friendly place? Why? Why not?

### ***Power Differentials:***

5. Who do you see as holding most of the power in your interactions with the male clients? What factors inform you of this view?
6. How does the use of power show up in your work with clients?
7. Where else have you seen this type of power used?
8. What sort of power do you see yourself having? What impact does this have on your male clients?

### ***Masculinity:***

9. What do you think men with mental illness find most difficult?
10. Do your male clients have contact with other men with mental illness? Why? Why not?
11. Do your male clients have contact with other services that work with people with mental illness? Are they useful?
12. What other types of health service would be useful for men with mental illness?
13. In what ways does masculinity help or hinder your male clients in managing their mental illness?
14. How do your ideas and understandings of masculinity affect the way you work with male clients?
15. What dilemmas do your male clients face in being a man with a mental illness?

16. Some people with health problems talk of how it was before ill health. What have your clients identified as valuing now since having ill health? What was important to them before? What has changed? Why?

***Barriers:***

17. What are the barriers that stop men from accessing mental health services like a community mental health team?
18. What would make it difficult for men to use a mental health services like a community mental health team?
19. What would you see as the invisible or visible barriers for your male clients?
20. Why would men be resistant or reluctant to access health services like a community mental health team?
21. If you were in there position what would you as a man find most difficult?

***Access:***

22. Do you think there is an inequity of health services for men compared with women? If so, where does this inequity come from?
23. What do you think men find useful or helpful about the community mental health team you're involved with?
24. Does the community mental health team cater for men? If so how is this shown? If not, why not?
25. What could a community mental health team provide that would be useful for men?
26. What would you change about the community mental health team you're involved with to make it more useful for your male clients?
27. What in your view should a men's health service look like?

***Sites of Risk:***

28. What are the risks for men using mental health services like a community mental health team?
29. Is a community mental health team a safe place for men?
30. What would make men reluctant to access health services like a community mental health team?
31. Is a health service like a community mental health team, a place of trust? Why/ Why not?
32. Is it a place where men can be vulnerable? Why? Why not?
33. What do you do to make it safe for men?
34. What do you think your male clients would find most risky about using a community mental health team?
35. How could community mental health teams be safer places for men?
36. People talk about experiencing a health problem and it being a catalyst for change. Has this been your client's experience? Why? Why not?

***Legitimate Others:***

37. What things would a man find easier to talk to a male clinician about? Why?
38. What things would a man find it easier to talk to a female clinician about? Why?
39. Who do your male clients talk to when things are getting tough? Why them?
40. When your male clients are going through tough times, what impact does this have on their other relationships such as Whanau? Family? Siblings? Wife? Partner? Children?
41. When your male clients are going through tough times, what impact does this have on their relationships with yourself and/ or other health professionals?

**-Many Thanks for your Valued Participation-**

7<sup>th</sup> June 2006

Dear

**Re: What Helps or Hinders Men's Access to a CMHT**

Firstly many thanks for assisting with the research. I've enclosed some copies of the;

- Information Sheet for Clients
- Interview schedule for Clients
- Interview schedule for Clinicians
- Consent forms for Clients
- Consent forms for Clinicians

These are for you to pass on to clients whom you think would be willing participants in the research study.

I'm hoping to start the interviews with clients and clinicians at the earliest convenience, and am able to start from now onwards.

- I'll phone in the new week to confirm a possible interview day/time with yourself
- I'll phone in the next 2 weeks to confirm some possible respondents for interviews or focus groups.
- I'll phone you at the end of this month to confirm possible dates and times for focus groups for Clinicians

Again many thanks,

Jimi McKay

(027) 358-7690 (cell)  
479-5867 (ddi)

29<sup>th</sup> August 2006

Dear

**Re: North Team Focus Group – Men's Health Research**

Firstly, many thanks for your willingness to participate I've been amazed at the high level of willingness of the North Team to be involved in this research project. It's really appreciated.

Enclosed are the set dates for the TWO focus groups;

- **Male Clinicians**      **Tuesday, September 19<sup>th</sup>**      **11.30am @ NCMHT**
- **Female Clinicians**      **Tuesday, September 26<sup>th</sup>**      **11.30am @ NCMHT**

The Focus groups are open to all those at the NCMHT who work with clients, so all are welcome on the respective days. Once the Clinicians focus groups are completed, then the last focus group for male clients will occur.

If you have any queries, please feel free to contact me on:

- 479-5867 (Uni DDI)
- 027 358-7690 (Cell/ Txt)
- [jimi-sarah@clear.net.nz](mailto:jimi-sarah@clear.net.nz)

Again Many Thanks,

Jimi McKay

7<sup>th</sup> September 2006

Dear

**Re: North Team – Men’s Health Research**

Firstly many thanks for your willingness to participate in the initial interview for the Men’s Health Research. It was much appreciated. All that data has been transcribed and initially analysed.

We are entering the last stage of the research project that involves running a focus group. I am aware that the group environment for some is a challenging one, yet also important in ensuring that the results collated are a fair and accurate reflection of the interviews.

Your involvement in this last part is important to ensure that the ideas and themes from the interviews are relevant, that ‘your’ views and perspectives are what the research reflects.

*I will follow up with a phone call within the next two weeks to enquire about participation, give further details, and answer any queries.*

Again, many thanks for your participation, the giving up of your time and energy. It’s much appreciated.

If you have any queries, please feel free to contact me on:

- 479-5867 (Uni)
- 027 358-7690 (Cell/ Txt)
- [mckja025@student.otago.ac.nz](mailto:mckja025@student.otago.ac.nz)

Again Many Thanks,

Jimi McKay

## **FOCUS GROUP QUESTIONS - Client**

### **ACCESS**

- Clinician's attempt to ensure equality in our relationship, but it's still not equal.
- I have experienced huge changes as a result of my involvement with a CMHT, having to go to appointments, see different health professionals, etc.
- Overall the CMHT was useful for me.
- Talking with other men (*non-clinicians*) is useful because it's normalising for me.

### **BARRIERS**

- Stigma is still a part of my illness experience, limiting what I do.
- Changes are needed for men, to be able to approach a CMHT, like making the waiting area more male friendly.
- Not enough time is made by clinicians to see clients.

### **COMMUNITY MENTAL HEALTH TEAM (CMHT)**

- My involvement with a CMHT is done cautiously as I did not know what would happen as a result of my going to a CMHT.
- My impression changed with time as my knowledge and understanding about the CMHT increased.

### **LEGITIMATE OTHERS**

- Family involvement had a negative affect on my recovery, as they don't understand what I need.
- I prefer to talk with females, as they are good listener, less confrontational, more intuitive, etc.
- The role of the person rather than there gender determines if I talk with them.

- Talking with friends, mates, or peers is a helpful thing for me, because I don't have to think about illness.

### **MASCULINITY**

- Men and women manage their illness differently. Women like to talk a lot I just want to get on with things.
- It is important for men to have a defined role and to know their role.
- Illness changed my role in a negative way, meaning I can't work; don't go out much, etc.
- Using a health services confirms the change in my role, leaving me feeling worse off.

### **POWER DIFFERENTIALS**

- The clinician has more power than me.
- The clinician uses their power in a negative way, such as changing my medications, directing me to do things, etc.
- The clinician and I have an equal amount of control.

### **SITES OF RISK**

- The CMHT is a risky place that positions men to be vulnerable, which is not helpful for me.
- Being a man with a mental health problem is viewed negatively, whereas being a man with a physical health problem is viewed as legitimate.
- Talking about my own health is not okay talking about men's health is okay.

- Talking about emotion is more the domain of women men don't need to talk about emotion as much.

## **FOCUS GROUP QUESTIONS - Clinician**

### **ACCESS**

- Work and/ or employment has a positive effect on men's mental health.
- Better access to work place health care and more education in the workplace for men about mental health issues (managing stress, feeling blue, etc.) is needed.
- Male client's access to a CMHT is via EPS, which is reflective of men waiting till the wheels have fallen off before getting help.
- Male clinicians prefer 'doing' things with male clients like working on developing motivation, occupation, interests, etc.
- There is not a lack of services but a lack of men using services. A generic 'Men's Health' service would be useful for men.

### **BARRIERS**

- Clinicians identified the limited time clients got as a barrier.
- The environment of the CMHT does not assist men to be vulnerable.
- The focus of mental health services is weighted towards looking at the clients past rather than looking forward.
- In a clinical setting like a CMHT, men tend come in and adopt a role similar to that of seeing a GP.
- Client's past/ historical negative experiences of MHS & CMHT as a barrier to access.

## **COMMUNITY MENTAL HEALTH TEAMS (CMHT)**

- The CMHT in terms of its physical and geographical location is not suited to males. (e.g. the waiting area, etc.)
- Clinicians identified giving the client the option of where first contact as much as possible.
- Two types of male client determined the type of contact, chronic long-term users and new users of mental health services. This was defined by a historical mental health service user context. (Ex-Cherry farm, Orokonui, etc.)
- Client contact with GP's is sporadic, with a focus by clients on physical problems.

## **LEGITIMATE OTHERS**

- Clients viewed family as important, more so than before illness.
- Male clients remained isolated and alienated from family, either by behaviour, by choice, or by their family's choice.
- Unhealthy male peer group noticeably impact men. Male clients need positive and significant male others, outside the MHS and CMHT.
- Talking about physical illness to men is okay/ legitimate; talking to men about mental illness is not okay/ sign of weakness.

## **MASCULINITY**

- Clinicians identified tensions between societal ideas of masculinity and their role as nurses. The dilemmas faced in role modelling behaviour that is viewed as weak (being vulnerable, showing emotion, etc).
- The male clinician's role assists clients by educating and challenging some of the client's misconceptions about masculinity, assisting with healthy expression of emotions, and modelling healthy male behaviour.
- Men's acceptance of illness means accepting a change in role. Male clients are reluctant to accept this change. Attempts to get back into things like work and relationships are used to avoid acceptance.
- Building trust is necessary for men to assist them in defining a new role.
- Genders work through certain issues differently. Men are more interested/focussed on independence and the now; on moving forward; having a mental illness or expressing emotion is viewed as getting in the way of that.

## **POWER DIFFERENTIALS**

- Clinicians hold most of the power at the start of the relationship with the client, and attempt to balance the power in their work with the client.
- Clients with a life beyond their illness have more power than those clients who were resistant, entrenched in the mental health service.
- Power is used to motivate and assist people in their recovery.
- Male clients retain control by missed appointments, limiting contact, etc.
- Male clients asked for help too little, too late resulting in clinicians needing to take over control.

## **SITES OF RISK**

- Clients risk is more perceived risk; ‘the what if or how is this going to be’; therefore the risk for men at CMHT is low.
- Clinicians viewed non-acceptance of illness as adding to clients risk; showing weakness and vulnerability in the locked ward environment is risky for men.
- Visiting GP was seen as risky, as was talking to GP about emotional problems.
- Men are more interested in talking to other men about their role (what they do, did, etc.). Men find it easier to talk to a female about emotional issues (how they feel, etc.).
- Men need to build a high degree of trust in a relationship to talk about deep stuff.
- Clinicians built trust by role-modelling vulnerability, sharing, etc.