

**WESTERN SYDNEY**  
UNIVERSITY



# THE SHED IN MT DRUITT:

ADDRESSING THE SOCIAL  
DETERMINANTS OF MALE  
HEALTH AND ILLNESS

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MHIRC works with an understanding that health is a dynamic state involving the interaction of the whole person with their physical and social environment. MHIRC's aim is to promote the health and wellbeing of men and boys, in particular those men and boys most marginalised and most at risk of poor health outcomes.

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## **NSW Male Health Clearinghouse**

MENGAGE.org.au is the NSW male health clearinghouse. It provides health practitioners working with and boys insights, resources and evidence of effective practice to improve their ability to deliver appropriate programs and make use of available research.



<http://bit.ly/TheShedEmerton>

# FOREWORDS

This is to state that I, Wesley Marne, would like to say something about the Shed. The Shed is situated at the Holy Family Catholic Church on Luxford Road, Emerton. The Shed is one of the best things that has happened in Western Sydney since I came here some forty years ago. The Shed is the only place where men can go for company and help.

The idea of the Shed goes back many years and no matter how we tried to get it started there was no help. We all talked about it, especially Father Paul Hanna, Coral McLean and a few others besides myself. About eight years ago a group of men got together with Coral McLean at the building where the shed is today. I did not know if there was finance available. But Western Sydney University came along with some money.

And the men themselves elected the first worker (Teddy Hart). From the very first this was a goer. The Shed was started because of the rate of suicides in the area. Since then the rate of suicides has been reduced. For a start it was for men only. But troubles don't revolve around men alone. For example domestic violence was one of the first problems that we had. So that the men voted that women could come along with the men and we sat down with these people and we listened to their troubles. From there we went with men to court and we soon represented the community in a lot of their troubles. The police came to our meetings. The Department of Housing came and we sorted out a lot of troubles there.

Legal Aid came along to help. Department of Community Services came and joined. Probation and Parole came along. Medical Services came and helped the men with their ailments. I could write all day about the numerous good things that have happened since the Shed has started. I would like to say that I am truly proud to have been associated with the Shed and I look back with pride at the best thing that has happened in Western Sydney and that is the Shed.

Uncle Wes Marne, Co-Chair,  
The Shed Board  
December 9 2012

The Shed is a Community based initiative for and by the local community. It engenders a sense of family, a sense of belonging, a place of listening, a place of welcome, a place for a 'feed and a yarn'. All of these underline contribute to a place of trust and respect.

It is based on the local voices and networks and has no need for advertising or media exposure.

The shed began as a response to suicide and followed a raft of conversations, research, and real respect between Western Sydney University, the aboriginal men and the local community- a good example of a community engagement program between the Major Tertiary Institution of Western Sydney and a local community with the largest public housing component in Australia. The participation of the local respected Elder of over forty years in the Mt. Druitt community, Uncle Wesley Marne, was significant in leading the way for the local men and the aboriginal community.

The shed represents a University coming to a local community to listen and learn from its narrative and further learn from the culture and stories of some of its most fragile members and develop some strategies for grass roots change.

In the beginning the shed was, and still is, a small and rather primitive attempt to acknowledge a need especially for men and take the risks involved in allowing the locals to set the agenda.

From the grass roots of the Mt. Druitt community, often pathologised by the media in a poor light, there is emerging a new pathway for fragile and wounded men and their families to take control of the processes and redefine responses at the primary level of care and healing.

This approach is predicated on the greatest resource in local communities, I refer to its people.

As a community model, it is messy but above all it is labour intensive not capital intensive as management- top- down models are.

As well as being a significant conversation and response within a local network, the shed has been part of a much wider framework and has been contributing nationally to the serious issues surrounding men's health and the isolation that comes from social exclusion. This is reflected in the large number of men and especially ATSI men in the custodial systems. Amongst one of the most urgent of the 339 Recommendations of the Royal Commission into aboriginal Deaths in Custody in 1991, was the need to reduce the over representation of ATSI in custody which at that time was 14% of all in custody. At present, over twenty years later, it is now double that percentage!

While there are many hundreds of Men's sheds across Australia, the shed maintains its own direction and destiny without copying any other. Eight years ago it would have been impossible to imagine that the Shed is networking and responding to so many needs even in a single day. Who knows where the story of the shed will have travelled eight years from now.

Father Paul Hanna, Co-Founder and Patron of The Shed  
December 9 2012

# 1. THE SHED IN MT DRUITT: ADDRESSING THE SOCIAL DETERMINANTS OF MALE HEALTH AND ILLNESS

This monograph is written with respect for the Aboriginal people of Mt Druitt and their Elders.

Foreword 1: Uncle Wes Marne

Foreword 2: Fr Paul Hanna, patron of the Mt Druitt Shed

## 1.1 INTRODUCTION

The Shed in Mt Druitt, Western Sydney, on a Wednesday: chaos. At least that's what it might look like to the first time visitor. For a man just wandering in looking for a cup of tea, however, it might be just the place. Because there are men hanging around drinking tea and coffee and there is a smell of something cooking in the background. The cook looks up from turning over a large amount of steaks, smiles, and says, "Hello, brother, grab yourself a cup of tea, lunch is up in about ten minutes". The cook is actually the Coordinator of the Shed. In addition to men chatting to one another, there are several other one-to-one conversations going on, some with men of all ages talking with what look to be (and are) young women lawyers: "We can help you with... Would you like it if I...?" A van rolls up and two Aboriginal health workers get out: "I'll give you a check up just as soon as I've had some of that nice lunch I smell", says one of them to a man sitting on the deck.

What is happening is that on Wednesdays the Shed in Mt Druitt, seen as a safe place by men, mainly Aboriginal, is open for service providers to contact the men of this area. Before the Shed opened in 2004, such contact was often difficult: offices can be forbidding places, despite individual efforts of officers to be welcoming. The Aboriginal mental health worker, a by now, much respected person on account

of her dedication and quiet respect for the men, is always busy listening to someone under a tree. A Probation and Parole officer, whom some men have to see and whose office might be particularly forbidding, can be seen chatting with one or two men who seem strangely at ease; he comes for lunch to their place (because the Shed IS their place) every Wednesday. A young trainee social worker is explaining to me, when asked what she is being taught about men, that, "The problem with men is that they don't talk". I ask her to turn round. She seems puzzled, but does so. A man is talking intently to the mental health worker under a tree. "Yes, but men don't talk," says the trainee social worker, "we had two sessions at university on that last week". I hope she visits the Shed more often (True story).

This paper is divided into two sections. In the first part we explain the background to the work of the Shed in Mt Druitt: how it came about and what it sets out to do. In the second part we give an account of the activities of the Shed. It has to be stated from the outset that the Shed didn't just "happen". Programs and projects are driven by ideas, either acknowledged or otherwise. In the case of the Shed, the driving ideas have been quite explicit from the first and we will describe them after a small introduction telling the "story" of the setting up of the Shed.



## 2. HOW IT STARTED

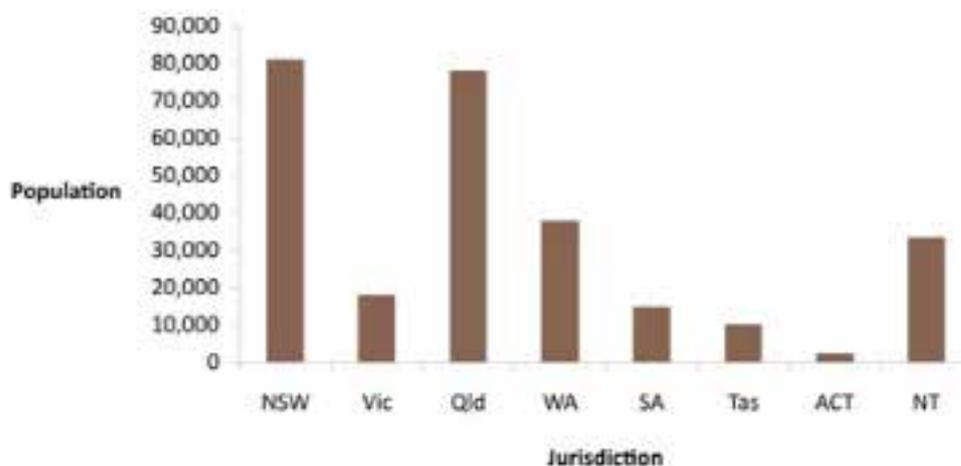
### 2.1 BACKGROUND

The Men's Health Information Centre (MHIRC) at Western Sydney University, was set up in 1999 with funding from NSW Health, as an acknowledgement of the need to draw attention to men's health and what was there or could be there to improve this, as well as to support those working to that end. Mr Micheal Woods, a senior lecturer at Western Sydney University, was the thinker behind this: he and Professor John Macdonald had been contacted by the local Division of General Practice because of the doctors' concern about not meeting men's health needs. The doctor in charge of the nearby RAAF base had a particular interest in the mental health of service men, both when serving abroad in situations often of great stress, and when on contrasting periods of relative inactivity on home base. From the outset, MHIRC, being a small body, had to adopt fairly modest aims, so we have had a focus on males of vulnerable groups:

*MHIRC focuses particularly on the health status of marginalised or disadvantaged males - this includes populations such as Aboriginal and Torres Strait Islander men, unemployed men, separated men, incarcerated men, new dads and other males who may find themselves at risk of increased stress and therefore poorer health outcomes.*

The intention to focus on disadvantaged men in Australia, and more especially in Western Sydney where MHIRC is situated, and where the country has the largest conglomeration of Aboriginal and Torres Strait Islander (ATSI) people, leads us to confront the precarious state of wellbeing of the men of the ATSI community.

Indigenous male populations, by jurisdiction, June 2009



Source: ABS, 2009 (2)

These men have the worst health outcomes of any population in Australia. The Australian Indigenous Health Info Net points out the underlying causes:

*Indigenous male health is also affected by contemporary structural and social factors, including economic opportunity, physical infrastructure and social conditions. These factors, known collectively as the 'social determinants of health', are manifest in measures such as housing, education, employment, access to services, social networks, connection with land, racism, and rates of imprisonment. Indigenous males suffer substantial disadvantage for all of these measures during their childhood, as adolescents, and*

*throughout their adult years. It is important to consider these social determinants in addressing the health of Indigenous males as it is here that resilience can best be supported and reinforced.* <sup>(3)</sup>

We have to make it clear that MHIRC in no way claims to be experts in matters to do with Aboriginal and Torres Strait islander people, but our concern with male health has led us to work with elders and men in this community and we try to work collaboratively with ATSI men and those concerned with their wellbeing. There are very few services for ATSI men in Western Sydney. Two of the Mhirc team are Aboriginal men.



## 2.2 FIRST STEPS

In 2002 MHIRC commissioned Dr Bob Morgan, a prominent Aboriginal scholar, to do a short scoping exercise to determine where best to start to work with Aboriginal and Torres Strait Islander (ATSI) men in Western Sydney. Dr Morgan reported that almost without exception, ATSI men said they would trust “Fr Paul’s Place”, meaning the grounds of the Holy Family parish in Emerton, Mt Druitt. The reason given was that since Fr Hanna and his colleague, Coral Maclean, had been working in a participatory and respectful way with the Aboriginal community of all shades of belief and none, for more than two decades, people felt “safe” there. For this reason, the physical location of the Shed is in the grounds of the Holy Family Parish even to this day. Ms Maclean, now sadly deceased, and Fr Hanna, now retired but the Patron of the Shed, were largely responsible for inculcating a spirit of respect and welcome to everyone coming through the door (or near the door) of the Shed.

This little monograph is dedicated to both Coral Maclean and Fr Paul Hanna.

From 2002 to 2004 there were a series of meetings between the MHIRC and agencies involved with Aboriginal men: Probation and Parole Services, the Police, the (then) Darug Aboriginal Medical Service, Western Sydney Area Health Service (including the Mental Health Team), the Mount Druitt Regeneration Project, the outreach services of the local church and others. Most of these agencies have had changes in their personnel and names and structures, but their service functions remain largely unchanged. Funding was obtained from the federal government, under its Suicide Prevention Program to employ two Aboriginal workers and the Shed was opened by the NSW Governor, Marie Bashir, in April 2004.



### 3. THE APPROACH

The principal “root” of the approach adopted by the Shed is to be found in a concern about male suicide in Australia and specifically in the work of MHIRC with Suicide Prevention on the Central Coast of NSW. This initiative led us to speak of the “social determinants of male suicide” (4). Contact with the excellent work done on the Central Coast (5) brought about the research carried out by the MHIRC team and

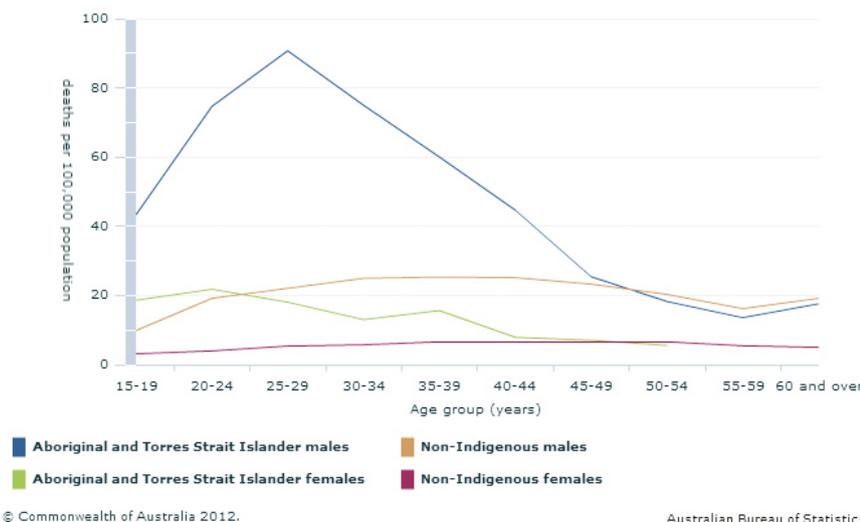
colleagues from the Central Coast project. This has been published as: Pathways to Despair: the social determinants of male suicide (4). This collaborative research involved interviews with families who had lost male relatives to suicide and with men who had seriously attempted to take their own lives.

### 3.1 MALE SUICIDE

Since its inception MHIRC had been concerned with both the extent of male suicide in Australia and also with the apparent lack of national interest in this tragedy. At least five men kill themselves a day, and one woman. The figures vary slightly from year to year but remain basically the same, with the demographics as shown in this graph remaining fairly constant.

Specifically MHIRC has had a concern about the high number of male suicides in the middle of their lifespan; when it was thought that suicide was mainly a youth issue there was an understandable sympathetic national response. But in fact, the tragedy is particularly associated with men in what should have been the middle of their lives and, with older men. The number of deaths in custody of ATSI men is frightening.

6.2. Age-specific suicide(a) rates(b) by Indigenous Status & sex, NSW, Qld, SA, WA, NT, 2001-2010(c)



Australian Bureau of Statistics: © Commonwealth of Australia 2012 (6)

We concluded in that paper:

*It appears from these interviews with survivors and with families and friends who had lost a male relative or friend, that the pathways to suicide are often influenced by a complex set of life circumstances. ....The pathways to despair, which can lead to suicidal thinking and suicide attempts, can accumulate over a period of encountering adverse life situations (adverse childhood experience, school, addiction to drugs, relationship strain, work-environment, community life, separation etc). Perhaps most important is the cumulative effect of difficulties in several of these areas: when several of the factors are simultaneously involved, there is almost inevitably a greater degree of risk. (4, pp 26-27).*

The title of this paper, Pathways to despair, was deliberately chosen, rather than Pathways to depression: “despair” seems to reflect more accurately the experience of the men encountered, rather than the often-used expression, depression. Apart from being somewhat vague, the term “depression” can lead to the medicalisation of social problems. As long ago as 1992, Conrad (7) had spoken of this tendency, even specifically referring to “unhappiness”:

*Medicalization occurs ....as part of doctor-patient interaction, when a physician defines a problem as medical (i.e. gives a medical diagnosis) or treats a “social” problem with a medical form of treatment (e.g. prescribing tranquilizer drugs for an unhappy family life) (7, p 209).*

MHIRC's work with men at risk has led us to be wary of the common tendency, not least of all by some prominent professionals, to say that the majority of people killing themselves are "mentally ill". While the M5 Project of the Australian College of General Practitioners (8) has much to commend it, it also risks giving the same impression, speaking of men killing themselves, it says:

*Depression is the most common cause of suicide. However, depression in men is often not diagnosed. Depression has varied symptoms and 1 in 8 men experience it in their lifetime (1 in 5 women) <sup>(8)</sup>.*

Our own study and work in the community suggest that while of course some people who take their own lives are indeed mentally ill and most are of course, mentally troubled (which is a different matter), it is sometimes misleading to attribute this tragedy too quickly to "mental illness" and likewise, therefore to "depression". To do so risks us being led to ignore those social factors which can lead people to the point of despair, where suicide seems like the only viable option. It also allows us to turn attention to understandably easier prevention activities, consisting of helping men "get in touch with their feelings" etc, always easier than helping people address the "causes of the causes". Depression of course, exists and must be addressed. In some ways the Shed in Mt Druitt is an effort to deal with depression, but not in the first place by "psychologising" the phenomenon and seeking solutions in "getting men to speak", placing the locus of the issue squarely inside the men, in some inadequacy, some social pathology. In the Shed, when

serious mental health issues are apparent, mental health workers are at hand with the men, or are contacted. But much of the cause of distress and even despair lies in the cumulative effect of difficult life events and the Shed workers "walk with" the men through the most pressing of these, which could involve housing, Apprehended Violence Orders (AVOs) and separation from children, police fines, financial stress, employment, or all of the above and more. "Walking alongside" is definitely the order of the day at the Shed, and although no one would claim that this particular "walk" on this particular day with this particular man has had the immediate effect of stopping him from killing himself, there can be no doubt many are turned away from a downward spiral of what has to be named as despair. Put more positively, the work of the Shed is often to help men walk with renewed confidence through life's many challenges.

The "big" word we have used in MHIRC's work has been *salutogenesis* <sup>(9)</sup>, when asked, especially by medical workers, why we use such a big word, we often reply that medicine is not shy of big words. Whereas *pathogenesis and pathologies* are words we have no difficulty in understanding as referring to those things which are not right or which foster illness, *salutogenesis* refers to those things which foster and encourage wellness and health in us, the capacity to deal with what comes our way and turn it to good. "Resilience" people say: yes, indeed, but more than resilience, what we are trying to foster in the Shed is the men's inherent capacity to draw strength from what is nourishing in life, as well as to handle the hard stuff.



The above photo shows some of the men who have used the Shed. They are leaning on the longest "didgeridoo" that we know of.

For a long time and to some extent even now, men's health work and research has focused largely on physical pathologies (like the prostate) or social pathologies, what we might call "men behaving badly", or at least "inadequately", leading to a great emphasis on behavioural change<sup>(9)</sup>. MHIRC and the Shed operate out of a commitment to a social determinants of health approach, as applied to men and as endorsed by the Australian National Male Health Policy<sup>(10)</sup>. The social determinants of health approach does not deny the importance of physical pathologies, nor the need for behaviour modification to improve health, but increasing amounts of research shows the importance of the context in which we live as impacting on our health and wellbeing. Where we live, work and what we earn and who sees us as being of value, are among what are called the social determinants of health<sup>(9) (10) (11) (12) (13)</sup>.

So, to ascribe issues in men's health as being due mainly to factors in a man's social conditioning, his "masculinity" and to ignore the impact of context (socio-economic, cultural etc) on men's health is to be blind to the facts and to ignore the body of research on the social determinants.

MHIRC has always endorsed a "social determinants of health" approach. By this we mean that we look at male health *in terms of the factors in society and life that build or undermine this health. Health is a dynamic reality shaped by many factors. An individual's health is the product of many aspects of their life, and the term used for the causes behind health status is the Social Determinants of Health (SDOH).*<sup>(1)</sup>

We learned from our study of suicide that these social determinants (such as love, meaningful work, position in society, religious faith and belonging etc) are like lifelines, allowing us to contribute to life and be nourished, both physically and emotionally; they keep people going.

Inversely, when they are missing: lack of love, or of meaningful work, or of a sense of belonging and value, people can find themselves on downward spirals of despair. Even on the road to suicide. That is why we called the study report *Pathways to despair, the social determinants of male suicide*.

We have found that the same framework applies to the work with Aboriginal men in Mt Druitt: there are similar things holding men in life, strengthening their capacity to deal with life's challenges and, inversely, when these are missing, weakening that capacity. Of course, the social determinants of male health in an Aboriginal community are marked by the cultural and other particular contexts of that community. The obvious example is the sense of belonging which Aboriginal people have associated with "country". This is a deeply held spiritual reality in this community and those of us who are not part of it can never really feel its true extent. But everyone can witness the sense of pride and self-respect which grows in Aboriginal men as they reconnect with Aboriginal culture. Male suicide is an all too frequently encountered phenomenon in this community, as is the experience of racism, incarceration, job, economic and housing insecurity: these things are often tragically inter-related.

## 4. ACTIVITIES OF THE SHED

### 4.1 THE SHED IN ACTION

*“We got to do something about AVO’s, most of the brothers inside are there for breaches.”*

The Shed staff, early on Monday morning are rushing in and out of shops to purchase tea, coffee, milk and fresh fruit for clients and service partners at Mt Druitt Local Court, who are there to appear for the AVO (Apprehended Violence Orders) hearing day. The staff struggles through the shopping centre car park with bags, where they pass both a pub and health clinic that are neighbours.

The reason staff from The Shed are attending court is to implement the Mt Druitt AVO Pilot Project, which is a unique collaboration between The Shed, government and non-government agencies.

The reasoning behind the pilot project is that it aims to address causation! It works on the assumption that if community or family members seek an Apprehended Domestic Violence Order (ADVO), or the police attend a residence where there has been some form of alleged or actual domestic violence (physical or mental), then there must be some underlying causes. In most cases disharmony in the home points to social, emotional, physical, financial or other environmental factors obviously impacting on the wellbeing of individuals, families and communities.

The project does not by any means want to undermine apprehended violence orders, as there is clearly a need for the protection of individuals and their right to be able to live in a safe environment. Consideration, however, should also be given to defendants’ and their families’ right to make informed decisions (for example about access to children) and seek rigorous therapeutic treatments that can address causation. The work of MHIRC has led us to understand that separation from children (apart, obviously, from cases where children are at risk) can be one of the contributing factors on the “pathway to despair”.

In order to attempt to address the needs of individuals, families and community, there has clearly been a need for effective collaborations that involve relevant services attending the court on the AVO hearing day. It is imperative that there be a point of engagement between services and people in terms of engagement and the signing up of people to therapeutic supports.

One of the identified gaps is the fact that Aboriginal Legal Services and generally Legal Aid NSW are unable to provide representation for defendants, unless there are criminal charges attached. More often than not the lack of legal representation for AVO matters results in people consenting to court orders that they may not necessarily understand, further resulting in what may be exacerbated levels of breaches. This can then lead to sentencing options including incarceration and increased levels of reporting to care and protection agencies, even if the order was unknowingly breached.

With the Shed’s aim of “walking with men in need”, the Mt Druitt AVO Pilot Project was developed out of the need of clients who attend The Shed. One Aboriginal male who had been recently released from a custodial sentence said, “We got to do something about AVO’s, most of the brothers inside are there for breaches”. Our social determinants of health/illness approach has led us to recognise that incarceration and in this case incarceration for breaches of AVOs is an important social determinant for many men.

The experience of the Shed has shown us that an AVO may quite often be the individual’s or families’ initial contact with justice system, and may result in being put on a pathway to despair.

The project provides the opportunity for people to be empowered with knowledge, and to be linked to the appropriate services that address their holistic needs, also enabling client engagement with therapeutic services, none of which may have occurred otherwise.





## 4.2 THE SHED - BEING THE 'MIDDLE MAN'

Aboriginal males have the highest rate of suicide in Australia, and to reinforce the “social determinants of health” approach to addressing Aboriginal male suicide, our experience at the Shed has led us to argue for greater consideration to be given to the context of Aboriginal males’ lives and life course in terms of:

- Contact with the justice system and the resulting incarceration rates;
- Prevalence of homelessness and lack of male accommodation;
- Socio-economic status of Aboriginal males, inclusive of unemployment rates, level of stable income and accumulated debt;
- Aboriginal male life expectancy;
- Physical health of Aboriginal males and the prevalence of preventable chronic disease;
- Oral health status of Aboriginal males;
- Intergenerational impact of the Aboriginal stolen generations and failure of government bureaucracies as well as other services to effectively support people that were institutionalised and have suffered physical, emotional and sexual abuse;
- The resulting negative impacts of forcible removal of Aboriginal people through government policy from their inherent right to culture, land and associated environs;
- The current increasing rate of removal of Aboriginal children from their families.

In order to effectively deliver a service, The Shed in its modelling had to first establish a “male friendly space” where males would come, sit and share their stories whether good or bad. More importantly a place to share their stories

in what they felt it was a non-judgemental environment that accepted them. Then they could talk to other people. The Shed, in the way it has grown, has enhanced that “male friendly space” to a point where the clients themselves, determined by their needs identify which services should be allowed to access “their space” at The Shed.

The Shed staff takes guidance from first and foremost Aboriginal males, and then scopes government through its policies, programs and Aboriginal focused strategies and the resulting service provision. They evaluate the difficulties those government and non-government services face in accessing and engaging Aboriginal community members, and more so Aboriginal males, since their needs are often more complex and who as a group are generally harder to engage and retain.

The service providers that come to The Shed are aware that there needs to be a high standard of service, and that The Shed, in its role, also advocates on our clients’ behalf. We therefore assist in preparing complaints to relevant bodies through the required procedures, and if the process fails, then with resulting complaints to independent bodies such as the Ombudsman, to ensure procedural fairness, or by raising ministerial correspondence via local members of parliament or government ministers directly.

The Shed’s values and intentions are to empower Aboriginal males and their families with knowledge and enhance their strengths in social capital and existing resilience. The Shed does not seek to create service dependency, but to empower individuals, families and community to better access, and to make accountable those service providers, which in effect are funded to target their needs.

## 4.3 SOCIAL DETERMINANTS OF HEALTH AND SERVICE MAPPING

The federal and state governments have over time created “silos” that aim to address specific areas of need, and therefore have created a network of bureaucratic red tape. The “silos and red tape” often become barriers to the consumers who need them most. The following is a framework that indicates services and service provision via the “silos”:

- Physical health
- Mental health
- Socio- economic
- Oral health
- Housing/environmental
- Cultural wellbeing

The need for some attempt to draw together or integrate services intended to help communities is one of the lessons we refer to in the following conclusions.

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(\*Legal Aid NSW has approved a temporary policy change to enable defendants to be represented for the purpose of piloting AVO defendants programs in NSW).

# CONCLUSION

We have often been asked what we have learned in our experiences at The Shed. Here are some tentative “learnings”:

- **“Suicide Prevention”.** Our experience of involvement with communities through The Shed has reinforced our conviction about the danger of claiming that “the majority of people killing themselves are mentally ill”. We of course acknowledge that this is a perfectly legitimate way of describing some people who tragically take their own lives, but in many cases people move down a spiral caused by the accumulation of very difficult life events. Their “life-lines” (which is a way of describing the social determinants of their health) have become frayed. We see our work as attempting to strengthen those life-lines. The Shed is funded by a grant from the Federal Government, Department of Health and Ageing, under their Suicide Prevention Program. Of course, we cannot “prove” that the drop in suicide rates in the area should be attributed directly to the Shed. But we can say with conviction that we have learned how to connect many men who need mental health services with appropriate provision, men who would otherwise not have had this access. Likewise, on a daily basis, the Shed workers “walk with” men and their families through serious challenges, which we know, if not addressed, can lead on downward spiralling paths of despair and even suicide.
- **Participation:** this is the basis of all genuine work with communities and one of the original ideas, or “pillars” of Primary Health Care (14); no work with Aboriginal communities could succeed unless those communities see in us people willing to listen and learn. What a colleague, Graham Fazio, might call “attentive and respectful loitering” (or genuine participatory research) should be a part of any program with the community. The Shed did not go in with a list of “programs”: any programs have grown out of the needs of men frequenting the Shed. For example “pre-packaged” (if we may use that word) tobacco cessation programs might please Health Systems, but unless they are led by men who have actually given up smoking, tend to be a waste of time. The Shed is not as participatory as it might be but we are on the way.
- **The sense of country.** “Belonging” is an important social determinant of health. We know it from research and from our own experience of social support. We have learned that the web of life that holds Aboriginal men in safety includes a sense of being part of a web of relationships, of kinship, of being part of a “mob”. This encourages us to help all men, Aboriginal or not, to strengthen their social support networks. As a project funded under a suicide prevention framework we see this sense of belonging as important “life-line” and The Shed itself as providing itself a sense of belonging.
- **A sense of the “spiritual”.** Research into the history of the National Aboriginal Community Controlled Health Services (NACCHO) shows that the Indigenous community in Australia took to the World Health Organisation in the 1970s a broad definition of health: “Not just the absence of disease, but the total physical, emotional and spiritual wellbeing of individuals and communities”. Spiritual does not equate neatly with “religious” and through the years in MHIRC and in the Shed we have learned to acknowledge and respect the “other” dimension to life, beyond what we see, more familiar to many Aboriginal people. We hope that some of this wider, richer sense of the world is being imparted to us also as we walk together with Aboriginal men.
- **Gender.** We have learned that Aboriginal families often have different views of gender than the non-Indigenous community which often imposes a particular white feminist-inspired understanding of gender relations on legal and social structures. Aboriginal women often speak to us of the “rightness” of the Shed as offering a place for “men’s business”. This view in no way condones violence against women but tends to see solutions as involving men and certainly not as involving the almost absolute separation of men from their children often the norm in instances in the wider community.
- **Integration.** Service providers generally work in silos. Our understanding of the interconnections between the social determinants of health and the real needs of families and individuals in western Sydney such as those we meet at the Shed indicate that unless there is a means of connecting up services we take the risk of seriously diminishing their impact. The Shed offers a one-stop shop for men and their families, service providers mingling with other services, seeing people in the total (often complex) reality of their lives.
- **Welcome.** Perhaps finally, as we see the workers at the Shed deal with all the men and their families who come through the door, we have witnessed the welcoming that seems to be part of Indigenous culture. The Shed is not designed as an Aboriginal project. The majority of men coming through the door have been from this community, given the nature of the location and need, but all are welcome and have been welcomed. Three quarters of the families accessing the Shed’s parental plan program have been non-Aboriginal. It is not sure that a non-Indigenous run Shed would have been as welcoming of all men.
- **We are still learning.**

# REFERENCES

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- (1) Men's Health Information & Research Centre, available from: [http://www.westernsydney.edu.au/mhirc/mens\\_health\\_information\\_and\\_resource\\_centre](http://www.westernsydney.edu.au/mhirc/mens_health_information_and_resource_centre)
- 
- (2) Australian Bureau of Statistics (2009) Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021. Canberra: Australian Bureau of Statistics
- 
- (3) Australian Indigenous Health InfoNet , Review of Indigenous Male Health, <http://www.healthinfonet.ecu.edu.au/population-groups/men/reviews/our-review> updated 2010, accessed 16/10/2012
- 
- (4) MHIRC Publications: Pathways to Despair: the social determinants of male suicide (2011). Available from: [http://www.westernsydney.edu.au/mhirc/mens\\_health\\_information\\_and\\_resource\\_centre/publications#pathways](http://www.westernsydney.edu.au/mhirc/mens_health_information_and_resource_centre/publications#pathways)
- 
- (5) Central Coast Suicide Safety Network <http://www.suicidesafetynetwork.com.au/> accessed 3rd December, 2012)
- 
- (6) Australian Bureau of Statistics. Available from: <http://www.abs.gov.au/ausstats/abs@.nsf/Products/7BC79569347A65D5CA2579C6001B6475?opendocument> (3rd Dec 2012)
- 
- (7) Conrad, P, (1992). Medicalization and Social Control. *Annu. Rev. Sociol.* 18:209-32
- 
- (8) M5project: Understanding Men's Health. Available from: <http://www.m5project.com.au/menshealth>
- 
- (9) Macdonald, J. (2005), *Environments for Health*, Earthscan, London.
- 
- (10) Australian National Male Health Policy, available from: <http://www.health.gov.au/malehealthpolicy>
- 
- (11) Kposowa, A.J. (2001). Unemployment and suicide: a cohort analysis of social factors predicting suicide in the US National Longitudinal Mortality Study. *Psychological Medicine.* 31, 127-138.
- 
- (12) Marmot, M. (1999). Job insecurity in a broader social and health context. WHO Regional Publications. European Series. 81, 1 – 9.
- 
- (13) Bottomly, J., Dalziel, E. & Neith, M. (2002). *Work Factors in Suicide*. Creative Ministries Network. East Victoria. Available from: [www.cmn.unitingcare.org.au/pdf/WorkFactorsinSuicide.pdf](http://www.cmn.unitingcare.org.au/pdf/WorkFactorsinSuicide.pdf)
- 
- (14) Macdonald, J. (2000). *Primary Health Care: medicine in its place*. Earthscan. London.



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