

BECAUSE MENTAL HEALTH MATTERS

Consultation on a New Focus for Mental Health And Wellbeing in Victoria



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Introduction

Women's Health Victoria is a statewide women's health promotion, information and advocacy service. We are a non government organisation with most of our funding coming from various parts of the Victorian Department of Human Services. We work with health professionals and policy makers to influence and inform health policy and service delivery for women.

The work of Women's Health Victoria is underpinned by a social model of health. We are committed to reducing inequities in health which arise from the social, economic and environmental determinants of health. These determinants are experienced differently by women and men. By incorporating a gendered approach to health promotion work that focuses on women, interventions to reduce inequality and improve health outcomes will be more effective and equitable.

Women's Health Victoria's vision is for a society in which there is an accepted approach to health that is empowering and respectful of women and girls; one that recognises the importance of gender in determining health outcomes and utilises a sound gender analysis in policy making and in health and community service design.

We work toward achieving this vision by incorporating the principles of integrated health promotion. This is implemented by:

- Having a strong focus on working in partnership with other organisations and opinion leaders. We use credible tools to determine and strategically plan for the creation of new partnerships and the development of existing ones.
- Using a mix of health promotion interventions that are focused at the population level to achieve our vision – a significant amount of our activity is spread across evidence-based health information provision, policy support, advocacy, social marketing and sector based capacity building.
- Clearly defining our community of interest as individuals and organisations that work in areas which influence health outcomes. Our community of interest includes but is not limited to health promotion practitioners, service and information providers, policy and opinion leaders, and researchers and educators.

Submission

Gender and Mental Health

Women's Health Victoria (WHV) welcomes the opportunity to respond to the Department of Human Services (DHS) *Because Mental Health Matters* consultation paper. WHV believe that the development of a new focus for mental health and wellbeing in Victoria is essential, and congratulates the Department on the progress on this.

The overarching premise of the consultation paper is very positive and WHV strongly supports a new, more inclusive mental health strategy that more accurately reflects the needs of those who come into contact with the system. However, as a health promotion organisation committed to the translation of women's health evidence into policy and practice, we are very concerned by the lack of gender responsiveness of the proposed strategy. On reading the consultation paper, it would appear that there are no gender issues in mental health and wellbeing. The evidence clearly does not support this view.

Mental health does not exist in isolation. Good or poor mental health is determined by multiple and interacting social, psychological and biological factors, just as health and illness in general are. The clearest evidence for this relates to the risk of mental illness, which is associated with indicators of poverty, low levels of education, poor housing and social exclusion¹. The greater vulnerability of disadvantaged people to mental illness may be explained by such factors as the experience of insecurity and hopelessness, rapid social change and the risks of violence and physical ill health².

The World Health Organisation (WHO) has identified gender as a determinant of health³. They note that the mental health disorders of childhood tend to be more common in boys than girls, but that as they get older, women are more likely to suffer poorer mental health, particularly depression, than men⁴.

In Australia, one in four women and one in six men will experience depression at some stage in their life⁵. Depression is *the* major health problem for Australian women and is frequently accompanied by other psychological problems such as anxiety disorders and post-traumatic stress disorder⁶. Anxiety and depression account for 18.1% of the total non fatal burden for Australian women's health and these conditions create a much more significant burden of disease for women than for men⁷.

Table 1: Sex differences in the prevalence of mental disorders across different life stages⁸

Life-cycle stage	Mental disorder	Male: female difference
Childhood	Pervasive developmental disorder Attention deficient hyperactivity disorder (ADHD) Conduct disorders Learning disability	Males >> Females Males >> Females Males >> Females Males >> Females
Adolescence	Depression Deliberate self-harm Eating disorders Substance abuse	Females >> Males Females > Males Females >> Males Males >> Females
Adulthood	Depression and anxiety Schizophrenia Bipolar disorder Substance abuse	Females > Males Males = Females Males = Females Males >> Females
Old age	Dementias Depression Psychoses	Females > Males ^a Females > Males Females >> Males

> Prevalence is approximately two to threefold greater

>> Greater than a threefold difference in prevalence

^a The difference in old age is likely to be due to the greater longevity of women

According to the Australian Bureau of Statistics, a number of gender differences in mental health were identified during 2004-05:

- Females were more likely than males to report a long-term mental or behavioural problems (11.4% of females compared to 10% of males).
- Women were also more likely to report high/very high levels of psychological distress than men (15% compared to 10%).
- Females reported higher rates than males for mental or behavioural problems overall in each five-year age group, with the exception of those aged under 18 years and those aged over 75 years⁹.

Locally, the *Victorian Population Health Survey* reported that women, on average, experienced higher levels of anxiety, distress and worry than men. In fact, the proportion of women with a high psychological distress score was nearly double the proportion of men with high scores¹⁰.

Women are also more likely than men to experience more than one mental disorder, and to be exposed to concomitant risk factors¹¹. An example is that women living in reduced socio-economic conditions are more likely to be exposed to partner violence and to be living with men who have substance abuse problems. These multiple-risk factors are predictive of high rates of psychiatric co-morbidity. Gender inequalities in income and wealth are often the result of lower education levels, greater caring responsibilities, casual and part-time work, less access to superannuation, and separation and divorce¹².

Growing up female plays a powerful role in shaping women's vulnerability to mental disorders¹³. There is a complex inter-relationship between gender and social inequalities and social factors such as a power (or lack thereof) in personal, economic, social, professional and political relationships can play a role in mental health and wellbeing¹⁴. It is understood that many of the issues that affect women's physical health: poverty, inadequate nutrition, being subjected to violence and abuse, also contribute to their poor mental health¹⁵. Other

contributing factors include healthcare and education restrictions or limitations, sexual discrimination, exclusion from community participation, and unfair labour practices^{16,17}.

Given the intention of the proposed strategy to provide generational reform, targeting efforts to prevent poor mental health, intervene earlier, and provide a broad and inclusive system that builds on existing knowledge and expertise, it is essential that it is built around the gendered evidence.

Part A

1. Policy Contexts and Links

The consultation paper outlines a number of Victorian Government policies that provide the context for the proposed mental health strategy. In understanding the link between these and the proposed strategy, it is vital that the gender responsiveness of the existing policies is considered. There are a handful of gender-specific policies and frameworks which maintain a strong connection between the evidence of gendered experience of health and wellbeing and Government planning. These include the Department of Human Services *Women's Health and Wellbeing Strategy*, Office of Women's Policy *Women's Safety Strategy*, and *Leading with Victoria's Women* and the Department of Justice's *Better Pathways: An Integrated Response to Women's Offending and Re-offending*. However, there are many other policies that have a connection with the proposed mental health strategy and these have varying degrees of success in responding to the gendered evidence.

- In *A Fairer Victoria*¹⁸, \$180.3 million is pledged to support people with mental illness. Even in targeting those with particular needs such as mothers with a mental illness or people with dual diagnoses, there is no link with the community or social connectedness. While this is an area of significant need, there does not appear to be any connection between this and the commitment of \$84.6 million to strengthening communities and participation. The money for community strengthening is targeted at volunteering, neighbourhood renewal and community self-help programs. This is good and builds on knowledge from previous programs and activities. However, the mental illness and community strengthening funds appear in isolation of each other and neither is gender responsive. Of the 63 new initiatives for both metropolitan Melbourne and regional Victoria, only one specifically targets the needs of disadvantaged women.
- The Department of Human Services' 2006 *Care in Your Community*¹⁹ focuses on a person and family-centred approach to integrated health care. However, the directions do recognise that there is a need for a gendered approach to mental health. There is significant evidence to show that caring is a gendered issue²⁰.
- In 2007 the *Families where a Parent has a Mental Illness Strategy*²¹ was pledged \$2.4 million to assist with training maternal and child health nurses to identify and respond to women with postnatal depression. This is a positive initial step to addressing this complex issue.
- *Future Directions: An Action Agenda for Young Victorians*²² (2006) sets out the Victorian Government's plans to provide for young people, ensure their rights are respected and they have real opportunities to build lives. Of the 40 'actions' listed, only one of these makes reference to gender and that is in the context of responding more effectively to family violence.

- The *Victorian Drug Strategy 2006-09*²³ notes some gender differences in data on drug use and abuse but the strategy's framework and objectives do not match the evidence of significant gender differences²⁴.
- The *Victorian Alcohol Plan 2008-13*²⁵ recognises the complex and compounding impact alcohol has on the lives of Indigenous women and makes one mention of providing gender-appropriate interventions and programs. However, the plan as a whole fails to respond to the significant evidence of different gendered experiences, services use and treatment needs of women compared to men²⁶.
- Only one future initiative in the *Victorian State Disability Plan 2002-12*²⁷ is gender responsive. As part of ensuring that all people have access to high quality health and community services in their local communities, the initiative aims to improve access to health screening programs and specifically, sexual and reproductive health services for women with a disability. Outside of this initiative which is sex or biologically distinct, the remainder of the Plan is not responsive to gender differences.
- The *Cultural Diversity Plan for Victoria's Specialist Mental Health Services 2006-2010*²⁸ identifies gender as a factor to be considered with cultural diversity, but is otherwise not responsive to gender differences. Within its 'Mental health and ethnicity' subheading it lists refugees and asylum seekers, older Australians from non-English speaking backgrounds, young people and children, and people in rural areas as risk categories, but does not identify women as a separate risk group.

WHV acknowledges that this policy climate, which is predominantly gender-unresponsive, does not provide the most fertile ground for the development of an evidenced-based gender-sensitive new mental health strategy. However, for the new strategy to be effective, to invest wisely, and to reduce the economic and social burden of poor mental health, it is imperative that it responds to the gendered evidence.

2. Overarching Vision and Framework for Change

The overarching vision of the proposed mental health strategy makes clear the desire for all Victorians to have the opportunity to fully participate in their communities and live without stigma or discrimination. The consultation paper recognises the need to orient the system to deal with discrimination, recognising the impact it can have on mental health and wellbeing. This must include gender. Victoria has State (Victorian Charter of Human Rights and Responsibilities), Federal (Sex Discrimination Act) and International (Convention on the Elimination of all forms of Discrimination Against Women (CEDAW)) responsibilities to ensure that discrimination on the basis of gender is eliminated.

According to the Victorian Charter of Human Rights and Responsibilities²⁹, everyone is entitled to equal and effective protection against discrimination. As part of ensuring the new mental health strategy is compatible with the charter, the discrimination women experience arising from a lack of gender responsive policies or programs must be addressed. As a signatory of CEDAW, Australia is required to take "all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, for all women to a full range of high-quality and affordable health care"³⁰. In addition to the effectiveness of gender responsive policies, the Department has legal obligations to ensure that the new mental health strategy and associated policies are not discriminatory due to a failure to respond to the gendered evidence.

The guiding principles of the framework for change (pg 22) are sound and well considered, especially the focus on prevention, a population- based approach, equity and diversity, social inclusion, and evidence-based practice. They enable the development of a policy which responds to the community and sector as a whole while respecting diversity and individual needs. An evidence-based gendered response to these guiding principles will ensure women's and men's experiences of health and wellbeing are translated into appropriate planning and service delivery.

It seems a lost opportunity then that the remainder of the consultation paper does not adhere to this framework. This is a fundamental concern with the proposed strategy. A solid and well thought out framework is not applied consistently throughout the paper. Although some of the principles are referred to in different sections, they do not achieve the same status they should as guiding principles. One issue this inconsistency raises is the possible ease with which the guiding principles may be lost in translation from a consultation paper to strategy document to policy and implementation. The application of the framework needs to be strong and consistent.

It is also unclear why the proposed strategy framework is not more closely aligned with the VicHealth Mental Health Promotion Framework³¹. The VicHealth framework, which has been advanced by the World Health Organisation³², recognises the key social and economic determinants of mental health, identifies population groups, action areas and settings. The population groups include and expand on those in the proposed strategy and the settings for action cover the broad range of social services and activities identified in the consultation paper as venues through which to target Victorians experiencing particular disadvantage and vulnerability. While the framework for change in the consultation paper is solid and the focus areas and goals pick up on many of the elements of the VicHealth framework, what is offered in the consultation paper does not form a cohesive whole. This could be improved by amending the consultation paper framework to more closely reflect the well established and accepted VicHealth framework and to connect more clearly with the proposed focus areas and goals. This would not require huge change, would provide a stronger vehicle to drive the entire strategy, and the mid and long term outcomes could form part of the strategy evaluation.

Currently within mental health planning, there is a great emphasis on acute treatment and crisis intervention. WHV supports the planned whole-of-government approach to a new mental health and wellbeing strategy and believes a strong focus on evidence-based prevention and early intervention, as particular guiding principles, is much needed.

As earlier discussed, there are a wide range of social factors which influence the mental health and wellbeing of women and girls. An evidence-based prevention approach would seek to address these. The 'Early Intervention' principle outlined in the consultation paper aims to play a mediating role 'early in life, early in illness, early in episode'. This also needs to reflect the gender differences in help-seeking behaviour, engagement with the health system, types of treatment received, the impact of treatment on social and living arrangements and caring responsibilities. The guiding principle of 'Equity and Diversity' recognises the role of social and economic disadvantage on mental health and wellbeing. A proposed strategy needs to see this not only in terms of the disadvantage individuals face (and the gendered experience of this) but the need to manage resource allocation for mental health services and programs to achieve equity.

While we are strongly supportive of a prevention and early intervention approach that, in the long term, aims to reduce the dependence on the acute sector, it is unlikely that we will see these types of planned results for decades. The consultation paper does not discuss resource allocation and it is very important that this new focus on prevention and early

intervention does not come at the expense of funding to the acute sector whose demands currently remain high and regularly unmet.

3. Current Challenges: Vulnerable and Disadvantaged Victorians

WHV agrees with the current challenge identified in the consultation paper that too many vulnerable and disadvantaged Victorians do not receive the help they need. We also believe that much of the sector planning and service delivery currently give inadequate attention to specific populations at risk of poor mental health or for whom mental health issues have the greatest impact.

Population groups particularly targeted by the proposed strategy included children and young people, families, those with dual diagnoses, those with contact with the criminal justice system, Indigenous people and communities, those with co-existing disabilities and refugees. Working with these population groups in particular, offers opportunities for real and lasting change for some of our most disadvantaged citizens. In addition to focussing on these groups as a whole, we encourage the DHS to recognise the double and sometimes triple disadvantages women within these groups face and the impact this can have on their mental health and wellbeing.

The Australian Bureau of Statistics (ABS) states that adults living in the most socio-economically disadvantaged areas in Australia have a higher prevalence of mental or behavioural problems and psychological distress³³. Socio-economic factors, such as lower rates of pay, part-time and casual employment and unemployment that increase vulnerability to depression³⁴. The WHO agrees that depression is more common among those who are economically vulnerable or who are living in poverty, and states that this population is usually women and children³⁵.

4. People and systems: The context for informing change

Addressing Population Diversity

As part of addressing population diversity the consultation paper acknowledges that life events influence our understanding and experience of mental health and wellbeing and briefly mentions the role of gender in this. This recognition of gender as a determinant of mental health and wellbeing is excellent but unfortunately gendered experience and the need for an evidence-based gendered response to mental health issues is absent from the remainder of the document.

The lack of integration of gender across the paper is apparent in the reference to assisting older people as part of addressing population diversity (page 29). The paper notes the increasing pressure on the health system from an ageing population as well as risks of dementia, reactive depression and social isolation. The paper also recognises that those from culturally and linguistically diverse groups are often at even greater risk of poor mental health outcomes. However, it fails to consider the gender differences in the mental health and wellbeing of older people³⁶ and culturally and linguistically diverse groups^{37,38}.

The consultation paper recognises the need to consider population-based measures that consider not only health status at a given time but key determinants of mental health and wellbeing. This is important. However, we hope the paper itself is not an indication of the breadth of data which will be taken into account as, apart from limited Medicare Better Access MBS data, not data within the paper is sex disaggregated. For example, the information on services received as identified by the Boston Consulting Group (2006) report notes a significant gap in access to mental health services leading to high levels of disability

and social disadvantage. It is difficult to see how the proposed strategy will be evidence-based when a proportion of the evidence that disability and social disadvantage creates a higher burden for women than for men is absent.

Sex disaggregated data (female and male) is important as it is the beginning of understanding differences in gendered experience (social constructs of women's and men's lives). For example a recent study concluded that depressed women with a history of childhood sexual abuse constitute a subgroup of patients who may require tailored interventions to combat both depression recurrence and harmful and self-defeating coping strategies³⁹. Without sex-disaggregated data, a gender analysis of their health needs would not have been possible⁴⁰.

One way in which sex disaggregated data can be sourced to inform the development of the new mental health strategy is through WHV's "*The Index*" (www.theindex.org.au). This fully searchable online database provides a gateway to evidence-based health and wellbeing data on Victorian women and girls across a wide variety of indicators relevant to a social model of health. It includes predominately Victorian data and where possible, access to sex-disaggregated diversity data for a given indicator. The Index is used by those working in policy development, planning, research and service provision to consider women and gender, resulting in a more detailed picture of Victorian women's lives and better health outcomes. Recently launched by the Minister for Women's Affairs, The Index would be an invaluable tool in understanding gender differences in mental health and wellbeing and addressing population diversity.

In addition to utilising existing data, the development of a new mental health strategy provides an opportunity to identify gaps in current data collection. It also provides means through which both new and existing indicators can be sex-disaggregated to provide a clearer picture of how well the new strategy is meeting its targets. There is a significant role for DHS Public Health Branch as well as other government departments and non-government data collection points to assist in the collection, analysis and reporting on gendered data

Part B

Focus area 1: Prevention

Goal 1.1: Creating wider opportunities for promoting mental health in local communities.

WHV supports the areas identified in the consultation paper for potential expansion, especially increased efforts for families and within workplaces, and statewide whole-of-government efforts to prevent violence against women.

Within the listed initiatives to support systemic change, WHV welcomes support to expand the evidence-base through existing work such as the Victorian Child and Adolescent Monitoring System, the Victorian Population Health Survey, and The McCaughey Centre (VicHealth Centre for Mental Health Promotion and Community Wellbeing). WHV would welcome being included in work to expand the evidence base. Continuing to build the evidence is vital but this evidence must be comprehensive and that means providing gendered data. The named initiatives currently produce limited gendered data and therefore cannot be relied on to fully inform the Government's efforts toward a comprehensive evidence-based mental health strategy. Options to address this include:

- ensuring all existing data collection systems record sex disaggregated information

- all data publications report their data by sex
- all data publications include gender analysis of the data in the narrative
- newly established data collection systems (or existing ones under review) include questions that will assist in understanding the gendered nature of the issue being investigated.

In terms of a robust prevention strategy, WHV advocates for the adoption of the VicHealth framework for the promotion of mental health and wellbeing. This framework focuses on the three key determinants of mental health: Social inclusion, Freedom from discrimination and violence, and Economic participation. There are a number of elements within each of these key determinants.

Social inclusion	Freedom from discrimination & violence	Economic participation
<ul style="list-style-type: none"> • Supportive relationships • Involvement in group activities • Civic engagement 	<ul style="list-style-type: none"> • Valuing of diversity • Physical security • Self-determination and control of one's life 	<ul style="list-style-type: none"> • Work • Education • Housing • Money

Social inclusion

Social support networks help individuals find solutions to problems; they validate people's identity, direct them to helpful information and can comfort them when needed⁴¹. Numerous studies have identified a relationship between depression and lack of social networks, with women being more vulnerable than men to the effects of reduced social support⁴². Although causal pathways are not clear, one recent study highlighted the value of emotionally supportive relationships in reducing the risk of major depression in women significantly more so than in men⁴³. In other research women living with mental illness, specifically schizophrenia, reported needing more people in their lives, particularly friends. This has been reported in prior research where women were found to be more likely than men to turn to members of their social network for emotional support in times of difficulties⁴⁴.

Social isolation is a gendered issue. The social constructs of women's lives mean they often find themselves more socially isolated women live longer than men and therefore are more likely to be elderly and single; women's comparative lack of financial resources mean they are less likely to be able to socialise⁴⁵; single parents with primary responsibility for children are more likely to be women. On the other hand, women are more likely than men to have stronger networks on which they can call for assistance and support. Therefore there is a need to consider a gendered social inclusion response in the prevention of mental health issues.

Social inclusion programs have been administered by various branches of government for a number of years now and much has been learned in that time about how to engage specific at-risk and hard to reach populations. This knowledge can be translated into policies and programs to *prevent* poor mental health and those policies and programs will be most effective when they are designed to target women and men separately and together.

Freedom from discrimination and violence

Violence is linked to increased incidence of depression and women are more likely to be victims of violence than men⁴⁶. The greatest risk of violence for women comes from their male partners, with between 10-50% of women globally affected by domestic violence⁴⁷. Access Economics reported that domestic violence accounted for 2.8% of the total Australian female burden of disease in 2002-03⁴⁸.

A 2004 VicHealth study found that “intimate partner violence has wide ranging and persistent effects on women’s physical and mental health with the greatest disease burden (60%) associated with mental health problems including suicide, drug use and risky levels of smoking and alcohol consumption”⁴⁹. Sexual violence in youth is linked to adolescent depression, and sexual abuse as a child is significantly associated with depression in adult women⁵⁰. Rape will cause one in three women to experience depression, excessively use drugs or attempt suicide⁵¹.

One recent Australian study found that a history of domestic violence was associated with decreased psychological wellbeing in mid-aged women⁵². In addition to mental health issues and risk taking behaviour, women who have experienced violence either as children or adults are also at increased risk of:

- Chronic pain syndromes
- Psychosomatic disorders
- Physical injury
- Gastrointestinal disorders
- Irritable bowel syndrome
- A variety of reproductive health consequences⁵³

In terms of diversity and discrimination, Australian Indigenous communities are at particular risk of depression and other mental health issues as a result of discrimination and disadvantage. Aboriginal women have a cultural history of trauma and loss linked to the impact of colonisation and family removal. They continue to experience disadvantage, high levels of domestic violence and sexual abuse⁵⁴.

In a heterosexist society where discrimination exists against sexualities not conforming to opposite-sex rules of attraction and behaviour (heterosexuality), high rates of depression, anxiety, suicide attempt and suicide completion can be found in lesbian, gay, bisexual and transgender communities⁵⁵.

Women account for over two thirds of carers in Australia⁵⁶, and women carers from culturally and linguistically diverse backgrounds, particularly older women, may not be able to access support groups and services due to language barriers. As carers from culturally and linguistically diverse backgrounds face additional language and social barriers that other carers do not face, they tend to experience poor mental health problems and are more likely to suffer from depression than the average person⁵⁷.

Economic participation

Much has been written about mental health and economic participation and the consultation paper addresses each of the different elements to varying degrees (Work: pg 108-110; Education: pg 59; Housing: pg 65, 92-97; Money: pg108-110). However, these are scattered throughout the focus areas and goals and are not considered in terms of *prevention* of poor mental health nor the intersections between them.

The social context of women’s lives mean they tend to have less financial security than men due to reduced workforce participation, access to education, and the need to take time out of work in order to care for children and other family members. Although tertiary education has been successful in encouraging more women to enrol in bachelor degrees which is often a prerequisite for higher paying work, there is still a significant gap between men and women’s average total earnings. Furthermore, many women who do participate in the workforce encounter reduced job security through part-time and casual work. The reduced hours of

these types of positions can result in less accumulated superannuation and so fewer savings for retirement.

Current workplace structures make it difficult for many women to meet their work and family commitments. As a result, many women who are primary carers, are in a position where they are forced into part-time or casual employment which offers very little job security if any at all. Work places need to be structured in a way where employees can balance their family and work commitments. This will mean that women are not placed at a disadvantage due to their family responsibilities. If workplaces provided paid or unpaid parental leave as well as flexible working hours, job share⁵⁸ along with providing an option to work at home, these measures would alleviate some of the disadvantages women face and would enable more women to participate in the workforce.

The casualisation of the workforce has affected many women because they are predominantly casual or part-time workers. In 2002, 71% of part-time workers were female⁵⁹. Working part-time and casually may give women more flexibility enabling them to work and juggle family commitments by using child care services, working from home or by arranging partners to work alternate hours to accommodate for child caring responsibilities. However, sole parents, the majority of whom are women, are unable to make these arrangements as they are not earning enough money to afford child care services and may not have a substitute caregiver⁶⁰.

Given that economic participation is a key determinant of mental health and it crosses a number of government portfolios, it is suggested that a cross-departmental group is established to investigate ways in which the elements of economic participation could be addressed as part of the long-term goals for the new mental health strategy.

Goal 1.3: Reducing the risk factors for poor mental health associated with substance misuse.

There is ample evidence to show that women and men experience mental health differently, present with different types of disorders, and approach treatment differently^{61,62,63}. Gender is also an important variable when looking at personality dispositions and substance use⁶⁴. A Victorian study showed that, while young males and females appear to use cannabis in similar numbers⁶⁵, females who used cannabis on a daily basis were eight times more likely to suffer high levels of depression than non-users⁶⁶.

The statistics are alarmingly clear. In Australia anxiety disorders are the most common form of mental illness and are more common in females⁶⁷. About 17% of women aged 18-60 suffer from depression or anxiety or both. This rises to 44% for women with an alcohol or abuse disorder and to 55% for women with a diagnosis of illicit substance abuse or dependence⁶⁸.

Australian statistics also indicate that women are more likely than men to use medication to improve mental wellbeing⁶⁹. These figures complement international findings that suggest that men see the use of illicit drugs as an adventure while women use them to relieve stress⁷⁰.

Research also clearly shows that men and women use and abuse drugs differently, that the effects of drugs are different for women and men, and that some treatments are better for women than for men^{71,72}.

While substance abuse in men accounts for 33% of the mental health burden⁷³, there is significant flow-on effect for the women and children in these men's lives. Although women's use of illicit drugs is lower than men's, research has identified that the health impact can be greater for women⁷⁴. There has been evidence available to support this for a number of years⁷⁵.

Goal 1.4: Renewing Victoria's suicide prevention focus through a wider range of government programs.

Globally, approximately three men will suicide for every one woman. This pattern is fairly consistent across all age groups with the exception of advanced old age (> 75 years) where the male: female ratio is even higher⁷⁶. Although men will more often complete their suicide, women, especially those younger than 30 years of age, more often attempt suicide⁷⁷.

Suicide and attempted suicide rates are higher in women who have been the target of violence. Women who have experienced violence are five times more likely to attempt suicide than those who have not⁷⁸. Research suggests that the relationship between violence and depression is causal - depression and anxiety increase when violence is ongoing⁷⁹ and decreases significantly once women stop experiencing violence⁸⁰. Women are also hospitalised for self-harm (not suicide) more frequently than men⁸¹.

Plans to build a more systematic focus on mental health promotion with regard to suicide prevention and to intervene earlier for young people are two excellent approaches. In the formation of strategies to implement these ideas, it is vital that the Government take into account the differences in harm behaviour between women and men and how best to tailor prevention programs to address this.

Focus Area 2: Early intervention

General Comments

WHV supports the approach to intervene earlier to achieve better outcomes for children, young people and families. We are pleased to see attention given to young people in particularly vulnerable situations such as those in contact with child protection or youth justice, who experience violence or homelessness, who have substance abuse issues or have a mental health issue. As with adults, there are gender differences in children and young people in these situations. Any initiatives to support them must take this into account.

Goal 2.1: Strengthening capacity for early identification and intervention through universal services, including early childhood services and schools

WHV supports the early identification of risks for social and emotional problems and mental health issues for both children and their mothers. Intervening early is a personally, socially and economically cost-effective way to reduce the burden of future mental health issues. We believe that the identification of abuse forms part of the early risk assessment and monitoring. It is estimated that around 50-55% of women with mental health problems or disorders are victims of child sexual abuse⁸².

We agree that maternity services offer an opportunity for early identification of mothers who may have mental health issues. Studies show that 17% of women giving birth in any year are likely to have postnatal depression, 10% antenatal depression, 0.2% will have postnatal psychosis and that 10% of male partners of women giving birth may also have postnatal depression. Women who experience perinatal mental illness are at increased risk of long term mental and physical illnesses and therefore being long term users of the mental health

and health systems and it makes sense to utilise existing maternity services in an attempt to intervene early and provide them with the support they need.

In their submission to the Federal Government's inquiry into mental health services in Australia, the Post and Antenatal Depression Association of Victoria (PANDA) reported that many women calling the PANDA helpline admit to supplying deliberately false positive answers to a self-report scale used by health professionals working with mothers in the first postnatal year, for fear of being seen as bad mothers, insane, or that their child/ren will be placed in protective care. This highlights both the stigma that can attach to mental illness and the need to ensure effective support is provided to women who feel they are experiencing, or at risk of, postnatal depression. Children whose parents have untreated perinatal mental illness may go on to demonstrate learning and developmental difficulties, hyperactivity disorders, mental illness and adult criminal behaviour⁸³.

It is suggested that in building a comprehensive system of prevention, early detection and care around postnatal depression, consideration be given to new social marketing and health promotion campaigns to help reduce the stigma associated with this condition.

In providing support to families, WHV recognises that all family members have a role to play, including both parents. It is important however to note that 42% of Australian children will spend at least some part of their childhood in a single parent family and that most single parents are mothers, with 8.5 out of 10 children living with their mother after parental separation. Single parent families experience three times the exposure to physical or threatened violence compared to the general population average⁸⁴, and violence is a well known predictor of future mental health issues. Intervening early to support mothers, particularly those at risk of violence, will have long term benefits for children. One approach may be to expand the professional training to identify women at risk of, or in, violent relationships to health workers such as maternal and child health nurses.

We congratulate the Victorian Government for its support of the Centre for Women's Mental Health at the Royal Women's Hospital. This centre will be a driving force for evidence of mental health issues for all women, not just mothers, and will make a vital contribution to the sector.

Goal 2.4: Building stronger, more resilient families where there is risk related to mental health problems or a combined mental health and drug and alcohol problem

WHV supports the expansion and broadening of the *Families where a parent has a mental illness Strategy* to include, among other new initiatives, parents with drug and alcohol issues.

As noted above, early intervention for children and young people often means addressing the needs of their parents. One Australian study that looked at the range of treatment services available to women with alcohol and drug problems noted that half of the women presenting for treatment were mothers and almost a third of these had children who had been removed from their care⁸⁵. Women wishing to seek treatment may be hampered by a lack of childcare⁸⁶, unsupportive or abusive partners, and/or a fear of having their children removed^{87,88}. These barriers are less likely to affect men in the same way as intimate partner violence and primacy of caring responsibilities are more often experienced by women. It is fair to expect that these barriers are even greater for women with mental health issues. In fact, it has been reported that many women who have experienced abuse and who utilise mental health services are seriously disadvantaged in their role as parents⁸⁹.

Enabling situations where women hide their mental health drug or alcohol problems is not appropriate for the woman or her family and it would seem appropriate to attempt to reduce

the stigma around disclosure of these issues as part of the new mental health strategy. However, this is a complex issue as if the mental health or drug or alcohol use puts dependents at risk, then a woman's fears of having her children taken away may be well founded. Options for consideration may be establishment of more in-patient treatment facilities that allow the woman's children to stay with her or greater access to intensive and supported out-patient treatment.

Focus Area 3: Access

General Comments

The goal of providing access to the right services at the right time is a worthy one. However, the consultation paper lacks any real detail on how initiatives will be resourced. A major concern of the current acute system is that it is significantly under resourced. WHV questions how much extra will be asked of the current system or what will be asked of a new system that is different. Will extra funds be allocated or will the sector be expected to manage change including the necessary capacity building within current allocation.

Goal 3.1: Providing access to 'right time, right place' mental health care by making it easier for people to obtain mental health information, referral and advice

As identified in the consultation paper, women outnumber men two to one with 25 to 44 year old women the greatest beneficiaries of the new Medicare Benefits Schedule (MBS) that focuses primarily on three new MBS Items that provide greater access to psychiatrists, psychologists and General Practitioners (GPs) who develop mental health plans and referrals. This is perhaps not surprising when you consider that women have the "highest levels of high prevalence mental health disorders such as depression and anxiety"⁹⁰.

However, in a submission to the Federal Government Inquiry into Mental Health Services in Australia, the Women's Centre for Health Matters reported that "anecdotal evidence is that the most marginalised women with mental health issues (such as those who are living in poverty or who have drug and alcohol addictions) are not benefiting from the [new Medicare] scheme. For example, the Management Plan has opened up counselling for people who could not pay before; however as bulk billing is rare, there is still a gap to pay - which means that for many women this is still out of reach". Although the new Medicare scheme is helping to provide the right service at the right time for many, further investigation is needed to ensure these support services can be accessed by all, including the most vulnerable in our communities. Geographic maldistribution of services will continue unless providers are attached to a public health facility such a Community Health Services.

A recent Victorian literature review identified large gaps in the availability of mental health services for rural women in particular⁹¹. This research pointed to the need for improvements in women's mental health awareness and training for General Practitioners. In a large national survey rural women reported that access to mental health counselling services were often unsuitable or non existent in their area. Where services are available, women faced long waits to see mental health professionals and concerns about their confidentiality⁹².

The Australian Longitudinal Study of Women's Health found that women with mental health problems are generally high users of health services such as General Practitioners and specialists and other services. However those who experience depression often fail to seek help for the condition and busy medical professionals may not recognise the signs of their distress. A failure to seek and/ or obtain help can feed into a cycle of worsening depression, social isolation and other ill health⁹³.

This same study found that women who did seek professional help, usually from their General Practitioner:

- Didn't expect it to be useful
- Attributed any improvements to family supports or their own resources
- Were positive about General Practitioners who listened and understood
- Had very negative attitudes to medication and saw it as covering up the problem⁹⁴

So it seems that women often encounter barriers to seeking help including a lack of appropriate services, costs, distance, and privacy. When services are available, they may or may not seek help. Further investigation is required to fully understand how best to address this.

Goal 3.3: Creating an integrated emergency service system that can respond effectively to people experiencing a psychiatric crisis

WHV supports a program of resourcing dedicated emergency departments with the capacity to deal with the mental health needs of the community. Although the consultation report does not suggest the establishment of dedicated inpatient units, work undertaken to build the capacity of emergency departments should align with the recommendations in the recent Department of Human Services final report on gender sensitivity and safety in adult acute inpatient units project⁹⁵. WHV also supports the view of the Victorian Women and Mental Health Network that existing local services should be more gender-sensitive. This can be achieved through sex separated sleeping areas divided by a nurses station, support for vulnerable patients, clear guidelines for patients regarding acceptable behaviour, clear policies for staff in responding to sexual behaviour, and training and debriefing for staff⁹⁶. Another concern for WHV is pregnant women who are experiencing mental illness and feel particularly vulnerable to violence while recovering as inpatients in mental health facilities.

Focus Area 4: Specialist Care

General Comments

WHV supports the building of a more proactive system of specialist community-based mental health care that is geared to early intervention, relapse prevention and recovery. It is important to support people to remain in the community wherever possible and this is especially important for those with caring responsibilities, the majority of whom are women⁹⁷.

Goal 4.1: Building a more proactive system of specialist community-based mental health care that is geared to early intervention, relapse prevention and recovery.

Addressing key service gaps- eating disorders

As part of addressing service gaps, there is a strong focus in the consultation paper on eating disorders. We acknowledge that this is an important area of work and one that is still not fully understood. The work undertaken in 2006 to map eating disorders service provision was very good. However, it is not the only specialist care need that offers patchy service provision and the focus on eating disorders in the consultation paper gives this priority out of context to other areas. It is interesting to note that the lack of agreement about the etiology of eating disorders makes it an ideal initiative for inclusion in the prevention component of the proposed mental health strategy, yet it is lacking from this section.

Goal 4.3: Improving consumer and carer experiences, making sure that expectations with regard to access, rights, equity and respect are met.

WHV supports the plan to strengthen consumer participation in mental health service development and decision making. Building the capacity of consumers and carers to be effective advocates is critical to this. We suggest that organisations such as The Health Issues Centre might be a good vehicle to assist in advancing these initiatives. Further, plans to strengthen Indigenous and culturally and linguistically diverse (CALD) cultural sensitivity

training should be extended to gender sensitivity for all mental health and allied workers, including emergency services.

Plans outlined in the consultation paper to engage consumers actively in their treatment and care, especially advanced care plans that can assist people to make contingency plans for times when they are unwell is a very positive approach. It is envisaged this will be especially helpful for women with mental health issues who also have caring responsibilities.

Women are predominantly the primary care providers of young children, the elderly, disabled⁹⁸ and mentally ill⁹⁹ family members and spouses. In 1998, AIHW reported that females accounted for 70% of the primary carers population¹⁰⁰. This is expected to continue as a recent study found that within three decades, people aged over 65 will constitute over 50% of the total number of voluntary carers in society and of that number, two thirds of them will be women¹⁰¹.

Whilst men carers tend to access services such as home help, nurses or residential services, women tend to under-utilise these services or not use them at all. This can perhaps be attributed to the societal expectation that women should take on and accept caring responsibilities due to their 'nurturing' nature. As a consequence, women may experience disapproval from society if resistance to the role of caring is shown or if they show that they are unable to cope¹⁰². In aiming to improve carer experiences, the proposed mental health strategy needs to reflect the gender differences in service and support use.

A report by Carers Association of Australia found that while care giving can have positive impacts, "carers are being harmed physically, mentally, psychologically, and socially by their caring responsibilities"¹⁰³. More than 85% of the carers surveyed in this study had been caring for a period of three to ten years. Of the carers surveyed 46% indicated that their overall health and wellbeing was not favourable and it was likely to be worse the longer they had been caring and many indicated that their emotional health had been adversely affected as a result of caring. Caring responsibilities created a barrier for up to 30% of women in terms of neglecting their own health or seeking medical advice¹⁰⁴.

In another study, most women carers felt they received little support from the health care system. As a result of the stress and restrictions on women's employment, social and leisure choices, women suffer emotionally, physically and financially. Many of these women are combining care giving with paid work and managing a household and therefore, their ability to cope comes at a personal cost¹⁰⁵.

Without appropriate support, carers can become consumers too. Many carers have commented on their emotional wellbeing and expressed that they experienced sadness, depression and anxiety¹⁰⁶. More than half of the sample said that these emotional states occurred because of "the stress of caring, social isolation, loneliness, changing of relationships, loss and grief." Some carers also commented that poor physical health and not being able to continue in paid work were other factors that contributed to their emotional health¹⁰⁷. A carer's mental health may vary in degree depending on the type of support networks they have in spheres such as family, society and community.

A new mental health strategy that is consumer and carer sensitive and aims to empower carers could establish carer driven advisory committees to ensure ongoing and high level input into service development, planning and care.

Focus Area 5: Complex Clients

Goal 5.2: Improving access to stable and affordable housing, together with appropriate and scaled support to reduce homelessness and sustain ten

WHV supports initiatives to prevent homelessness, help people find pathways out of homelessness and supporting people with mental illness when they are homeless. We call on the proposed mental health strategy to consider the gender differences in housing stress and homelessness, understanding the impact this can have on mental health and wellbeing.

Access to safe, stable and affordable housing is critical for women's ability to participate in work, access local service health services and other amenities. Research suggests that high rise, multi-dwelling units can impact negatively on mental health and well being, especially for mothers and young children, as they can contribute to social isolation, lack play space for engagement with others and are often carry a social stigma of living in high-rise accommodation¹⁰⁸.

Women are particularly vulnerable to homelessness as a result of relationship breakdown and family violence. Two groups are at particular risk of homelessness after the loss of a partner. They are women with children who remain in the family home and widows (typically women) because they suffer an abrupt fall in income. Evidence indicates that divorce and separation are a major source of disruption to home ownership¹⁰⁹.

Women have been identified as one of the most vulnerable groups within society in terms of security of housing and it is not envisaged that this will change in the foreseeable future¹¹⁰. In improving access to stable and affordable housing, gender differences must be taken into account. For example, emergency accommodation must provide space for women to remain with their children; women with children who are at risk of homelessness should be given priority for beds as their housing situation will have impacts on more than just themselves; women, especially mothers, with mental health issues should be assisted to secure tenured housing as evidence shows the positive long term impact on economic participation and social inclusion from stable housing.

Goal 5.3: Focusing on the needs of people from particular vulnerable and disadvantaged groups

WHV endorses a focus on specific groups who a experience high level of disadvantage including people experiencing a concomitant mental health and substance misuse problem (dual diagnoses); adults and young people with mental health problems and other complex needs engaged in the criminal justice system, Indigenous people, their families and communities; people with a mental illness and co-existing disability; and refugees with mental health problems, particularly survivors of torture. We ask that particular attention is given to women within these groups who are often even more vulnerable as a result of the social construct of their lives.

The Better Pathways Strategy¹¹¹ is an excellent example of how government can focus on the gendered aspect of a particular disadvantaged group. In the case of Better Pathways, the Department of Justice undertook research to understand the complex issues involved in women's offending and reoffending. The subsequent policy strategy acknowledged that by responding to women's particular needs, characteristics and life experiences, they would be more effective in reducing women's offending and reoffending.

There is also significant evidence regarding women prisoners and mental health issues. A New South Wales study found that female prisoners have a higher prevalence of psychiatric disorder than male prisoners¹¹². Approximately 90% of female reception prisoners had experienced a mental disorder in the 12 months before their incarceration compared with

78% of male prisoners. Among sentenced prisoners the relevant figures were 61 percent for men and 79 percent for women. The same study found that substance use disorders were more common among females than males in both newly admitted (75% female vs. 64% male) and already sentenced groups (57% female vs. 34% male).

As well as existing mental health issues, prior detention and abuse is common for women prisoners. Sisters Inside records show that over 50% of women in prison had been placed in care as children and approximately one quarter had been imprisoned in a juvenile detention centre. Prior to incarceration, 98% of women prisoners had experienced physical abuse and 89% had experienced sexual abuse¹¹³.

The Dame Phyllis Frost Centre and Tarrengower are the women's prisons in Victoria. Implementation of the Women's Service Standards and Better Pathways has led to new mental health services for women prisoners in these facilities over the past 2 years. These services should be evaluated. Referral pathways post release require focus. Given the high rates of mental health issues for women prisoners, and a genuine concern to focus on the needs of people from particular vulnerable and disadvantaged groups including those in contact with the criminal justice system, incarceration is an opportunity for intensive assistance. The Government is congratulated for responding to this evidence and providing appropriate services for women in and post prison.

Focus Area 6: Workforce

General Comments

Investment in research and education, health promotion and case management or shared care of clients with complex needs requires massive workforce capacity building. WHV supports initiatives that retain and upskill existing workers. It is important that competent and experienced workers are not lost from the system as their knowledge will take decades to replace. Systematically improving the capability of the broader health and community services workforces through education and training could include mental health first aid courses for health and community services workforce.

The consultation paper recognises that Victoria is currently heavily reliant on overseas medical graduates in mental health services. It notes that international recruitment will continue to play an important role to address mental health skills needs that cannot be met locally. WHV is concerned to ensure that overseas trained medical professionals receive appropriate cultural orientation, training and support. Individuals with mental health issues are already vulnerable and medical professionals who find cultural differences a barrier to providing the services their patients need will further exacerbate these problems. In addition, overseas trained medical professionals are often sent to rural and regional areas of the state where problems can be compounded by the social isolation experienced by both the medical professionals and patients.

Focus Area 7: Partnerships

Goal 7.1: Designating local area partnerships to drive population-based service planning and coordination across the continuum of mental health

With the future of mental health services so dependent on collaboration, it is critical that partnership governance is sound. The consultation paper proposal to use Primary Care Partnerships as the base for future service rollout is a flawed one as the major players or those you would have in a consortium are not necessarily in the current configuration of Primary Care Partnerships. A collaborative mental health consortium should include housing, welfare, vocational return to work programs and linkages to Commonwealth systems. Rather

than the current Primary Care Partnerships model, better models may be Headspace or the Mental Health Integration Project out of the United Kingdom. Regardless of which collaborative model is adopted, it must have an evaluation phase built in.

Goal 7.3: Embedding accountability for outcomes associated with mental health into funding and reporting systems at all levels, including general health and social support services.

In terms of embedding accountability, WHV believes all services (whether public or private) in receipt of government funding should be required to implement gender responsive services. An excellent model for this approach is the introduction of a 'Gender Equality Duty' in the United Kingdom in 2007 as an amendment to the Equality Act¹¹⁴. The amended Act places a statutory duty on all public authorities, including National Health Service (NHS) organisations to create and implement a *Gender Equality Scheme* (GES), which 'has due regard' for the following:

- 'eliminate unlawful discrimination and harassment that is unlawful...and in relation to employment and vocational training (including further and higher education), eliminate discrimination and harassment against transsexual individuals
- 'eliminate discrimination that is unlawful under the Equal Pay Act 1970...'
- 'promote equality of opportunity between men and women'

Each funded organisation is responsible for researching, planning, implementing, publishing and reviewing their GES. Failure to do so is a legal offence. Organisations have a 3 year period in which to research and plan their GES ready for implementation. Accompanying supportive documentation has been developed to assist organisations comply with the new requirements. For further information see:

<http://www.nhsemployers.org/excellence/excellence-403.cfm>

WHV supports the application of an overarching framework and refers to the earlier discussion about the VicHealth Mental Health Promotion Framework¹¹⁵. However, as identified in the VicHealth framework, there are distinct mid and long term outcomes that measure the wellness of service users and how this is reflected in a broader society. This is a quite different approach to outcome measures based on service delivery such as bed days. WHV believes that Victorians would benefit from a framework with both types of outcome measures and strongly endorses those outlined in the VicHealth framework:

Intermediate Outcomes		
Individual	Organisation & Community	Societal
Increased sense of: <ul style="list-style-type: none"> • Belonging • Self-esteem • Self-determination & control 	<ul style="list-style-type: none"> • Accessible and responsive organisations • Safe, supportive & inclusive environments 	<ul style="list-style-type: none"> • Integrated & supportive public policy & programs • Strong legislative platform • Resource allocation
Long-term Benefits		
<ul style="list-style-type: none"> • Less anxiety & depression 	<ul style="list-style-type: none"> • Improved productivity at work, home & school 	<ul style="list-style-type: none"> • Reduced health inequalities

<ul style="list-style-type: none"> • Less substance misuse • Improved physical health 	<ul style="list-style-type: none"> • Less violence & crime 	<ul style="list-style-type: none"> • Improved quality of life & life expectancy
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Goal 7.4: Creating an organised statewide research and knowledge management capacity to provide a robust evidence-base on mental health interventions

WHV agrees with the need for a strategic approach to research and for systemic evaluation and knowledge dissemination. However, this needs to incorporate gender and advance our understanding of the gender differences in mental health and wellbeing. Similarly, we support the Collaborative Centre for Mental Health Intervention on the condition that all of its research is gendered.

This is important as evidence suggests a gender bias in mental health research, and that women have been excluded from research studies. Furthermore, “investigators often neglect gender as a variable interpreting their results”¹¹⁶. We support the gaps in research on the mental health needs of women identified by the Royal Women’s Hospital. These included:

- Prevalence, risk factors and clinical course of specific disorders
- Response to the range of treatment interventions
- The link between social capital and mental health
- Gender differences in mental health help seeking behaviour
- Interaction between gender and other diversity lenses in mental health and wellbeing
- Gender appropriateness of current research tools
- Effectiveness of women-specific mental health care services; and
- Further research into women-specific mental health issues.

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