Women's Health Victoria's submission informing the Terms of Reference for the Victorian Royal Commission into Mental Health, January 2018.

Opening remarks

Women's Health Victoria (WHV) welcomes the Victorian Government's commitment to a Royal Commission into Mental Health. We congratulate the Government on the broad scope proposed and on the commitment to implement all recommendations.

WHV is a Victorian statewide women's health promotion, advocacy and support service. We collaborate with health professionals, researchers, policy makers, service providers and community organisations to influence and inform health policy and service delivery for women. WHV is committed to improving women's mental health, including through primary prevention, advocacy and awareness raising, capacity building and direct service delivery. We look forward to working with the Government both to inform the work of the Royal Commission, and to support the implementation of its recommendations.

In this submission, we outline some of the key issues WHV will be exploring in its more detailed submission to the Royal Commission after the Terms of Reference (TOR) have been finalised. We have also provided feedback specifically on the TOR, consistent with the structure of the online consultation survey. Finally, we have attached or provided links to a number of key materials (reports, research summaries and other evidence) which we think will be useful references for the Commission, and which demonstrate the importance of applying an intersectional gender lens across all aspects of mental health reform.

Centring the voices of those with lived experience

As you are aware, there has already been enormous community interest in the Royal Commission, particularly from women. According to *The Age,* as of the 16th of January 2019, 4500 submissions had already been received, 75 per cent of which have come from women. *The Age* also stated that 80% of those who had made submissions have themselves used mental health services in Victoria in the last 5 years or have someone close to them who has.

This level of engagement before the TOR have even been finalised is remarkable and indicates strong community interest in improving the way we deal with mental health in Victoria. It is likely that many of the submissions received by the Commission will contain recommendations for improvements based on personal experiences. While we understand the Commission intends to focus on identifying policy solutions to improve mental health, it is important that the experiences of those affected by mental illness in the past are also properly acknowledged and validated. Centring the experiences of people with lived experience of mental health problems from diverse backgrounds, including those who have used mental health services, will build confidence in the Royal Commission process as well as helping to design effective solutions. People with lived experience should be embedded at all levels of the Commission.

It will be important to ensure that the processes developed by the Royal Commission to hear or take evidence from people with lived experience are accessible and are carefully designed so as not to be retraumatising. A range of different mechanisms should be provided for people to give evidence (e.g. oral and written evidence, private hearings, surveys etc) and the Commission should hold hearings in rural and regional Victoria. WHV also recommends that, similar to the Royal Commission into Institutional Responses to Child Sexual Abuse, support should be provided for people with lived experience who wish to give evidence. We suggest that a range of support services who can meet the needs of particular population groups be resourced to provide this support. Given the particular needs and experiences of women, a support service with expertise in women's mental health should be resourced to support and coordinate consumer input from women, such as the Victorian Women's Mental Health Network.

Key issues for the Royal Commission's consideration

The gendered nature of mental health

There is extensive and compelling evidence that women's needs, experiences and outcomes in relation to mental health are influenced both by biological sex and by socially constructed gendered norms, practices and expectations. Mental disorders represent the leading cause of disability and the highest burden of non-fatal illnesses for women in Australia[1] and young women report the highest rates of mental disorder of any population group (30% for women aged 16 to 24).[2] There are also strong links between women's physical and mental health. Women are 1.6 times as likely as men to suffer coexisting mental and physical illness. These multimorbidities are associated with increased severity of mental illness and increased disability.[3] Other examples of the gendered experience of mental health include:

- **Depression and anxiety** rates among women and girls are high. A 2017 survey of over 10,000 Australian women found that 40% had been diagnosed with depression or anxiety.[4] Twice as many adolescent girls from rural areas report symptoms consistent with depression compared to their male counterparts.[5]
- In Australia, two in every five women (41%) have experienced **violence** since the age of 15 years. Around one in three (34%) has experienced physical violence - almost one in five (19%) has experienced sexual violence. The negative impacts of violence on women's health include poor mental health, in particular anxiety and depression, as well as problems during pregnancy and birth, alcohol and illicit drug use, suicide, injuries and homicide.[6]

[1] Investing in Women's Health (2016) Australia Public Health Policy Collaboration, Victoria University.
[2] Investing in Women's Health (2016) Australia Public Health Policy Collaboration, Victoria University.
[3] Investing in Women's Health (2016) Australia Public Health Policy Collaboration, Victoria University.
[4] Women's Health Survey 2017 (2017) Jean Hailes for Women's Health, Melbourne.
[5] Growing Up Unequal (2017) Women's Health Victoria
[6] Violence against Women in Australia: Research Summary (2017) VicHealth, Melbourne.

- Women are more likely to **self-harm** than men and are at risk of starting to self-harm from early adolescence.[7] 45% of Australian women aged 18-23 years have reported ever self-harming,[8] and rates among young women are rising in Australia and around the world.[9] Aboriginal and Torres Strait Islander women are hospitalised for self-harm at twice the rate of non-Aboriginal women and hospitalisation rates generally increase with level of disadvantage and degree of remoteness. Trans young people also have high rates of self-harm.[10]
- **Suicide** is often framed as a men's issue (reflecting that prevalence rates are higher for men). However, suicide research consistently demonstrates that women have higher rates of suicidal behaviour, and whereas young men's suicide rates have reduced since the late 1990s, young women's have not. The numbers of people who injure themselves without the intention of suicide and those who engage in non-fatal suicide behaviour cannot be separated within the existing data collection systems.[11]
- It is estimated that 20% of Australian women have experienced **postnatal depression**, that is, depression in the 12 months after birth.[12] While recognition of perinatal depression and anxiety has improved, many women still experience barriers to accessing services and supports.
- Young women report considerably higher concerns about **body image** than young men (41.1% compared with 17%).[13] Poor body image limits women's participation in physical activity[14] and women and girls with poor body image are more likely to have unsafe sex.[15]
- In Australia, it is more common for women to provide care (including for people with mental illness) and to have **caring responsibilities** involving greater time and intensity. In Victoria, 71% of all primary carers are women. The undervaluing of women's unpaid care work is linked to poorer health and wellbeing outcomes for carers and limits women's participation in the paid workforce.

As demonstrated by some of the examples above, **gender also intersects with other forms of inequality to negatively affect health outcomes**. For example, **women with disabilities** experience high levels of family and sexual violence and face additional barriers to seeking support and leaving abusive relationships[16] including ableism. Women with disabilities are less likely to be in paid employment than their male counterparts, are more vulnerable to living in insecure or inadequate housing and are more likely to live poverty.[17] They are over-represented in institutional

[7] Looking the other way: young people and self-harm (2016) Orygen,The National Centre of Excellence in Youth Mental Health, Melbourne.
[8] Holder C, Fitzgerald D (2016) ALSWH data book for first survey of 1989-95 cohort. Australian Longitudinal Study on Women's Health, Newcastle..
[9] Morgan C, et al (2017) Incidence, clinical management, and mortality risk following self-harm among children and adolescents: cohort study in primary care BMJ.
[10] Suicide and hospitalised self-harm in Australia Trends and analysis :Hospitalised intentional self-harm: 2010-11 (2014) Australian Institute of Health and Welfare, Canberra.
[11] Suicide and Suicidal Behaviour in Women – Issues and Prevention (2015) Suicide Prevention Australia, Sydney.
[12] Perinatal depression: data from the 2010 Australian National Infant Feeding Survey (2012) Australian Institute of Health and Welfare, Canberra.
[13] Mission Australia youth survey report 2016 (2016) Mission Australia, Sydney.
[14] Physical Activity and Sport Participation Campaign : insights report (2016) TNS Consultants for the Australian Government Department of Health.
[15] Body image and sexual functioning (2012). Weiderman, *In:* Encyclopedia of body image and human appearance. Vol 1.
[16] Voices Against Violence Paper One: Summary Report and Recommendations (2014) Woodlock, Healy and Geddes et. al, Melbourne.
[17] Assessing the situation of women with disabilities in Australia – a human rights approach (2011) Women with Disabilities Australia.

care and experience difficulties in accessing appropriate health services and treatment.[18] Forced sterilisation, contraception and menstrual suppression are also key issues facing women living with disabilities.[19]

Migrant and refugee women are less likely than Australian-born women to use preventative and primary health and social support services (and as such are overly represented in acute and crisis care) and less likely to have access to evidence-based and culturally relevant information to facilitate decision-making around their health.[20] Residency and visa status determines different health access entitlements, rendering the Australian health system difficult to navigate and can restrict access to health services for some visa-holders.[21]

The number of **incarcerated women** in Australia has increased by 50% in the past five years (compared with 37% for men),[22] and Aboriginal and Torres Strait Islander women are 21.2 times more likely to be incarcerated than non-Aboriginal women.[23] Compared to male offenders, female offenders are 1.7 times more likely to have a mental illness,[24] more likely to have an acquired brain injury,[25] and more likely to have minimal employment histories, unstable housing and be the primary carer for children.[26] Prior to incarceration, these women have often experienced sexual assault and/or intimate partner violence.[27]

These significant inequities in mental health outcomes demonstrate the need for an intersectional gendered approach to mental health – from primary prevention, through to early intervention, treatment and recovery.

Evidence also suggests that the needs and experiences of women have often not been considered in mental health policy or service design, or that they have been considered of secondary importance. For example, a 2018 report from the Mental Health Complaints Commissioner found that 80 per cent of concerns about sexual safety in acute mental health inpatient units were about women's experiences. Women consistently reported feeling unsafe in a mixed-gender acute inpatient environment, with particular fears about being placed in intensive care areas (ICAs – also called high dependency units). The complaints analysis identified ICAs as the area where 'sexual safety breaches' (defined by the Mental Health Complaints Commission as experiences in which a person does not feel or is not sexually safe, including sexual assaults and sexual harassment) were most often reported. Men were identified as individual perpetrators in 83 per cent of complaints, and as having participated in a further 7 per cent of 'sexual safety breaches'. The most common pattern of alleged 'sexual safety breaches' involved men breaching the sexual safety of women.[28] Despite consistent calls for **women-only inpatient wards** and international evidence that this is the most

[18] Submission to the National Human Rights Consultation (2009) Women with Disabilities Australia, Tasmania.
[19] Sterilisation of Girls with Disability: The State Responsibility to Protect Human Rights (2018) Women with Disabilities Australia (WWDA): Hobart, Tasmania.
[20] Sexual and Reproductive Health Data Report June 2016 (2016) Multicultural Centre for Women's Health, Collingwood.. .
[21] Women's Health Map: Assisting Immigrant and Refugee women to Navigate the Australian Health System, Peer Education Resource for Community Workers (2015) Multicultural Centre for Women's Health: Melbourne.
[22] Corrective Services, Australia, September quarter 2018 (2018) Australian Bureau of Statistics.
[23] Pathways to Justice–Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples (ALRC Report 133),(2017) Australian Law Reform Commission.
[24] Victorian Ombudsman Investigation into the rehabilitation and reintegration of prisoners in Victoria (2015) Office of the Victorian Ombudsman, Melbourne.
[25] Acquired brain injury in the Victorian prison system Victoria. (2011) Corrections Victoria, Department of Justice, Melbourne.
[26] Addressing women's victimisation histories in custodial settings (2012) Australian Institute of Family Studies, Melbourne. Prior to incarceration, these women have often experienced sexual assault, intimate partner violence.
[27] The forgotten victims: prisoner experience of victimisation and engagement with the criminal justice system: key findings and future directions (2018) ANROWS, Melbourne.
[28] The Right to be Safe: Summary Report (2018) Mental Health Complaints Commissioner, Melbourne.

effective strategy for improving women's sexual safety in inpatient facilities, these are not routinely provided Victoria. This demonstrates a lack of understanding and/or prioritisation of women's needs and experiences.

Mainstreaming a gender-sensitive approach to mental health policy and service provision – from primary prevention/ mental health promotion, through to early intervention, treatment (including both community and acute mental health services) and recovery will help to address these inequalities. This approach would also include gender sensitive strategies for men and boys (such as the continuation of Men's Sheds).

Mental health across the life course

WHV also recommends that the Commission take a **life course approach** to addressing mental health, recognising that different drivers of poor mental health, mental health conditions and barriers to accessing support affect different age cohorts. For example, young women are more likely to experience relationship violence and sexual harassment in the workplace than other age groups, and post-natal depression affects women of reproductive age. Poor body image affects women of all ages but is most likely to begin in adolescence. A life course approach should also recognise that investing in improving the mental health and resilience in young people through health promotion and primary prevention is likely to translate into a reduction in poor mental health outcomes later in life. Research, evaluation and data collection should also be considered within the TOR, including longitudinal research to strengthen the evidence base in relation to effective health promotion and early intervention.

A strong focus on primary prevention

Our submission to the Royal Commission will be advocating for an intersectional gender lens to be applied from prevention and early intervention through to treatment and recovery.

In particular, there is a need for a stronger focus on primary prevention/ health promotion at a whole-of-population level. Such work should both be informed by and inform best practice and the evolving evidence base and should include universal stratgeis as well as message tailored for different groups (for example non-English speakers). Effective health promotion saves costs for government by reducing the need for acute and crisis support. The approach taken to the primary prevention of family violence and all forms of violence against women in Victoria offers a useful example of the application of the public health approach to prevention. Its key features are:[29]

- A focus on addressing the 'drivers' of poor mental health (these might include gendered violence, trauma, poor body image and homelessness among others);
- An intersectional whole-of-population focus, supplemented by tailored approaches for specific population groups;
- Use of the socio-ecological model, which includes:

[29] Refer to Change the Story for an example of the application of this model in the PVAW space.

- Addressing the structural, as well as individual, drivers of poor mental health
- Mutually-reinforcing interventions across multiple settings where people live, work and play (such as schools, workplaces, sporting clubs etc)

In the case of primary prevention of family violence and all forms of violence against women, this approach has been supported by a dedicated government strategy (*Free from Violence*) and accompanied by investment (though limited), with activity coordinated by a central body or bodies.

Any primary prevention strategy for mental health must address the gendered drivers of poor mental health for women and men, and link to existing frameworks and strategies that are already seeking to address these drivers, including the national framework for primary prevention of violence against women, *Change the Story*, the Victorian primary prevention strategy, *Free from Violence*, and the Victorian gender equality strategy, *Safe and Strong*. These frameworks and strategies identify effective approaches for addressing the gendered norms, practices and structures that drive gendered violence and poor health outcomes for women and men. This is not to detract from the importance of early intervention, treatment and recovery:

- **Early intervention** – Mental health inequality between and men and women widen significantly during adolescence. Poor body image, experiences of sexual harassment, violence and trauma increase the likelihood of anxiety and depression among young women. Intervening early can provide young people with knowledge, skills and strategies to support better mental health. Early intervention also includes addressing the specific mental health needs of 'at risk' populations (such as incarcerated women, women experiencing violence, and women experiencing homelessness).
- **Treatment and recovery –** Mainstream mental health service providers (both in community and acute settings) should be resourced and supported (for example, through training and capacity-building) to provide gender-sensitive services and support. This includes the provision of single sex inpatient wards (with support/flexibility/options for gender non-conforming people).

Across all aspects, the Commission should take an evidence-based approach, identifying examples of effective approaches and interventions, while at the same time identifying opportunities to test new and promising approaches and build the evidence base.

Terms of Reference

In relation to the TOR specifically, WHV recommends that a broad scope is maintained and that the TOR explicitly include the application of an **intersectional gendered lens** across all issues and areas of focus. One of the strengths of the Royal Commission into Family Violence was that it highlighted the gendered prevalence of family violence, and brought the experiences of women experiencing compounding inequalities and disadvantage to the fore in its findings and recommendations. We recommend this Royal Commission take a similar approach.

While we appreciate the Commission's need to define a clear scope and prioritise certain issues, we would suggest that the ranking approach in the survey is not the best approach. All aspects of the mental health system are important

and interrelated. Investment in prevention, for example, should not be seen as competing with investment in acute mental health services. Adequate resourcing and a coordinated approach are essential for both.

Similarly, there are a range of different service systems with which mental health services need to be integrated, in addition to alcohol and other drug services. These include housing and homelessness, family violence, justice and correctional, and employment services. The Commission should also consider the intersection between State and Commonwealth services, including both Commonwealth-funded mental health services and other Commonwealth services, including in particular the National Disability Insurance Scheme. Whole of system integration and resourcing is key to providing a holistic approach to the individual's needs and ensuring there is 'no wrong door' for accessing support, as is ensuring equity and accessibility.

Consistent with our recommendation that an intersectional gendered lens be applied to the Commission's work, WHV believes there is sufficient evidence to warrant self-harm being included in the list of priorities. As noted in Key Issues above, we recommend the Commission place a strong focus on examining what works in primary prevention. Primary prevention strategies for mental health should address the underlying social inequalities (including gender inequality) that contribute to poor mental health outcomes and lead to unequal access to services and supports.

In addition, the Commission should explore opportunities for education and awareness-raising to break down stigma and educate the community and health and social service providers about less well understood conditions and how to seek or provide support.

The TOR should recognise the contribution of carers and address their needs. Carers including unpaid and paid carers, most of whom are women. The current system relies heavily on unpaid and low-paid carers to'pick up the pieces' left by an inadequately resourced specialist mental health system. Specialist mental health services must be adequately resourced to reduce the systematic reliance on unpaid and low-paid care. At the same time, carers' voices and experiences should be included throughout the Royal Commission process and specific recommendations should be developed to better support, resource and value their work.

The TOR should also include a focus on workforce needs, including consideration of how to support a sustainable, specialist mental health workforce, as well as a 'generalist' workforce with appropriate knowledge and skills to support people with mental health needs across the related community and social service sectors. As part of this, the Commission should consider specific workforce needs in primary prevention/ health promotion, including the need for both a specialist primary prevention workforce and a generalist prevention workforce embedded across the settings where people live, work and play (such as schools, workplaces, sporting clubs, etc).

Additional resources

WHV would like to take the opportunity to draw the Commission's attention to resources we consider relevant in informing the TOR, including:

- *Growing Up Unequal* (2017) - This paper by WHV explores how sex and gender impacts the health and wellbeing of young women and includes a focus on how gender inequality impacts mental health.
- *Advertising (In)equality* (2018) - This paper by WHV provides an overview of significant literature currently published on the nature of gender portrayals in advertising, and the impacts of these representations on women's health and wellbeing. Gender-stereotyped portrayals limit the aspirations, expectations, interests and participation of women and men in our society. These portrayals are associated with a range of negative health and wellbeing outcomes.
- *Great Expectations* (2018) – This paper by WHV explores how the perinatal period marks an enormous transition and upheaval in women's lives, challenging body image, relationships, intimacy and mental health. Research shows that when a woman's prenatal expectations regarding her pregnancy, delivery, infant, support network, and sense of self as a mother are compromised, she is more likely to experience lower levels of self-esteem and higher levels of depression, anxiety, and stress.
- *I Never Realised They Were So Different: Understanding the impact of the Labia Library* (2018) - The Labia Library is an online resource developed by Women's Health Victoria (WHV) in response to increasing demand for female genital cosmetic surgery, also known as labiaplasty. The vast majority of survey respondents indicated a positive perception of the resource, often experiencing a significant reduction in anxiety, and reassurance of normality associated with genital appearance.
- Spotlight on Self-harm (2018) - This Spotlight features a list of up-to-date and freely available research and resources on the topic of women and self-harm. Self-harm rates are high for young women with a mental illness including depression, anxiety, post-traumatic stress disorder, and eating disorders. In Australia and internationally, self-harm in young women is on the rise, highlighting the need for widely available, gender-sensitive treatment which addresses coping behaviours as well as the reasons women turn to self-harm.
- Mental Health Indicators displayed on the The Victorian Women's Health Atlas - The Victorian Women's Health Atlas is a tool to assist in the identification of how gender impacts on key health areas including mental health. The Atlas enables comparison between Local Government Areas, Regions and the State. The purpose of the Atlas is to increase the availability of reliable data for evidence-based decisions about service design, emerging priorities and program planning. Indicators for mental health include personal wellbeing, close-knit communities, community connectedness, anxiety and depression and psychological distress.
- *Investing in Women's Mental Health* (2016) – This report from the Australian Health Policy Collaboration discusses the extensive evidence that women's mental health needs are significantly different from those of men. This paper argues that it is time for a new approach aimed at tackling gendered risks and enhancing protections across the life course.