Women's Health VICTORIA

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Royal Commission into Victoria's Mental Health System

Submission prepared by Women's Health Victoria, July 2019

Introduction

Women's Health Victoria (WHV) welcomes the opportunity to provide input into the Royal Commission into Victoria's Mental Health System. WHV is committed to improving women's mental health, including through advocacy and awareness raising, primary prevention, capacity building and direct service delivery. As a Victorian statewide women's health promotion 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 the social model of health which focuses on addressing the social and economic determinants of health, such as freedom from discrimination and harassment, and equitable access to economic power and resources. A social determinants approach to mental health aims to improve mental health in the population and reduce inequities by focusing on improving the conditions in which people are born, grow, live, work and age.[1]

Overview

Summary of key issues

Women and girls are not referred to in the Royal Commission's Terms of Reference as a cohort requiring focused attention. This is out of step with international best practice which recommends mainstreaming a gender equity approach in relation to all aspects of mental health.

According to the World Health Organisation, **gender is a critical, overlaying social determinant of mental health and mental illness**:

> Gender determines the differential power and control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health risks. Gender differences occur particularly in the rates of common mental disorders – depression, anxiety and somatic complaints.[2]

However, the morbidity associated with mental illness has received substantially more attention than the gender-specific determinants and mechanisms that promote and protect mental health and foster resilience to stress and adversity.[3]

[1] WHO (2014) Social determinants of mental health. World Health Organization. Geneva. Available from: https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf
[2] WHO (2019) Gender and mental health. World Health Organization. Geneva. Available from: https://www.who.int/mental_health/prevention/genderwomen/en/
[3] WHO (2019) Gender and mental health. World Health Organization. Geneva. Available from: https://www.who.int/mental_health/prevention/genderwomen/en/

Recognising that gender is a key social determinant of health, WHV's submission provides strong evidence that sex and gender-based inequality drives unequal mental health outcomes between women and men in relation to a wide range of conditions and experiences, and that, by addressing gender inequality and taking a gendered approach to mental health, we have the opportunity to significantly improve outcomes for women and girls, as well as men and boys and gender diverse people.

> 'There is an urgent need to counter the gender-blindness[4] of mental health policy which serves to make these experiences invisible. Policies which reinforce this invisibility are not only ineffective; they are part of the problem. It is time to change course.'[5]

Our submission focuses on the need for an intersectional gender-sensitive approach to be applied to all areas of mental health policy, health promotion and service provision. This includes consideration of how both sex and gender-based inequality (as well as other forms of discrimination such as racism and ableism) profoundly shape mental health outcomes, and consumers' experiences of the mental health system.

Our submission provides evidence that:

1. **Discrepancies in mental health are strongly gendered**

Data show that discrepancies in mental health outcomes are strongly gendered. For example:

- An Australian survey of young people's mental health over a five year period found that females were around twice as likely as males to meet the criteria for having a probable serious mental illness.[6]
- A 2017 survey of over 10,000 Australian women found that 40% had been diagnosed with depression or anxiety.[7] The last National Survey of Mental Health and Wellbeing, held in 2007, found that women were significantly more likely than men to experience anxiety (32% compared to 20.4%) and depression (17.8% compared to 12.2%).[8]
- While eating disorders can occur across all ages, socio-economic groups and genders,[9] being female and experiencing puberty are key risk factors for the onset of an eating disorder.[10]

Despite this, major mental health reforms have tended to take what is referred to as a 'gender-blind' or gender-insensitive approach, thereby missing key opportunities to design more effective and cost-effective interventions and improve outcomes.

2. **Gender inequality drives poor mental health outcomes for women and girls**

Mental health and wellbeing is determined by a combination of genetic/biological, social/ environmental and personal/individual factors. These factors are strongly influenced by sex and gender. Sex and gender differences encompass the roles and responsibilities that society assigns to men and women, and their position in the family and community. Evidence confirms that these factors

[4] While the term 'gender blind' is often used to describe approaches that fail to consider the role of sex or gender and therefore perpetuate gender inequality, in consultation with Women with Disabilities Victoria WHV now uses the term 'gender insensitive'.
[5] Duggan, Maria (2016) Investing in women's mental health: strengthening the foundations for women, families and the Australian economy. Australian Health Policy Collaboration, Melbourne. Available from: https://www.vu.edu.au/sites/default/files/AHPC/pdfs/investing-in-womens-mental-health.pdf
[6] Mission Australia, Black Dog Institute (2017) Youth mental health report: Youth Survey 2012-16. Mission Australia. Sydney. Available from: https://www.missionaustralia.com.au/publications/research/young-people/706-five-year-mental-health-youth-report
[7] Women's Health Survey 2017 (2017) Jean Hailes for Women's Health, Melbourne. Available from : https://jeanhailes.org.au/survey2017/report_2017.pdf
[8] ABS (2008) 4326.0 National Survey of Mental Health and Wellbeing: Summary of Results, 2007 Australian Bureau of Statistics. Canberra, p 27. Available from: https://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/$File/National%20Survey%20of%20Mental%20Health%20and%20Wellbeing%20Summary%20of%20Results.pdf
[9] Eating Disorders Victoria (2015) Risk factors. EDV. Abbotsford, Vic. Available from: https://www.eatingdisorders.org.au/eating-disorders/what-is-an-eating-disorder/risk-factors
[10] Treasure J, Claudino AM, Zucker N (2010) Eating disorders. *Lancet*. 375 (9714):583-93

all have a great influence on the causes, consequences and management of diseases and ill-health and on the efficacy of health promotion policies and programs.[11] For example, a global study published in 2018 found a significant correlation between gender inequality and gender disparities in mental health suggesting that 'women suffer mentally more than men in societies with greater levels of gender inequality.'[12]

For example, factors associated with women's higher rates of depression and anxiety are clearly linked to gender-based inequalities and include: discrimination, poverty and socioeconomic disadvantage; insecure, low status employment; gendered expectations of high levels of unpaid domestic labour and caregiving; and differential exposure to physical and sexual violence.[13]

3. A gender-sensitive approach to mental health reform is critical

Gender-sensitive approaches to mental health for women are evident in relation to post-natal depression and anxiety, but are notably lacking in relation to other mental health conditions.

Gender-sensitive approaches to mental health for women and girls should, among other things:

- Prioritise understanding mental distress in the context of women's lives
- Be co-designed with women and enable women to be involved in initiatives intended to promote good mental health and to make choices about mental health care and treatment
- Address reproductive and life stage elements of mental health and wellbeing
- Address the mental health impacts of gendered experiences including sexual abuse, family violence and poor body image
- Be responsive to the diversity of women's needs, experiences and backgrounds including race, sexuality and disability.[14]

Unfortunately, despite widespread acceptance of gender as a key determinant of mental health, there is limited evidence about effective gender-sensitive interventions. This highlights the **need for significant investment in building the evidence base for gender-sensitive approaches to support the mental health of women and girls**. These could include trauma-informed care, single sex/gender services and peer support models, and a gendered approach to health promotion and prevention.

4. Investing in gender equality is a primary prevention strategy for mental health

A gendered approach to prevention means addressing the broader context of gender inequality that drives poor and unfair mental health outcomes for women and girls, as well as contributing to a host of other social and health inequalities including violence against women.

By investing in and strengthening gender equity we can address the social determinants that lead to unequal mental health outcomes for women. In other words, investing in gender equality is a primary prevention strategy for mental health.

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[11] Ostlin P, Eckermann E, Shankar Mishra U et al. (2006) Gender and health promotion: a multisectoral policy approach. *Health Promotion International* 21(S1):25-35. Available from: https://academic.oup.com/heapro/article/21/suppl_1/25/766144

[12] Shoukai Y (2018) Uncovering the hidden aspects of inequality on mental health: a global study. *Translational Psychiatry* 9(98):1-10. Available from: https://www.nature.com/articles/s41398-018-0148-0.pdf
This is one of the first studies to successfully provide statistical evidence of an association between gender disparities in psychiatric disorders and social inequalities at a global level. The study results only demonstrated correlations rather than causal links between inequality and depressive disorders.

[13] WHO. Department of Mental Health and Substance Dependence (2012) Gender disparities in mental health. World Health Organization. Geneva. Available from: https://www.who.int/mental_health/media/en/242.pdf

[14] This list has been adapted from the principles provided by : British Medical Association (2018) Addressing unmet needs in women's mental health. BMA. London. Available from: https://www.cancerresearchuk.org/sites/default/files/womens-health-full-report-aug2018_0.pdf

Structure of submission

This submission argues that there is a need to apply an intersectional gender lens across all areas of mental health reform – from prevention and early intervention through to treatment and recovery – including investing in (new and existing) intersectional gender equity strategies to support the primary prevention of mental ill-health. It is divided into five main sections:

1. Evidence that discrepancies in mental health are strongly gendered
2. The social determinants of mental health for women and girls
3. The importance of gender-sensitive approaches to improving the mental health of women and girls
4. Gender equality and primary prevention for mental health
5. Urgent issues with the current system, including the need to centre the voices of women with lived experience of mental ill-health

We have signposted in each section how the content of our submission responds to the specific questions posed by the Royal Commission in its submission template.

1. Evidence that discrepancies in mental health are strongly gendered

This section of the submission relates to questions 1 & 5 in the Royal Commission submission template.

Globally, women are nearly twice as likely as men to suffer from mental illness.[15] Mental disorders represent the leading cause of disability and the highest burden of non-fatal illnesses for women in Australia.[16] 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 multi-morbidities are associated with increased severity of mental illness and increased disability.[17]

Biological factors related to sex mean that women experience specific mental health conditions linked to their reproductive capacity such as post-natal anxiety and depression. The brain structure and response to stress also differ between females and males.[18] However, rigid gender-based expectations and stereotypes and gendered structural inequalities also play a key role in influencing outcomes because of the different stressors experienced by women and men, as well as the response they receive from health professionals and support services.

Clear gender-based discrepancies in mental health have emerged as a result of these factors.

For example:

- **Postnatal depression**: It is estimated that 20% of Australian women have experienced postnatal depression, that is, depression in the 12 months after birth.[19]

[15] Shoukai Y (2018) Uncovering the hidden aspects of inequality on mental health: a global study. *Translational Psychiatry* 9(98):1-10. Available from: https://www.nature.com/articles/s41398-018-0148-0.pdf
[16] Duggan, Maria (2016) Investing in women's mental health: strengthening the foundations for women, families and the Australian economy. Australian Health Policy Collaboration, Melbourne. Available from: https://www.vu.edu.au/sites/default/files/AHPC/pdfs/investing-in-womens-mental-health.pdf.
[17] Duggan, Maria (2016) Investing in women's mental health: strengthening the foundations for women, families and the Australian economy. Australian Health Policy Collaboration, Melbourne. Available from: https://www.vu.edu.au/sites/default/files/AHPC/pdfs/investing-in-womens-mental-health.pdf.
[18] Shoukai Y (2018) Uncovering the hidden aspects of inequality on mental health: a global study. *Translational Psychiatry* 9(98):1-10. Available from: https://www.nature.com/articles/s41398-018-0148-0.pdf
[19] Perinatal depression: data from the 2010 Australian National Infant Feeding Survey (2012) Australian Institute of Health and Welfare, Canberra.

- **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.[20] The last National Survey of Mental Health and Wellbeing, held in 2007, found that women were significantly more likely than men to experience anxiety (32% compared to 20.4%) and depression (17.8% compared to 12.2%).[21]
- **Obsessive Compulsive Disorder** (OCD): Women are more likely than men to report obsessions focusing on contamination (e.g. fear of spreading or contracting illness) and corresponding cleaning compulsions. Conversely, sexual obsessions (e.g. obsessive fears of being homosexual or being a paedophile) are more frequently observed in men. These gender differences appear to be stable across cultures, indicating that biological factors or cross-cultural gender norms play a role.[22] Women are more likely to experience co-morbid OCD and eating disorders, which may relate to gendered social roles. [23]

Gender discrepancies in young people's mental health

While girls and boys enjoy comparable levels of mental health and self-confidence before puberty, during adolescence, young women's mental health outcomes worsen compared with young men's.[24] An Australian survey of young people's mental health over a five year period found that females were around twice as likely as males to meet the criteria for having a probable serious mental illness.[25] Young women report the highest rates of mental disorder of any population group (30% for women aged 16 to 24).[26]

- Depression and anxiety are frequently experienced by women with common **reproductive health conditions** like polycystic ovarian syndrome (PCOS). Approximately 34% of women with PCOS have depression compared to 7% of women in the general population and around 45% have anxiety, compared to 18% of the general population. [27] These conditions emerge during adolescence, but may not be diagnosed until much later. It has been shown that the longer it takes to receive a diagnosis of PCOS, the more likely women are to be depressed or anxious.[28] 70% of Australian women with PCOS remain undiagnosed, and there is a lack of consistency in assessment and management of the condition.[29]

[20] Women's Health Survey 2017 (2017) Jean Hailes for Women's Health, Melbourne. Available from : https://jeanhailes.org.au/survey2017/report_2017.pdf
[21] ABS (2008) 4326.0 National Survey of Mental Health and Wellbeing: Summary of Results, 2007 Australian Bureau of Statistics. Canberra, p 27. Available from: https://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/$File/National%20Survey%20of%20Mental%20Health%20and%20Wellbeing%20Summary%20of%20Results.pdf
[22] Stein D, Vythilingum B (eds.) (2015) Anxiety disorders and gender. Springer International. Available from: https://www.springer.com/gp/book/9783319130590
[23] Mathis, Alvarenga, Funaro, Torresan, Moraes, Torres, et al. (2011) Gender differences in obsessive-compulsive disorder : a literature review. *Revista Brasileira de Psiquiatria*. 33:390-9. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1516-44462011000400014
[24] Hankin B, Young J, Abela JRZ, et al. (2015) Depression from childhood into late adolescence : influence of gender, development, genetic susceptibility, and peer stress. *Journal of Abnormal Psychology*. 124 (4):803-16. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4662048/
[25] Mission Australia, Black Dog Institute (2017) Youth mental health report: Youth Survey 2012-16. Mission Australia. Sydney. Available (direct download) from: https://www.missionaustralia.com.au/publications/research/young-people/706-five-year-mental-health-youth-report
[26] Duggan, Maria (2016) Investing in women's mental health: strengthening the foundations for women, families and the Australian economy. Australian Health Policy Collaboration, Melbourne. Available from: https://www.vu.edu.au/sites/default/files/AHPC/pdfs/investing-in-womens-mental-health.pdf.
[27] Jean Hailes for Women's Health (2016) PCOS : emotions [Webpage]. Available from: https://jeanhailes.org.au/health-a-z/pcos/emotions
[28] Jean Hailes for Women's Health (2017) Health A-Z: endometriosis [Webpage]. Available from: https://jeanhailes.org.au/health-a-z/endometriosis
[29] Boyle J, Teede HJ (2012) Polycystic ovary syndrome: an update *Australian Family Physician* 41(10): 752-756. Available from: https://www.racgp.org.au/afp/2012/october/polycystic-ovary-syndrome/

- While **eating disorders** can occur across all ages, socio-economic groups and genders,[30] being female and experiencing puberty are key risk factors for the onset of an eating disorder.[31] Eating disorders are the third most common chronic illness in young females.[32] The mortality rate for people with eating disorders is the highest of all psychiatric illnesses, and over 12 times higher than for people without eating disorders. This includes increased risk of suicide.[33]
- **Suicide and self-harm**: Suicide is the leading cause of death for young women aged 15-24[34] and, alarmingly, the suicide rate among young women has increased by 47% over the past decade.[35] Further, nearly 1 in 3 girls aged 16-17 have self-harmed.[36] Measured by hospital admission, the intentional self-harm rate for women (which does not differentiate suicide attempts and non-suicidal self-injury) is now 40% higher than men's, with a large increase in the adolescent years.[37] The number of women aged 15-24 years who injure themselves so severely that they require hospital treatment has increased by more than 50% between 2000 and 2016.[38]

Evidence strongly indicates that these discrepancies are driven by sex- and gender-based expectations and experiences, and that the decline in young women's mental health is linked to societal factors rather than poor health care.[39] This is explored in greater depth in section 2.

Inequalities in mental health outcomes among women

Sex and gender-based inequalities intersect with other forms of inequality such as geographic isolation, racism, ableism and homophobia, to negatively affect mental health outcomes. This accounts for discrepancies in mental health outcomes among different groups of women. For example:

- **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.[40] Suicide rates among Aboriginal and Torres Strait Islander women aged 15-19 are nearly six times higher than the corresponding rates for non-Aboriginal young women.[41]
- **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

[30] Eating Disorders Victoria (2015) Risk factors. EDV. Abbotsford, Vic. Available from: https://www.eatingdisorders.org.au/eating-disorders/what-is-an-eating-disorder/risk-factors
[31] Treasure J, Claudino AM, Zucker N (2010) Eating disorders. *Lancet*. 375 (9714):583-93
[32] NEDC (2012) An integrated response to complexity: National eating disorders framework. National Eating Disorders Collaboration. Sydney. Available from: https://www.nedc.com.au/research-and-resources/show/an-integrated-response-to-complexity-national-eating-disorders-framework
[33] National Eating Disorders Collaboration (2012). Eating disorders in Australia. Sydney: NEDC. Sydney, p. 7. Available from: https://www.nedc.com.au/assets/Fact-Sheets/Eating-Disorders-in-Australia-ENG.pdf
[34] AIHW (2018) Deaths in Australia: web report. Supplementary tables. Table S3.2 leading causes of Death, by age group, 2014-16. https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia/data.
[35] ABS (2016) Intentional self-harm (Suicide) (Australia) : Table 11.3 - Intentional self-harm, age-specific death rates, 10 year age groups by sex, 2006–2015 [Excel download]. *In:* 3303.0 : Causes of Death, Australia 2015. Available from: https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3303.02015?OpenDocument
[36] Robinson J, McCutcheon I, Browne V, et al. (2016) Looking the other way: young people and self-harm. Orygen, The National Centre of Excellence in Youth Mental Health. Melbourne, p. 12. Available from: https://www.orygen.org.au/About/News-And-Events/Looking-the-Other-Way-Young-People-and-Self-Harm
[37] AIHW (2014) Suicide and hospitalised self-harm in Australia ; Trends and analysis, Flinders University, page 65 https://www.aihw.gov.au/getmedia/b70c6e73-40dd-41ce-9aa4-b72b2a3dd152/18303.pdf.aspx?inline=true
[38] Suicide Prevention Australia (2016) Suicide and Suicidal Behaviour in Women – Issues and Prevention, page 6. Available from: https://apo.org.au/node/56174
[39] Rowlands, Dobson and Mishra (2015) Physical health of young, Australian women : a comparison of two national cohorts surveyed 17 years apart. *PLOS One*. 10 (11 - e0142088):1-12. Available from: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0142088
[40] Harrison JE, Henley G (2014) Suicide and hospitalised self-harm in Australia: trends and analysis: hospitalised intentional self-harm: 2010-11 Australian Institute of Health and Welfare, Canberra. Available from: https://www.aihw.gov.au/reports/injury/suicide-hospitalised-self-harm-in-australia/contents/table-of-contents
[41] Suicide Prevention Australia (2016) Suicide and Suicidal Behaviour in Women – Issues and Prevention, page 24. Available from: https://apo.org.au/node/56174

care) and less likely to have access to evidence-based and culturally relevant information to facilitate decision-making around their health.[42]

- The number of **incarcerated women** in Australia has increased by 50% in the past five years (compared with 37% for men),[43] and Aboriginal and Torres Strait Islander women are 21.2 times more likely to be incarcerated than non-Aboriginal women.[44] Beyond Blue reports that the most common mental health condition in incarcerated Aboriginal women is post-traumatic stress disorder (PTSD) which is often misdiagnosed or not diagnosed.[45] Compared to male offenders, female offenders are 1.7 times more likely to have a mental illness.[46]
- Twice as many **rural adolescent girls** report symptoms consistent with depression compared to their male counterparts.[47] This is exacerbated by a lack of mental health services including insufficient funding for comprehensive mental health programs; stigma around mental health which is more pronounced in smaller communities; and a lack of transport options.
- **Lesbian and bisexual women, people with intersex characteristics and trans women** are at increased risk of suicidal behaviour, being almost four times as likely as their cis/heterosexual peers to have tried to self-harm or suicide.[481]

Intersectional factors and experiences compound poor mental health for women and lead to discrepancies in outcomes among women, worsening inequality. 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. For example, programs to reduce heterosexism and challenge rigid gender norms would have a preventative impact on mental health for LGBTIQ people.[49]

These gendered discrepancies in mental health outcomes warrant closer attention by the Royal Commission. The following sections of the submission focus on understanding the social determinants that lead to poor or unequal mental health outcomes for women, and the need to invest in gender equality strategies for mental health.

2. The social determinants of mental health for women and girls

This section of the submission relates to questions 2 & 5 in the Royal Commission submission template.

The Royal Commission must incorporate a closer examination of how gender inequality and gendered social determinants shape mental health risk factors and outcomes for women and the need for more equitable gender-sensitive approaches to mental health promotion, supports and services.

[42] Sexual and Reproductive Health Data Report June 2016 (2016) Multicultural Centre for Women's Health, Collingwood. Available from: http://www.mcwh.com.au/downloads/MCWH_SRH_Data_Report_July_2016.pdf
[43] Corrective Services, Australia, September quarter 2018 (2018) Australian Bureau of Statistics. Available from: https://www.abs.gov.au/ausstats/abs@.nsf/mf/4512.0
[44] Pathways to Justice–Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples (ALRC Report 133),(2017) Australian Law Reform Commission. Available from: https://www.alrc.gov.au/publications/indigenous-incarceration-report133
[45] The family business: improving the understanding and treatment of post-traumatic stress disorder among incarcerated Aboriginal and Torres Strait Islander women Beyondblue, 2015
[46] Victorian Ombudsman Investigation into the rehabilitation and reintegration of prisoners in Victoria (2015) Office of the Victorian Ombudsman, Melbourne.
[47] Black, Roberts and Li-Leng Depression in rural adolescents : relationships with gender and availability of mental health services. *Rural and Remote Health*. 12 (2092):1-11, p. 7. Available from: https://www.rrh.org.au/public/assets/article_documents/article_print_2092.pdf
[48] Suicide Prevention Australia (2016) Suicide and Suicidal Behaviour in Women – Issues and Prevention, page 23. Available from: https://apo.org.au/node/56174
[49] Rainbow Health Victoria and Thorne Harbour Health, Royal Commission into Victoria's mental health system. Consumer Talking Points (2019).

Greater equality between women and men is a precondition for (and an indicator of) equitable, prosperous and healthy communities and an important social determinant of health.[50] There are well established links between the risks of mental illness and the social realities of women's lives. These include women's relatively lower incomes and access to household resources and responsibility for childcare and other caring responsibilities, as well as experiences of sexual abuse and domestic violence.[51]

Exposure to male violence

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 and 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 alcohol and illicit drug use and suicide.[52] An Australian study found that approximately 77% of women who have experienced three or four types of gender-based violence had anxiety disorders, 56% had PTSD and 35% had made suicide attempts.[53]

A Victorian study found that 42% of women who died from suicide between 2009 and 2012 had a history of exposure to interpersonal violence, with 23% having been a victim of physical violence, 18% suffering psychological violence, and 16% experiencing sexual abuse.[54] A 2019 study found women with a history of sexual assault have significantly higher odds of clinically significant depressive symptoms, anxiety, and poor sleep than women without this history.[55] Up to 85% of people (mostly women) diagnosed with Borderline Personality Disorder have experienced trauma including physical, sexual, emotional abuse and neglect.[56]

Exposure to sexual harassment and gender-based discrimination

Women and girls commonly experience sexual harassment online, in public spaces and in the workplace over the life course and this impacts their mental health. For example, women are significantly more likely than men to have experienced sexual harassment in the workplace at least once in the last year.[57]

According to *Everyone's business: Fourth national survey on sexual harassment in Australian workplaces*, in the vast majority of cases the perpetrator is a man and in many cases the harassment is ongoing over an extended period. Substantially more women than men said the most recent incident of workplace sexual harassment had impacted negatively on their mental health or caused them stress (40% compared to 29%) and half the victims reported having experienced similar

[50] According to the World Health Organisation, the social determinants of health are 'the conditions in which people are born, grow, work, live, and age' and the wider set of forces and systems shaping these conditions such as distribution of money, power and resources.

[51] British Medical Association (2018) Addressing unmet needs in women's mental health. BMA. London. Available from: https://www.cancerresearchuk.org/sites/default/files/womens-health-full-report-aug2018_0.pdf

[52] VicHealth (2017) Violence against women in Australia: research summary. Victorian Health Promotion Foundation. Melbourne. Available from: https://www.vichealth.vic.gov.au/media-and-resources/publications/violence-against-women-in-australia-research-summary

[53] Rees S, Silove D, Chey T, Ivancic L, Steel Z, Creamer M, Teesson M, Bryant R, McFarlane AC, Mills KL, Slade T 2011, 'Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function', JAMA, vol. 306, no. 5, pp. 513–521

[54] MacIsaac MB, Bugeja L, Weiland T, Dwyer J, Selvakumar K, Jelinek GA 2017, 'Prevalence and characteristics of interpersonal violence in people dying from suicide in Victoria, Australia', Asia Pacific Journal of Public Health, vol. 30, no. 1, pp. 3 6–44.

[55] Rebecca C. Thurston,. Karen A. Matthews, et. al. (2019), Association of Sexual Harassment and Sexual Assault With Midlife Women's Mental and Physical Health, JAMA, Available from: https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2705688

[56] Rao, S. and J. Beatson (2019). Developing a state-wide service for the treatment of patients with Borderline Personality Disorder. Humanising mental health care in Australia. A guide to trauma-informed approaches. R. Benjamin, J. Haliburn and S. King. New York, Routledge: 367-379.

[57] AHRC (2018) Everyone's business: Fourth national survey on sexual harassment in Australian workplaces. Available from: https://www.humanrights.gov.au/our-work/sex-discrimination/publications/everyones-business-fourth-national-survey-sexual

harassment before.[58] A 2016 Australian meta-analysis showed that more intense yet less frequent harmful experiences (e.g. sexual coercion and unwanted sexual attention) and less intense but more frequent harmful experiences (e.g. sexist organisational climate and gendered harassment) had similar negative effects on women's well-being.[59]

Unequal caring responsibilities

All over the world women are the predominant providers of informal care for family members with chronic medical conditions or disabilities, including the elderly and adults with mental illnesses.[60] In Victoria, 71% of all primary carers are women.[61] Women are also more likely than men to have care responsibilities involving greater time and intensity.[62]

Despite our society's reliance on it, women's unpaid care work is often taken for granted because of the expectation that unpaid care is naturally or traditionally women's responsibility, and not really 'work'. Supports for carers tend to be 'gender neutral', failing to take into consideration the specific health and financial impacts of being a carer for women. Indeed, 'unremitting responsibility for the care of others' has ben identified by the World Health Organisation as a gender specific risk factors for common mental disorders that disproportionately affect women.[63]

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[64] compounding the impacts of other forms of gender inequality women experience (such as pay inequality). It is also related to the undervaluing of paid work in care-related or 'feminised' industries, including the health workforce. Carers are likely to accrue little or no superannuation because of lowered participation in paid work and reliance on income support. This impacts the ability of carers to fund their own retirement or future care needs.

WHV's Issues Paper, *Great Expectations: How gendered expectations shape early mothering experiences*, found that social factors and unequal caring responsibilities place women at increased risk of postnatal depression.[65] Fear of judgement and a desire to present as a 'good mother' leads to women concealing depressive symptoms and not seeking help.[66] There is also a strong association between poor social support and poor mental health in mothers.[67]

[58] AHRC (2018) Everyone's business: Fourth national survey on sexual harassment in Australian workplaces. Available from: https://www.humanrights.gov.au/our-work/sex-discrimination/publications/everyones-business-fourth-national-survey-sexual
[59] Sojo, VE; Wood, RE; Genat, AE, (2016) Harmful Workplace Experiences and Women's Occupational Well-Being: A Meta-Analysis, PSYCHOLOGY OF WOMEN QUARTERLY, 2016, 40 (1).
[60] Sharma, Chakrabarti, Grover (2016) Gender differences in caregiving among family - caregivers of people with mental illnesses. World J Psychiatry. 2016 Mar 22;6(1):7-17. Available from: https://www.ncbi.nlm.nih.gov/pubmed/27014594
[61] Carers Victoria (2018) Carers in Victoria: the facts Carers Victoria, Footscray, Vic. For more information see WHV's (2018) Spotlight on Women and Unpaid Care: https://womenshealthvic.com.au/resources/WHV_Publications/Spotlight_2018.07.10_Spotlight-on-women-and-unpaid-care_Jun-2018_(Fulltext).pdf Primary carer is defined here as the carer who provides the majority of ongoing informal assistance to a person with a disability.
[62] AHRC (2013) Investing in care: recognising and valuing those who care. Australian Human Rights Commission, Sydney
[63] World Health Organisation (2019), Gender and Women's Health, Gender and mental health disparities: The facts. Available from: https://www.who.int/mental_health/prevention/genderwomen/en/
[64] Women's Health Victoria (2018) Spotlight on Women and Unpaid Care. Available from: https://womenshealthvic.com.au/resources/WHV_Publications/Spotlight_2018.07.10_Spotlight-on-women-and-unpaid-care_Jun-2018_(Fulltext).pdf
[65] Anderson R, Webster A, Barr M (2018) Great expectations: how gendered expectations shape early mothering experiences. Women's Health Victoria. Melbourne. (Women's Health Issues Paper; 13). Available from: https://whv.org.au/resources/whv-publications/great-expectations-how-gendered-expectations-shape-early-mothering
[66] Buchanan S, Loudon KJ (2015) "First-time mother syndrome"? first-time mothers' information practices and their relationships with healthcare professionals [Conference Paper] *In:* i3 Information Interactions and Impact Conference (2015 Apr. 23-26 : Aberdeen). University of Strathclyde, Glasgow. Available from: https://pureportal.strath.ac.uk/en/publications/first-time-mother-syndrome-first-time-mothers-information-practic
[67] Holden L, Dobson A, Byles J, et al. (2013) Mental health: findings from the Australian Longitudinal Study on Women's Health. Women's Health Australia, Herston, Qld. - (Major Report H). Available from: https://www.alswh.org.au/images/content/pdf/major_reports/2013_major%20report%20H.pdf

Unequal access to economic resources

In 2019 in Australia, women earn on average $239.80 less a week than men[68] due to factors such as:

- discrimination and bias in hiring and pay decisions
- women and men working in different industries and different jobs, with female-dominated industries and jobs attracting lower wages
- women's disproportionate share of unpaid caring and domestic work
- lack of workplace flexibility to accommodate caring and other responsibilities, especially in senior roles
- women's greater time out of the workforce impacting career progression and opportunities.[69]

Exclusion from (and interruption of) employment, and uneven sharing of caring responsibilities, leave women at a significant disadvantage economically over their lifetimes. For example, the gap in superannuation at retirement is 46.6 per cent.[70]

Having less access to financial resources limits women's ability to escape family violence and attain appropriate and stable housing for themselves and their children. Family violence is the single biggest cause of homelessness in Victoria. More than one third of women accessing homelessness services do so because they are fleeing family violence.[71] Safe, secure and stable accommodation is protective of health, including mental health.

Family violence, housing and mental health

Family violence is the single biggest cause of homelessness in Victoria. More than one third of women accessing homelessness services do so because they are fleeing family violence.[72]

The relationship between family violence and homelessness is complex, as it is often underpinned by a range of factors including gender inequality, socioeconomic disadvantage and mental illness, as well as poor access to income support and housing.[73] Women who have experienced domestic violence or abuse are at a significantly higher risk of experiencing a range of mental health conditions including post-traumatic stress disorder (PTSD), depression, anxiety, substance abuse, and thoughts of suicide.[74]

Compounding this, homelessness and inappropriate housing expose people to a wide range of risk factors for their mental and physical health and wellbeing. These include violence and abuse, harmful alcohol and other drug use, poor nutrition and sleep, severe social isolation, lack of amenities for self-care, disease, and exposure to the elements. All of these are major stressors that are highly likely to compromise mental and physical wellbeing and pose additional challenges for providing continuing care.[75]

In contrast, safe, secure and stable accommodation is protective of health, including mental health. Appropriate accommodation not only removes the risks associated with

[68] Workplace gender equality Agency (2019) Australia's Gender Pay Gap Statistics, Available from: https://www.wgea.gov.au/data/fact-sheets/australias-gender-pay-gap-statistics
[69] Workplace gender equality Agency (2019) Australia's Gender Pay Gap Statistics, Available from : https://www.wgea.gov.au/data/fact-sheets/australias-gender-pay-gap-statistics
[70] Australia. Parliament. Senate Standing Committees on Economics. Economics References Committee (2015) Inquiry into the economic security for women in retirement. Available from: URL
[71] Council to Homeless Persons (2014) Fact sheet: family violence and homelessness. CHP. Collingwood, Vic. Available from: https://chp.org.au/wp-content/uploads/2015/06/Family-violence-fact-sheet-FINAL.pdf
[72] Council to Homeless Persons (2014) Fact sheet: family violence and homelessness. CHP. Collingwood, Vic. Available from: https://chp.org.au/wp-content/uploads/2015/06/Family-violence-fact-sheet-FINAL.pdf
[73] CHP Available from: https://chp.org.au/wp-content/uploads/2015/06/Family-violence-fact-sheet-FINAL.pdf
[74] Rihan Parker (2019) How domestic violence affects women's mental health, VincentCare. Available from: https://vincentcare.org.au/how-domestic-violence-affects-womens-mental-health/
[75] Department of Health (2006) Accommodation *In:* Pathways of recovery: preventing further episodes of mental illness. Available from: http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-p-mono-toc~mental-pubs-p-mono-bas~mental-pubs-p-mono-bas-alt~mental-pubs-p-mono-bas-alt-acc

unsuitable accommodation or homelessness, but also provides a base from which a person with mental illness can focus on their recovery. It enables people to develop links with organisations and services within their community, and allows them to channel their energy into other factors supportive of their ongoing wellbeing (such as education or employment).[76] Affordable and secure housing is essential for women experiencing family violence and their children.

An example of gender-sensitive program that addresses the mental health aspects of women's unequal access to economic resources is Women's Health in the North's (WHIN) 'Let's Talk Money' program.[77] 'Let's Talk Money' is a financial capacity-building program delivered by peer educators in community languages. While the focus of this program is women's financial literacy, it provides a safe space for women to explore mental health issues that are related to violence they may have experienced during the migration journey, settlement process or due to family violence, especially financial abuse.

Sexualisation and objectification

Researchers have suggested that the steep rise in depression and anxiety rates among young women could be attributable to increased sexualisation and objectification of girls and young women, as well as exposure to social media and increased pressure on school performance.[78] Girls and women who are regularly exposed to sexually objectifying media content are more likely to objectify themselves and internalise unrealistic appearance-related ideals. In turn, this increases body dissatisfaction, contributes to disordered eating, lower self-esteem and reduced mental health and results in reduced satisfaction in sexual relationships and reduced participation in physical activity and exercise.[79]

The nature of gender portrayals in advertising, and the impacts of these representations on women's health and wellbeing are explored in WHV's recent Issues Paper *Advertising (In)equality: The impacts of sexist advertising on women's health and wellbeing* (2018).

Another WHV Issues Paper *Growing Up Unequal: How sex and gender impact the health and wellbeing of young women* (2017)[80] found that challenging sexualisation and objectification of women and girls at the societal level has the potential to improve young women's body image, increase their physical activity, and improve their mental and emotional wellbeing, sexual experiences and relationships.

Sexist attitudes and norms

Sexist attitudes and norms continue to seriously impact the mental health and wellbeing on young women and girls. For example:

[76] Department of Health (2006) Accommodation *In:* Pathways of recovery: preventing further episodes of mental illness. Available from: http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-p-mono-toc~mental-pubs-p-mono-bas~mental-pubs-p-mono-bas-alt~mental-pubs-p-mono-bas-alt-acc
[77] https://www.whin.org.au/current-work/economic-equality/lets-talk-money/
[78] Fink, Patalay, Sharpe and et al. (2015) Mental health difficulties in early adolescence : a comparison of two cross-sectional studies in England from 2009 to 2014. *Journal of Adolescent Health*. 56 (5):502-7, p. 505. Available from: https://www.jahonline.org/article/S1054-139X(15)00064-6/fulltext
[79] Mandy McKenzie, Megan Bugden, Dr Amy Webster and Mischa Barr (2018) Advertising (In)equality: The impacts of sexist advertising on women's health and wellbeing, Women's Health Victoria. Available from: https://womenshealthvic.com.au/resources/WHV_Publications/Issues-Paper_2018.12.06_Advertising-inequality-the-impacts-of-sexist-advertising_Dec-2018_(Fulltext-PDF).pdf
[80] Amy Webtser, Renata Anderson and Mischa Barr, (2017). Growing Up Unequal: How sex and gender impact the health and wellbeing of young women. Women's Health Victoria. Available from: https://whv.org.au/resources/whv-publications/growing-unequal-how-sex-and-gender-impact-young-womens-health-and

Movement in public spaces

More than half of Australian girls report that they are sometimes, seldom or never 'valued for their brains and ability more than their looks'.[81] Experimental studies have found that when women perceive that their bodies are the focus of attention, they talk and participate less in social interactions.[82] Young women also report feeling concern about the presence of males when exercising and worry about being judged, humiliated and harassed.[83] This is pertinent to mental health because a growing body of evidence suggests that exercise is helpful in supporting good mental health.[84]

VicHealth collects data on Victorians' self-reported 'perceptions of safety', asking respondents how safe they feel when walking alone in the local area at night ('safe' or 'very safe'). In 2015, the perception of safety state average for women was only 44.0% compared with 78.8% for men.[85] The safety discrepancy is even more stark in specific regions, for example Frankston, where the average for women is 25.4% compared with 68% for men.

Discounting of pain

Women's experience of pain, particularly in relation to common reproductive health issues such as period pain, PCOS and endometriosis, is also impacted by sexist attitudes and norms, including among health professionals, with detrimental impact on their mental health. As noted in section 1, there is a strong association between reproductive health conditions affecting women (like PCOS) and depression and anxiety. Delays in diagnosis and inconsistent management of the condition may reflect sexist attitudes towards women and their experience of pain. For example, dysmenorrhea (or painful menstruation) is highly prevalent and is the leading cause of absence from school and work among women of reproductive age. However, 2018 research shows that dysmenorrhea is not seen as a legitimate health issue by health care providers.[86] Internationally, studies have shown that women with abdominal pain wait longer in emergency departments, are given lower amounts of pain killers after longer waiting times.[87] More up to date Australian research is needed.

Suicide and self-harm

Suicide is often framed as a men's issue (reflecting higher overall prevalence among men). However, suicide research consistently demonstrates that women have higher rates of suicidal behaviour and, whereas the suicide rate for young men has decreased since the late 1990s, the rate for young women has not.[88] Due to the influence of gendered norms and attitudes, suicidal behaviour and self-harm in women can be viewed by family, health professionals and the community as attention-seeking, manipulative and non-serious,[89] which can negatively influence how young women are treated.

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[81] IPSOS Australia (2016) Everyday sexism : girls' and young women's views on gender inequality in Australia. Available from: https://www.ourwatch.org.au/getmedia/1ee3e574-ce66-4acb-b8ef-186640c9d018/Everyday-Sexism_version_03.pdf.aspx
[82] Heflick NA, Goldenberg JL (2014) Seeing Eye to Body. Current Directions in Psychological Science. 23 (3):225–9.
[83] van Bueren D, Elliott S, Farnam C (2016) 2016 Physical Activity and Sport Participation Campaign : insights report, p. 7. Available from: https://campaigns.health.gov.au/sites/g/files/net3246/f/insights_report.pdf
[84] Black Dog Institute (2017) One hour of exercise a week can prevent depression. Black Dog Institute. Randwick, NSW. Available from: https://www.blackdoginstitute.org.au/news/news-detail/2017/10/04/one-hour-of-exercise-a-week-can-prevent-depression
[85] 2015 VicHealth Community Indicators Survey: Perceptions of Safety indicator as displayed on The Victorian Women's Health Atlas, Women's Health Victoria. See 'Perceptions of Safety' data. Available from: https://victorianwomenshealthatlas.net.au/#!/atlas/Violence%20Against%20Women/V/Perceptions%20Of%20Safety/V_01/2015%20%25%20People%20who%20feel%20safe%20when%20walking%20alone%20at%20night/143/F/state/all/false
[86] Chen X. Chen*, Claire B. Draucker and Janet S. Carpenter, (2018) What women say about their dysmenorrhea: a qualitative thematic analysis, BMJ. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5833075/pdf/12905_2018_Article_538.pdf
[87] Chen, Shofer, Dean, et al. (2008) Gender disparity in analgesic treatment of emergency department patients with acute abdominal pain. Acad Emerg Med. 2008 May;15(5):414-8. Available from: https://www.ncbi.nlm.nih.gov/pubmed/18439195
[88] Suicide Prevention Australia (2016) Suicide and suicidal behaviour in women: issues and prevention, page 6. Available from: https://apo.org.au/node/56174
[89] Suicide Prevention Australia (2016) Suicide and suicidal behaviour in women: issues and prevention, page 8. Available from: https://apo.org.au/node/56174

The intersection of gender-based discrimination with other forms of inequality

Women with disabilities

In 2017-18, 57% of people with a profound or severe disability reported experiencing a mental or behavioural health condition.[90] Gender-based inequality and ableism intersect to influence the mental health of women with disabilities. This includes high levels of family and sexual violence and additional barriers to seeking support and leaving abusive partners[91] including ableism. Women with disabilities are less likely to be in paid employment than their male counterparts, are at greater risk of living in insecure or inadequate housing and are more likely to live in poverty.[92] They are over-represented in institutional care and experience difficulties in accessing appropriate health services and treatment.[93] Forced sterilisation, contraception and menstrual suppression are also key issues facing women living with disabilities.[94]

People with disabilities make up twenty per cent of the population and experience higher levels of isolation, discrimination and violence, all of which are key determinants of mental health. Despite this, the mental health system has on the whole not developed tailored responses to support people with disabilities and the degree to which people with disabilities experience direct and indirect discrimination from the mental health system has not been investigated.

For women with disabilities, peer support groups have been shown to be an effective way to reduce isolation, to learn about rights, and for women to share strategies for advocacy and system access.[95] These impacts can prevent further isolation, health deterioration or exposure to family violence. Unfortunately, in the new NDIS market-model funding environment, the future of community-based peer support groups has never been more insecure.

Migrant and refugee women

Migration-related factors are recognised as social determinants of health. Conditions surrounding migration and resettlement may exacerbate health inequities, exposing women and their families to increased health risks and poorer health outcomes,[96] including mental health. Women seeking asylum and those from refugee backgrounds, in particular, are at increased risk of poorer health and wellbeing due to both pre-migration experiences, including exposure to trauma, and post-resettlement experiences.[97] Residency and visa status determines different health access entitlements, rendering the Australian health system difficult to navigate and restricting access to health services for some visa-holders.[98] As a result, mental health (anxiety, depression and post-traumatic stress disorder) and reproductive health are areas of increased risk for migrant and refugee women.[99] Different attitudes

[90] Australian Bureau of Statistics (2019) National Health Survey: First Results, 2017-18. Available from: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2017-18~Main%20Features~Mental%20and%20behavioural%20conditions~70

[91] Voices Against Violence Paper One: Summary Report and Recommendations (2014) Woodlock, Healy and Geddes et. al, Melbourne.

[92] Assessing the situation of women with disabilities in Australia – a human rights approach (2011) Women with Disabilities Australia.

[93] Women with Disabilities Australia (2009) Submission to the National Human Rights Consultation. WWDA. Tasmania. Available from: http://wwda.org.au/papers/subs/subs2006/

[94] Sterilisation of Girls with Disability: The State Responsibility to Protect Human Rights (2018) Women with Disabilities Australia (WWDA): Hobart, Tasmania. Available from: http://wwda.org.au/wp-content/uploads/2018/09/Sterilisation-of-Girls-with-Disability-Cashelle-Dunn-2018-1.pdf

[95] For more information please see the submission prepared for the Royal Commission by Women with Disabilities Victoria. See also: Woodlock, D., Healey, L., Howe, K., McGuire, M., Geddes, V. and Granek, S., Voices Against Violence Paper One: Summary Report and Recommendations (Women with Disabilities Victoria, Office of the Public Advocate and Domestic Violence Resource Centre Victoria, 2014).

[96] Lili Smith (2015) Health Outcomes of Migrants: A Literature Review, Migration Council of Australia. Available from: https://www.ogmagazine.org.au/20/1-20/better-outcomes-migrant-refugee-women/

[97] Lili Smith (2015) Health Outcomes of Migrants: A Literature Review, Migration Council of Australia. Available from: https://www.ogmagazine.org.au/20/1-20/better-outcomes-migrant-refugee-women/

[98] 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. Available from: http://www.mcwh.com.au/downloads/Womens_Health_Map.pdf

[99] Jaqueline Boyle and Suzanne Willey (2018) Supporting Better Outcomes for Migrant and Refugee Women. Obstetrician and Gynaecology Magazine. Available from: https://www.ogmagazine.org.au/20/1-20/better-outcomes-migrant-refugee-women/

to – and stigma around – mental health issues across different cultures may influence reporting rates and be a barrier for migrants in accessing information and assistance.[100]

Incarcerated women

Incarcerated women experience high levels of mental ill-health, victimisation, substance abuse and social disadvantage.[101] Incarcerated women are more likely than the general population to have an acquired brain injury,[102] and experience unstable housing.[103] They are more likely than incarcerated men to have minimal employment histories[104] and to be the primary carer for dependent children.[105] Prior to incarceration, these women have often experienced sexual abuse and/or intimate partner violence.[106]

Women entering prison are more likely than their male counterparts to report a history of mental health issues (62% and 47% respectively)[107] and 38% of incarcerated women are on medication for mental health issues (most commonly antidepressants or antipsychotics) compared to 22% of male prisoners.[108]

The social determinants of mental health and gender inequality

It is important to reiterate that each of the gendered social determinants or drivers of women's mental health are expressions of a wider context of gender inequality in which women's lives are lived. These determinants are not experienced in isolation form one another, but rather concurrently and cumulatively over the course of women's lives, with experiences of violence and trauma being compounded by a lack of financial resources and caring responsibilities, for example. Addressing this wider context of gender inequality has the potential to have a significant impact on improving mental health outcomes for women and girls. This is explored further in section 4.

3. The importance of gender-sensitive approaches to improving the mental health of women and girls

This section of the submission relates to questions 1, 2 & 9 in the Royal Commission submission template.

Attention to social factors, including gender inequality, is critical in approaches to mental health; these social determinants of mental health can be improved dramatically through the implementation of appropriate government policies and heightened community awareness.[109]

Unfortunately, despite mounting evidence that sex and gender are critical in mental health, the specific risk factors, needs and experiences of women have often not been considered in mental health policy or service design, or they have been considered of secondary importance.

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[100] Lili Smith (2015) Health Outcomes of Migrants: A Literature Review, Migration Council of Australia. Available from: https://www.ogmagazine.org.au/20/1-20/better-outcomes-migrant-refugee-women/
[101] Stathopoulos M, Quadara A, Fileborn B, Clark H (2012) Addressing women's victimisation histories in custodial settings Australian Institute of Family Studies, Melbourne - (ACCSA Issues; 13).
[102] In 2011, Corrections Victoria reported that 33% of women had an Acquired Brain Injury (compared to an estimated 2% of the general population). Acquired Brain Injury in the Victorian Prison System, (2011) Corrections Victoria, Department of Justice, Melbourne, p. 6.
[103] Women in the Victorian Prison System, (2019) Corrections Victoria, Melbourne, p. 9. (26% of women entering prison on remand reported experiencing homelessness or housing instability compared to 0.4% of Victorians who are estimated to be homeless).
[104] Stathopoulos M, Quadara A, Fileborn B, Clark H (2012) Addressing women's victimisation histories in custodial settings Australian Institute of Family Studies, Melbourne - (ACCSA Issues; 13).
[105] Women in the Victorian Prison System, (2019) Corrections Victoria, Melbourne p. 8. (21% of women in remand are primary carers compared to 14% of men on remand.)
[106] Stathopoulos M, Quadara A, Fileborn B, Clark H (2012) Addressing women's victimisation histories in custodial settings Australian Institute of Family Studies, Melbourne - (ACCSA Issues; 13).
[107] The health of Australia's prisoners 2015 (2015) Australian Institute of Health and Welfare 2015, p. 37.
[108] The health of Australia's prisoners 2015 (2015) Australian Institute of Health and Welfare, p. 45.
[109] Shoukai Y (2018) Uncovering the hidden aspects of inequality on mental health: a global study. *Translational Psychiatry* 9(98):1-10. Available from: https://www.nature.com/articles/s41398-018-0148-0.pdf

Sexual safety in acute mental health inpatient units

A 2018 report from the Victorian Mental Health Complaints Commissioner found that 80% 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 expressed about being placed in intensive care areas (also called high dependency units). The most common pattern of alleged 'sexual safety breaches' involved men breaching the sexual safety of women. Men were identified as individual perpetrators in 83% of complaints, and as having participated in a further 7% of 'sexual safety breaches'.[110]

The MHCC investigation included a comprehensive review of national and international literature. Among its chief recommendations is ensuring that unit planning, design and maintenance support sexual safety, with a particular focus on responding to the needs of women and other at risk cohorts:

'*Pilot and evaluate single-gender units, with a priority on piloting women-only units, and consider ways in which all inpatient units can be designed or adapted to provide additional flexible areas to meet the needs of varying inpatient populations, including trans or gender diverse people*.'[111]

Despite consistent calls for **women-only inpatient wards** and growing international evidence that suggests this is critical for improving women's sexual safety in inpatient facilities,[112] these are not routinely provided in intensive care areas of inpatient units in Victoria.[113]

A gender-sensitive approach to improving mental health understands and acknowledges the ways that a broader context of gender inequality shapes women's mental health experiences and needs.

Mainstreaming a gender-sensitive approach to mental health– 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 evidence-based gender-sensitive strategies for men and boys and gender diverse people.

Gender-sensitive approaches to mental health for women are evident in relation to post-natal depression and anxiety, but are notably lacking in relation to other mental health conditions, including anxiety, anxiety disorders, depression and self-harm. Interestingly, gender-sensitive approaches seem to be more common and more generally accepted in relation to the mental health and wellbeing of men and boys. For example, the Sax Institute published an 'evidence check' in 2014 examining the evidence for a gender-based approach to mental health. The aim of the evidence check was to explore the evidence base for the proposition that 'being male' is a key consideration for understanding mental health outcomes and service development, that is, whether a gender-based approach to mental health programs is defensible, especially for prevention, early intervention and stigma reduction. The report found that:

> It is important that programmes take a gender-based approach to working with men because there is a strong relationship between adherence to traditional masculinity and poorer mental

[110] The Right to be Safe: Summary Report (2018) Mental Health Complaints Commissioner, Melbourne. Available from: https://www.mhcc.vic.gov.au/news-and-events/news/ensuring-sexual-safety-in-acute-mental-health-inpatient-units
[111] The Right to be Safe: Summary Report (2018) Mental Health Complaints Commissioner, Melbourne. Available from: https://www.mhcc.vic.gov.au/news-and-events/news/ensuring-sexual-safety-in-acute-mental-health-inpatient-units
[112] Chris Hawley, Maria Palmer, Kiri Jeffreys et. al. (2103)The effect of single sex wards in mental health, Nursing Times, Vol 109 https://www.cqc.org.uk/sites/default/files/20180911c_sexualsafetymh_report.pdf
[113] The Right to be Safe: Summary Report (2018) Mental Health Complaints Commissioner, Melbourne. Available from: https://www.mhcc.vic.gov.au/news-and-events/news/ensuring-sexual-safety-in-acute-mental-health-inpatient-units

health help-seeking, higher levels of mental health stigma, suicide attempts and body image concerns.[114]

A range of prominent interventions are aimed at addressing the social determinants of men's mental health and/or providing gender-sensitive services for men. These include the national Men's Sheds Association, Men's Line and Movember.

Public attention and government and philanthropic investment in men's mental health has increased over the last decade. The Commonwealth Government's 2011 *Taking Action to Tackle Suicide* package, for example, provided $23.2 million over four years for support services and campaigns to address male suicide in recognition of 'the social determinants that increase the risk of suicidality for men'.[115] Investment is now urgently warranted to investigate and address the social determinants of self-harm, suicidality and other prevalent mental health conditions in women.

Despite the lack of established examples of gender-sensitive mental health interventions or support for women and girls, there are many international examples of guidelines or principles which are likely to lead to effective interventions, including the following example form the British Medical Association:

Gender-sensitive mental health services for women and girls should:

- Prioritise understanding mental distress in the context of women's lives
- Be co-designed with women with lived experience
- Enable all dimensions of problems experienced to be addressed
- Address sexual abuse, domestic violence, body image concerns, reproductive and life stage elements of health and wellbeing
- Be sensitive to the diversity of women's needs, experiences and backgrounds including race, sexuality and disability
- Enable women to make choices about their care and treatment
- Provide women-only spaces, particularly in inpatient settings, which enable women to feel secure, safe and respected
- Empower women to develop skills for addressing their difficulties
- Promote self-advocacy and advocacy for women who need support to voice their views
- Value women's strengths and potential for recovery.[116]

Gender-sensitive service delivery also recognises that women who have fewer resources in terms of time, money, language proficiency and health insurance often face unique barriers to accessing the healthcare system.[117]

In Canada, work is under way between the Centre for Excellence in Women's Health and the mental health and substance use systems to bring sex, gender and trauma-informed approaches to the

[114] Robertson S, Bagnall AM, Walker M (2014) Evidence for a gender-based approach to mental health programs. Sax Institute for the Movember Foundation. Available from: https://www.saxinstitute.org.au/wp-content/uploads/A-gender-based-approach-to-mental-health-programs.pdf

[115] Sarah Squire (2018) Women and Children being left behind in Australia's Mental Health Priorities, Power to Persuade Blog, Available from: https://www.powertopersuade.org.au/blog/women-and-children-being-left-behind-in-australias-mental-health-priorities/28/2/2018?rq=mental%20health

[116] British Medical Association (2018) Addressing unmet needs in women's mental health. BMA. London. Available from: https://www.cancerresearchuk.org/sites/default/files/womens-health-full-report-aug2018_0.pdf

[117] Women's Centre for Health Matters (2009) WCHM Position Paper on Gender Sensitive Health Service Delivery. WCHM. Canberra. Available from: http://www.wchm.org.au/wp-content/uploads/2015/02/WCHM-position-paper-on-gender-sensitive-health-service-delivery.pdf

substance use response sector. This includes consideration of how sex and gender each impact substance use and help-seeking, in order to support the development of gender-informed services.[118]

Closer to home, Centres Against Sexual Assault (CASAs) provide a gender-sensitive response to sexual assault with a focus on mental health.

Gender-sensitive, trauma-informed services: Centres Against Sexual Assault

Centres Against Sexual Assault (CASA) in Victoria operate from a structural feminist analysis of sexual assault, and are committed to addressing the gendered, cultural, economic and social inequalities that result in the perpetration of sexual assault and violence against women and children. Provision of accessible, effective and consistent quality services to victim/survivors of sexual assault requires an understanding of the gendered causes and consequences of sexual assault. CASA service users have the value of non-pathologising, trauma-informed care, which contrasts with some service users' experience of mental health services. For example:

'H': In the mental health care system, the client stated that her trauma symptoms were often pathologised which led to feelings of invalidation, fear and shame. The client stated that her sexual assault was identified as needing a separate form of therapy as the psychologists did not feel they had the means or time to adequately address it in their counselling sessions. This further highlighted and reinstated feelings of invalidation and shame.[119]

By contrast with this approach, CASAs make explicit the link between rights, empowerment and long-term healing for victim survivors of sexual assault.

Applying an intersectional gender lens to improving women's mental health

Because gender inequality intersects with other social determinants such as racism, homophobia and ableism, as well as access to economic resources, some groups of women are more likely to experience poor mental health.

For example, twice as many rural adolescent girls report symptoms consistent with depression compared to their male counterparts.[120] While more research is needed to determine the effect of socio-economic status on rates of depression among rural populations, the study found that lack of availability and long waiting lists for mental health services, stressors involved in interpersonal relationships, and a perceived lack of mental health support accounted for higher rates of depression among young rural women.[121] Gender-sensitive online interventions may help to improve outcomes for girls in rural areas.

Research suggests that same-sex attracted and gender queer (SSAGQ) young people living in rural and regional Victoria face added pressures due to higher levels of homophobia, increased surveillance, and reduced access to relevant information, resources and services.[122] Young people

[118] See the *New Terrain* report for more information: Schmidt R., Poole, N., Greaves, L., and Hemsing, N. (2018). New Terrain: Tools to Integrate Trauma and Gender Informed Responses into Substance Use Practice and Policy. Vancouver, BC: Centre of Excellence for Women's Health. Available from: http://bccewh.bc.ca/wp-content/uploads/2018/06/NewTerrain_FinalOnlinePDF.pdf

[119] For further information please refer to the submission prepared by CASA Forum, from which this excerpt is drawn.

[120] Black, Roberts and Li-Leng Depression in rural adolescents : relationships with gender and availability of mental health services. *Rural and Remote Health*. 12 (2092):1-11, p. 7. Available from: https://www.rrh.org.au/public/assets/article_documents/article_print_2092.pdf

[121] Black, Roberts and Li-Leng Depression in rural adolescents : relationships with gender and availability of mental health services. *Rural and Remote Health*. 12 (2092):1-11, p. 7. Available from: https://www.rrh.org.au/public/assets/article_documents/article_print_2092.pdf

[122] Leonard, Marshall, Hillier, Mitchell and Ward (2010) Beyond homophobia: meeting the needs of same sex attracted and gender questioning (SSAGQ) young people in Victoria : a policy blueprint, p. 11. Available from: https://www.glhv.org.au/policy/beyond-homophobia

from migrant and refugee backgrounds are often reluctant to seek professional support with their psychosocial problems due to a range of individual, cultural, and service-related barriers.[123]

Addressing mental health in same sex attracted migrant and refugee women

The **Our Voices, Changing Cultures Project**, delivered by the Multicultural Centre for Women's Health, was designed specifically to build resilience, capacity and leadership among young same-sex attracted women from culturally diverse immigrant and refugee backgrounds.

Through group discussions and performance-based workshops, the project created a space for young same-sex women to feel safe to discuss issues that affect them. Creating this space helped to link up same-sex attracted women who may be dealing with cultural and migration related issues with each other, enabling them to share their experiences and strategies, and helping to improve their mental health.[124]

Culturally-sensitive health information – the FARREP program

One important example of the delivery of culturally-sensitive health information by women educators in safe women-only spaces is the Family and Reproductive Rights Education Program (FARREP) program. This program works with women and girls from diverse ethnic, cultural and religious backgrounds who have migrated from countries where female genital mutilation or cutting (FGM/C) is practised. FARREP workers focus on the delivery of culturally-sensitive health information to women that is responsive to mental health issues that can affect women's engagement with health services, including PTSD. In Victoria, FARREP is delivered by the Royal Women's Hospital as well as women's health services such as WHIN and Women's Health West.

Young women with disabilities are subjected to dual discrimination and stereotyping on the basis of gender and disability, adversely affecting self-esteem and expectations.[125] For young Aboriginal and Torres Strait Islander women, the compounding effects of a history of colonisation and dispossession, intergenerational trauma, removal from family and community, racism and discrimination[126] have a detrimental effect on mental health.

Addressing suicide and self-harm among Aboriginal and Torres Strait Islander communities: iBobbly

Connection to country and culture is important to the health of Aboriginal and Torres Strait Islander young women and strengthening this connection is widely considered the key to disrupting cycles of disadvantage.[127] Programs to address Aboriginal and Torres Strait Islander mental health and suicide prevention should include community-specific and community-led programs that focus on strengthening social and emotional wellbeing and cultural renewal, and should be delivered by community members.[128]

[123] Centre for Multicultural Youth (2014) Mind Matters, p.8. Available from: https://www.cmy.net.au/sites/default/files/publication-documents/Mind%20Matters%202014.pdf
[124] Multicultural Centre for Women's Health (2016) Final report: Our Voices, Changing Cultures Project
[125] Women with Disabilities Australia (2015) Submission to the UN Committee on the Rights of the Child (CRC) : development of the General Comment on the Rights of Adolescents, p. 9. Available from: http://wwda.org.au/wwda-submission-to-the-united-nations-on-the-rights-of-adolescents/
[126] Suicide Prevention Australia (2016) Suicide and suicidal behaviour in women: issues and prevention, page 24. Available from: https://apo.org.au/node/56174
[127] Aboriginal Family Violence Prevention and Legal Service Victoria (2016) A Victorian Government gender equality strategy : submission by FVPLS Victoria, p. 15. Available from: https://djirra.org.au/wp-content/uploads/2018/02/Submission-A-Victorian-Gender-Equality-Strategy-FVPLS-Victoria-FINAL.pdf
[128] University of Western Australia. School of Indigenous Studies Solutions that work : what the evidence and our people tell us : Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report [ATSISPEP Report], p. 56. Available from: https://www.pmc.gov.au/resource-centre/indigenous-affairs/solutions-work-what-evidence-and-our-people-tell-us

Recent research has found that Aboriginal young people have a high uptake of digital technology and social media[129] indicating the potential for the development of effective specialist digital/online health resources for Aboriginal young people. The **iBobbly App** has been designed for Aboriginal young people aged 16-35 who are experiencing suicidal ideation and mental distress. iBobbly delivers messages and information to reduce suicidal thought in a culturally relevant way. Developed by the Black Dog Institute in partnership with Aboriginal organisations, the iBobbly pilot has received strong positive feedback. The app format overcomes geographical isolation and privacy concerns, giving it strong potential to reach those who don't normally seek help. [130]

An intersectional gender-sensitive approach to mental health should recognise and respond to the needs of women and girls experiencing different, intersecting forms of inequality and discrimination. This means both ensuring that universal approaches to mental health promotion and service delivery account for these differences, but also that tailored approaches – like those outlined in the case studies above – are developed to respond to the needs and experiences of particular groups, Gender-sensitive approaches should be designed by those groups of women whom they are intended to benefit.

From primary prevention through to treatment and recovery services, interventions should be gender-sensitive but also culturally safe, inclusive and accessible. A 'No Wrong Door' approach can be achieved though the co-design of services and interventions with the target population, training and support from specialist organisations (e.g. Aboriginal Community Controlled Organisations and specialist women's services), workforce capacity building and partnerships and linkages.

Mental health reforms must also engage with people at every life stage. By focusing only on interventions and services for young people, for example, we risk perpetuating the marginalisation of middle aged and older women. Older women's mental health is impacted by cumulative experiences of gender inequality and discrimination throughout their lives. Peer support programs for older women provided in aged care or local government settings are one example of a life stage approach to mental health. For example:

Older Women's Wellness Centres

The Older Women's Network Australia (now the National Older Women's Network Australia) has urged the federal government to invest in community-based wellness centres for older women. The Older Women's Network in Sydney has successfully set up three Wellness Centres, run by and for older women in partnership with professional workers, with most of the funding coming from local government. OWN notes:

'[t]hese centres have proved extremely cost effective and have achieved much in improving the health and self esteem of participants, as well as combating social isolation and reducing dependence on clinical or institutionally based services...

As well as helping older women overcome social isolation, and maintaining their own independence and mental and physical health, [wellness] centres enhance older women's decision-making capacity and involvement in local communities.'[131]

[129] Emma Rice, Emma Haynes, Paul Royce and Sandra Thompson (2016) Social media and digital technology use among Indigenous young people in Australia: a literature review, International Journal for Equity in Health. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4881203/

[130] Black Dog Institute (2015) The extension of iBobbly : an app to reduce suicidality among young Aboriginal and Torres Strait Islander people : final report for the New South Wales Mental Health Commission, p. 2. Available from: https://nswmentalhealthcommission.com.au/sites/default/files/Final%20report%20iBobbly%20NSW.pdf

[131] Older Women's Network Australia, Submission to the Inquiry into Long-term Strategies to address the Ageing of the Australian Population over the next 40 Years. No date shown. Available from: www.aphref.aph.gov.au_house_committee_ageing_strategies_subs_sub58%20(1).pdf

OWN identified the Bankstown Older Women's Network Wellness Centre as an example of a successful peer support model to support older women's mental and physical health and wellbeing.[132]

The need to build the evidence base for effective gender-sensitive interventions

In addition to driving poor mental health outcomes and gendered inequalities in mental health, failure to centre consideration of sex and gender in mental health can only contribute to inefficiency, ineffective interventions, and higher costs. Unfortunately, despite widespread acceptance of gender as a key determinant of mental health, there is limited gender-disaggregated data about the prevalence of mental health conditions (for example, the National Survey of Mental Health and Wellbeing has not been run for over 10 years) and there is limited evidence about effective gender-sensitive interventions for women and girls. This highlights the need for significant investment in building the evidence base for gender-sensitive approaches.

Across the spectrum from prevention to recovery, investment should be guided by existing evidence, 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. Gender-disaggregated data should be collected and analysed to support a better understanding of the mental health needs, experiences and outcomes of women, men and gender diverse people.

Demystifying data – the Victorian Women's Health Atlas

The Victorian Women's Health Atlas (the Atlas) is a ground-breaking interactive tool developed by Women's Health Victoria to illustrate the relationship between gender and health.

The Atlas provides easy access to sex-specific data on a range of key health and socioeconomic issues that affect Victorian women, including mental health. Interactive maps allow users to visualise, track and compare selected health indicators, across regions and local government areas in Victoria. It is the first tool of its kind to display sex-disaggregated data, highlighting the disparity in health outcomes between females and males for every local government area in Victoria. Data is presented in the form of maps, bar charts and fact sheets, accompanied by a gender analysis, that builds a clear picture of current health trends.

The up-to-date, reliable, gendered data available through the Atlas provides an evidence base to inform advocacy, service planning and monitoring and evaluation at the local, regional and statewide levels.

Currently the Atlas includes the following mental health indicators: Personal Wellbeing; Close Knit Community; Community Connectedness; Anxiety and Depression; Psychological Distress; and Self-Harm.

4. Gender equality and primary prevention for mental health

Empowered women contribute to the health and productivity of whole families and communities, and they improve prospects for the next generation.[133] When women and girls live free from violence, poverty, and rigid stereotypes that limit their potential, mental health is improved, the economy is stronger, and our pool of future leaders is more diverse.

[132] Bankstown Older Women's Network: https://www.cbcity.nsw.gov.au/communityccb/Pages/Bankstown-Older-Women%27s-Network.aspx
[133] United Nations Population Fund (2015) Gender equality [Webpage]. Available from: https://www.unfpa.org/gender-equality

By investing in and strengthening gender equity we can address the social determinants that lead to poor and unequal mental health outcomes for women. In other words, investing in gender equality is a primary prevention strategy for mental health.

Gender inequality is recognised as the primary driver of violence against women.[134] For this reason, primary prevention efforts in relation to violence against women have focused on increasing gender equity. The approach taken to the primary prevention of violence against women in Victoria offers a useful example of the application of the public health approach to prevention. Applied to mental health, its key features might be:[135]

- A focus on addressing the 'drivers' of poor mental health (including gendered violence, trauma, housing and financial insecurity, and poor body image among others);
- An intersectional whole-of-population focus, supplemented by tailored approaches for specific population groups;
- Use of the socio-ecological model, which includes:
    - 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 violence against women in Victoria, this approach has been supported by a dedicated government strategy (*Free from Violence*) and accompanied by (albeit limited) investment, with activity coordinated by a central body or bodies.

Any primary prevention strategy for mental health must address the gendered social determinants of poor mental health for women, men and gender diverse people, 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 family violence 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.

Investing in gender equity is key to preventing violence against women and can also improve the health and wellbeing of men and boys and gender diverse people. In this way, addressing gender inequality may be the most effective and cost-effective way to improve outcomes across a range of social and health issues. Applying an intersectional lens will ensure interventions are sensitive, appropriate and effective, and that they support equity among girls and women. WHV recommends that the Commission gives these matters close consideration.

A strong focus on primary prevention does not detract from the importance of early intervention, treatment and recovery. An intersectional gendered approach should guide all aspects of mental health reform – from primary prevention, through to early intervention, treatment and recovery. Such work should both be informed by best practice (where available) and contribute to the evolving evidence base, and should include universal strategies as well as strategies tailored for different population groups.

[134] Our Watch, ANROWS and VicHealth (2015) Change the story : a shared framework for the primary prevention of violence against women and their children in Australia, p. 24. Available from: https://www.ourwatch.org.au/getmedia/1462998c-c32b-4772-ad02-cbf359e0d8e6/Change-the-story-framework-prevent-violence-women-children.pdf.aspx

[135] Refer to Change the Story for an example of the application of this model in the PVAW space:
Our Watch, ANROWS and VicHealth (2015) Change the story : a shared framework for the primary prevention of violence against women and their children in Australia. Available from: https://www.ourwatch.org.au/getmedia/1462998c-c32b-4772-ad02-cbf359e0d8e6/Change-the-story-framework-prevent-violence-women-children.pdf.aspx

It is also essential that specialist women's services are resourced to provide expert advice to support mainstreaming of gender-sensitive approaches to mental health to ensure that 'mainstreaming' does not lead to the loss of specialist expertise.

5. Urgent issues with the current system, including the need to centre the voices of women with lived experience of mental ill-health

This section of the submission relates to questions 2 & 9 in the Royal Commission submission template.

In preparing to make this submission WHV has researched widely, participated in community consultations, and reviewed and provided feedback on the submission prepared by Mental Health Victoria. Through this collective work, some urgent issues with the current mental health system in Victoria have been identified which we think should be priorities for the Royal Commission. These include:

1. Funding mental health services to clear long waitlists in community and acute settings and prioritising access and continuity of care over service age limits.
2. Supporting better integration between the acute system (particularly hospital emergency departments), GPs and community mental health services.
3. Moving away from a crisis-focused/rationing model for mental health service provision toward greater resourcing for prevention and early intervention.
4. Addressing workforce shortages to support continuity of care and retention of skilled workers.
5. Designing, implementing and evaluating mental health services in partnership with those who have a lived experience, and their families/carers.

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 Commission's process and findings as well as helping to design effective solutions. 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 Women's Mental Health Network Victoria.[136]

We also support the specific recommendations made by Mental Health Victoria in regard to:

- Establishing an independent Mental Health and Wellbeing Commission to oversee and implement systems transformation, independent monitoring and oversight.
- Investing in housing and employment strategies which recognise the importance of secure and appropriate housing, and participation in the workforce as key to improving mental health outcomes.
- Better integration with the NDIS to make sure that no one experiencing poor mental health falls through the cracks and that everyone has access to appropriate services and supports.

For further information please refer to the submissions prepared by VCOSS and Mental Health Victoria.

Conclusion

Mental health and wellbeing is determined by a combination of genetic/biological, social/ environmental and personal/individual factors. These factors are strongly influenced by sex and

[136] Victorian Women's Health Network [Website] Available at: https://wmhnv.org.au/

gender. Despite this, major mental health policy frameworks, health promotion efforts and mental health service delivery have tended to take what is referred to as a ‘gender-blind’ or gender-insensitive approach, thereby missing key opportunities to design more (cost) effective interventions and improve outcomes. To the extent that gender-sensitive or gender-specific interventions have been designed and implemented, these have tended to be targeted at improving men’s mental health and have failed to recognise the significant impact of gender on the mental health of women and girls.

In order to optimise health outcomes, a gender-sensitive approach should be applied to understanding and addressing all mental health issues, and should include a specific focus on improving the mental health outcomes of women and girls. This is particularly critical in relation to conditions including suicide and self-harm, eating disorders, and depression and anxiety.

In addition to gender, race, culture, class, employment status, sexuality, disability, age, and immigrant status are important determinants of women’s health and equality. An intersectional approach is required to ensure that mental health interventions across the spectrum from prevention to recovery are inclusive of, and can reach, all groups of women.

There is irrefutable evidence that sex- and gender-based inequality drives unequal mental health outcomes. By investing in an intersectional approach to gender equality, we have the opportunity to significantly improve mental health outcomes and reduce the costs of mental ill-health, while simultaneously supporting the prevention of violence against women and improving equity, inclusion and wellbeing across the whole community.

Additional resources

WHV would like to take the opportunity to draw the Commission's attention to resources we consider particularly relevant to the Inquiry:

- Mental Health Indicators displayed on the Victorian Women's Health Atlas – The Victorian Women's Health Atlas was developed by WHV as 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.
- *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 Women & Self-harm (2018) - This WHV 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.
- Spotlight on Anxiety & Women's Health (2019) - This WHV Spotlight features a list of up-to-date and freely available research and resources on the topic of women and anxiety. One in three women, compared to one in five men will experience an anxiety disorder in their lifetime, and anxiety disorders are the leading contributor to the burden of disease in Australian girls and women aged five to 44. Women's higher likelihood of developing anxiety symptoms and related disorders are thought to arise from a combination of genetic, biological and socio-environmental factors.
- *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.