Input to the Terms of Reference for the Royal Commission into Mental Health

SUBMISSION

Women's Health in the South East Inc (WHISE)
24 January 2019

Acknowledgement of the Traditional Owners

Women's Health in the South East acknowledges the traditional owners of the land of the Southern Metropolitan Region of Melbourne including the Bunurong People and Wurundjeri People of the Kulin Nation. We pay our respects to elders past, present and emerging. WHISE acknowledges that sovereignty of this land has never been ceded and we are committed to honouring Australian Aboriginal and Torres Strait Islander peoples in our work.

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WHO IS WHISE?

Women's Health in the South East (WHISE) is the regional women's health service for the Southern Metropolitan Region.

WHISE is a not-for-profit organisation that focuses on empowering women. We work to improve the health and well-being of women in our region by providing health information and education to governments, organisations, education providers, and community groups.

Our team of health promotion professionals work to promote gender equality, sexual and reproductive health and the prevention of violence against women.

WHISE proudly provides settlement services for refugee and migrant women. Funded through the Federal Government, our team assist women to access mainstream services, increase their knowledge of Australian society, and to help them better participate in the broader community. We run support sessions, provide assistance to liaise with government departments and referrals when required.

Primary prevention

Primary prevention in health promotion is at the very core of what we do. It is a deliberate way of changing the underlying causes of poor health. Rather than treating disease, our work seeks to prevent disease. WHISE work aims to reduce incidence of poor health of women in our community.

We train and raise understanding about gender equality because we know that this is the root cause of violence against women. We work in partnership with communities on sexual and reproductive health to support women to take control over their own health and well-being.

Health Promotion and Primary Prevention increases community well-being and most importantly for us, empowers women.

Where we work

We work across 10 local government areas. Our area of work is called the South Metropolitan Region and consists of approximately 1.3 million people, representing about one-quarter of the state's total population.

We cover Port Phillip, Bayside, Kingston, Frankston, Stonnington, Glen Eira, Dandenong, Cardinia, Casey and Mornington Peninsula.

Introduction and summary

Women's Health in the South East (WHISE) congratulates the Victorian State Government on the establishment of a Royal Commission into Mental Health. We are pleased to contribute to the terms of reference into the Royal Commission through our submission.

The work of WHISE has focused on improving the health and wellbeing of women across the Southern Metropolitan Region. Working collaboratively with women and service partners, WHISE has been pivotal in providing information, research and advocacy in a wide range of areas including sexual and reproductive health, the prevention of violence against women and gender equity. As a leading women's health service in the area, WHISE has sought to actively respond to the needs of the local community. Our commitment to understanding women's experiences through the lens of a social model of health as well as through a feminist framework has enabled WHISE to more holistically understand women's lives and to acknowledge the diversity of women in the region.

To this end, WHISE advocates that the terms of reference also include:

1. The impact of gender and intersectionality on mental health – taking a gendered lens
2. The role of primary prevention in improving mental health of our community
3. The role of regional implementation of public mental health strategies to accommodate regional variability
4. The role of workforce planning and capacity and capability building to respond to changes in regional social and economic demographics

It is important to distinguish between mental health and mental illness or mental disorders. For WHISE, mental health is "a broad term that encompasses the general state of a person's mental wellbeing. It's more technically defined as a person's condition regarding their psychological and emotional well-being" (Wilson, 2018). Mental health issues in this sense are often experienced more frequently and may arise as a response to stress in one's personal or work life and the intersectionality of a experiences that impact on wellbeing. Mental illness can be longer lasting and more acute. WHISE acknowledges the different experiences that community members have with mental health and wellbeing, and that while mental health issues are often less severe, they may and often do, "develop into a mental illness if they are not effectively dealt with" (Department of Health, 2018). We know that, "Positive mental health serves (are) a powerful protective factor against mental illness" (Saxena, et al., 2006).

The Need for a gendered perspective

According to the report, Investing in Women's Mental Health, Strengthening the foundations for women, families and the Australian economy (Duggan, 2016), mental disorders "represent the leading cause of disability and the highest burden of non-fatal illnesses for women in Australia". The report reveals many concerning facts including;

- 43% of women (3.5 million) have experienced mental illness at some time,
- Australian women are more likely than men to have experienced symptoms of a mental disorder during the previous 12 months (22% of women compared to 18% of men)
- Young women report the highest rates of mental disorder of any population group (30% for women aged 16 to 24)
- Women are more likely than men to have or report symptoms of anxiety disorders 18% (11% of men) - affective disorder such as depression - 7% (5% of men) - eating disorders 15% of young women have had an eating disorder at some point in their lives, and eating disorders are the third most common chronic illness amongst young women in Australia; deliberate self-harm – females record higher age-adjusted rates of hospitalization due to intentional self-harm than males across all age groups (10–14 to 60–64)
- Perinatal depression – one in five mothers of children aged 24 months or less are diagnosed with depression. More than half of these mothers reported that their diagnosed depression was perinatal (that is, the depression was diagnosed between pregnancy and the child's first birthday). This represents an estimated 111,000 Australian mothers being diagnosed with depression, and 56,000 with perinatal depression annually.
- The number of hospital admissions for specialized psychiatric care following a principal diagnosis of recurrent depressive disorders and specific personality disorders was substantially higher for females than males during 2007–08
- In the same period, females aged 35–44 were the highest consumers of Medicare-subsidised mental health-related GP services
- Women in Aboriginal and Torres Strait Islander communities have much poorer physical and mental health than other Australians including much higher rates of mental health condition and higher rates of morbidity and premature mortality associated with comorbid conditions, including diabetes and cervical and ovarian cancers; Anxiety and depression are the foremost health problems reported by indigenous women in Australia; The suicide rate of Aboriginal and Torres Strait Islander women is highest within the 20-24 years old age group (21.8 per 100,000), which is more than five times higher than their corresponding nonindigenous counterparts (4.0 per 100,000).

These statistics reveal the highly gendered nature of several mental health issues in the community. As Duggan (2016) explains,

> *Gendered explanations are relevant to understanding the variations of health and disease amongst men and women in the population and are particularly helpful in*

understanding why certain groups of girls and women are at risk of poor mental health. It is suggested that three key gendered factors in interaction shape risks across the life course for women. Some women are at particularly high risk of mental illness due to the interrelated dynamics of social inequalities, the impact of negative life experiences (for example violence and abuse) and gender expectations.

As such, WHISE believes that a gendered analysis and lens be applied to each of the themes of the Royal Commission. The historically narrow view of the masculine and feminine highlights the challenges and complexities that arise when this binary is applied across specific areas of concern including mental health. This is particularly apt when the wider social landscape alongside the dominant patriarchal paradigm is not acknowledged or seen to not have an impact on people's experiences.

Family violence and its impact on women's mental health

As a health promotion organisation, WHISE recognises the relevance and significance of the gendered nature of several mental health issues. In particular, WHISE understands the continued impact on women's mental health as a result of family violence and sexual abuse.

As has been widely documented, violence against women is an urgent public health and human rights issue. As the latest crime statistics reveal, the rate of family violence incidents in Victoria has increased by 18.2% from 2014 to 2018 (Crime Statistics Agency, 2019). This is a significant increase and highlights the continuing role and thus impact on women's health and wellbeing including mental health.

Data suggests that there is a strong link between the experience of family violence and the development of a mental health condition as a result. A report examining the health outcomes of intimate partner violence (IPV) against women by ANROWS (Lum On, et al., 2016) "found that IPV increased the risk of subsequent depression" amongst many victims. This was the case even when participants with past histories of depression were excluded. Similarly, in a longitudinal study (Loxton, et al., 2017) it was found that "intimate partner violence adversely impacted on mental and physical health over the 16-year study period and across generations". Disturbingly, the study also found that mental health continued to be a factor and impacted women well into very old age, unlike the impact on physical health (Loxton, et al., 2017).

In other studies, the impact of family violence on women's mental health was seen in the development of PTSD amongst a high number of survivors (Ferrari, et al., 2016). In their study, Ferrari et al revealed that a significant number of participants who had experienced family violence "reported symptoms of PTSD at the time they filled in the questionnaire used in the study". It was found that the risk of developing PTSD was higher among women who had experienced IPV than other mental health conditions. The study also found that, "participants in the study had substantially more psychological distress" (Ferrari, et al., 2016) than the general population in the United Kingdom.

Additionally, the study revealed that "an increasing severity of IPV was associated with worse mental health".

In addition to the impact of family violence on women's mental health, research reveals that family violence also impacts on children who are witness to or hear about family violence in their homes. As is revealed in the report Children affected by domestic and family violence: A review of domestic and family violence prevention, early intervention and response services (Campo, et al., 2014), "in relation to the impact of exposure to DFV, empirical studies in the past 20 years have established the negative psychosocial and developmental outcomes for children exposed to DFV".

In responding to the needs of victims of family violence, WHISE urges the Commission to use a family violence framework. Using a framework such as 'Change the Story' allows for a holistic approach to understanding the drivers and impact of family violence on women, children and perpetrators.

The importance of a primary prevention approach

Given the impact of social issues/problems such as family violence on women's mental health, and the gendered nature of much of mental health (as indicated by statistics and research), the role of primary prevention becomes vitally important. As stated previously, primary prevention of disease and illness in women through health promotion is at the core of the work of WHISE. Health Promotion and Primary Prevention saves lives, increases community well-being and most importantly for WHISE, empowers women, "so that they can enjoy health (and have a) good quality of life..(which is a) pre-requisite for achieving their potential in other facets of their lives" (Keleher, et al., 2007). WHISE embraces the Ottawa Charter (for Health Promotion, 1986) which recognizes that health is a "positive concept…(and) goes beyond healthy life-styles to well-being" (World Health Organisation, 2018). Furthermore we note the evolution of the Charter at` the 6th Global Conference on Health Promotion in Bangkok (2005) which recognizes the increasing global changes and trends affecting health and well-being and, because of this the evolution of Health promotion strategies to address increasing inequalities and complexities in our community (World Health Organisation, 2005).

In terms of mental health and primary prevention, WHISE highlights the relevance and intersection of the 'social' with the 'personal'. A primary prevention approach acknowledges that addressing issues of mental health must go beyond the individual and individualistic approaches. Instead, WHISE considers the importance of a holistic approach where the wider social dynamic is viewed as playing a critical role in someone's personal experience. As such, social problems including family violence, isolation, financial stress, homelessness and so on, must also be considered, understood and addressed (where possible). These conditions play a significant role in the way people respond to specific circumstances and how they attempt to exercise agency. As Saxena et al reveals, "There is strong evidence on risk and protective factors and their links to the development of mental disorders. Risk factors are associated with an increased probability of onset, greater severity or longer duration of major health problems [including mental health]. Protective factors refer to

conditions that improve people's resistance to risk factors and disorders" (Saxena, et al., 2006). At the macro level, risk factors include issues such as poverty, war, and inequality. At the personal level, risk factors might include biological, cognitive, emotional and family dynamics (which may be determined to a large extent by macro level issues).

Saxena et al (2006) recognise the value of addressing macro level issues and the way this impacts on improved mental health outcomes for individuals and communities. For example, research into the impact of improving insecure housing found that people reported better mental health overall (Saxena et al, 2006).

As well as emphasising the role of primary prevention to help stem the development of more serious mental illness amongst individuals, primary prevention is also beneficial to help reduce stigma associated with a mental health issue in the community (Weiss, et al., 2001). In addition to helping reduce the suffering from stigma, however, the efforts from a primary prevention approach can also "counter psychological defence mechanisms of minimization and denial fostered by stigma, which discourage appropriate help-seeking for mental health problems, even when services are available" (Weiss, et al., 2001). In one study it was found that contact with adults suffering from a mental illness as well as educational programs seemed to "significantly improve attitudes and behavioural intentions toward people with mental illness, with contact yielding significantly better change, at least among adults" (Corrigan, et al., 2012). In this research, stigma and negative attitudes towards those with a mental health issue was significantly reduced.

The importance of a regional/local approach

WHISE believes that understanding the needs of the local community is best done through a regional/local approach. A one size fits all approach is not able to fully integrate the specific needs of an area.

The Southern Metropolitan Region (SMR) region for example, is a diverse and expansive area that covers 10 local government areas including suburbs from South Melbourne to the Mornington Peninsula and east to Casey and Cardinia. With such a wide-ranging population and geographical area diversity exists, both in terms of socio-economic status (SES); ethnicity (both migrants and refugees) as well as the presence of several minority groups including indigenous population and LGTBIQA+ community. To the south of the region, affluent and wealthy areas can be found while the south east reveals some of the most economically marginalised areas within Victoria.

These contrasting demographics highlight the diverse needs amongst the various municipalities. In terms of mental health, the various groups residing there might be impacted differently according to their specific experiences; whether that be isolation, resettlement or marginalization.

The need for targeted services to tackle mental health issues is therefore vital. A specific strategy may not be applicable across all areas, nor in every situation. People's experience of depression or

anxiety for example may vary across individuals and groups depending on age and/or gender. Moreover, ethnicity and socio-economic status may also impact on the way individuals not only experience a mental health issue, but how they interpret their experiences and the types of support they might need or seek out. For others, the decision to seek support at all will be dependent on various factors too (as mentioned above).

The role of workforce planning and capacity development

For WHISE any outcome of the Royal Commission need to be mindful of the impact that implementation will have on the existing and future workforce. Further, the implementation of the Royal Commission into Family Violence has taught us, that both prevention and response skills need to be considered in improving health outcomes.

WHISE advocates that the Royal Commission terms of reference including outcomes based on effective workforce planning and consideration as to how recommendations for policy, structural and cultural changes will need to be supported through the workforce.

Further, lessons from the implementation of recommendations on Family Violence, have also taught us that workforce planning and development needs to be:

- Regionally based
- Set in a realistic context of economic and social growth drivers
- Based on contemporary workforce planning and development practice
- Industry driven

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