Good Shepherd
Australia New Zealand

Submission to the Royal Commission into Victoria's Mental Health System

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About us

Good Shepherd Australia New Zealand was established to address the critical, contemporary issues facing women, girls and families. We work to advance equity and social justice, and to support our communities to thrive. We aspire for all women, girls and families to be safe, well, strong and connected.

A central part of our purpose is to challenge the systems that entrench poverty, disadvantage and gender inequality. The Women's Research, Advocacy and Policy (WRAP) Centre does this through a range of research, policy development and advocacy activities.

Acknowledgements

We thank the practitioners from Good Shepherd client services who shared their practice wisdom with us and which we have referenced in this submission. Their insights from working directly with women, girls and families place the determinants of poor mental health and the gaps across the service system sharply into focus.

Endorsements

This submission has been endorsed by the National Foundation for Australian Women.

Executive summary

We welcome the Royal Commission into Victoria's Mental Health System. The Royal Commission offers a unique opportunity to consider the range of factors which contribute to both poor mental health and good mental health.

We note that there are multiple challenges within the mental health service system including responding to high demand, funding shortfalls, lack of access, poor integration with intersecting service systems, and related areas for policy development and service improvement. Genuine reform will not be possible without significant investment and redesign to place the person at the centre of service delivery.

This submission focuses on gender differences in the prevalence, presentation, treatment, and prevention of mental health conditions and suicidality. It explores bias and gaps in knowledge, including a range policy and practice issues in response to Questions 1, 4, 5, and 9 as posed in the Royal Commission's 'Outline of questions' guide. We also draw on case studies and the practice wisdom of Good Shepherd Australia New Zealand staff, including their reflections on working with children, young people and families.

Applying a gender lens enables a deep understanding of the complex economic and social drivers for mental health conditions, which can in turn inform the development of effective prevention and intervention initiatives.

Ten recommendations are made to inform improved prevention, intervention, response and recovery initiatives with a focus on women, girls and their families.

We welcome the opportunity to provide oral evidence in relation to any of the matters raised in this submission.

Recommendations

Recommendation 1: Develop integrated campaigns to increase awareness of women and girls' mental health, inform positive behaviour change across health and other service settings, and reduce stigma.

Recommendation 2: Increase investment in data collection and research to:

- Increase systematic collection and reporting of gender disaggregated data on women's mental health, including suicide, suicidal behaviour, and self-harm; and demographic categories which include at-risk cohorts

- Support research into what works to mitigate poor mental health among women, and what works to facilitate good mental health among women (including risk and protective factors).

Recommendation 3: Develop a targeted strategy to improve the mental health of women and girls, and to mainstream women and girls' mental health across existing strategies and service responses, particularly for vulnerable groups of women; and ensure that consumer participation sits at the centre of program ideation, design, development, testing and evaluation.

Recommendation 4: Ensure that new mental health strategies and services are inclusive of a diversity of women and girls, including dedicated funding streams to address the specific needs of:

- Aboriginal and Torres Strait Islander people

- LGBTIQ+ communities

- Culturally and Linguistically Diverse communities

- Recently arrived migrants and emerging communities

- Other cohorts at high risk of poor mental health, including people navigating the criminal justice system, people in closed environments and people with complex needs.

Recommendation 5: Advocate to the Commonwealth Government to expand the Medicare rebate for psychological treatment beyond the current 10 sessions per year.

Recommendation 6: Increase existing levels of funding for mental health services and develop a variety of program supports to improve pathways and provide continuity of care (for example, referral systems such as post-discharge services from hospitals to community mental health follow-up and other services).

Recommendation 7: Improve integration between services and programs across sectors, such as community services, housing and employment, and incentivise collaborative partnerships that place the individual at the centre of service delivery (for example, embedding complementary support services, such as financial counsellors, in mental health service teams).

Recommendation 8: Increase investment in prevention and early intervention in the early years and primary school age, with continued support into adolescence and young adulthood, including extending the Mental Health in Schools secondary school program to primary schools across the state.

Recommendation 9: Invest in workforce development to ensure that the needs of women and girls engaging in self-harm and suicidal behaviour are met, including appropriate training, supervision and quality assurance frameworks.

Recommendation 10: Expand investment in initiatives that address systemic gender issues under the Safe and Strong Gender Equality Strategy to better support the mental health of women, girls and families.

1. Introduction

Good Shepherd Australia New Zealand (Good Shepherd) has a long history of working with women, girls and families, particularly those who are most vulnerable. The Women's Research, Advocacy and Policy (WRAP) Centre has a special focus on how structural disadvantage is experienced by women and girls. This submission is therefore focused on gender differences in the prevalence, diagnosis and treatment of poor mental health. It explores the social and economic determinants of mental health, funding discrepancies, access issues, lack of service integration, bias and gaps in knowledge, and related areas for policy development and service improvement.

In addition to academic and grey literature, this submission also includes case studies and insights from practitioners such as psychologists, counsellors, financial counsellors and financial capability coaches working in Good Shepherd services and programs.

2. Why a gender lens on mental health is critical

This section includes content relevant to the Royal Commission's *Question 1: What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?*, *Question 4: What makes it hard for people to experience good mental health and what can be done to improve this?*, and *Question 5: What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?*

There are significant gender differences in the prevalence of mental health conditions as well as gender bias in treatment and gender-specific risk factors which are seldom understood. Despite the significance of these differences for women, community awareness and funding for programmatic interventions has been skewed in favour of men's mental health initiatives (Squire, 2018).

Men's mental health has received significant attention in recent years due to their higher rates of suicide (Australia Bureau of Statistics, 2018) and lower rates of help-seeking (Parent et al, 2018). For example, the federal government's 2011 Taking Action to Tackle Suicide package 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" (Department of Health, 2014, p. 19).

While supporting men's mental health and reducing their suicide risk is important, there has been no corresponding recognition of – or substantial investment in – women as a specific group, with the exception of perinatal mental health (Squire, 2018). This low priority is problematic as there are gender differences in the causes of mental ill-health, along with differences in presentation, diagnosis and treatment.

2.1 Women experience high levels of compromised mental health

Public perception may be that men experience worse mental health than women, but the data contradicts this belief. For example, the Australia Bureau of Statistics (Australia Bureau of Statistics, 2013) informs us that women report higher rates of mental disorders in the past 12 months (22.3 per cent compared to 17.6 per cent for men) including anxiety (18 per cent, compared to 12 per cent men) and affective disorders including depression (7 per cent, compared to 5 per cent for men).

While women have slightly lower rates for lifetime mental disorders compared to men (43 per cent, compared to 48 per cent for men), they have significantly higher lifetime rates of affective/ depressive disorders, at 18 per cent (compared to 12 per cent for men) and much higher lifetime anxiety rates of 32 per cent (compared to 20 per cent for men) (Australia Bureau of Statistics, 2013).

Eating disorders

In addition to higher rates of common mental health conditions such as anxiety and depression, women and girls are overrepresented among those with eating disorders; around 75 per cent of people experiencing anorexia nervosa or bulimia nervosa are female, with the peak period for onset being adolescence (National Eating Disorders Collaboration, ND). Approximately 15 per cent of women in Australia experience an eating disorder in their lifetime. Eating disorders represent the second leading cause of mental disorder disability for girls (National Eating Disorders Collaboration, ND). There is a common association between eating disorders and self-harm (Vieira et. al., 2017).

In addition to genetic vulnerability and psychological traits, social-cultural factors including unrealistic ideals of beauty are a known risk factor for developing an eating disorder (National Eating Disorders Collaboration, 2013). The complexity of social networking, an increasingly visual tween culture and the early sexualisation of girls have also been identified as factors negatively affecting girls' mental health (McGuire & Maury, 2017).

Suicidality

Male suicidality is often presented as the key indicator of poorer mental health for men, and it is true that men are three times more likely than women to die by suicide (Suicide Prevention Australia, 2016).[1] While this statistic is widely known, women's greater suicidality is rarely reported. Known as the 'gender paradox' (Canetto & Sakinofsky, 1998), women have higher rates of suicidal behaviour than men, even though men are more likely to die by suicide. Specifically, women have higher rates of suicidal ideation, at 2.7 per cent of the population (compared to 1.9 per cent for males), suicide plans (0.7 per cent compared to 0.4 per cent for men), and suicide attempts (0.5 per cent compared to 0.3 per cent in men). Women are one and a half times more likely to be hospitalised for self-harm than men, with an alarming increase in self-harming behaviours amongst young women aged 15-24 years. Aboriginal and Torres Strait Islander women are almost twice as likely to be hospitalised for self-harm than other women (Suicide Prevention Australia, 2016).[2]

Post-Traumatic Stress Disorder (PTSD)

Another fact seldom reported is that women are twice as likely to experience post-traumatic stress disorder (PTSD) than men. PTSD is most often associated with men in military service; it is therefore important to point out that research indicates men and women in the military have similar levels of PTSD – women are not more disposed to experiencing it (Jacobson, Donoho, Crum-Cianfione & Maguen, 2015). Rather, it appears that women are exposed to more traumatic events than men, and family violence appears to be the primary driver of PTSD symptoms for women (Krahé, 2018). A recent study of 150 pregnant rural and remote Indigenous women

found that an astounding 40 per cent reported PTSD symptoms (Mah, Weatherall et al, 2017). Unfortunately identifying the causes was outside the study's scope, as was comparing against women who were not pregnant.

These rates are highly concerning since the negative health effects of PTSD are well known, and include a doubling of diabetes risk for women (Roberts, Agnew-Blais, et al, 2015), and an increase in incidences of heart attack and stroke (Sumner, Kubzansky, et al, 2015). PTSD symptoms during pregnancy also pass on negative health effects to unborn children through what researchers describe as "toxic" levels of the stress hormone cortisol (Seng, Li et al, 2017). When parents are experiencing PTSD it can also limit parenting capabilities, which disrupt the healthy development of children (van Ee, Kleber & Jongmans, 2015).

PTSD is by definition compromised mental health, but it also often co-resides with and exacerbates depression and anxiety in women, and can be a contributor to suicidality (Stanley, Hom, Spencer-Thomas & Joiner, 2017). Additionally, women whose PTSD is as a result of sexual assault have much more vivid recall of the

[1] See Figure 2, p. 11.
[2] Ibid. See Table 1, p. 14.

traumatic experience than women who experience PTSD as a result of other types of traumatic experiences (Millon, Change & Shors, 2018).

Self-harm

The hospitalisation rates for self-harm are alarmingly skewed towards girls and young women, as illustrated in Figure 1 (Suicide Prevention Australia, 2016). Furthermore, these figures have risen dramatically in recent years, as illustrated in Figure 2 (Ibid.). The Australian Institute of Family Studies (2014) reports on findings from the Longitudinal Study of Australian Children (LSAC) which show that 10 per cent of all teens aged 14-15 years practised self-harm and 5 per cent had attempted suicide.[3] However, a gender-disaggregated examination of the data reveals stark differences between males and females. While 8 per cent of males had thoughts of self-harm and 4 per cent had actually self-harmed, 25 per cent of females had thoughts of self-harm with 15 per cent engaging in self-harm activities; this is nearly four times the rate as males.

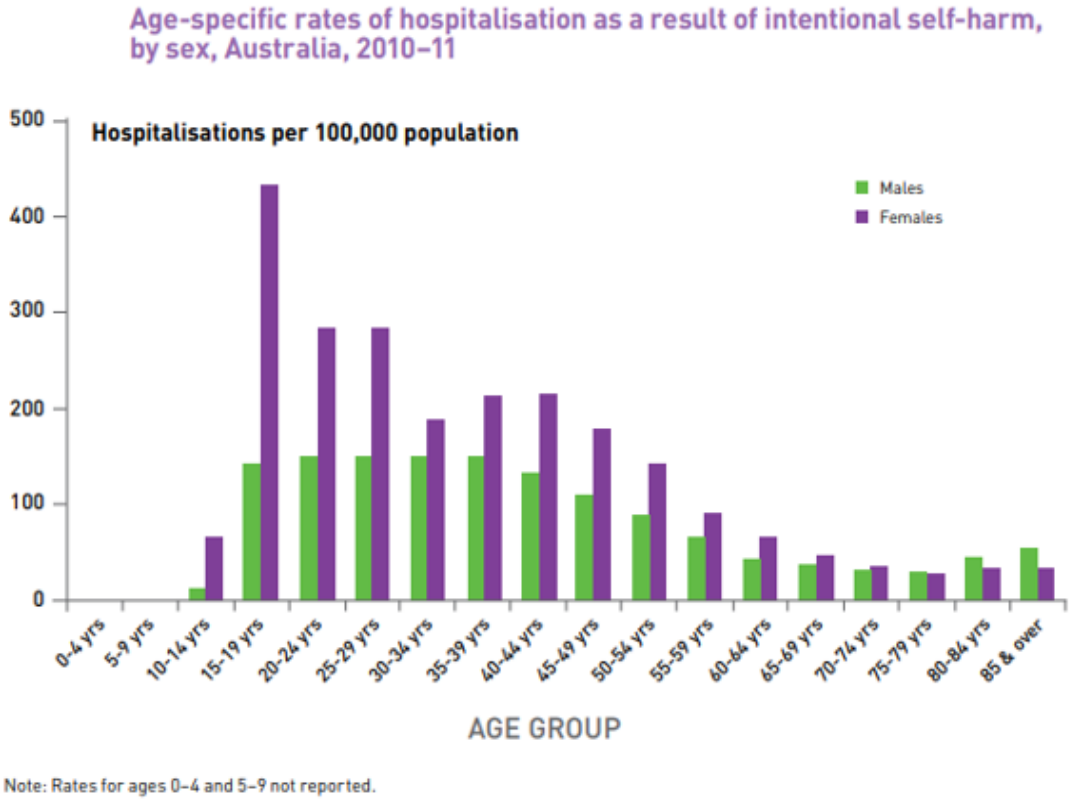

Figure 1: Hospitalisation rates for self-harm by sex and age. Source: Suicide Prevention Australia, 2016.

[3] AIHW (2014). See Figure 14.1, p. 85. Retrieved from https://www.aihw.gov.au/getmedia/b70c6e73-40dd-41ce-9aa4-b72b2a3dd152/18303.pdf.aspx?inline=true

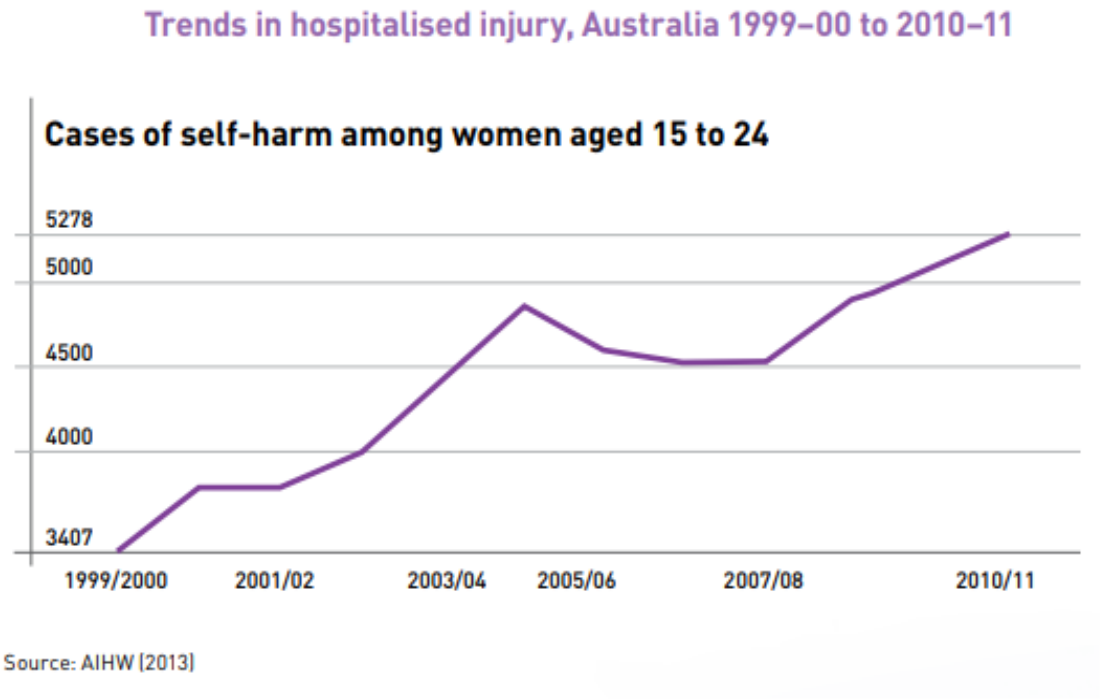

Figure 2: Increase in self-harm for young women. Source: Suicide Prevention Australia, 2016.

Suicidality shows a similar trend; while 6 per cent of boys reported thinking about suicide and 4 per cent made an attempt, this rose to 12 per cent of girls who thought about suicide, with 6 per cent attempting; see Figure 3 (Ibid.).

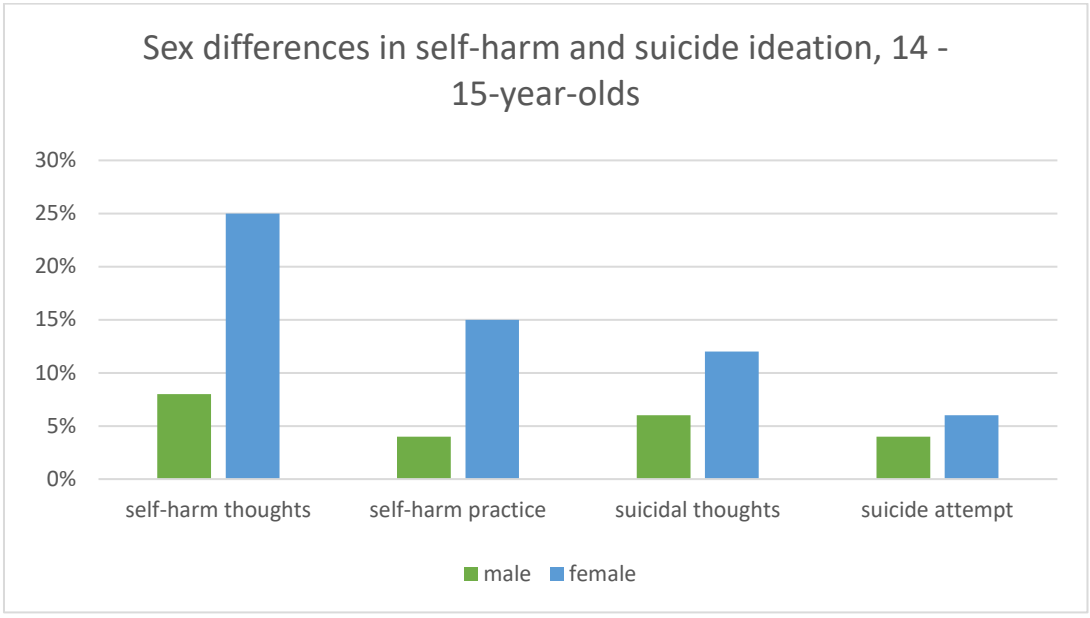

Figure 3: Sex differences in self-harm and suicide ideation, 14-15-year-olds. AIFS (Longitudinal Study of Australian Children data).

This data clearly indicates that there are significant gendered differences in mental health, and, contrary to popular belief, nearly all the disparities indicate that women and girls are experiencing an unprecedented yet hidden level of mental ill-health.

2.2 Gender differences and gender bias in diagnosis and treatment

It is becoming widely accepted that medical research suffers from a dangerous, and at times fatal, bias towards males. Some well-known examples include divergent symptoms for heart attacks between men and women, resulting in a high rate of undiagnosed heart problems and death rate in women because male symptoms are the standard diagnostic tool (Webster, 2016). Clinical trials for medicine are also often exclusively conducted on men, with the assumption that a slight reduction in potency is all that is needed to ensure safe treatment for women (Colville, 2017); and yet, men's and women's bodies react differently to a wide range of inputs because there are fundamental and complex differences between them (e.g., Graves, 2017; Li & Graham, 2017). Even with an increasing awareness of the need to recruit both males and females, a recent review of 768 published studies found that analysis by gender ranged between 1-16 per cent of studies focused on the causes and treatments of mental health disorders (Howard, Ehrlick, Gamlen & Oram, 2016).

An increase in the use of psychotropic medications has particular impacts for women. Women experience more severe side effects from psychotropic medication per dose of medication than men, including greater weight gain, cardiovascular and metabolic side effects, however clinicians are not always aware that these effects are gendered (Abel & Newbigging, 2018). There are also gender differences in brain structure and responses to stress (Shoukai, 2018, cited in Women's Health Victoria, 2019).

In addition to biological differences, social differences can have a profound effect on mental health diagnosis and treatment. For example, research has found that women with severe mental illness are up to five times more likely to have experienced rape, attempted rape, or family violence (Khalifeh et al, 2014). Despite this link, medical and mental health professionals struggle to identify the signs of family violence or sexual assault (Oram, Khalifeh & Howard, 2017), in part because women are reluctant to disclose such information to a medical professional (World Health Organisation, ND). Even when violence is disclosed, medical professionals at times repudiate women's experiences, fail to provide appropriate referrals or support, or even mimic perpetrator behaviour (Keeling & Fischer, 2014). Some professionals are aware that women experience PTSD at twice the rate of men. As a result, women's PTSD is under-reported, under-diagnosed, and often left untreated (Riddle, 2018).

Recently published Australian research indicates that telephone crisis-line workers consistently identified suicide potential for both males and females, but were less likely to provide appropriate intervention support to female callers (Hunt et al, 2018). The social stigma commonly attached to suicide has a dual aspect for women

because of the way it is gendered in attitudes and behaviours. For example, the stereotype of the 'attention-seeking' young female who is trying to manipulate those around her is a strong cultural narrative which has played out among professionals in health care settings (Suicide Prevention Australia, 2016, p. 17).

> "Further training in suicide prevention from a trauma informed perspective is required for workers in health settings…young people, and occasionally adults, are often considered 'attention seekers' and as wasting time of service providers. Young people engaging with the health system are frequently discharged from hospital without community support which has led to further attempts at suicide within a short space of time."
>
> *Good Shepherd practitioner*

Lack of diagnosis and treatment can have profound effects on families, and children in particular. For new mothers, maternal depression can affect the mother-infant relationship, including attachment, child growth and cognitive development (Stewart et al, 2003). Suicide is the leading cause of maternal death in Australia, when late maternal deaths (within 12 months after the end of pregnancy) are included (Ellwood & Dahlen, 2016).

The World Health Organisation (2013) notes a range of gender specific risk factors for common mental health disorders that disproportionately affect women. These include family and sexual violence, socioeconomic disadvantage, low income and income inequality, low social status and disproportionate responsibility for the care of others. We explore these social and economic determinants of women's mental health in detail below.

3. Understanding the social and economic determinants of mental health

This section includes content relevant to the Royal Commission's *Question 1: What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?, Question 4: What makes it hard for*

people to experience good mental health and what can be done to improve this?, and *Question 5: What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?*

There are many individual, familial and societal factors at play in determining whether someone develops a mental health condition. Mental health conditions are caused by a range of factors including individual characteristics such as genetics, biology and psychological traits. However, increasingly health researchers are examining causal elements outside of the individual – the social and economic determinants of mental health. As noted above, there are a range of environmental factors which disproportionately affect women. We explore these in further detail below.

3.1 Gender inequality

There is one overarching social and economic determinant of poor mental health where the evidence is startling – gender inequality. As the World Health Organisation notes:

> Many of the negative experiences and exposures to mental health risk factors that lead to and maintain the psychological disorders in which women predominate involve serious violations of their rights as human beings including their sexual and reproductive rights (2013, p. 4)

Inequality in the workplace, including direct and indirect sex discrimination, the omnipresent gender pay gap, women's concentration in low paid industries and occupations, and precarious working conditions including poor quality part-time work, all negatively impact on women's capacity to earn a decent income while simultaneously eroding physical and mental health.

3.2 Stereotypes and the sexualisation of women and girls

Gender stereotypes affect all of us. They have particular impacts on men's mental health and help-seeking behaviour. For example, rigid conceptions of masculinity, including the stereotype of the stoic Australian male, have been shown to be strong contributing factors in male suicide rates (Player et al, 2015). In one study almost all of the men reported that these beliefs led them to isolate themselves when feeling down, while failure to manage emotions was perceived as a loss of control and led to anxiety about having these 'weaknesses' revealed to others (Player et al, 2015).

Gender inequality affects girls from a very young age, beginning with stereotypes and reinforced through practices such as giving girls less pocket money than boys (Heritage Bank, 2015) despite their greater share of household chores, as detailed in Growing Up Unequal (Webster et. al., 2017). A staggering 98 per cent of 10-17 year

old Australian girls surveyed by Plan International Australia (2017) said they did not receive equal treatment to boys. After inequality, the girls surveyed by Plan were most concerned with being scrutinised for their appearance rather than appreciated for their abilities and talents. Almost all (93 per cent) of the survey respondents aged 15-17 said it would be easier to get ahead in life if they were not judged on their appearance.

Women are routinely viewed as sexual objects by others, with negative effects for women's mental health and wellbeing (Moradi & Huang, 2008). Perceptions of sexualised portrayals of girls can lead people to see them as lacking intelligence and other mental attributes, and moral worth. In one study, young girls who were depicted in a sexualized manner were perceived as more responsible for behaviour that harmed them; people also cared less about them when they were harmed and helped (Holland & Haslam, 2015).

The complexity of social networking, an increasingly visual tween culture and the early sexualisation of girls have also been identified as factors negatively affecting girls in the middle (8-12) years (McGuire & Maury, 2017). Other factors for girls include the early onset of puberty, which can create emotional and mental health difficulties. Conversely, poor mental health may also trigger the early onset of puberty (McGuire & Maury, 2017, p. 24). Girls who experience the early onset of puberty can face social and sexual risks due that stem from gender inequality and stereotypes (McGuire & Maury, 2017, p. 24).

These issues, combined with the average onset for eating disorders between the ages of 12 and 25 years, (with a median age of around 18 years) (Volpe et. al., 2016), mean that young girls are particularly vulnerable to poor mental health from a young age.

Good Shepherd practitioners have observed that there are gaps in the mental health service system in responding to the needs of girls and young women. This is particularly the case in relation to non-acute specialist treatment for eating disorders, where community-based services are not always available.

> "There is a lack of recognition of the intersecting nature of eating disorders with other diagnoses of mental health—including depression. A multi-disciplinary service response, which includes specialisation is necessary and currently absent."
>
> *Good Shepherd practitioner*

3.3 Economic inequality and the feminisation of poverty

> "There is an under-emphasis placed on the link between the deprivation of basic needs (such as housing and finances) and its link to mental health outcomes. A coordinated systems-approach to poverty and disadvantage, and public health is required to improve overall long-term mental health outcomes"
>
> *Good Shepherd practitioner*

Low income

There is a strong relationship between low socioeconomic status and poor mental health, which the World Health Organisation notes can be observed in children as young as three (2014, p. 20). The links between income and mental health are incontrovertible:

> Economic policies that cause sudden, disruptive and severe changes to the income, employment and living conditions of large numbers of people who are powerless to resist them, pose overwhelming threats to mental health. Disruptive, negative life events that cannot be controlled or evaded are most strongly related to the onset of depressive symptoms (World Health Organisation, 2013, p. 15).

A recently-published global analysis indicates that women experience depression at twice the rate of men, and that inequality – both fiscal and gender – is highly correlated (Yu, 2018). Women disproportionately carry the burden of poverty (Munoz Boudet, Buitrago, et al, 2018), including in Australia (Australian Council of Social Service and University of New South Wales, 2018), and it is perpetuated through their experiences of employment, the disproportionate amount of unpaid work that falls to women, and punitive income support policies. Housing insecurity and homelessness also play a significant role. The connections between these elements of poverty and mental health are reflected in the lives of Good Shepherd clients.

> "Ongoing housing insecurity is a significant issue—particularly housing support services for young people who cannot live at home due to family violence. An increase in medium-long term housing would have a significant impact on positive mental health outcomes."
>
> *Good Shepherd practitioner*

Women's workforce participation is often prescribed to allow for caring duties; see Figure 4 (AIFS, 2019). However, women are also more likely to experience reduced pay and career opportunities than their male counterparts even in the absence of children (Sanders, Zeng, Hellicar & Fagg, 2017), and as demonstrated by a persistent pay gap which starts when young people first enter the workforce (Workplace Gender Equality Agency, 2019). The 'motherhood penalty' results in mothers being seen in a negative light in the workplace; effects include the withholding of opportunity, and underpayment due to a misconception that they are not productive workers (Vemiers & Vala, 2018; Kleven, Landais & Søgaard, 2018).

Discrimination at work during pregnancy, parental leave or return to work affects a staggering one in two mothers in Australia (Australian Human Rights Commission, 2014), while 39 per cent of women report being sexually harassed at work in the preceding five years (Australian Human Rights Commission, 2018). Single mothers are more likely to experience discrimination during pregnancy compared to partnered mothers and experience greater financial impacts (Australian Human Rights Commission, 2014, p. 37).

Two thirds (72 per cent) of women who have experienced discrimination during pregnancy, parental leave or return to work reported that the discrimination affected their mental health (Australian Human Rights Commission, 2014, p. 32). Effects included stress and lowered self-esteem and confidence. Many of the women interviewed by the Australian Human Rights Commission reported that their experiences of discrimination affected their mental health significantly:

> Women said that they were diagnosed with depression and suffered from severe anxiety, despite no previous medical history of mental health issues, following their experiences of discrimination.' (2014, p. 77).

Due to their greater responsibility for child rearing women are more likely to be in precarious employment – that is, employment that is marked by low income, few or no entitlements, short-term contracts, and holding little organisational power or status. These experiences can erode physical and mental health through increased anxiety over job security, lack of autonomy, low status, and few or no benefits such as personal leave (Maury, 2017), while also entrenching financial disadvantage. This can be seen in recent research that examines the gender gap in retirement incomes (Coates, 2018) and the increasing cohort of older women who are experiencing housing precarity (Australian Human Rights Commission, 2019).

Many older women find themselves without an adequate income when they retire, particularly those who do not own their own home and find themselves at the mercy of the private rental market (Crawford, 2016). It is therefore not surprising that depression is a significant issue for many women in mid-life (Lawrence et al, 2000) with the peri-menopausal period bringing with it a 16 fold increase in diagnoses of depression (Cohen et al, 2006).

"There is a fundamental lack of understanding about the root causes of mental ill-health, including that it just 'descends' down from somewhere—rather than acknowledging the socio-cultural factors that impact on mental health outcomes. The system mirrors this rather than empowers people. A lot of young people are seen as solely responsible for their own mental health outcomes, without any systems level evaluation of the factors that impact on it—including those that are beyond their control."

Good Shepherd practitioner

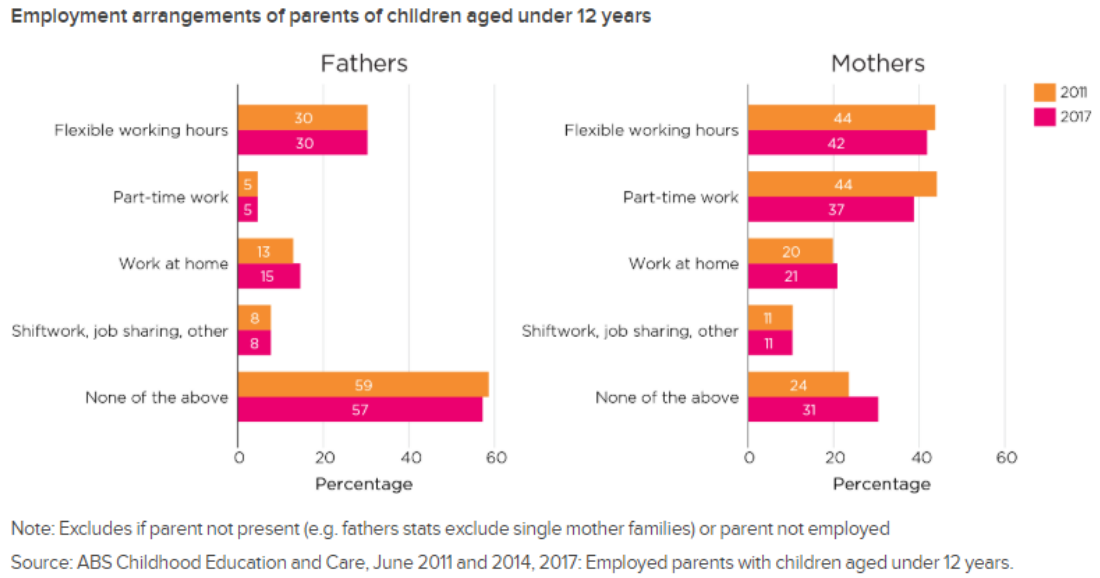

Figure 4: Employment arrangements of parents of children aged under 12 years. Source: AIFS.

Unpaid work

Analyses of household data show that women continue to bear the overwhelming responsibility for child rearing and other unpaid work in the household, with total paid and unpaid work hours skyrocketing when women become mothers (while fathers' total work hours remain largely unchanged) (Argyrous, Craig & Rahman, 2017). The motherhood penalty from time spent out of the employment market while caring for children casts a long shadow of women's working lives (Kleven, Landais & Søgaard, 2018).

The penalty attached to the physical and emotional 'labour of love' is broader than caring for young children. For many women – especially those in mid-life – care is a lifelong responsibility involving care for teenagers and emerging adults, ageing parents and/or partners (Australian Human Rights Commission, 2013). This time of life coincides with financial pressures to remain in the workforce to increase

superannuation balances, which for women are often depleted through many years spent in low paid work or out of the workforce.

A heavy load of unpaid work in addition to paid work results in women feeling significant time pressure. Time for sleep and leisure is particularly scarce for mothers of young children, and in order to spend more time with their children, "…working mothers average less time in housework, personal care and childfree leisure time than other parents" (Craig, 2005, p. 13). This experience is associated with outcomes such as poor health and reduced life satisfaction (Brown, Brown & Powers, 2001).

Welfare conditionality

Over the last two decades social security payments have been increasingly linked to compulsory 'mutual obligations' such as job search and other compliance activity. Of particular relevance to women's mental health are the Welfare to Work policy reforms, which were introduced in 2006. These changes were introduced with the aim of increasing employment participation and the self-reliance of people otherwise dependent on social security payments, including single mothers with school-aged children, the long term unemployed and people with disabilities.

Good Shepherd has published a research report on the experiences of single mothers under the Welfare to Work system (McLaren, Maury & Squire, 2018). This research found that many women appeared to be referred to Welfare to Work when they were not in a position to participate in employment. This included experiences of poor mental health, past or ongoing experiences of intimate partner violence, intensive caring duties and disability. Despite this, very few women received referrals or assistance from their jobactive provider to access appropriate support.

Research participants also reported that face-to-face interactions with providers were experienced as stressful and undermining of self-worth. Several participants reported 'microaggressions' from providers and an adherence to negative stereotypes about single mothers. Women reported having been yelled at, and in one case sexually harassed, by providers. These experiences resulted in some women developing anxious behaviours such as hypervigilance.

The research also found that despite the complex barriers to employment faced by individuals participating Welfare to Work, providers were unable to offer tailored, specialised services. Providers are not required to have specialised skills, training or accreditation to work with vulnerable people.

Good Shepherd practitioners highlighted the need for a coordinated response to respond to the barriers faced by clients navigating Centrelink and other government services.

> "Dealing with bureaucracy and the complex systems required to access support when you already have compromised mental health is compounding mental health difficulties, and preventing opportunities for recovering or improving outcomes."
>
> *Good Shepherd practitioner*

Good Shepherd has also investigated the impact of another form of welfare conditionality called ParentsNext, a program targeting single mothers of children aged 6 months to 6 years which was referred to a Senate Community Affairs References Committee in late 2018. Our submission to the Committee noted that heavy compliance activities and the threat of income sanctions were not advancing the program's aim of enhancing job readiness but were instead adding to participants' stress and reducing their autonomy (Squire & Maury, 2019).

Single parent families have the highest poverty rate of all family types in Australia, while children in single parent families, with a poverty rate of 39 per cent, are more than 3 times as likely to live in poverty as children in couple families (13 per cent of whom are in poverty) (Australian Council of Social Service, 2018). The research on this topic is unequivocal: adequate income (whether through income support and/or child support) leads to reductions in child maltreatment (Cancian, Yang & Slack, 2013); increases in positive child development markers, maternal health, and mental health (Milligan & Stabile, 2011); improved child test scores in reading and maths (Dahl & Lochner, 2012); and improved overall educational performance (Duncan, Morris & Rodrigues, 2011).

Conversely, reduction in income support for single parents is directly correlated to a range of negative outcomes for children, including poor mental health, emotional difficulties, behavioural problems (Hirokazu, Lawrence & Beardslee, 2012), increased anxiety, increased social isolation and relational support, and an increased sense of social stigma (Ridge, 2013). As one researcher succinctly frames it:

> High levels of family economic distress and vulnerability compromise child wellbeing, and exposure to such risks differs by race and ethnicity. Welfare agencies that restrict entry, push welfare exits, and offer only a work-first message exacerbate rather than help the situation of poor families (Danziger, 2010, p. 541).

The system of social security programs framed as 'support' is contributing to poor mental health outcomes for many women. The experience of Centrelink clients who have been issued 'robo-debt' debt notices, many of which have reportedly been in error, has also resulted in extensive psychological distress (Senate Standing Committees on Community Affairs, 2017).

> "Dependency on Centrelink (as a system) for basic financial assistance and meeting of criteria for things like ParentsNext is compounding existing mental health issues. Essentially these systems require individuals to function beyond their capacity (at times)."
>
> *Good Shepherd practitioner*

3.4 Financial hardship and stress

As noted above, economic security and mental health are strongly linked. The economic participation and wellbeing of women is one Good Shepherd's five impact areas. We respond to women and families experiencing financial stress on a daily basis though our financial counselling services. In undertaking this work we understand that, as Salignac et al (2019) frame it:

> Financial wellbeing is not just about an individual's financial circumstances. A person's household, community and social contexts as well as transitional or life-course events (e.g. moving out of home, having a baby, changes to employment status and income, and retirement) and financial shocks, can contribute to it in the present and future.

We have observed first-hand the clear link between financial hardship and poor mental health. The effects of financial hardship are multifaceted and include physical, psychological and cognitive effects (Maury, 2019).

Relationship breakdown and reliance on low levels of income support and/or precarious forms of employment are common features of women's experience of financial hardship. Nearly all of the women who participated in Good Shepherd's Welfare to Work research (McLaren, Maury & Squire, 2018) reported having their income support payments cut. As a result, some women went without eating, while others relied on food banks or family members to meet their essential costs. Only four out of the 26 women interviewed would be able to raise $2,000 in an emergency, from either borrowing from family or selling assets. Many single parents of young children live in fear of the day when their youngest child turns eight and they will be moved onto the lower Newstart payment.

The experience of financial counsellors is that financial difficulties, debt and vulnerability are an important mental health co-morbidity (Financial and Consumer Rights Council Inc., 2019). There is an increasing demand for financial counselling as financial decision-making has become more challenging in an increasingly complex and diverse financial system (Salignac et al, 2019). Rising living costs, unfair utility contracts, the expansion of the use of credit to pay for essential services, and credit products such as payday lending place vulnerable people under considerable stress.

As the case study in the Family and Sexual Violence section of this submission shows, practical assistance at the right time can significantly reduce the impact of financial hardship and stress as contributing factors to poor mental health. Alternatively, as the case study below shows, without alignment between the work of financial counsellors and the mental health service system, sustained positive outcomes may not be possible.

CASE STUDY – Financial hardship and stress

A 51 year old woman was referred to Good Shepherd financial counselling services for support in addressing three credit card debts. The debts had built up over three years following a relationship breakdown. The relationship breakdown was a result of her partner's drug addiction which caused the failure of their business and the loss of the family home to pay credit card debts. The client and her children became homeless and unemployed. The client experienced domestic and financial abuse from ex-partner; as a result she was unable to work due to debilitating depression and anxiety. She and her two children were being treated for mental health issues that continued through Good Shepherd's engagement with the family. After one year of financial counselling sessions, the credit card debts were waived on grounds of financial hardship that were put forward on her behalf by Good Shepherd. With support, she retrained and got a job—this however was unable to be sustained due to ongoing depression and anxiety. The client remains financially insecure as a result of her compromised mental health.

The Financial and Consumer Rights Council Inc (2019) notes the bidirectional relationship between financial hardship and poor mental health:

> A deterioration in a person's financial position can cause situational distress and left unaddressed can be a major contributor in triggering a mental health crisis. At the same time, long term mental health conditions can contribute significantly to the likelihood of a person making poor financial decisions, or living in poverty, along with other co-morbidities such as harms from substance use or gambling.

This relationship is best understood through an ecological perspective which sees an individual's financial wellbeing in interaction with their environment - that is, a person's relationships as well as social and institutional structures (Salignac et al, 2019).

The relationship between financial and psychological stress also needs to be understood in the context of events across the life-course. Challenging life course events can have different consequences depending on when they occur in the life trajectory. Accumulated life course periods of financial stress from adolescence to mid-age predict poorer mental health later in life (Elwér et al, 2015).

Many of our financial counselling clients have experienced economic abuse, as illustrated by the case study above. Economic abuse – a form of intimate partner violence – refers to behaviours that are intended to "control a woman's ability to acquire, use and maintain economic resources" (Adams et al, 2008, p. 564). It often presents with other forms of family violence and can continue long after the relationship has ended, thereby eroding the victims' financial security. One third of the women we interviewed for the Welfare to Work report reported current or previous experiences of family violence (McLaren, Maury & Squire, 2018).

CASE STUDY – Financial hardship and stress

A 49 year old woman, living with schizophrenia was referred to Good Shepherd's financial counselling services to assist with credit card debt. Her presentation at the meeting was one of distress and anxiety. She was supported by her sister, who also acts as her Power of Attorney. As a result of a physical injury, the client was unable to work. Through the advocacy and support of the financial counselling service, the debt was able to be waived. Situational anxiety compounding her already compromised mental health was reduced and she felt more settled to work on her daily routine without fear of being harassed for payments.

3.5 Family and sexual violence

Experiences of violence have a profound impact on women's health and wellbeing, and can lead to chronic physical or psychological impairment and ongoing trauma for women (Ellsberg et al, 2008) and children (Evans, Davies & DiLillo, 2008). Intimate partner violence is defined as "a pattern of assaultive and coercive behaviours, including physical, sexual and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners" (UN Women, 2008). This form of violence takes many forms and is intended to humiliate, manipulate and control (Stauchler et al, 2004).

Abusive relationships are correlated to poor overall physical health, including sleep disorders, an increase in chronic conditions, and reduced reproductive and gynaecological health. They are also linked to severe mental health effects, including experiences of post-traumatic stress syndrome (PTSD), anxiety, depression and self-harm (Dillon et al, 2013). There are indications that traumatic brain injury leaves women more prone to severe and ongoing mental health problems compared to men (Endocrine Society, 2017). Even mild head injuries can result in poor mental health (Stein, Jain, & Giacino, 2019).

With one in six women experiencing physical or sexual violence by current or former partner and one in three women experiencing physical violence from a current or former partner since the age of 15 (Australian Bureau of Statistics, 2017), demand on the mental health service system is likely to increase in future.

"Individuals who have experienced trauma are more likely to experience further victimisation, for example, inadequate responses to sexual assault can lead to not only ongoing mental health concerns, but also vulnerability to further assaults."

Good Shepherd practitioner

A recent systematic review and meta-analysis has shown a three times increase in the likelihood of depressive disorders, a four times increase in the likelihood of anxiety disorders, and a seven times increase in the likelihood of PTSD among women who have experienced family violence (Oram, Khalifeh & Howard, 2016). An Australian study indicates that 89 per cent of women exposed to three or four types of gender-based violence have experienced a mental disorder (Rees et al, 2011).

CASE STUDY – Family violence

A single mother of two children was referred to the Good Shepherd financial counselling service having accrued significant debt as a result of family violence. Throughout the financial counselling process it was observed that the client's decision making capacity was clouded by her compromised mental health—presenting with significant anxiety. She was also isolated with minimal family or community support. Her mental health was compromising decision making around housing and her children, which in turn was creating greater risk of further financial debt and non-compliance with child protection requirements. The financial counselling process was critical to creating stability and an achievable plan to alleviate debt which in turn supported her compromised mental health that stemmed from violence and financial insecurity. Good Shepherd was able to support her to secure tenancy, maintain parental custody of her children and cease all further legal action regarding debt. She remains connected with community services to continue to build financial literacy skills and self-empowerment.

Women who have experienced violence also report higher rates of suicide attempts, with 35 per cent of women exposed to gender-based violence reporting suicide attempts (ibid.).

3.6 Dowry abuse and forced marriage

Dowry abuse and forced marriage are two practices which have only recently been acknowledged as forms of family violence in Australia, with the State of Victoria leading the way. Both forms of violence have specific mental health impacts with

delayed help-seeking due to factors such as compounded trauma, sociocultural and familial barriers, the experience of isolation and a lack of appropriate services.

The Victorian Royal Commission into Family Violence recognised forced marriage and dowry abuse explicitly as practices of family violence. This followed the presentation of evidence which highlighted the impact of these practices on women, particularly women from Culturally and Linguistically Diverse (CALD) backgrounds. As a result, Recommendation 156 required a change to the *Family Violence Protection Act (2008)* (Vic) to list forced marriage and dowry abuse as statutory examples of family violence; this change was enacted in 2018.

Dowry abuse

For over a decade we have seen the practice of dowry in marriage throughout our work in the field of family violence with individuals from CALD backgrounds. It is a practice that remains largely unidentified and unrecognised within legal and policy frameworks. Dowry payment for marriage, whilst outlawed in some countries including India, is still practiced as a cultural norm in some countries. Migrant diaspora communities living in Australia continue to engage in the practice of dowry. The practice of dowry is understood to be part of complex family structures and traditional cultural practices that inform the daily lives of women and men.

Good Shepherd does not consider the practice of dowry in and of itself to be harmful or abusive. Dowry abuse refers to violence (sexual, physical or psychological) that arises in the context of a dowry negotiation and into a marriage. This can be in the form of ongoing demands for 'gifts' starting before marriage to long after the marriage has taken place. It can also refer to ongoing violence as a result of what is perceived to be an unsatisfactory dowry amount or arrangement. International research has well documented the various forms that dowry abuse can take, including battering, mutilation, rape, acid throwing, wife burning murder and suicide (Patel, Handa, Anitha, Jahangir, 2016)

In our practice experience, women subjected to dowry abuse experience compounded trauma because not being able to comply with dowry demands often leads to various forms of abuse and violence. They experience difficulties accessing services as their movement is often controlled by their spouse. Many women in this situation are often new migrants to Australia and are unfamiliar with available supports for both material assistance and support with the mental health implications of being abused, controlled and left isolated.

In 2018, we provided a submission to a Senate inquiry into the practice of dowry and the incidence of dowry abuse in Australia (Vidal & Saca, 2018). Here, we noted our experience that individuals from CALD communities experience compounded trauma from violence. They often lack the secure base that is required to engage in help-seeking. Migrants to Australia may lack the family and community supports in order to make help-seeking a viable and safe option. There is also a lack of culturally

specific and inclusive services that provide proactive outreach to women from these communities.

Delayed help-seeking exacerbates the impact of violence and in turn, further compromises mental health. As demonstrated by the ASPIRE project, the consequences of domestic and family violence:

> …may be heightened for immigrant and refugee women in light of evidence that suggests that these women are likely to ensure family violence for longer periods of time before seeking help. This potentially increases the likelihood of chronic physical sequelae and the development of severe mental disorders including suicidality (Vaughan et al, 2018, p. 19)

Some of our casework has illustrated high levels of suicidal ideation as women feel that they have no way out of their situation. They also report feelings of shame due to social stigma that is attached to separation and divorce. They believe their families and communities would not support their separation and they would be left destitute.

Services which come into contact with immigrant and refugee women are often not sufficiently inclusive:

> Immigrant and refugee women have limited access to preventative programs across Australia and as a result are overrepresented in the crisis response system (Vaughan et al, 2018, p. 14)

There is also an absence of guidelines domestically and internationally to inform the health sector response to women from immigrant and refugee backgrounds or broader CALD communities. This is further compounding poor mental health outcomes for this cohort.

Forced marriage

Forced marriage was introduced into the *Commonwealth Criminal Code Act (1995)* (Cth) in 2013, defined and understood under Commonwealth law as a practice of slavery. This differs from the approach adopted in Victoria which clearly identifies forced marriage as an explicit form of family violence. The common trend concerning forced marriage in Australia involved Australian residents or citizens under the age of 18 being forced into marriage overseas. Often, relatives are alleged to have organised or be organising a marriage without free and full consent (Australian Government Interdepartmental Committee on Human Trafficking and Slavery, 2016).

The impact on individuals subject to a forced marriage is wide-ranging and it is common for individuals when seeking assistance to not explicitly report their concerns in relation to a forced marriage. More commonly individuals seek assistance for issues associated with related abuse and violence, examples include— mental ill-health such as suicide attempts/ ideation; physical health concerns,

including sexual and reproductive health; safety concerns such as physical violence or threats.

Consistent with international research, our experience illustrates that self-harming behaviour is overwhelmingly represented amongst this cohort (Bhardwaj, 2001; Cooper, Murphy & Webb, 2010; Howard, Trevillion & Agnew-Davies, 2010); however the support structures which may otherwise be engaged with in these situations (such as family and community) are compromised given the nature of the abuse being perpetrated by parents or other family and community members. Individuals often remain isolated, and the service system is not equipped with knowledge about this form of abuse to render their interventions adequate (McGuire, 2014; Lyneham & Bricknell, 2016).

Given the nature of familial offending in these situations, grief and loss is also a significant experience, particularly for young people who, at the time of deciding not to go through with a proposed marriage often, lose connection with their parents, siblings, wider family network and community. The long-term impacts of this are devastating and further compounded by the lack of service infrastructure that can provide safe and long-term accommodation for individuals to rebuild their lives.

4. The need for a holistic, cross-sector approach

This section includes content relevant to the Royal Commission's *Question 1: What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?*, *Question 4: What makes it hard for people to experience good mental health and what can be done to improve this?* and *Question 9: Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?*

As detailed above, the determinants of poor mental health span across a number of policy and practice domains. With many contributors to poor mental health lying outside of the mental health service system, a cross-sectoral intergovernmental and community response is required. Without a coordinated systems response the provision of care will be patchwork in nature, with vulnerable people slipping between the cracks. With momentous reforms underway in as a result of the Royal Commission into Family Violence – which address one of the key drivers of poor mental health – Victoria is uniquely positioned to lead commensurate large scale change. The following section steps out key areas for change relevant to women and girls' mental health, as well as

other changes to improve prevention, intervention, response and recovery for all cohorts of people.

4.1 Improve awareness of women and girls' mental health

Improving awareness of women and girls' unique mental health needs is essential; this includes general community awareness as well as sector and workforce specific awareness in order to improve policy and service provision. A life stage approach with focus on particular sites and transition points across the life course is also required, given the differing needs of specific age cohorts such as the early and middle years of children's lives, adolescence and older adulthood.

Drawing on learnings from successful investments in awareness, anti-stigma and behavioural change campaigns addressing other populations groups (for example, men and older adults), a similar level of investment should be made to developing integrated social marketing campaigns. In relation to theoretical approaches and formats there could be learnings from recent initiatives supporting the mental health of men and boys, including gendered aspects of mental health stigma.[4] Campaigns should draw on insights regarding the social determinants and unique contributing factors for different cohorts of women and girls, and include the views of people with personal experience of poor mental health.

Recommendation 1: Develop integrated campaigns to increase awareness of women and girls' mental health, inform positive behaviour change across health and other service settings, and reduce stigma.

4.2 Gender sensitive data collection and research

Awareness raising must be underpinned by a strong evidence base. Gender sensitive data collection and research is required to better understand the experiences and unmet needs of women and girls. This is particularly the case for self-harm and suicidality – and the experiences of Aboriginal and Torres Strait Islander girls and young women in particular – given recent upward trends in prevalence.

An incomplete evidence base means little is known about what works to support women and girls beyond the importance of trauma-informed care (Bateman et. al., 2013) and the need for single-gender services such as women-only inpatient units (Victorian Mental Health Complaints Commissioner, 2018).

[4] The Movember Foundation's website lists several reports which provide evidence on 'what works' across several types of mental health prevention and intervention: https://au.movember.com/about/publications

Sufficient funding should also be provided to evaluate gender differences in the impact of new prevention, intervention, response and recovery initiatives, and research on what works to promote good mental health for women and girls.

Recommendation 2: Increase investment in data collection and research to:

- Increase systematic collection and reporting of gender disaggregated data on women's mental health, including suicide, suicidal behaviour, and self-harm; and demographic categories which include at-risk cohorts

- Support research into what works to mitigate poor mental health among women, and what works to facilitate good mental health among women (including risk and protective factors).

4.3 Dedicated and integrated mental health strategy for women and girls

There is a need for comprehensive mental health policies which are designed to counter systemic bias and identify and respond to women's needs.

While the evidence base on how to improve women's mental health is still developing, Abel and Newbigging (2018) list several characteristics of gender sensitive services that could guide the development of effective mental health interventions for women and girls:

- Prioritise understanding mental distress in the context of women's lives
- Co-design services 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-patient 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.

Women and girls require targeted mental health policy development across the domains of prevention, intervention, response and recovery. Strategy development should meaningfully involve women and girls with lived experience of poor mental health, including suicidality, as well as family members and carers.

In addition to a dedicated strategy, women and girls' mental health should be embedded within existing mental health and suicide prevention frameworks. Mental health measures should also be mainstreamed as part of other strategies targeting women and services supported to ensure they provide gender-sensitive responses. These include interventions to address family violence, sexual assault and sexual harassment, and physical health initiatives. Mental health metrics should also be added to relevant existing program evaluation methodologies to measure mental health impacts.

Recommendation 3: Develop a targeted strategy to improve the mental health of women and girls, and to mainstream women and girls' mental health across existing strategies and service responses, particularly for vulnerable groups of women; and ensure that consumer participation sits at the centre of program ideation, design, development, testing and evaluation.

4.4 An intersectional approach

Gender-based discrimination is not the only form of systemic discrimination that affects mental health. For example, LGBTIQ+ communities much experience higher rates of depression and anxiety disorders, largely because of the discrimination they experience (Beyond Blue, 2012).

Another example is Aboriginal and Torres Strait Islander people, whose experiences of racism in health settings is associated with increased psychological distress, beyond what would be expected in other settings (Kelaher et. al., 2014). A study on racial discrimination in Victorian Aboriginal communities found that 97 per cent of the 755 people surveyed had experienced racism in the previous 12 months, and two-thirds of those who experienced 12 or more incidents of racism reported high or very high psychological distress (using a five-question version of the Kessler scale) (Ferdinand et. al., 2013). Aboriginal Victorians who experienced the most racism also recorded the most severe psychological distress scores.

Understanding how different forms of discrimination intersect with mental health is critical to the development of any new prevention or intervention initiatives. This includes actions to improve service responses in the health system so that they are culturally safe. Guidelines for mental health and family violence sector responses are also needed to inform responses to forms of family violence which are not currently well served, such as dowry abuse and forced marriage.

Recommendation 4: Ensure that new mental health strategies and services are inclusive of a diversity of women and girls, including dedicated funding streams to address the specific needs of:

- Aboriginal and Torres Strait Islander people
- LGBTIQ+ communities
- Culturally and Linguistically Diverse communities
- Recently arrived migrants and emerging communities
- Other cohorts at high risk of poor mental health, including people navigating the criminal justice system, people in closed environments and people with complex needs.

4.5 Addressing factors within the mental health service system

Good Shepherd practitioners working across the fields of family violence, youth and family services and financial counselling consistently raised access issues, such as the need for increased funding to reduce waiting lists and the impact of current funding under Medicare (mental health care plans limited to 10 sessions per year; gap fees).

> "Mental health care plans attached to Medicare are inadequate, and finding a 'gap-free' service is becoming increasingly difficult. The gap-fee has become prohibitive for accessing support—particularly eating disorders."
>
> *Good Shepherd practitioner*

> "Arbitrary timelines attached to the length of support available which are not linked to needs or presenting issues…there needs to be flexibility for decisions about the length of service to be based on clinical assessments."
>
> *Good Shepherd practitioner*

Recommendation 5: Advocate to the Commonwealth Government to expand the Medicare rebate for psychological treatment beyond the current 10 sessions per year.

Practitioners also noted the lack of service provision to neglected groups such as children, adolescents and parents with mental ill-health.

> "There is an over-emphasis on "parents as protective factors" for young people, however, this is not always the case; including situations where parents themselves have compromised mental health and are triggered by their child's suicidality."
>
> *Good Shepherd practitioner*

> "The mental health system for adults is insufficient, which has a direct correlation with the mental health outcomes for young people who are dependent on parents and carers for meeting basic physical and emotional needs. An investment in systems to support parents and carers would change the dynamic within parent/carer-child relationships and in turn would have a positive impact on the mental health of young people."
>
> *Good Shepherd practitioner*

Good Shepherd practitioners highlighted the need for more comprehensive integration of existing mental health services, such as the acute system and community mental health series, as well as child protection, housing and other community services. Better links are also required between family support services and mental health services. Our financial counsellors noted the need to increase awareness of financial counsellors among mental health practitioners, and develop models which align financial counsellors with mental health counsellors to help alleviate financial distress as a source of poor mental health.

> "Continuity of care across multiple service providers is critical to building stability, safety and trust—essential components for mental health recovery."
>
> *Good Shepherd practitioner*

Recommendation 6: Increase existing levels of funding for mental health services and develop a variety of program supports to improve pathways and provide continuity of care (for example, referral systems such as post-discharge services from hospitals to community mental health follow-up and other services).

Recommendation 7: Improve integration between services and programs across sectors, such as community services, housing and employment, and incentivise collaborative partnerships that place the individual at the centre of service delivery (for example, embedding complementary support services, such as financial counsellors, in mental health service teams).

The experience of Good Shepherd practitioners is that wellbeing support is not uniform or consistent across the public education system, and an absence of alternative education options for young people aged 10-14 years means that a considerable number of young people are unable to attend school because of their poor mental health. This has long term implications not only for their mental health, but for their development and goal attainment across the lifespan. With half of all adult mental health conditions beginning before age 14 (Kessler et al, 2005), there is a need to invest earlier to support the needs of children and young people before they enter secondary school and become eligible for youth services such as headspace.

Recommendation 8: Increase investment in prevention and early intervention in the early years and primary school age, with continued support into adolescence and young adulthood, including extending the Mental Health in Schools secondary school program to primary schools across the state.

Given the increasing rates of self-harm and suicidal behaviour among women and girls there is a an urgent need for support following self-injury and suicide attempts, including social and emotional support in response to experiences of stigma and shame, and enhanced support for families and carers. There is also a need to ensure that when suicidal women present for health care that staff provide a compassionate response to address their psychological distress and their mental health needs.

Recommendation 9: Invest in workforce development to ensure that the needs of women and girls engaging in self-harm and suicidal behaviour are met, including appropriate training, supervision and quality assurance frameworks.

4.6 Addressing factors outside of the mental health service system

As addressed earlier in this submission, there are several factors outside of the mental health system that affect women's mental health, including the gender pay gap, discrimination, unequal sharing of caring responsibilities, housing precarity and family violence. As the National Mental Health Commission (2012) has noted, improving mental health is about tackling causes such as these and investing in the

things which enable good mental health – what the Commission terms a "contributing life":

> A contributing life means a fulfilling life enriched with close connections to family and friends, as well as experiencing good health and wellbeing to allow those connections to be enjoyed. It means having something to do each day that provides meaning and purpose, whether this is a job, supporting others or volunteering. It means having a home and being free from financial stress and uncertainty.

Good Shepherd supports investment in community strengthening interventions such as grassroots community programs, non-stigmatising peer to peer programs, and practical supports. These initiatives would help people experiencing mild to moderate psychological distress and prevent mental health conditions from worsening to the point where clinical assistance is required.

> "We need to consider the role of community and the development of 'community spaces' that promote 'natural networking' and meet the innate human need of belonging and inclusion—acknowledging that often times, when this is missing, individuals experience poorer mental health outcomes."
>
> *Good Shepherd practitioner*

Investment in upstream prevention at the community level would over time contribute to a reduction in poor mental health and savings in the mental health service system.

Addressing structural barriers in areas such as employment would also have a positive impact on mental health. For example, in relation to employment inequalities, Platt, Prins, Bates & Keyes (2016) found that the higher prevalence of anxiety and depression in women was mitigated by the elimination of the gender wage gap.

Comprehensive services to protect and support women leaving violence and meeting the large unmet needs for transitional and permanent housing are two critical areas nominated by practitioners in Good Shepherd services as fundamental to addressing the mental health needs of the communities we serve. These needs could be addressed by continuing the implementation of the Royal Commission into Family Violence reforms and increasing investment in mental health through an expansion of the Victorian Government's Safe and Strong Gender Equality Strategy.

Recommendation 10: Expand investment in initiatives that address systemic gender issues under the Safe and Strong Gender Equality Strategy to better support the mental health of women, girls and families.

5. Conclusion

The multiple challenges within the mental health service system require significant investment and redesign in order to respond to unmet need, poor integration of existing mental health services and lack of coordination with intersecting service systems. Genuine reform must place the person at the centre of service delivery and address the multiple policy and practice domains which affect mental health.

With many contributors to poor mental health lying outside of the mental health service system, a cross-sectoral intergovernmental and community response is required. Without a coordinated systems response prevention, intervention, response and recovery will be partial, with the most vulnerable people slipping between the cracks.

For women and girls the case for system reform could not be more urgent. As the World Health Organisation (n.d., p. 17) notes, when women stop experiencing violence their mental health improves, while for those who continue to experience violence their mental health deteriorates. It stands to reason that addressing other social and economic determinants will also result in improvements to women's mental health. With a precedent set by the wide-ranging recommendations of the Royal Commission into Family Violence and accompanying investment in policy and practice change, the Victorian Government is well placed to again lead the nation – this time by securing better psychological health and wellbeing for women, girls and families.

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