Feedback on T*owards One Human Services System (*the discussion paper to inform the development of a Human Services Blueprint)

The Women's Centre for Health Matters Inc. (WCHM) is a community-based organisation that works in the ACT and surrounding region to improve women's health and wellbeing.

WCHM believes that health is determined not only by biological factors, but by a broad range of social, environmental and economic factors known as the 'social determinants of health'. We acknowledge that that the environment and life circumstances that each woman experiences have a direct impact on her health, and in many cases, women's poor health is rooted in social disadvantage. For these reasons, WCHM is committed to taking a 'whole of life' and social approach to women's health, that is also firmly situated within a human rights framework.

WCHM is an organisation that works closely with groups of women who may experience, or are experiencing disadvantage, social isolation and marginalization. We use social research, community development, advocacy and health promotion to ensure women have access to reliable and broad ranging health-related information which allows them to make informed choices, and to advocate to influence changes in health-related services (including human services) to ensure responsiveness to ACT women's needs.

Creating good health in the ACT for women means acting on the social determinants of health — the factors, conditions, actions and environments that shape health, but which lie outside the health care system. Health for women in the ACT depends on supportive work, home and community environments, developing personal skills, and ensuring that services are geared to women's needs.

Women's Centre for Health Matters believes a whole of government approach to addressing the issues is more important than ever in order to achieve more efficient and better coordination of service delivery. By responding to the discussion paper WCHM is seeking to ensure that the preferences, views and concerns of ACT women are heard, especially in relation to those who have special needs and who are vulnerable.

Overall comments

The definition of disadvantage in the discussion paper is very narrow, and focusses on a traditional view of disadvantage as stemming from poverty or impoverished lives and a lack of opportunity. It does not reflect an understanding of the differences in gender that can cause poverty and disadvantage.

Disadvantage does occur because an individual's access to resources and opportunities are compromised or limited. But we know from our work with women in the ACT that disadvantage does not just stem for early life disadvantage but can be caused for example by an event, life stage or crisis which triggers disadvantage (a divorce, the loss of a job, a health episode, acquiring a disability, or experiencing trauma as a result of a sexual assault or domestic violence).

And for women it is more often systemic issues such as wages, employment conditions, affordability of housing, transport, childcare, and accessibility of services that create the conditions that influence whether they are disadvantaged or not. There are patterns in the ACT of a lack of service access and social participation as a result of affordability issues. And for women, disadvantage and social exclusion may also result from discrimination and stigmatisation (mental health, institutionalization) and impact on access to services and supports.

The discussion paper is focused on a discussion about delivery of programs delivered by the Community Services Directorate (Disability, Therapy, Housing, Care and Protection) and events (Multicultural Festival) rather than what needs to be involved in a human service system for the ACT. The Blueprint would benefit from being re-framed around a whole of government approach and the social determinants of health to ensure the provision of a human service system that recognises a full range of linked assistance is needed to meet identified needs and as well as the specific needs of different groups or individuals within the ACT (their age, life stage, culture and gender).

Human services need to be available to help people navigate through periods of crisis or one-off situations or through periods of depression, disability or a mental or physical health crisis. And this requires that individuals are not expected to fit into services or programs, but that the system changes to respond to their individual circumstances and backgrounds.

KEY RECOMMENDATIONS:

- The Blueprint needs to address the fact that marginalisation in the ACT is gendered and ensure in the design of an integrated human services system that services and pathways are sensitive to gender differences and the intersections of gender with disability, cultural background, socio-economic status, caring responsibilities etc.
- The Blueprint needs to incorporate trauma sensitivity.
- The Blueprint needs to ensure that the human services system does not inadvertently contribute to the exacerbation and compounding of issues that disproportionately affect women, (particularly marginalised groups of women) by not adequately addressing current service gaps and the creation of unnecessary silos.
- There is an assumption in the paper that the right services are already available in the system, some caused by previous, so it is crucial that the Blueprint recognises that there may be gaps that and ensure that these gaps in service do not remain.

Attachment A provides more detail of our understanding about the issues for ACT women.

Attachment A

Gender and disadvantage/marginalisation in the ACT

As far back as 2002 the report *Locating Poverty in the ACT* (NATSEM) identified that 'financially disadvantaged Canberrans are more likely to be ….. women.'
Marginalisation is gendered. This was a key finding of the recently released NATSEM report on disadvantage in the ACT. The longitudinal study found that there was

- "a *much higher proportion of women than men living in marginalised circumstances – two-thirds of those marginalised in 2001. Women were also more likely to remain marginalised, with the proportion of women increasing from 67 to 75 per cent over the decade."*[1]

A number of factors contribute to these gender differences in marginalisation. In particular, women are disproportionately affected by caring responsibilities and by gendered forms of violence. These two things have manifold economic, health and social consequences and intersect with other forms of disadvantage.

As such, it is crucial in the design of an integrated human services system that services and pathways through services are sensitive to gender differences and the intersections of gender with disability, cultural background, socio-economic status, caring responsibilities etc.

Care and Work

Mothers

The majority of primary carers of children are women. Mothers are more likely to work part time or not at all. This has significant consequences for long term economic security particularly in the event of relationship breakdown. Consequences include significantly less superannuation, less professional development opportunities, concentration in low paid, part time, but flexible jobs. Lack of professional development opportunities and slowed career progression has consequences for the kinds of jobs available to mothers when they *do* return to full time work. Furthermore the cost of childcare makes many low paying fulltime jobs of little net financial benefit to the household.

81% of single parents are women[2]. Single mothers are also less likely to be employed (55%) than single fathers (72%)[3]. While single parent households make up only 6% of households they make up 18% of low economic resource households[4]

[1] Cruwys, Tegan, Berry, Helen, Cassells, Rebecca, Duncan, Alan, O'Brien, Léan, Sage, Brie and D'Souza, Gabriela (2013) Marginalised Australians: characteristics and predictors of exit over ten years 2001-10 Canberra, ACT, Australia: University of Canberra
[2] 6224.0.55.001 - Labour Force, Australia: Labour Force Status and Other Characteristics of Families, Jun 2012
[3] ibid
[4] 4102.0 - Australian Social Trends, March Quarter 2012

Gendered Violence and Trauma

Women make up the majority of victims of sexual assault, child sexual assault and domestic and family violence. The prevalence of violence in the lives of many women has enormous implications for the human services system and service delivery- the consequences of gendered violence cross sectoral boundaries and require holistic, collaborative and specialist approaches to providing support. System wide trauma sensitivity will radically reduce the risks and costs of re-traumatising people in the very places where they should be supported.

Sexual Assault

Child sexual Assault

In 2011-12, there were 5, 828 substantiated cases of child sexual assault in Australia.[5] In the same year, girls were twice as likely as boys to be the victim in a substantiated case of sexual abuse.[6] Population surveys on child sexual assault estimate that anywhere between 1 and 45% of women have experienced some form of child sexual assault (depending on what definition was used).[7]

Sexual Assault

Because the vast majority of people who experience sexual violence do not report it to the police, recorded crime figures do not give an accurate picture of its prevalence. Population surveys can be more informative; however, because definitions of 'sexual violence' vary surveys may not capture the same data, and they are unlikely to capture the population groups that are most vulnerable to experiencing sexual violence. All of this means that it is likely that any figures we have on sexual violence are underestimations of the real extent of the problem.

- It is estimated that 1 in 5 women and 1 in 20 men are survivors of sexual assault (since the age of 15)[8].
- 1 in three girls and one in 6 boys will be sexually assaulted by the age of 18.
- Almost 1 in 5 women report that their most recent incident of sexual violence, since the age of 15, was perpetrated by a current partner[9].
- Only 1 in 7 women sexually assaulted by a current partner reported it to the police; slightly more women (just over 1 in 6) who were assaulted by any other male did the same.[10]
- Perpetrators of sexual violence against women are most likely to be family members or friends—not strangers.[11]
- Available evidence shows us that 93% of perpetrators of sexual violence are male.[12]

In the ACT

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[5] http://www.aifs.gov.au/cfca/pubs/factsheets/a142086/index.html
[6] http://www.aifs.gov.au/cfca/pubs/factsheets/a142086/index.html
[7] http://www.aifs.gov.au/cfca/pubs/factsheets/a144254/index.html
[8] http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4533.0Chapter2652011
[9] http://www.aifs.gov.au/acssa/pubs/sheets/rs5/index.html
[10] http://www.casahouse.com.au/index.php?page_id=154
[11] http://www.aifs.gov.au/acssa/pubs/sheets/rs5/index.html
[12] National Crime and Safety Survey, 2002.

There is currently no data that can indicate exactly how many people in the ACT have experienced sexual violence. The Canberra Rape Crisis Centre (CRCC) keeps statistics on their service users which can give some sense of the size of the issue—however, it's likely that many incidents do not even come to the attention of services. CRCC's statistics for 2012-13 show that:

- CRCC attended 261 callouts over 2012-13 (an increase of 40% on the previous year). The increase is due to changes in the support and reporting mechanisms around sexual assault in the ACT, and the increased public awareness on sexual assault as a result of the announcement of the Royal Commission into Institutional Reponses to Child Sexual Abuse.

- Similar to callouts, the total calls received by CRCC's crisis line was a record high for the agency. A total of 10,859 calls were received over the 2012-13 period (a 21% increase on the previous year). This equates to 30 calls every day of the year, responding to someone in the community affected by sexual assault.

- A total of 7,202 sessions were provided to women aged 26 and over, and 5,685 sessions were provided to young people between 12 and 25 years. A total number of 1,394 sessions were provided to men aged 16 and over.

Domestic Violence

While there is limited data available on domestic violence, we do know that it is an extremely widespread problem. Every community in Australia feels the impact of domestic violence in one way or another.

- One in 3 women will experience violence in her lifetime.
- In Australia, 1 in 6 adult women has experienced actual or threatened violence by a partner.
- Domestic violence is vastly underreported to authorities.
- Domestic violence is linked to gender inequality.
- More than a third of all homicides between 2008 and 2010 occurred in a domestic context. In fact, a woman is more likely to be killed in her own home by her male partner than anywhere else.

In the ACT

There is currently no available data that can indicate exactly how many people in the ACT have experienced domestic violence. The ACT Domestic Violence Crisis Service (DVCS) keeps statistics on their service users which can give some sense of the size of the issue—however, it's important to understand that the majority of incidents of domestic violence will not be reported to police, and it's likely that many do not even come to the attention of services.

DVCS statistics from 2012-13 indicate the following:

- 1096 clients were assisted on post-incident crisis visits with ACT Policing.
- 13,959 calls were received on the 24/7 crisis line.
- 160 bed nights were provided to families/individuals receiving emergency motel accommodation.

- 25-34 year olds were the most common age group DVCS worked with, followed closely by 35-44 year olds.
- 7.5% of DVCS's service users identified as Aboriginal and/or Torres Strait Islander. (Given that Aboriginal and Torres Strait Islander people make up only 1.2% of the ACT's population, this group is very much overrepresented as DVCS service users.)
- 31.75% were from culturally and linguistically diverse backgrounds (women from Indian and Chinese backgrounds are the two most represented by a significant margin).

Impacts of sexual assault and domestic violence

The impacts of sexual assault and domestic violence are varied, profound, and can be long-lasting. Survivors may continue to need support years after the violence has finished. It also has a range of consequences for families, communities and ultimately society.

PHYSICAL HEALTH

- Intimate partner violence has been identified as the leading contributor to death amongst women aged 15 – 44 in Australia – a greater risk than high blood pressure, smoking, and obesity.
- As well as leaving survivors with serious physical injuries, domestic violence has been shown to lead to long term physical, mental, and intellectual disabilities, including acquired brain injury and traumatic brain injury.
- Violence against pregnant women can lead to miscarriage, later trimester bleeding and infection, abdominal trauma, and death.
- There is evidence that there are both short and long-term health impacts (including disability) for unborn children whose mothers experience violence during pregnancy. This includes foetal death, foetal fractures, low birth weight and injury.
- Sexual violence can cause pain and injury, infections, fertility problems, unwanted pregnancy, or even miscarriage.

MENTAL HEALTH

- Overall there is an extremely high prevalence of trauma in mental health consumer population and it must be acknowledged that people with trauma histories who develop mental illness receive a wide range of diagnoses. This can obfuscate the extent of trauma in the eitiology of mental illness overall.
- There are many studies which show that domestic violence has serious impacts on survivors' mental health. It can lead to depression, post-traumatic stress disorder, anxiety disorders, and other stress and trauma-related syndromes.
- In Australia, it is estimated that nearly 18% of all depression experienced by women and 17% of all anxiety disorders experienced by women are associated with domestic or family violence.
- Children who are exposed to domestic violence are also likely to experience these impacts.
- Survivors of domestic violence are more likely to have problems with alcohol, to smoke, and to use non-prescription drugs.

- Women who have experienced domestic violence are at much greater risk of attempting suicide than women who have not.

ECONOMIC IMPACTS

• The largest proportion of the economic burden of domestic violence is borne by victims – more than half, according to some studies. This includes costs associated with homelessness, loss of employment, and healthcare linked with domestic violence.

• Domestic violence cost Australian businesses $175.2 million in 2002-03, with employee absenteeism, permanent loss of labour, and employee death all contributing factors. Without any effective intervention, this figure has been projected to rise to $456 million in 2021-22.

HOMELESSNESS

- There are extremely high rates of multiple, compounded trauma in women who are homeless. This includes before, during and after homelessness.
- One in four people accessing specialist homelessness services cite domestic and family violence as the reason for needing assistance – it's the most common reason given.[13]
- 90% of people using homelessness services report that they grew up with conflict in the house. This suggests that childhood exposure to domestic violence is a major risk factor for homelessness later in life.[14]

Women and Mental Health

Gender differences in prevalence

There are also significant gender differences in the prevalence of mental illnesses diagnoses. This means that if effective supports for different kinds of mental health issues is lacking it disproportionately effects women.

Eating disorders:

Lifetime prevalence of Anorexia and Bulimia combined for women:1.3%- 3.6%; for men 0.2%-1.6%[15]. 8.8% of adolescent women in Australia meet criteria for an eating disorder.

Borderline personality disorder and Complex Trauma

Despite the degree of unmet need for people with this diagnosis (which is very contested and may be better understood as complex trauma) the prevalence of Borderline Personality Disorder is higher than that of Schizophrenia and Bi-polar combined at 2-6%[16]. The vast majority of people with this diagnosis have history of trauma. Borderline Personality Disorder is stigmatised especially by health professionals.

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[13] http://www.homelessnessaustralia.org.au/images/HPW_2013/Hidden_Homeless_-_DV.pdf
[14] http://www.homelessnessaustralia.org.au/images/HPW_2013/Hidden_Homeless_-_DV.pdf
[15] Paying the Price: The social and economic impact of eating disorders in Australia.
[16] http://bpdresourcecenter.org/factsStatistics.html Univerity hospital Columbia and Cornell.

75-90% of people with this diagnosis are women. There is an extremely high suicide risk associated with BPD and borderline personality disorder features. The suicide rate of women with this diagnosis is 800 times greater than the general population.[17]

Despite this there are evidenced based treatments and a high recovery rate for people who have access to the right kind of treatment and support.

Affective disorders: Women are more than twice as likely to experience depression as men.

Antenatal Depression, Postnatal Depression and Puerperal Psychosis are, for obvious reasons gender specific disorders. While it is being increasingly acknowledged that some men can experience post natal depression this is relatively rare.

Post Traumatic Stress Disorder women are almost twice as likely to be diagnosed with post-traumatic stress disorder than men accounting for the higher rates of anxiety disorders seen in women.

There are also higher rates of co-morbidity in women with mental illness than in men with mental illness.

Trauma Informed Care

Both service level and systemic trauma sensitivity are required to meet the obvious need in the community and in particular the needs of women. Trauma is a public health issue and disproportionally effect women. There is a more than adequate research base supporting best practice in this area, however implementation across Australia is lacking. We highly recommend *The*

Systemic trauma sensitivity

The costs of re-traumatising people during access to services that should be supporting them are too great to be ignored. Re-traumatisation exacerbates and entrenches presenting issues, places greater demand on services, contribute to disengagement with services due to distrust and escalates crises.

The redesign of the human services system is an opportunity to implement *systemic* trauma-sensitivity. This goes beyond some services adding on training in trauma sensitivity to otherwise business as usual, and goes beyond some services being trauma sensitive while others are not. Trauma is gendered and implicated in mental health and illness, housing and homelessness, drug and alcohol, criminal justice system, disability, and legal needs. Co-ordination of services is critical as is high level quality assurance mechanisms.[18]

Trauma specialist services

Specialist services equipped and experienced in working with women with complex needs is equally critical. Recent cuts to the very services that specialise in working with trauma and complex needs has left significant gaps in services, at a time of increasing demand.

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[17] Ibid.

[1818] Last Frontier: Practice Guidelines for the Treatment of Complex Trauma and Trauma Informed Care and Service Delivery released in 2012.