Submission to:

Human Rights Unit, Legislation and Policy Branch, Justice and Community Safety Directorate
Email: escr.consultation@act.gov.au

Submission to the Community Consultation:

Economic, Social and Cultural Rights -

A good idea for inclusion in the ACT?

Women's Centre for Health Matters Inc.

August 2011

The Women's Centre for Health Matters acknowledges the Ngunnawal people as the traditional owners and continuing custodians of the lands of the ACT and we pay our respects to the Elders, families and ancestors.

We acknowledge that the effect of forced removal of Indigenous children from their families as well as past racist policies and actions continues today.

Submission to the ESCR Discussion Paper
Women's Centre for Health Matters Inc.
August 2011

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Introduction

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 focuses on groups of women who experience disadvantage, social isolation and marginalisation (women with disabilities, institutionalised women, women living with mental health issues, women from culturally and linguistically diverse backgrounds (CALD), and older women) and uses social research, community development, advocacy and health promotion to

- provide women with access to reliable and broad ranging health-related information which allows informed choices to be made about each woman's own health and wellbeing, and
- advocate to influence change in health-related services to ensure responsiveness to women's needs

Response to the consultation on the inclusion of economic, social and cultural rights in the Human Rights Act

The Women's Centre for Health Matters (WCHM) welcomes the opportunity to provide a submission to the Human Rights Unit of the Justice and Community Safety Directorate regarding the inclusion of economic, social and cultural rights into the Human Rights Act 2004 (ACT) and to support our responses with evidence published by the Centre and its partners on the specific needs of women living in the ACT and surrounding region.

In writing this submission WCHM has chosen to limit its responses to those areas in which it has the most knowledge: ACT women's preferences, views and concerns. This response is informed by the views and concerns of our partners (including Women With Disabilities ACT, the Women and Mental Health Working Group and the ACT Women And Prisons group) with whom we work closely on the specific issues for and needs of ACT women, and with feedback from a variety of ACT women and service providers through focus groups and other consultation processes.

WCHM supports the inclusion of economic, social and cultural rights (ESCR) in the Human Rights Act 2004 (ACT), because we believe that these rights cover the basic areas of life

that are fundamental for women to achieve equitable opportunities and access in order to live a healthy and dignified life - education, adequate housing, high standards of physical and mental health, work opportunities and conditions of employment as well as participation in cultural life.

And WCHM considers that improving human rights protections for vulnerable women such as those living with mental illness, with lived experience of prison, and with disabilities is imperative given the marginalisation, stigma and discrimination that they can face in all aspects of their lives.

Background: Women in the ACT

This submission aims to highlight the importance of gender issues found through WCHM's research with ACT women. Health for women in the ACT depends on supportive work, home and community environments, developing personal skills, and ensuring that health services are geared to women's needs.

From WCHM's findings the needs of women in the ACT relate to:

- inequality of access to the services that support health and wellbeing due to cost, physically inaccessible services and services not being culturally appropriate or gender sensitive;
- inequality of access to the social and economic resources necessary to achieve and maintain good health such as education, income, employment, transport and a safe place to live; and
- inequality between different groups of women because of their life circumstances and experiences.

Women comprised 50.7% of the total ACT population in 2006. (ABS 2007, 2006 Census Tables, Cat. No. 2068.0, ABS, Canberra). Overall ACT women are generally better educated, have higher incomes, and have higher housing standards than women nationally.

But 'social and economic advantage often masks pockets of disadvantage' (*The Australian Capital Territory Chief Health Officer's Report 2010*) and there are a significant number of women who are marginalised and isolated from their community and its wider standard of living. According to the report Locating Poverty in the ACT, by the National Centre for Social and Economic Modelling in 2002, 'financially disadvantaged Canberrans are more likely to be ….. women.' Specifically, the report indicates that 56.9% of the ACT population who experience poverty are women.

The private rental market in the ACT is competitive and difficult to access, with rent rates in the ACT amongst the highest of all the major capital cities. High average incomes for some ACT residents distort the figures of affordability, and hide the inaccessibility of the private

market for disadvantaged women when long waiting lists make public housing difficult to access.

According to the report *Health Status of Women in the ACT* (*Population Health Research Centre, ACT Health (2008)*)

- Women are traditionally over-represented in the lower socio-economic groups (low wages, single parents).
- ACT women had lower average earnings than men.
- One in ten ACT females reported that they had times when food ran out and there was no money to buy more.
- Women were more likely than men to report having a mental health condition such as depression and anxiety, and were also more likely to report high to very high levels of psychological distress.
- The ACT female population is increasing most rapidly in the 50 to 69 year age group.

While the ACT had the lowest rate of homelessness nationally, around 47% of the people who experience homelessness in the ACT each year are women. (*Australian Bureau of Statistics, Australian Census Analytic Program: Counting the Homeless, ABS Cat. No. 2050.0, Canberra: Australian Bureau of Statistics, 2001*).

Social disadvantage is associated with potentially avoidable poor health outcomes. In the ACT, indicators of material disadvantage have been linked to poorer health status, and lower levels of service utilisation and service access.

Right to Health

The ICESCR states that every person has the right to the highest attainable standard of physical and mental health. This means that the 'underlying determinants of health' – such as nutritional, social, and environmental factors – need to be addressed and protected under this right. The right to health also asserts that access to health care facilities, goods and services must be provided to the population equally. They must be available and reasonable measures must be taken to ensure the provision of a functioning public health system and health care facilities, goods and services that are available in sufficient quantity. They must be accessible - reasonable measures must be taken to ensure that health facilities, goods and services are accessible without discrimination, and they must be physically accessible; economically accessible (or affordable); and be accompanied by access to appropriate information. And they must be appropriate from a gender, cultural and age perspective.

Right to Education

As the ESCR background paper notes, the right to education is founded in the belief that education "is essential to the full development of a person's personality and sense of dignity." Central tenets to the right to education include that higher education is "equally

accessible to every person," and the need for educational institutions to be "flexible ... and tailored to the needs of individual students who may have different needs."

Education is one of the most underlying determinants of health, because it provides financial resources through increased employment, skills to increase health literacy, and social connectedness which improves wellbeing[1].

WCHM's research has found that education is linked in significant ways to health and wellbeing outcomes for women, especially for women experiencing disadvantage. This means that enshrining the right to education in ACT's Human Rights Act is an important aspect to improving the quality of health and wellbeing of women living in the ACT, especially for vulnerable groups.

Right to Housing

The ICESCR states that every person has a right to adequate housing. Elements to the right to housing include ensuring that "disadvantaged groups are given priority in Government housing policies and laws." Having access to adequate housing is also an essential ingredient in being able to participate in the community.

The right to housing relates to having somewhere to live that is *adequate,* including legal security of tenure, affordability; accessibility, habitability, location and cultural adequacy.

Right to Employment/Work

The right to work includes a provision about protecting and promoting access to employment, without discrimination, and that services must be available to assist and support people who are seeking employment. Employment is also a key social determinant of health because it provides "financial security, self esteem and social engagement[2]", and poverty and relative deprivation have been shown to have an impact on health and wellbeing. Without employment, women may experience financial hardship including insufficient superannuation at the time of retirement[3], and insufficient funds for medical treatment and medical costs.

Right to Cultural life

The ability to participate, access and contribute to cultural life, and to enjoy the benefits of scientific progress, are important aspects to community life and are protected under the ICESCR. ACT is a multicultural city and has a variety of multicultural strategies in place. The protection of these rights in would benefit all people who have come here from a large number of diverse cultures, religions and languages.

[1] ACT women's plan 2010-15: p 13; Nutbeam, D, 2001, 'Health Literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century', in Health Promotion International, vol 15, no 3, pp. 259-267 cited in Cannon, R. and South Australian Council of Social Services, p. 10.
[2] *Disability, ageing and carers: Summary of findings,* 2003: 4430.0.
[3] ACT women's plan 2010-15: p. 12.

ESCR of women with lived experience of prison

Women who are or have been incarcerated represent one of the most marginalised groups in our community. Women's offending and imprisonment is often closely related to women's poverty. They are disproportionately affected by homelessness, violence, sexual assault, mental illness, substance abuse, and poverty. The discrimination they suffer as a result of the stigma associated with incarceration further undermines their ability to integrate back into the community. When women are released from prison they face the same barriers to re-entry as men—social stigmatization; lack of adequate housing; and few or no employment opportunities. Many women cannot obtain government support to secure adequate housing because they do not have custody of their children, and they cannot secure custody of their children because they do not have adequate housing.4 Protecting the human rights of women in prison and women exiting prison is central to addressing these issues.

The ACT prison – the Alexander Maconochie Centre (AMC) - currently houses approximately 200 male and 20 female prisoners and emphasises human rights principles and adherence to the 'Healthy Prison' concept. As women only make up a small proportion of the total prison population, the prison focuses many of its procedures on male prisoners and the gender-specific needs of women are overlooked.

Education

Quality education and training is currently not very accessible to the women incarcerated in the ACT. WAP's 2010 submission to the Alexander Maconochie Centre review found that there are real inadequacies in the provision of education and training opportunities for women prisoners. Training options for women at AMC were limited to vocational courses on OH&S training, barista skills and hairdressing; these courses were also initially only available to women once they had been sentenced, despite the fact that women were often incarcerated at AMC for a longer period on remand than when they were sentenced. The limited focus of the training meant that it was not responsive to individual needs or differences in skills or ability – that is, it was not "tailored to the needs of individual students who may have different needs." Women entering prison often have numeracy and literacy skill deficits, but as there is no initial standard assessment upon entry these issues go unidentified and are not addressed by available education and training opportunities. There is a real need to protect the right of women in prison to accessible, flexible, quality education and training options. Enshrining this right in the Human Rights Act will ensure that health and wellbeing outcomes for women in prison and exiting prison is improved.

Housing

Women who are or have been incarcerated are a highly disadvantaged group, and are at a greater risk of experiencing homelessness than the general population. Research shows that women prisoners are much more likely to be responsible for the maintenance of a house than male prisoners, and so are likely to lose their home (and often consequently their

[4] Women's Centre for Health Matters / Women and Prisons group ACT Joint Budget Submission 2011/12.

children) when they are taken into custody.[5] As a result of this, as noted in the Women Exiting Corrections Program Concept Paper:

"Women exiting detention are particularly vulnerable to homelessness, often relying on previous contacts who may themselves be offenders, returning to previously violent relationships, or forced to provide sexual favours for accommodation. This sub-group therefore requires immediate support upon release from detention."[6]

There is some evidence to suggest that facilitating women ex-prisoners' access to appropriate housing also reduces recidivism; however, high levels of recidivism indicate that housing and support services for women exiting the corrections system are currently lacking.[7] Protecting the rights of these women to access adequate housing is an important part of ensuring their health and wellbeing post-release, and preventing recidivism.

Health

The ACT Women and Prisons group believes that the environment and life circumstances that each woman experiences impact directly on her health, and in many cases, poor health is rooted in social disadvantage. Women who have experienced institutionalisation usually have a history of disadvantage, abuse, and social, economic, political, and legal marginalisation, which results in poor health and wellbeing outcomes (including mental health).[8] Current standards of health care, health promotion and mental health services in the Alexander Maconochie Centre are inadequate to meet the high needs of women prisoners. WCHM and WAP's submission to the AMC review reported that women in the AMC do not have access to good nutrition information and nutritious food; have their medication needs attended to after the male prisoners; are subjected to inadequate suicide prevention measures; are subjected to frequent lockdowns caused by staff shortages; have limited access to beds for acute mental health treatment; have difficulty accessing health services through custodial officers; have limited access to female GPs; and are not connected with external health services upon release. The health services at the AMC are fragmented and siloed, and it can be difficult for women prisoners to navigate the system.[9]

Enshrining the right to health in the ACT Human Rights Act would provide added protection for women prisoners accessing health services in prison, and ensure that this disadvantaged group is supported to enjoy the highest attainable standard of physical and mental health as a human right.

[5] Budget submission 2011-12.
[6] Women Exiting Corrections Program Concept Paper, p 1.
[7] *Carnaby's Report* 1998.
[8] Women's Centre for Health Matters / ACT Women and Prisons Group joint submission to the Independent Review of the Alexander Maconochie Centre, September 2010, p 2.
[9] AMC Independent Review submission, p 4-5.

Employment/Work

Women who are entering prison are often already socially and economically marginalised, and being imprisoned further impacts upon this. Low educational attainment and the stigma associated with institutionalisation often mean that women prisoners struggle to find employment post-release. The work opportunities that are available tend to be low-paying, marginal positions, which leave them susceptible to poverty and homelessness. Research suggests that participation in education and training prior to custodial release significantly decreases women's chances of returning to prison,10 and U.S. and Australian studies found that young women in the criminal justice system identified economic independence as amongst their most pressing needs.11

Our research documents that there are few employment and work experience opportunities available to women imprisoned at AMC, and so there's little opportunity for them to develop employability skills or to be connected to employers post-release.12 This is also the case at the Bimberi Youth Justice Centre; WCHM's research has found that young women at Bimberi do not have access to the same level of vocational training opportunities as the young men, and their aptitudes and interests are ignored when they're being assigned to training programs. 13 Given the established link between unemployment and offending, it's important to assist women to achieve economic independence as much as possible post-release in order to facilitate their re-entry into the community and prevent recidivism.

Guaranteeing the right to work, including equal and non-discriminatory access to work and training, in the ACT Human Rights Act would ensure that women in prisons are given a chance to improve their prospects of employment during prison and post-release, and thus result in better health and wellbeing outcomes for these already disadvantaged and marginalised women.

For women with lived prison experience the inclusion of the right to education may also reduce recidivism and increase workforce participation post release.

Cultural Life

Women with lived experience of prison are at great risk of social isolation and marginalisation. After the alienation of prison life, re-entering the community upon release can be challenging for women who are dealing with trauma and struggling with a range of other issues. This can be particularly difficult for women from minority groups, from culturally and linguistically diverse backgrounds, and for Aboriginal and Torres Strait Islander women

[10] Victor Callan and John Gardner, 'Vocational education and training provision and recidivism in Queensland correctional institutions research report', National Centre for Vocational Education Research, 2005, p4.
[11] Chesney-lind and Sheldon 1992 in Christine Alder, 'Young women and juvenile justice: objectives, frameworks and strategies.' Paper presented at Australian Institute of Criminology Conference Juvenile Crime and Juvenile Justice: Towards 2000 and Beyond, Adelaide, 26 and 27 June 1997.
[12] WCHM Submission to Young People Transitioning out of Care discussion paper.
[13] Women's Centre for Health Matters and ACT Women and Prisons submission to the Review of the Bimberi Youth Justice Centre 2011, p 9.

(who are hugely overrepresented in the criminal justice system in Australia).[14]

The ACT Women and Prisons Group research has found that women incarcerated at the AMC have little or no access to recreation activities, and that most women find that there is a lack of consistency in accessing library and internet services. Internet use at the AMC is heavily monitored and restricted to a few sites that have been deemed appropriate by staff. There are also very limiting restrictions on the number of books that women can borrow each week from the AMC library.[15] This means that women imprisoned in the ACT have little opportunity to participate in 'cultural life' through recreational activities or access to literature, and are prevented from enjoying the benefits of technology through restrictions on their use of ICT. Protecting the rights of women in prison to participate in cultural life and enjoy the benefits of science and technology would have real benefits for these women in terms of their social connectedness, their intellectual/educational achievements, and thus their health and wellbeing.

ESCR of Women living with Mental Health Issues

The past twenty years have seen a significant body of research in the mental health field that highlights the difficulties experienced by people living with mental health issues. They constitute one of the most vulnerable, disadvantaged and marginalised groups in contemporary Australian society.

It is well known that mental illness can have a significant impact on a person‟s education, employment, relationships, and health (eg. Kitchener, Jorm, & Kelly, 2010).

For women living with mental health issues, this disadvantage can be twofold. The common difficulties associated with being a woman—lower socio-economic status than men; higher incidences of violence against women; under-representation of women in positions of power; lower rates of labour force participation[16]; an over-representation of women in part-time and casual work and the gender pay equity gap[17]—are compounded by the presence of a mental illness.

There is also a strong relationship between social status and mental health[18], which greatly affects women. As a consequence, women experience mental health issues at a higher rate than men[19,20]. They also experience it differently through the biological, psychological and

[14] Women's Centre for Health Matters / Women and Prisons ACT Joint Submission to the ACT Budget Consultation 2011/12.
[15] Data from WAP peer support visits, 2010-11.
[16] Labour force participation rate for women was 58 per cent in January 2008. (DFAT, http://www.dfat.gov.au/facts/women.html)
[17] The gender pay gap for full-time adult ordinary time female employees was 16.7 per cent in August 2008. (FAHCSIA, http://www.facs.gov.au/sa/women/progserv/economic/Pages/payequity.aspx)
[18] D.E. Stewart, "Social Determinants of Women's Mental Health" in *Journal of Psychosomatic Research*, Sep 2007.
[19] The Women's Health Council, 2007, *A Guide to Creating Gender-Sensitive Health Services*

social factors which cause the illness; the course and expression of the illness; the age of onset as well as the symptoms experienced and comorbidity with other illnesses[21].

According to WCHM research, there are approximately 23,000 women living with diagnosed mental or behavioural conditions in the ACT, with 23.5 per cent of these women reporting only poor to fair health status. 14,000 women in the ACT are experiencing economic disadvantage. Women with diagnosed mental or behavioural conditions are over-represented in the lowest income quintile (approximately 7,300 women). Unpartnered women with children in receipt of income support payments are more than twice as likely to have a mental disorder than the general population (AFFIRM, 2005), and the labour force participation rate for people living with mental illness stands at just 28.2 per cent (ABS, 2004).

Education

For women living with mental health issues, education needs to be accessible and flexible as they may have spent time out of the workforce recovering from mental health issues or even in a caring role for a family member living with mental health issues. Inclusion of the right to education will improve mental health and wellbeing through increased participation in the community and increased social connectedness.

Health

Women's mental health is best understood by considering not only the biological and physiological contexts of a woman's life, but also the social, cultural, economic and personal contexts, or the social determinants of health[22]. Programs and practitioners that encourage and implement this approach, those that are 'gender-sensitive', achieve better health outcomes for women. In contrast, 'gender neutral' or 'gender blind' approaches neglect the unique needs of women with mental health problems, perpetuating mental health inequalities between men and women. It is therefore essential that people working with and to support women with mental health issues participate in education and employment, understand the impact of gender on mental health, the concept of 'gender sensitive practice' and the ways in which social determinants impact on women's health and well-being.

Women with mental health issues find it difficult to access health care. WCHM believes that women have the right to recovery based health care that takes into account gender sensitivity & the social determinants of health.

[20] F. Judd, S. Armstrong, J. Kulkarni, "Gender-sensitive mental health care" in *Australasian Psychiatry,* Vol 17 (2) 2009
[21] Ibid.
[22] D.E. Stewart, "Social Determinants of Women's Mental Health" in *Journal of Psychosomatic Research*, Sep 2007

Barriers to accessing mental health care services, including preventive programs, and acquiring information to make informed decisions are a part of the social determinants of women's lives which can lead to health inequalities, even in the ACT. These include:

- shortages of general practitioners and psychologists
- the cost of accessing the services and the lack of bulk billing in the ACT
- services being ill equipped to deal with the complexity of the health, social and emotional wellbeing and cultural needs of women from disadvantaged groups
- a lack of gender sensitive services and information

Out of pocket expenses are greatly impacting on many ACT women's access to health care, and many are forgoing basic services and provisions to cover their health costs or missing recommended follow up visits, not having treatment or deciding not to visit their doctor, or buy their medicine. This is exacerbating mental health problems and costs to themselves and the health system.

Work /Employment

Employment provides "financial security, self esteem and social engagement[23]", and poverty and relative deprivation have been shown to have an impact on health and wellbeing. Without employment, women may experience financial hardship including insufficient superannuation at the time of retirement[24], and insufficient funds for medical treatment and medical costs. It can also be difficult for women with mental health issues to access income support due to the nature of mental illness and Centrelink eligibility requirements.

Despite the important role of participation, there are several barriers in place for women with mental health issues in seeking education and employment opportunities. Often women with mental illness do not have the resources to obtain and sustain full time work. Barriers include difficult work hours[25], the cyclical nature of mental health issues[26], and difficulties finding employment due to the stigma associated with mental illness. As a result, women living with mental health issues may stay outside the paid labour force, take up casual or part-time employment, work in positions beneath their skill level, or leave employment when diagnosed or when experiencing episodes of mental illness[27].

A further barrier to participating in work and study for women with mental health issues is that they are often also acting in caring roles, including caring for someone with a disability or parenting. Women are the majority in carer populations, and in comparison to male carers women are more likely to: take on caring responsibilities at an earlier age[28,] be a caregiver in

[23] *Disability, ageing and carers: Summary of findings,* 2003: 4430.0.
[24] ACT women's plan 2010-15: p. 12.
[25] Mental Health Council of Australia, p. 71.
[26] National Centre for Social and Economic Modelling, p. viii.
[27] Mental Health Council of Australia, p. 71.
[28] *Disability, ageing and carers: Summary of findings,* 2003: 4430.0, p. 5.

the home[29], care for more than one person, and deliver complex care[30]. Women also continue to have the responsibility for the majority of household tasks. As a result of this gender inequity in caring roles, women are disadvantaged in a variety of ways. For example, carers have higher levels of depression that the non-caring population[31], and many women are engaged in reciprocal care arrangements where the care giver and receiver is not clear.

Working provides income, skills, confidence and social interaction to women living with mental health issues therefore improving their health and wellbeing. The inclusion of the right to work would ensure that work for women living with mental health issues is flexible, fair and equal in opportunity.

Cultural Life

Participation in community and cultural life is essential to a person's mental health and wellbeing. Since deinstitutionalisation, people with mental health issues are more socially disconnected. WCHM conducted a recent study into the benefits of peer support for women living with mental health issues and found that there were barriers to participation including transport and cost. The inclusion of the right to participate in cultural life would ensure that women would be able to take part in

There is much criticism of the experiences of and care provided for people with mental illness in psychiatric facilities of the past. However, some argue that psychiatric facilities fulfilled a clinical and human need,[32] due to the 'forced togetherness' of hospital life which may have provided a ready-made social network and sense of belonging for inpatients.[33] Post deinstitutionalisation, which occurred in Australia in the 1970s, services moved to a more therapeutic community-based model of delivery.[34] This resulted in increased human rights for people living with a mental health issue, but also the unwanted consequence of increased social isolation.[35]

For example, people living with mental health issues find it more difficult than others to develop and maintain social relationships.[36] Barriers include the social stigma surrounding mental illness, loss of social roles associated with impairments in functioning, lack of social structures to bring people together in the community, and the social disability associated with the disorder itself.[37] People with mental illness have comparatively smaller social networks

[29] D Doherty, S Benbow, J Craig & C Smith, 'Patient's and carers' journeys through older people's mental health services: Powerful tools for learning', *Dementia,* vol. 8, 2009, p. 261.
[30] Navaie-Waliser, M, A Spriggs & P Feldman, 'Informal caregiving: differential experiences by gender', *Medical Care,* vol. 40, no. 12, 2002, pp. 1250-6.
[31] Pinquart et. al, p. 33
[32] P Carling, *Return to community: Building support systems for people with psychiatric disabilities*, Guildford Press, New York, 1995.
[33] L Davidson, MA Hoge, ME Merrill, J Rakfeldt & EEH Griffith, 'The experience of long-stay inpatients returning to the community', *Psychiatry,* vol. 58, no. 2, 1995, pp. 122-132.
[34] LI Stein & MA Test, *Alternatives to mental hospital treatment,* Plenum Press, NY, 1978.
[35] Riessman et. al; Godley et. al.; Skirboll et. al.
[36] Davidson et. al, *Supported Socialization*.
[37] Davidson et. al, *Supported Socialization.*

than people without mental health issues,[38] and it is not uncommon for people with mental illness' interactions to be limited largely to medical practitioners, family members and peers living with mental health issues.[39] Consequently, many people with mental health issues report spending much time alone,[40] and therefore experience feelings of loneliness,[41] a lack of community connectedness[42] and dissatisfaction with the social support they do receive.[43]

Moreover, a growing amount of literature identifies lack of community support rather than a person's symptomatology to be the dominant factor in re-admission to psychiatric inpatient care,44 where up to half of all discharged psychiatric inpatients are re-hospitalised within twelve months.45 For example in the ACT, a lack of transitional support and poor psychiatric discharge practices have been identified as major contributors to recidivism.46

[38] F Baker, D Jodrey, J Intagliata & H Strauss, 'Community support services and functioning of the seriously mentally ill', *Community Mental Health Journal,* vol. 29, no. 4, 1993, pp. 321-331; T Harris, GW Brown & R Robinson, 'Befriending as an intervention for chronic depression amongst women in an inner-city 2: Role of fresh-start experiences and baseline psychosocial factors in remission from depression', *The British Journal of Psychiatry,* vol. 174, no. 3, 1999, pp. 225-32; CC Tolsdorf, 'Social networks, support and coping: An exploratory study', *Family Process,* vol. 15, no. 4, 1976, pp. 407-17; J Walsh, & PR Connelly, 'Supportive behaviours in natural support networks of people with serious mental illness', *Health and Social Work,* vol. 27, no. 4, 1996, pp. 296-303.

[39] B Angell, 'Contexts of social relationship development among assertive community treatment clients', *Mental Health Services Research,* vol. 5, no. 1, 2003, pp. 13-25; Borge, L, EW Martinsen, T Rudd, O Watne & S Friss, 'Quality of life, loneliness and social contact among long-term psychiatric patients', *Psychiatric Services,* vol. 50, no. 1, 1999, pp. 81-84; WF Dailey, MJ Chinman, L Davidson, L Garner, E Vavrousek-Jakuba, S Essock, K Marcus & JK Tebes, 'How are we doing? A statewide survey of community adjustment among people with serious mental illness receiving intensive outpatient services', *Community Mental Health Journal*, vol. 36, no. 4, 2000, pp. 363-82; S Meeks & SA Murrell, 'Service providers in the social networks of clients with severe mental illness', *Schizophrenia Bulletin,* no. 2, 1994, pp. 399-406.

[40] L Davidson & DA Stayner, 'Loss, lonliness, and the desire for love: Perspectives on the social lives of people with schizophrenia', *Psychiatric Rehabilitation Journal,* vol. 20, no. 3, 1997, pp. 3-12; L Davidson, DA Stayner & KE Haglund, 'Phenomenological perspectives on the social functioning of people with schizophrenia' in KT Mueser & N Tarrier (eds), *Handbook of social functioning in schizophrenia',* Allyn & Bacon Publishers, Massachusetts, 1998, pp. 97-120.

[41] Davidson et. al., *Loss, loneliness;* Green, G, C Hayes, D Dickinson, A Whittaker & B Gilheany, 'The role and impact of social relationships upon well-being reporting by mental health service users: A qualitative study', *Journal of Mental Health UK,* vol. 11, no. 5, 2002, pp. 656-579.

[42] P Crotty & R Kulys, 'Social support networks: The views of schizophrenic clients and their significant others', *Social Work,* vol. 30, no. 4, 1985, pp. 301-09; Davidson et. al, *Supported socialisation;* RW Goldberg, AL Rollins & AF Lehman, 'Social network correlates among people with psychiatric disabilities', *Psychiatric Rehabilitation Journal,* vol. 26, no. 4, 2003, pp. 393-402; RL Leavy, 'Social support and psychological disorder: A review', *Journal of Community Psychology,* vol. 11, no. 1, 1983, pp. 3-21; E Rogers, SW Anthony & A Lyass, 'The nature and dimensions of social support among individuals with severe mental illnesses', *Community Mental Health Journal,* vol. 40, no. 5, 2004, pp. 437-50.

[43] A Bengtson-Tops & L Hansson, 'Quantitative and qualitative aspects of the social network in schizophrenic patients living in the community. Relationship to sociodemographic characteristics and clinical factors and subjective quality of life', *International Journal of Social Psychiatry,* vol. 47, no. 3, 2001, pp. 67-77; J Carron, R Tempier, C Mercier & P Leouffre, 'Components of social support and quality of life in severely mentally ill, low income individuals and a general population group', *Community Mental Health Journal,* vol. 34, no. 5, 1998, pp. 459-475; TA Furukawa, H Harai, T Hirai, T Kitamura & K Takahashi, 'Social support questionnaire among psychiatric patients with various diagnosis and normal controls', *Social Psychiatry and Psychiatric Epidemiology,* vol. 34, no. 4, 1999, pp. 216-22.

[44] L Davidson, M Chinman, B Kloos, R Weingarten, D Stayner & JK Tebes, 'Peer support among individuals with severe mental illness: A review of the evidence', *Clinical Psychology: Science and Practice,* vol. 6, no. 2, 1999, pp. 165-87.

[45] WD Klinkenberg & RJ Calsyn, 'Predictors of receipt of aftercare and recidivism among persons with severe mental illness: A review', *Psychiatric Services*, vol. 47, no. 5, 1996, pp. 487-96.

[46] Morgan Disney and Associates, *Needs assessment/analysis framework: Report for Women's Centre for Health Matters*, Canberra, 2007.

Housing

To achieve and maintain housing tenure, women living with mental health problems need to feel secure and safe in their physical and social environment; require accessibility and proximity to social, cultural and family networks,carers, shops, support services, medical and alternative treatments and programmes, recreation options, transport, amenities and community services that assist people with mental health problems to maintain tenure.

ESCR of Women with a disability

The social exclusion and discrimination faced by people with disabilities has increasingly been recognised as a human rights issue.Women with a disability suffer the dual disadvantage related to their gender and their disability and evidence shows that income poverty, social isolation, and access to health and other service are a problem for women in this cohort.(*Women With Disabilities Australia: Policy Paper: 'Assessing the situation of women with disabilities in Australia: A human rights approach'(July 2011))*

Women with disabilities face significant barriers to accessing health services, programs and opportunities available for other people without disabilities. This can occur for a range of reasons that may include inadequate or inappropriate buildings and infrastructure, financial cost, and discrimination. .(*Women With Disabilities Australia: Policy Paper: 'Assessing the situation of women with disabilities in Australia: A human rights approach'(July 2011))*

As a group, women with disabilities in Australia experience many of the now recognised markers of social exclusion - socioeconomic disadvantage, social isolation, multiple forms of discrimination, poor access to services, poor housing, inadequate health care, and denial of opportunities to contribute to and participate actively in society. Women with disabilities remain largely invisible and voiceless, ignored by national policies and laws, even though they face multiple forms of discrimination, structural poverty and social exclusion. Their issues and needs are often overlooked within services and programs. They remain marginal to social movements designed to advance the position of women, and the position of people with disabilities. .(*Women With Disabilities Australia: Policy Paper: 'Assessing the situation of women with disabilities in Australia: A human rights approach'(July 2011))*

Women with disabilities are less likely to be in paid work than other women, men with disabilities or the population as a whole. They are less likely than their male counterparts to receive adequate vocational rehabilitation or gain entry to labour market programs. Women with disabilities earn less than disabled men, are in the lowest income earning bracket, yet pay the highest level of their gross income on housing, and spend a greater proportion of their income on medical care and health related expenses. .(*Women With Disabilities Australia: Policy Paper: 'Assessing the situation of women with disabilities in Australia: A human rights approach'(July 2011))*

Women with disabilities are substantially over represented in public housing, are more likely to be institutionalised than their male counterparts and are often forced to live in situations in which they experience, or are at risk of experiencing, violence, abuse and neglect. .(*Women With Disabilities Australia: Policy Paper: 'Assessing the situation of women with disabilities in Australia: A human rights approach'(July 2011))*

The Convention on the Rights of Persons with Disabilities (CRPD), ratified by Australia in 2008, acknowledges the impact of multiple discriminations caused by the intersection of gender and disability, prioritises women with disabilities as a group warranting specific attention, and calls on States Parties to take positive action and measures to ensure that women and girls with disabilities enjoy all human rights and fundamental freedoms (Article 6).

Housing

Having access to adequate, safe and secure housing substantially strengthens the likelihood of women with disabilities being able to enjoy certain additional rights. Housing is a foundation from which other legal entitlements can be achieved. For example: the adequacy of one's housing and living conditions isclosely linked to the degree to which the right to environmental hygiene and the right to the highest attainable level of mental and physical health can be enjoyed. The World Health Organization has asserted that housing is the single most important environmental factor associated with disease conditions and higher mortality and morbidity rates (OHCHR 2008). .(*Women With Disabilities Australia: Policy Paper: 'Assessing the situation of women with disabilities in Australia: A human rights approach'(July 2011))*

Health

Women with disabilities in Australia not only represent one of the groups with the highest risk of poor health, but also experience socioeconomic disadvantage, social isolation, multiple forms of discrimination, poor access to services and inadequate health care (WWDA 2009, Iezzoni et al 2001, Veltman et al 2001). Although there has been limited research in Australia on the health concerns of women with disabilities, we know that women with disabilities experience major inequalities in health status, and that they experience significant disadvantage in the social determinants29 of those inequalities. For example, the link between low socio-economic status and poor health has been well documented (WWDA 2005, CSDH 2008). Women with disabilities throughout Australia bear a disproportionate burden of poverty and are recognised as amongst the poorest of all groups in society (WWDA 2006). (*Women With Disabilities Australia: Policy Paper: 'Assessing the situation of women with disabilities in Australia: A human rights approach'(July 2011))*

And women with disabilities spend more of their income on medical care and health related expenses than men with disabilities (Frohmader 2002, Salthouse and Howe 2004).

Work/Employment

In 2003, the unemployment rate for people with disability (almost 9%) was significantly higher than for people without disability (5%). The rate was twice as high (10%) for people with severe or profound limitations, and almost 3 times as high (14%) for people who did not need help with core activities but had schooling or employment restrictions (Disability in Australia: AIHW, 2008)

Of those with a reported disability (just under one in five Australians), 87% had a specific limitation or restriction; that is, an impairment restricting their ability to perform communication, mobility or self-care activities, or a restriction associated with schooling or employment. (ABS, 2009)

'There are a number of barriers that stand in the way of women with disabilities in Australia taking up and maintaining paid employment, and these include negative social attitudes & discrimination including employers' and co-workers' attitudes; poverty; lack of access to education and training; poor job design and inflexible work arrangements; inaccessible and unresponsive employment services; insecure housing & accommodation and lack of awareness about rights.' .(*Women With Disabilities Australia: Policy Paper: 'Assessing the situation of women with disabilities in Australia: A human rights approach'(July 2011))*

'For many women with disabilities in Australia simply 'wanting' a job does not equate to 'finding' one33. In order for women with disabilities to seek and retain employment, they need the elimination of discrimination and negative stereotypes from both a gender and disability perspective which compound their exclusion from support services, social and economic opportunities and participation in community life.' .(*Women With Disabilities Australia: Policy Paper: 'Assessing the situation of women with disabilities in Australia: A human rights approach'(July 2011))*

Other

While we have focused on women living with mental health issues, women with lived experience of prison and women with disabilities the same issues apply to other vulnerable groups of women including older women and CALD women.

For example for culturally and linguistically diverse (CALD) women living in the ACT, English language skills are consistently acknowledged to be a huge advantage in settling in Australia. Many of these women struggled with the language and it is considered one of the biggest barriers to achieving social connectedness[47], and access to health services and employment. 22% of ACT women were born overseas (*ACT Multicultural Strategy 2010-2013)*.

[47] Brewer, R. Jan 2009. Culturally and linguistically diverse women in the Australian Capital Territory: Enablers and barriers to achieving social connectedness.

The National Women's Health Policy 2010 released in December recognises CALD women as one of five groups that can be at significantly higher risk of poor health. Women from CALD backgrounds, especially women from new and emerging groups, are at a higher risk of poor health outcomes than the mainstream population. While this group is vulnerable in all regions, in the ACT their situation is exacerbated by the fact that the communities are smaller, more spread out and therefore more isolated than in other states and territories. Drawing on our work some of the issues faced by CALD women include

- Social isolation
- Discrimination/racism and lack of CALD women in leadership positions
- Mental health issues (e.g. trauma) which are compounded by the huge stigma surrounding mental illness and seeking treatment
- Language and employment barriers
- Intergenerational conflict e.g. young people dropping out of school
- Difficulty accessing health services

Conclusion

In order for the Human Rights Act to have better meaning and understanding by the community it must include ESC rights. WCHM believes that the inclusion of economic, social and cultural rights into the Human Rights Act 2004 (ACT) would provide an additional protection to vulnerable groups of women.

The CEDAW outlines a number of areas in which the human rights of women need to be protected, such as employment, education, and access to health services, and many elements of ECSR are already protected in ACT and Commonwealth laws.

But many women remain vulnerable to discrimination in achieving their basic rights because they are unable to access appropriate or affordable housing, employment, health, and education, and women who are marginalised have inadequate food, shelter and clothing, combined with a lack of adequate housing, education and access to health care.

For them, it is only when they can access basic economic, social and cultural rights that they can then understand and access their civil and political rights. Inclusion of ECS rights in human rights legislation will contribute to reducing the marginalisation of vulnerable women who are in need of protection.

WCHM looks forward to participating further in the consultation process and to the development of a Human Rights Act that encompasses economic, social and cultural rights.