Submission to:
Department of Health and Ageing
Email: roadmap@health.gov.au

Submission on *Ten Year Roadmap for National Mental Health Reform*

from
the Women's Centre for Health Matters Inc.
and
the ACT Women and Mental Health Working Group

January 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 effects of forced removal of Indigenous Australian children from their families as well as past racist policies and actions continue today.

Submission on *Ten Year Roadmap for National Mental Health Reform*
Women's Centre for Health Matters Inc.
January 2011

This document was prepared by WCHM staff member:
Laura Pound: Mental Health Project Officer

Enquiries on this submission may be directed to:
Marcia Williams: Executive Director
ed@wchm.org.au

PO Box 385, Mawson, ACT, 2607
Phone (02) 6290 2166
Facsimile (02) 6286 4742
admin@whcm.org.au
www.wchm.org.au

Introduction

About the Women's Centre for Health Matters

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 focuses on groups of women who experience disadvantage and uses social research, community development, advocacy and health promotion to empower these women to achieve the highest possible standard of 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 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.

About the Women and Mental Health Working Group

WCHM provides project and secretariat support to the ACT Women and Mental Health Working Group (WMHWG), whose membership comprises of local service providers, Government representatives, other community organisations and peak bodies, and women living with mental health issues. The ACT WMHWG was established in 2007 to provide a regular forum in which members could work together on matters impacting on women in order to provide improved outcomes for them, and to develop and maintain a full range of women friendly services.

Response to the *Ten Year Roadmap for National Mental Health Reform*

WCHM and WMHWG welcome the opportunity to participate in the *Ten Year Roadmap for National Mental Health Reform* consultation process. WCHM is an organisation that works with women who may experience or are experiencing disadvantage, and works to ensure that these women's views and experiences are heard. We are therefore keen to ensure that the roadmap is inclusive of the needs of our community's women, particularly those women who are most vulnerable.

As a result, we have chosen to provide this written submission to the consultation about the roadmap for mental health reform rather than participate in the online survey process that the Department of Health and Ageing prepared. In this way, WCHM is more able to provide feedback in the areas of our expertise, rather than providing responses to the focussed questions where we may have no evidence or informed view. It was disappointing that the survey could not be viewed in full prior to completing it, which made the process of collating and submitting good quality and coordinated feedback difficult. The short consultation timeframe of two weeks was also difficult in this regard.

In writing this submission WCHM has chosen to limit its responses to those aspects of the draft roadmap in which it has the most knowledge and expertise: ACT women's preferences, views

and concerns. This response is therefore informed by feedback from a variety of ACT women and service providers, WCHM's research and consultations, and the views of partners with whom we work closely.

Gender sensitivity

While women are acknowledged as a separate group at times within the roadmap, women are not defined as a marginalised population that faces social barriers (p. 4). The mental health needs of women are different from that of men's, and their gender roles and the social circumstances of their lives influence their mental health and wellbeing.

Gender intersections with other disadvantage

It is vital that the roadmap recognises that some women living with mental health issues are faced with additional disadvantage and marginalisation. For example, those who are released prisoners or have been institutionalised, those from Culturally And Linguistically Diverse (CALD) backgrounds (particularly those from refugee backgrounds), or those who have co-morbid physical disability. This is because marginalised groups have different experiences and therefore needs from Australia's mental health system. As Women's Health Victoria states:

> Gender also intersects with other factors such as race and ethnicity, sexual preference, disability, age, religion and social class, thus exposing women to multiple forms of discrimination. While many women experience discrimination to some extent, some groups of women are particularly exposed to compounded discrimination, that is, discrimination on multiple or intersecting grounds.[1]

The United Nations Committee to Eliminate Discrimination against Women (CEDAW) has also recognised the importance of intersectional disadvantage:

> ... certain groups of women, in addition to suffering from discrimination directed against them as women, may also suffer from multiple forms of discrimination based on additional grounds such as race, ethnic or religious identity, disability, age, class, caste or other factors. Such discrimination may affect these groups of women primarily, or to a different degree or in different ways than men. State parties may need to take specific temporary special measures to eliminate such multiple forms of discrimination against women and its compound negative impact on them.[2]

Enshrining gender sensitivity in the roadmap

Women experience their mental health differently to men. Research has found that the prevalence of psychiatric disorders is greater in women than in men.[3] Further, there are

[1] Women's Health Victoria, 'Women and mental health', Women's health issues paper, no. 5, November 2009.
[2] United Nations, *Convention on the elimination on all forms of discrimination against women*, General recommendation no. 25, article 4, paragraph 1, http://www.un.org/womenwatch/daw/cedaw/recommendations/General%20recommendation%2025%20(English).pdf.
[3] F Judd, S Armstrong & J Kulkarni, 'Gender-sensitive mental health care', *Australasian Psychiatry,* vol. 17, no. 2, 2009

differences in the biological, psychological and social factors which cause the illness; impact on the course and expression of the illness; and impact on age of onset, symptoms and comorbidity with other illnesses.[4]

There is also a strong inverse relationship between social status, and physical and mental health outcomes.[5] This greatly affects women, as women's status remains lower than men's in almost every society. This is reflected in the high incidence of violence against women; women's lower socio-economic status; an under-representation of women in positions of power; and an over-representation of women in part-time and casual work, amongst other things.

Therefore, the roadmap must include a strong focus on strategies that create gender sensitive policy and service delivery to ensure that women's mental health is understood within not only the biological and physiological contexts of a woman's life, but also the social, cultural, economic and personal contexts.[6] Evidence suggests that when this gender-sensitive approach is implemented, women achieve better health outcomes. In contrast, 'gender neutral' or 'gender blind' approaches neglect the unique needs of women with mental health issues, perpetuating health inequalities between men and women.

Gender sensitive health services are more than just 'women only' services: they are characterised by availability, accessibility, affordability and appropriateness (see Appendix A for specific principles of gender sensitive mental health service delivery).[7] These characteristics should be goals reflected in the roadmap for mental health reform.

Collecting sex disagregated data to measure outcomes

An additional aspect of creating a gender sensitive mental health system is collecting sex disaggregated data, in other words data thas has been disaggregated by biological sex and thus presents information specific to the life experiences of males and females.[8]

Collecting sex disagreggated data will further gender sensitivity when measuring mental health outcomes and the success of the roadmap, and highlight the disparity and complexity between the lived experience of men and women. The Australian Government will also be more able to meet the needs of women living with mental health issues by creating more responsive health services, government legislation, policies and budgeting.

Sex disaggregated data should be combined with or can be focused on specific diversifying factors such as age, education, cultural background, disability and occupation.[9] Further, sex

[4] Judd, Armstrong & Kulkarni.
[5] BP Dohrenwend, 'Socio-economic status and psychiatric disorders', *Social Psychiatry and Psychiatric Epidemiology*, vol. 25, 1990.
[6] DE Stewart, 'Social determinants of women's mental health', *Journal of Psychosomatic Research*, September 2007.
[7] Women's Centre for Health Matters, *Position paper on gender sensitive mental health service delivery,* Canberra, November 2009.
[8] Asia-Pacific Economic Cooperation, *Framework for Integration of Women in APEC*, APEC Secretariat, Singapore, 1999, p. 4.

disaggregated data is best collected utilising a multimethod approach that takes into account both quantitative and qualitative measures. This technique ensures the sensitivity and accuracy of the information collected, which is particularly important because women and men often have different ways of expressing themselves, preferences for interactions, and different responsibilities/availabiliy for research. Moreover, it allows greater sensitivity and flexibility when researching individuals or groups who are dissadvantaged not only by gender but also by other factors, such as cultural or linguistic diversity.

Example: Gender sensitive education and employment strategies

Several roadmap principles and goals focus on building opportunities for people living with mental health issues to work, study and train. This is a positive goal, however women experience additional barriers to education and employment that must be acknowledged and addressed through specific measures.

For example, women are the majority in carer populations, including caring for someone with a disability or parenting. In comparison to male carers women are more likely to: take on caring responsibilities at an earlier age,[10] be a caregiver in the home,[11] care for more than one person, and deliver complex care.[12] Women also continue to have the responsibility for the majority of household tasks. As a result of this gender inequity in caring and household roles, women are disadvantaged in accessing employment and education a variety of ways.

Example: A gender sensitive approach towards mental health carers

It is positive to see that mental health carers and strategies to support their involvement are included in the roadmap. However, measures must be gender sensitive, because care-giving is a gendered phenomenon, and women are the predominant care-givers in contemporary Australian society. Women who are mental health carers experience significant disadvantage both as a result of their gender, and persistent community stigma and misinformation relating to mental illness.

[9] Victorian Women's Health and Wellbeing Strategy, Gender *and diversity lens for health and human services: Victorian Women's Health and Wellbeing Strategy Stage Two: 2006*-2010, Portfolio Services and Strategic Projects, Melbourne, 2008, p. 8.
[10] Australian Bureau of Statistics, *Disability, ageing and carers in Australia: Summary of findings,* Canberra, 2003.
[11] 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.
[12] M Navaie-Waliser, A Spriggs & P Feldman, 'Informal caregiving: differential experiences by gender', *Medical Care,* vol. 40, no. 12, 2002, pp. 1250-6.

Recommendations

1. The roadmap should recognise the impact of multiple disadvantage affecting women living with mental health issues.
2. The roadmap should include an increased focus on gender sensitive goals and outcomes (for example in relation to strategies addressing employment and carers), and on addressing the needs of marginalised populations including women. For example, an additional key principle could recognise that people experience mental health differently.
3. Sex disaggregated data should be collected to measure the outcomes of roadmap strategies and goals in a gender sensitive manner.

The social determinants of mental health

It is positive that the roadmap for mental health reform acknowledges that mental health is not only a medical issue, and identifies employment and social connectedness as areas to address. However, the social determinants of mental health model should be more widely reflected in the roadmap, with key strategies that meet the holistic needs of people living with mental health issues.

Mental wellbeing is determined by many intertwined economic, social and cultural conditions that impact on people's health and wellbeing. These conditions, or social determinants of mental health, include:

- Gender
- Access to health services
- Social support networks/isolation
- Experiences of violence
- Housing and homelessness
- Income and income distribution
- Education and literacy
- Social safety nets
- Unemployment and employment security
- Age
- Indigenous status
- Cultural status and citizenship
- Early life development
- Geographical location
- Food security
- Access to resources and opportunities[13]

From the social determinants of mental health perspective, health services and medical intervention are only one element of improving the mental health of women. The roadmap should therefore increase its focus on health and wellbeing measures that address the social and environmental determinants of health, in tandem with biological and medical factors.[14]

[13] M Marmot & R Wilkinson, 'Social determinants of health', cited in Maslen, S, *Social determinants of women's health and wellbeing in the Australian Catholic Territory,* Women's Centre for Health Matters, Canberra, 2008, http://www.wchm.org.au/GeneralWCHMPublications.htm p. 3.
[14] Aged Community and Mental Health Division, *A stronger primary health and community support system: policy directions*, Victorian Department of Human Services, Melbourne, 1998.

Example: Violence against women

The World Health Organisation emphasises that women who have experienced violence, whether in childhood or adult life, have increased rates of depression and anxiety, stress related symptoms, pain syndromes, phobias, chemical dependency, substance use, suicidality, somatic and medical symptoms, negative health behaviours and poor subjective health.[15]

For many women, experiencing violence can lead to poor mental health, social marginalisation and poverty. WCHM research also shows that many women living with mental health issues in prison have experienced physical, sexual or psychological abuse.

Recommendation

4. The roadmap should outline more strategies to address the broad array of social determinants that influence mental health and wellbeing.

Accessible mental health services and information

WCHM research shows that access to health services in the ACT is a significant barrier for many women with mental health issues, especially those from disadvantaged groups. Barriers to accessing mental health care services and information include:

- Shortages of general practitioners and psychologists
- The cost of accessing services and the lack of bulk billing in the ACT
- Services being ill equipped to deal with the complex health, social, emotional and cultural needs of women from disadvantaged groups
- A lack of gender sensitive services and information
- Lack of awareness of existing services[16]

In particular, health and wellbeing information is especially vital for women because they are often the primary seekers of health and wellbeing information, not only for themselves, but also for their children and other family members. Accessible health and wellbeing information would strengthen women's self-management and play a part in reducing women's reliance on the mental health system. This is because women with knowledge of available options are better equipped to use the health care system effectively; especially in understanding what issues can be dealt with at home, how best to deal with issues and when to contact a health care provider. Good quality health and wellbeing information can successfully substitute consultations with health professionals, which can increase a woman's autonomy and save her money.[17]

[15] World Health Organisation, *World report on violence and health: A summary,* 2004, p. 4.
[16] Carnovale, A & E Carr, *It goes with the Territory! ACT women's views about health and wellbeing information,* Women's Centre for Health Matters, Canberra, July 2010.
[17] Aged Community and Mental Health Division.

Moreover, improved access to mental health services and information has the added benefit of helping to address mental health issues before they become acute episodes, in alignment with principles of early intervention.

Recommendation

5. The roadmap should outline the ways in which access to mental health services and information will be improved, and how progress in this area will be measured.

Consumer centeredness and a recovery focus

The roadmap should include an increased focus on providing people living with mental health issues with an integral role in decision making over their care, including choices between services and input into policy and service delivery. It should also commit to strategies towards more meaningful consumer and carer participation. Consumer centred care, where consumers have increased power in decisions, leads to better mental health services and outcomes.

Further, WCHM and WMHWG believe that the mental health system should have a recovery focus. Traditionally, mental illness is understood within the context of a medical framework, whereby a consumer's condition is considered biologically based;[18] consumers are subject to a medical interpretation of their experiences and views;[19] and only the biological and cognitive processes are addressed by mental health practitioners.[20] A consequence of the medical approach is that it often renders an individual powerless to contribute to their own recovery process.

An alternative way in which to understand and treat mental illness is within the recovery framework. The term recovery does not necessarily refer to an absence of symptoms or injury, but the opportunity to live a satisfying and fulfilling life (as defined by the person in recovery) in the presence or absence of ongoing symptoms. The recovery perspective aims to transcend the limitations of the medical framework; reorient the individual as empowered to participate in their treatment; and redefine themselves as unique individuals who are not (just) their mental illness.

Recommendation

6. Roadmap principles and strategies should include an increased focus on consumer centeredness, involvement in decision making and recovery.

[18] S Mead, D Hilton & L Curtis, 'Peer support: A theoretical perspective', *Psychiatric Rehabilitation Journal,* vol. 25, no. 2, 2001, pp. 134-141.
[19] S Zinman & HT Harp, *Reaching across: Mental health clients helping each other.* California Network of Mental Health Clients, California, 1987.
[20] A Adame, & L Leitner, 'Breaking out of the mainstream: The evolution of peer support alternatives to the mental health system', *Ethical Human Psychology and Psychiatry,* vol. 10, no. 3, 2008, pp. 146-162.

Peer support

The draft roadmap for mental health reform recognises the positive impacts of peer support and commits to increasing the number of peer support workers in clinical mental health services. Peer support groups that sit within the community should also receive additional support including funding and training opportunities.

Research conducted by WCHM in 2011 shows that peer support outside of medical services are a gender sensitive way to assist in mental health recovery, with benefits including:

- Increased mental health and wellbeing, including increased knowledge of symptoms and supports available, more periods of wellness and self management, and increased support when experiencing an episode
- Increased social connectedness and sense of belonging
- Increased confidence, benefiting community participation through volunteering and work
- Health promotion, through encouraging information sharing and knowledge about mental health and wellbeing[21]

Peer support groups in the community help to prevent social isolation, which is recognised as an important issue to address in the draft roadmap. Peer support is absolutely vital because people living with mental health issues often find it difficult to develop and maintain social relationships.[22] It is not uncommon for interactions to be limited mostly to medical practitioners, family members and other peers living with mental health issues;[23] and comparatively, they have smaller social networks than people without mental health issues.[24] Consequently, many people with mental illness report spending a lot of time alone, and experiencing feelings of isolation, loneliness,[25] a lack of community connectedness,[26] and dissatisfaction with the social support that they do receive.[27]

Furthermore, literature identifies lack of community support, rather than a person's symptomatology to be the dominant factor in re-admission,[28] with up to half of all discharged

[21] L Pound, K Judd & J Gough, *Peer support for women living with mental health issues: The views of ACT women*, Women's Centre for Health Matters, September 2011.
[22] L Davidson, G Shahar, DA Stayner, MJ Chinman, J Rackfeldt & JK Tebes, 'Supported socialisation for people with psychiatric disabilities: Lessons from a randomized controlled trial', *Journal of Community Psychology,* vol. 32, no. 4, 2004, pp. 453-77.
[23] B Angell, 'Contexts of social relationship development among assertive community treatment clients', *Mental Health Services Research,* vol. 5, no. 1, 2003, pp. 13-25.
[24] 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.
[25] G Green, 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.
[26] 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.
[27] 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.
[28] 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.

psychiatric inpatients re-hospitalised within twelve months.[29] Low levels of social support are intrinsically linked to poor mental and physical health outcomes.[30] Assisting mental health consumes to develop social networks, social skills and good relationships with others can therefore greatly assist consumers, particularly upon discharge from hospitalisations.

Recommendation

7. The roadmap should include recognition of the importance of peer support groups that sit outside of clinical services and provide an alternative to traditional mental health services.

Clear targets, strategies and outcomes

The roadmap for mental health reform outlines many positive perspectives and outcomes for change in Australia's mental health system in general terms. However, the document needs to include more concrete details and defined commitments to ensure that the roadmap is useful and lives on in policy, funding and service delivery decisions.

The roadmap should:

- Include identifiable and clear goals, and outline how outcomes will be achieved and measured with specific strategies. The roadmap should be more than a general guide to Government on which mental health issues to focus attention and funding on, as this duplicates already existing policies and frameworks.
- Outline specific areas where funding will be spent and how much of the national health budget will be spent on mental health, as roadmap goals cannot be achieved without strong funding commitments.
- Detail strategies and outcomes about how all levels of Government will collaborate in order to reduce duplication of effort, services and costs, contributing to a more efficient response to mental health.

Recommendation

8. The roadmap for mental health reform should contain more detail including:

- Specific strategies that outline how goals will be achieved and measured
- Outline of the Government's commitment to mental health funding and how it will be allocated against goals

[29] Klinkenberg, WD & 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.
[30] L Berkman, 'The relationship of social networks and social support to morbidity and mortality', in S Syme & SL Syme (eds), *Social Support and Health*, Academic Press, Orlando, 1985, pp. 3-22.

Whole of Government approach

Mental health is everybody's business and therefore needs to be addressed at every level of Government, not just within health or even education and employment. The roadmap therefore needs to reflect in more detail the Government's commitment to an integrated whole of government response to implementing and measuring strategies. For example, the roadmap could link with departments responsible for justice, human services and FaHCSIA, and with strategies in other portfolios such as the *National Plan to Reduce Violence against Women and their Children* (2011) and women's health strategies and policies.

Recommendation

9. The roadmap for mental health reform should contain detail on how different sections of Government will collaborate to implement strategies and measure outcomes.

Conclusion

This submission to the draft *Ten Year Roadmap on National Mental Health Reform* aims to highlight issues from the perspective of women living with mental health issues, particularly women in the ACT. We look forward to learning the outcomes of the consultation and participating further in the process.

References

Aged Community and Mental Health Division, *A stronger primary health and community support system: policy directions*, Victorian Department of Human Services, Melbourne, 1998.

Angell, B, 'Contexts of social relationship development among assertive community treatment clients', *Mental Health Services Research,* vol. 5, no. 1, 2003, pp. 13-25.

Asia-Pacific Economic Cooperation, *Framework for Integration of Women in APEC*, APEC Secretariat, Singapore, 1999.

Australian Bureau of Statistics, *Disability, ageing and carers in Australia: Summary of findings,* Canberra, 2003.

Australian Bureau of Statistis, *Disability, aging and carers in Australia: Summary of findings*, Canberra, 2004.

Baker, F, 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.

Barnes, M, A Davis, S Guru, L Lewis & H. Rogers, *Women-only and women-sensitive mental health services: A summary report*, University of Birmingham, United Kingdom, 2002.

Bengtson-Tops, A & 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.

Carnovale, A & E Carr, *It goes with the Territory! ACT women's views about health and wellbeing information,* Women's Centre for Health Matters, Canberra, July 2010.

Crotty, P & 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, L, 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.

Davidson, L, G Shahar, DA Stayner, MJ Chinman, J Rackfeldt & JK Tebes, 'Supported socialisation for people with psychiatric disabilities: Lessons from a randomized controlled trial', *Journal of Community Psychology,* vol. 32, no. 4, 2004, pp. 453-77.

Doherty, D, 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.

Dohrenwend, BP, 'Socio-economic status and psychiatric disorders', *Social Psychiatry and Psychiatric Epidemiology*, vol. 25, 1990.

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.

Judd, F, S Armstrong & J Kulkarni, 'Gender-sensitive mental health care', *Australasian Psychiatry,* vol. 17, no. 2, 2009.

Klinkenberg, WD & 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.

Marmont, M & R Wilkinson, 'Social determinants of health', cited in Maslen, S, *Social determinants of women's health and wellbeing in the Australian Catholic Territory,* Women's Centre for Health Matters, Canberra, 2008, http://www.wchm.org.au/GeneralWCHMPublications.htm.

Navaie-Waliser, M, A Spriggs & P Feldman, 'Informal caregiving: differential experiences by gender', *Medical Care,* vol. 40, no. 12, 2002, pp. 1250-6.

Pound L, K Judd & J Gough, *Peer support for women living with mental health issues: The views of ACT women*, Women's Centre for Health Matters, Canberra, September 2011.

Stewart, DE, 'Social determinants of women's mental health', *Journal of Psychosomatic Research*, September 2007.

United Nations, *Convention on the elimination on all forms of discrimination against women*, General recommendation no. 25, article 4, paragraph 1, http://www.un.org/womenwatch/daw/cedaw/recommendations/General%20recommendation%25025%20(English).pdf.

Victorian Women's Health and Wellbeing Strategy, Gender *and diversity lens for health and human services: Victorian Women's Health and Wellbeing Strategy Stage Two: 2006*-2010, Portfolio Services and Strategic Projects, Melbourne, 2008.

Women's Centre for Health Matters, *Position paper on gender sensitive mental health service delivery,* Canberra, November 2009.

Women's Centre for Health Matters, *Position paper on sex disaggregated data,* Canberra, November 2010.

Women's Health Victoria, 'Women and mental health', Women's health issues paper, no. 5, November 2009.

World Health Organisation, *World report on violence and health: A summary,* 2004.

Zinman, S & HT Harp, *Reaching across: Mental health clients helping each other,* California Network of Mental Health Clients, California, 1987.

Appendices

Appendix A: Characteristics of gender sensitive mental health service delivery

- A holistic approach to mental health, where women are treated as whole individuals rather than as their illness or diagnosis – using a social model rather than medical model.
- Offer women choices about the type of support they receive, and who provides it to them (i.e. the choice between a male or female doctor). This is of particular importance for some CALD women, Aboriginal and Torres Strait Islander (TSI) women, women who have suffered trauma, and/or women who may feel uncomfortable disclosing personal information to a male practitioner.
- Provide women with opportunities to be actively involved in their own care and treatment, including service planning and delivery (i.e. advanced directives).
- Offer women choice in treatment options, which may include medication, talking therapy and/or other community-based services like peer support.
- Have staff that treat women with respect, give them time to talk and listen to what they have to say, including the provision of long consultations and more preventative health measures and counselling where needed.
- Have staff and practitioners with qualifications in women's health and/or are trained to understand the impact of gender on mental health and well-being.
- Are culturally sensitive.
- Understand that all health issues and life events may affect men and women differently across their lifespan and use a life course approach in service planning and delivery.
- Take into account the 'social determinants of health', that is, they acknowledge the way that women's personal circumstances and socio-economic status affects their mental health. For example, a woman's child and/or other caring responsibilities, her relationships, housing status, income, age, sexuality, ethnicity, religion and cultural and linguistic background, all have the potential to negatively impact upon a her mental health and wellbeing.
- Employ a holistic, individual approach to service delivery that recognises that women often have a multitude of concurrent challenges, which often lead to a cycle of difficulties.
- Pathways of care are easy to navigate, information is provided in preferred formats, and for those women who experience difficulty in understanding and/or navigating the health system, assistance is provided.
- 'Women only' spaces within their buildings.
- Provide family-friendly and more specifically child-friendly environments, and services are inclusive of family.
- Keep women's personal information confidential at all times.
- Have a stable and secure funding base, which allows them to offer consistency and longevity in the support they provide.[31]

[31] Barnes, M, A Davis, S Guru, L Lewis & H. Rogers, *Women-only and women-sensitive mental health services: A summary report*, University of Birmingham, United Kingdom, 2002.