Royal Commission into Mental Health

Women's Health In the North (WHIN) is the women's health service in the northern metropolitan region of Melbourne.

Women's Health Goulburn North East (WHGNE) is the regional women's health promotion agency for the Goulbourn and Ovens Murray area.

We welcome this Royal Commission into Mental Health, and thank the Victorian Government for its leadership on such a critical and prevalent issue.

We urge the Victorian Government to:

(1) Take a gendered approach to mental health, recognising the different risk and experience of men and boys from those of women and girls

This approach recognises that the gender binary of masculine and feminine is inaccurate, problematic, and contributes to mental ill-health for many. It will be simple to apply such an analysis, enquiring as to how the context of, and experience and treatment of mental health is different for men, women, girls, boys and people of diverse sexual and gender identities.

We know a little about these gender differences and harm in a mental health context. For example, research tells us that more women attempt suicide but more men die from a suicide attempt.[1] We know that LGBTI people are 14 times more likely to attempt suicide than others.[2] We know women are treated differently within the health system – their health concerns taken less seriously,[3] and their ability to pay for services compromised by a male-dominated gender schema, a persistent pay gap, and socialised roles as carer to children, ageing parents and others.[4] Masculinities theorists identify that patriarchy ultimately damages men who aspire to and closely conform to notions of the ideal man.[5] Along with male privilege come poorer physical and mental health for men than women and higher levels of alcohol abuse and loneliness.[6, 7] The disconnection men are encouraged to develop from their emotions, for example, in preparing for positions of authority where ruthlessness and manipulation is a strength, contributes to the mental health costs borne by men.[8] The implications of gender differences must be explored in the Royal Commission's investigation into mental health, and in the recommendations.

(2) Use a family violence framework to understand women's mental health, perpetrator tactics, and to improve the service system

Research shows that women who experience intimate partner violence and / or sexual violence are more likely to report poorer mental health.[9] Evidence supports the causal relationship between intimate partner violence and: anxiety, depression, suicide and self-inflicted injuries, eating disorders, alcohol use disorders and homicide and violence.[10] It is critical to acknowledge:

That men's violence impacts on women's mental health

In 2004, a landmark VicHealth study found that intimate partner violence was the leading contributor to preventable death, preventable disability and preventable illness in women aged 15 – 44.[11] The greatest disease burden was on women's mental health, adding up to 73.5% of the preventable disease burden.[12]

In order to appropriately respond to women who have experienced family violence, the mental health sector needs to understand the ways in which women's mental ill health is caused and impacted by men's use of violence, and is a symptom of interpersonal and societal oppression rather than an individual pathology.

That perpetrators target and exacerbate women's mental health

Perpetrators of family violence seek out and target women who they perceive to be 'vulnerable', which includes women with living with a mental illness or disability. Perpetrators create circumstances and situations that make women appear or feel 'crazy', often increasing or exacerbating women's symptoms, whilst increasing their own power and credibility. As such, mental health practitioners are at risk of colluding with the perpetrators and pathologising the victim/s. The mental health sector requires an understanding of perpetrator belief systems, tactics and they ways in which they attempt to groom workers, to ensure they are responding to and challenging their use of coercion, control and violence to increase the safety of women and children.

That perpetrators use mental illness to excuse their use of violence

Perpetrators of family violence are often provided with a diagnosis from a psychologist or psychiatrist, and then use this diagnosis to excuse their violence. Likewise, many support workers across the community and government sectors attempt to explain his behaviour against his family as a symptom of his mental illness (for example, perpetrators are often described as 'narcissistic' whereas a family violence lens would view him as entitled).

Those who use a family violence framework understand that mental health is a risk factor, not a cause of family violence. Perpetrators of family violence are often very strategic and targeted with their use of violence, indicating they are capable of making clear and controlled decisions about when and how their violence will be used. The mental health sector needs to have a thorough understanding about family violence perpetrators, their belief systems and their tactics to ensure they are not pathologised and excused. This is an important part of managing the risk that perpetrators pose, whether they have a legitimate mental illness or not. It is also the best way to ensure a change process towards safety is embarked upon.

The importance of integration and the use of a family violence framework

In order to accurately and appropriately respond to victims and perpetrators of family violence, the mental health sector needs to work closely with the family violence and related sectors to ensure accountability, knowledge transfer and empathy. Integration, consultation, co-location, effective policies, training and the consistent use of a family violence framework are all important steps in prioritising the safety of victims, and striving for accountability with perpetrators of family violence.

(3) Examine the gendered impact of disaster on mental health, recognising the community-wide impact of disasters.

The experience of Black Saturday in 2009, Ash Wednesday in 1983 and other disasters in our state's recent history indicates that 'recovery' is long, and the mental health impact of such disasters will never be overcome for many survivors. Following Black Saturday, despite immense funding and good will, pathologising and treatment of individuals was not always appropriate nor effective in circumstances where whole communities were devastated.[13]

After disasters, and in general, men are reluctant to seek help for mental health issues. Because our society values masculinity that is strong and self-sufficient, men tend to see help-seeking behaviour as a weakness. This is reinforced by workplaces that penalise those who seek psychological help, perhaps particularly in emergency management where fire-fighters are 'kept off fire-trucks' for Occupational Health and Safety reasons. Yet it is merely an assumption that those *not* seeking help are psychologically fit for the role.

Mental health is worsened by workplaces that make no allowances for traumatised disaster survivors. A participant in research after Black Saturday spoke of her husband:

> [He] did go and apply for a position [and was told he would] have to work six days a week. Seven in the morning until six at night' … That was the start of the deterioration of mental health of the men up here. They were more or less sat back and told, 'You're too traumatised. You're incompetent. You can't do anything'.[14]

Research on long-term disaster resilience in 2018 found that mental health issues affected people from Canberra to remote Victoria, and informants pointed to lack of understanding of the long-term nature of disasters' impacts – by government, by the health industry and by fellow Australians.[15] Mental health issues were community-wide. As whole communities took the force of the flames or the floods, survivors afterwards struggled to understand what had happened – to their sense of self, their partner, children, and community. And still, years on, the wider, unaffected community continues to minimise and misunderstand long-term consequences of disaster experience. Informants spoke of post-traumatic stress disorder (PTSD), and in less diagnostic terms of being traumatised, anxious, depressed, more fragile, stressed, tired and exhausted. Women and men changed under the weight of their experiences and memories. To this day, triggers for unease or panic are found in the smell of smoke or dry gum leaves, black landscapes, helicopters overhead or warnings of Code Red Days or increasing flood levels.

The one in six figure of Australians affected by disaster will only increase through climate change and increasing and more frequent extreme weather events.[16] The long-term human and economic cost of disasters in terms of mental health is yet to be acknowledged. This Royal Commission is well-placed to inform this little-understood aspect of mental health.

(4) Take into account the gendered nature of poverty in the risk and experience of mental health.

Socio-economic status plays a determining role in mental health, and individuals' lack of funds relates directly to the services available, particularly to *women* facing mental health issues. Lack of financial resources contributes to mental ill-health and impedes timely, accessible and affordable intervention by mental health professionals. This is exacerbated in rural areas.

In recent research, (*Living Longer on Less*)[17] women spoke of financial stress and the implications on mental health ranging from the risk of early dementia due to past head trauma, to heightened stress levels, anxiety, and clinical depression. One woman said:

> I guess that big thing, it is the mental health I think that I struggle with most ... poverty does compound [things] like when I'm feeling really poor that's when all those issues are thrown up and the gremlins start.

In this research conducted in NMR and Hume region, level of poverty among the women who participated was not evident from their demeanour, yet the extent of it emerged during the interviews, when they spoke of struggling just to survive. One woman said that, if not for her son, she would consider suicide. Another made a light-hearted comment revealing a grimmer reality about the effect of relentless poverty:

> We've got a little saying in our group, we might ring a friend and say, 'Is that my suicide prevention counsellor?', 'Yes, speaking'.

The connection between poverty and mental health also works in reverse, where mental ill-health has adverse economic consequences from both lost income and increased health costs.[18]

(5) Explicitly acknowledge the mental health implications for LGBTI people of living in a society where strong, vocal and powerful segments of society deny equal rights.

LGBTI people are at great risk of mental ill-health with the highest rates of suicidality of any Australian population, and therefore of utmost importance to this Royal Commission.[19] One compelling statistic on mental health is that same-sex attracted Australians have up to 14 times higher rates of suicide attempts than their heterosexual peers.[20] For trans Australians, up to 50% have attempted suicide. A third of trans and a quarter of GLB Australians 'met the criteria for experiencing a major depressive episode in 2005, compared with 6.8% of the general population'.[21]

(7) Prioritise the prevention and early intervention theme as the factors that contribute to poor mental health arise at individual, community and societal levels. Health promotion research has, for many decades, proven the economic benefits of prevention. Effective prevention and early intervention measures will be premised on acknowledgement that mental health intersects with other factors, such as discrimination against women, sexual and gender identity, ethnicity, disability, age, religion and social class.

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