WOMEN'S MENTAL HEALTH NETWORK VICTORIA

SUBMISSION TO THE ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Committee of Management

July 2019

WOMEN'S MENTAL HEALTH NETWORK VICTORIA

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WOMEN'S MENTAL HEALTH NETWORK VICTORIA

The Women's Mental Health Network Victoria (the Network) congratulates the State Government on the Royal Commission into Victoria's Mental Health System and is pleased to contribute this submission.

ABOUT WOMENS MENTAL HEALTH NETWORK VICTORA INC.

The Women's Mental Health Network Victoria is a network of more than 180 women consumers, carers, health professionals and women who are interested in women's mental health. The focus of our work is to promote awareness of issues that impact on women's mental health and support women in the mental health system by highlighting the gender sensitive practice that takes into account the lived experiences of women as they interact with the system at any stage.

Central to the Network operations is the recognition of consumers' lived experience and their expertise and ability to partner in their own recovery. We aim to bring together women who have the passion, expertise, innovation, hope and determination - to make a powerful voice for change.

The Network is a charitable association registered and run largely by volunteers - we have been influential in the Mental Health sector over many decades. We have worked tirelessly for positive change in the experience of female psychiatric patients when accessing mental health services.

A Committee of Management manages the Network's aims -

- Provide information about the prevention and management of women's mental health issues to health professionals, service providers, carers, consumers and the public
- Promote research into women's mental health issues
- Promote opportunities for training and education in women's mental health issues and women-sensitive practice
- Develop partnerships with key mental health and women's organisations to promote responsiveness to women's mental health and to create opportunities for women consumers, carers and service providers to work together in addressing mental health issues, and to share their experiences and information
- Promote systemic change in order to make mental health policies and services more responsive to women's needs

Over the past three decades, the Network has developed a broad-ranging perspective on women's mental health and provides a valuable forum for consultation.

Amongst our activities, the Network has worked collaboratively with the Victorian Department of Health & Human Services:

- Prompting funding at election platforms for improving women sensitive inpatient care 2008
- The gender sensitivity and safety in adult acute inpatient unit's project in 2008 and in 2009
- *Chief Psychiatrists Guidelines on Promoting Sexual Safety, Preventing and Responding to Sexual Activity* and *Managing Allegations of Sexual Assault in Adult Acute Inpatient Units 2009 VIC*
- Gender sensitive safe practice training modules for which we now hold the licence (2014).
- Service guidelines on gender sensitive safe practice VIC 2011
- Promoting human rights (Chief Psychiatrist State VIC project) 2018
- Mental Health Complaints Commission VIC – contribution to their Forum on Sexual safety & citation *Right to be Safe Report 2018*
- Membership of Diverse Communities and Intersectionality Working Group - Gender Equality Bill VIC 2018

We believe that the mental health system requires a large-scale reform at the systems layer.

The Network actively collaborates with women with a lived experience so their voices are included in consultations that affect them. Our collaboration informs this submission.

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WOMEN'S MENTAL HEALTH NETWORK VICTORIA

EXECUTIVE SUMMARY

INTRODUCTION

Central to the Network is the recognition of consumers' lived experience and their expertise and ability to partner in their own recovery. We aim to bring together women who have the passion, expertise, innovation, hope and determination - to make a powerful voice for change.

During May 2019, the Women's Mental Health Network Victoria (WMHNV) developed a survey focused around key issues relating to women's mental health, to gather input from women in the community that could be integrated into this submission for the Royal Commission into Mental Health. The survey was sent to all the members of the network, and a link placed on our Network website and social media platforms, for anyone in the broader public to access. 56 people completed the survey, with 89% identifying as female, 7% as male, and 3% preferring not to state gender. We have chosen to highlight 5 key aspects from this piece of research.

We believe that the mental health system requires a large-scale reform at the systems layer. The Network actively collaborates with women with a lived experience so their voices are included in consultations that affect them. Our collaboration informs this submission.

SUMMARY

A responsive health system is a human rights issue – the Network aims to keep women's issues out in the public space and provide women with a voice so that healing environments are the focus for policy makers and direct service providers.
We network with women consumers, carers and workers to transform service responsiveness. We aim to empower women through consumer designed programs and consumer designed workforce development. Our *Actions of Change*[1] support women's human rights, their dignity and hope.

- Promote Women-Only Corridors being used for their purpose in mental health facilities
- Promote More Research and A Gender Lens on any social Data collection and Analysis Practice
- Prioritise Women Living in Regional and Rural Areas
- Advocate the Need for Gender Sensitive Safe Practice Education to be an Integral and Continual Part of health Professionals' Training
- Champion and Guide All Workforce Training to Include Gender Sensitive Safe Practice as its Core
- Build an Alliance for Gender Sensitive Services Across Australia
- Continue to Build Mental Health Awareness by Widespread Networking, Social Media Campaigns and Targeting of The Media
- Empower and Inform Women Consumers via Training and Forums and that
- Carers Need To Be Included

CONCLUSION

This submission is based on the combined research, evidence and practice experience of our organisation and years of working to provide a voice for women with mental ill health. We want to see a system that works for the people it is intended to support, that upholds and respects peoples' human rights and enables their recovery. It should be a place people can get the support they need in a trauma-informed and gender-sensitive way, with a commitment to principles of human rights, collaboration, access and choice.
Please listen to what consumers, carers and workers have been saying and dealing with for far too long - A broken system! Please provide radical and extensive reforms, not just add-ons that have done more to cripple functioning than improve overall outcomes for consumers. We need decent funding to make change effective, including respecting the rights and space for females in a male dominated system. If we can do it for level crossings…then surely we can invest appropriately for suffering human beings.

[1] Women's Safety Matters 2018 WMHNV Publication www.wmhnv.org.au/publications

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RECOMMENDATIONS

The following recommendations are submitted by the Women's Mental Health Network.

Recommendation 1: Ensure that female only spaces are facilitated and utilised for the purpose they were designed inclusive of these key pillars of implementation:

- As a basic principle, men are not placed in female only corridors irrespective of male bed pressures, women are given priority of a female bed when accessed as acute in their own right, not compared to common practice of assessing males as a higher risk than females.
- local policies and staff training provide clear and practical guidance to implement safe bed allocations in this regard
- regular gender sensitivity and safety audits are established and required for all mental health services, to ensure that best practice is being implemented (e.g. Physical spaces and safety tools are utilized, and are effective and functional).
- that hospital management are trained in gender-sensitive and safe practice, understand best practice and the research underpinning it, and actively promote and role model these approaches.

Recommendation 2: that policy direction and funding of hospitals including all new capital works be linked to safety of female inpatients – inclusive of dedicated women only corridors in wards and therapeutic areas. As this has proven difficult to maintain, it may be necessary to move to female only wards.

Recommendation 3: that state funding for services, programs and bed allocations be based on key indicators that drive women sensitive service focus.

Recommendation 4: that an immediate injection of targeted funding be provided by state governments to mental health services across acute, subacute, rehabilitation and community care for the promotion of women-sensitive programs (inclusive of Prisons and Forensic facilities).

Recommendation 5: that mental health workforce curriculum be reviewed to ensure quality of care training includes trauma informed care and gender sensitive practice

Recommendation 6: that the state health service- agreements ensure that systems include trauma-informed care services inclusive of aboriginal issues such as stolen generation trauma, cultural needs and aged care

Recommendation 7: that mental health workers be employed in all Family Violence related services, including immediate addition to staff in Family Violence Safety Hubs

Recommendation 8: ensure that all mental health staff are trained to respond to a lived experience of 'stolen generational trauma'.

Recommendation 9: that a state-wide mental health framework is developed on trauma informed care inclusive of stolen generational context and newly arrived lived experience of conflicts in war.

Recommendation 10: That policy making and reporting by state and national departments reflect gender analysis practice and improved application of gender disaggregated data collection[2].

Recommendation 11: That funding for mental health care be linked to indicators that reflect gender budgeting.

Recommendation 12: that state treasury funding practice is informed by gender budgeting methodology to ensure key accountabilities for program delivery is equitable and women focused.

[2] Gender Transformative Practice ARROW 2014

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Recommendation 13: That state funds are dedicated to sex disaggregated data collection and reporting as best practice for government and peak research bodies to ensure a gender lens on the needs analysis that informs policy and program development.

Recommendation 14:

There needs to be a significant increase in funding to mental health services in regional/rural settings to reduce the impact of obstacles to accessibility. Particular focus should be given to:

- establishing ongoing affordable group treatment and psycho-social programs to enhance recovery
- increased incentives to attract mental health professionals to re-locate into regional/rural areas
- increased transport options, including expansion of the Royal Flying Doctor Wellbeing Service and community bus programs
- increased funding for Telehealth, and expanded accessibility to this option for health service providers and their patients
- the establishment of specialist trauma recovery treatments programs in regional areas, and specialist trauma professional development training for public and private mental health professionals who may be accessed by clients with trauma histories
- establish clear referral pathways and information for clients with trauma histories to locate Medicare-accredited Psychologists/Social Workers with specialist skills in in working with trauma, family violence, and sexual abuse.

Recommendation 15: all health workforce training to include gender sensitive safe practice as its core[3].

Recommendation 16: that mental health workforce curriculum be reviewed to ensure quality of care training includes trauma informed care and gender sensitive practice.

Recommendation 17: that the state fund WMHNV to rollout to acute and community areas their licensed gender sensitive safe practice training for the mental health sector in context of the service guidelines.

Recommendation 18: that the state funds an agreement with WMHNV to develop gender sensitive safe practice training development to ensure any relevant education / workforce can build capability to respond (inclusive of all health workers, GP division, allied health, sector partners such as Ambulance, Police and any other.

Recommendation 19: that the State commit to a Coordinating Hub with regard to Implementation of NDIS.

Recommendation 20: that the state commit to a networking point for safe consumer-consumer contact and access to consumers for NGO's and related allied services.

Recommendation 21: that all NDIS staff be trained in awareness of mental ill health and how to support those women with a lived experience accessing this system.

Recommendation 22: that all state plans linked the Victorian 10 Year Mental Health Plan be better a connected in ways that incorporate Recovery Goals without prejudice.

Recommendation 23: fund the gap in community mental health services for people not eligible for the National Disability Insurance Scheme (NDIS).

Recommendation 24: build an alliance for gender sensitive services across all service systems to ensure they are consistent and effective in assessing mental health concerns.

[3] Women's Safety Matters WMHNV 2018

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Recommendation 25: improve access to assistive technologies and support for older women with disabilities or with restrictive functional capacity.

Recommendation 26: invest in and improve access to services information to ensure women especially in regional, rural and remote areas[4], can identify services relevant to their needs.

Recommendation 27: establish a state funded media department to reinforce positive media on mental health matters.

Recommendation 28: that the state fund WMHNV to promote forums that provide consumers, carers and health professional a unique experience of sharing and collaboration.

Recommendation 29: that the state fund WMHNV to continue the development work on programs that provide women consumers' confidence to be able contribute back into their communities', on a board/committee or return to the workforce.

Recommendation 30: Increase the consistent use of a family/carer "lens" in mental health services, on every aspect of service delivery, from admission through to post-discharge support by:

- ensuring carers are included and validated in patient care planning, and that their wisdom is integrated in a collaborative and useful way, to enhance the admission and recovery experience
- ensuring carer inclusion is supported through staff training, and through prompting questions in admission, planning and discharge documents, and case conferencing
- addressing the dilemmas and inconsistencies in eligibility and other processes for utilising NDIS funding in the mental health context
- carer's are notified immediately when their relative/friend is subject to an alleged assault on the psychiatric unit.

"…there is no early intervention or post-vention support

if you live in smaller regional towns.

I would like to see PARCS there for all regional hospitals that don't offer mental health - being dragged off 2 hours away to be discharged with no help to get home puts women and their children at risk."

"Even though I am health literate I am disregarded and labelled.

The stigma is incredible and despite being witness to the scariest events and suicide attempts as the first person - no one has ever asked if I am ok."

[4] National Women's Health Policy 2020

WOMEN'S MENTAL HEALTH NETWORK VICTORIA

SECTION ONE

INTRODUCTION

The Women's Mental Health Network Victoria Inc. (the Network), is an organisation with more than 180 members consisting of women consumers, carers, health professionals and women who are interested in women's mental health. The focus of our work is to promote awareness of issues that impact on women's mental health and support women in the mental health system by highlighting the gender sensitive practice that takes into account the lived experiences of women as they interact with the health system at any stage.

Central to the Network is the recognition of consumers' lived experience and their expertise and ability to partner in their own recovery. We aim to bring together women who have the passion, expertise, innovation, hope and determination - to make a powerful voice for change.

Mental health disorders represent the leading cause of disability for women in Australia. Women at all stages of life are at greater risk than men of mental ill-health (National Women's Health Policy 2020):

- 43% of women have experienced mental illness at some time
- Eating disorders are the third most common chronic illness amongst young women in Australia Women are 1.6 times as likely to suffer coexisting mental and physical illness
- Members of the LGBTI community experience higher levels of depression, anxiety and affective disorders than their peers
- Women who experience family and intimate partner violence are more likely to report poor mental health, physical function and general health than other women. Intimate partner violence is the greatest health risk factor for women in their reproductive years. It contributes more to the burden of disease (the impact of illness, disability and premature death) of adult women in their reproductive age (18-44 years) than any other risk factor, including smoking, alcohol and obesity. It contributes an estimated 5.1 per cent of the burden in women aged 18-44 years.

During May 2019, the Network developed a survey focused around key issues relating to women's mental health, to gather input from women in the community that could be integrated into this submission for the Royal Commission into Mental Health. The survey was sent to all the members of the Network, and a link placed on our Network website and social media platforms, for anyone in the broader public to access. 56 people completed the survey, with 89% identifying as female, 7% as male, and 3% preferring not to state gender. We have chosen to highlight 5 key aspects from this piece of research.

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SECTION TWO

RESPONSE

A responsive health system is a human rights issue – the Network aims to keep women's issues out in the public space and provide women with a voice so that healing environments are the focus for policy makers and direct service providers.

We network with women consumers, carers and workers to transform service responsiveness. We aim to empower women through consumer designed programs and consumer designed workforce development. Our *Actions of Change*[5] support women's human rights, their dignity and hope.

HOW TO DELIVER THE BEST MENTAL HEALTH OUTCOMES AND IMPROVE ACCESS TO AND THE NAVIGATION OF VICTORIA'S MENTAL HEALTH SYSTEM FOR PEOPLE OF ALL AGES

1. PROMOTE WOMEN-ONLY CORRIDORS BEING USED FOR THEIR PURPOSE IN MENTAL HEALTH FACILITIES

WOMEN'S INPATIENT UNIT SAFETY[6] IS STILL AN ISSUE

Consumers continue to experience intimidation, sexual harassment and assault whilst receiving inpatient care.

Further, too many women still experience fear in what should be **safe and healing environments**. The Network's public consultation for the Royal Commission identified that attitudes of staff also contribute to unsafe care in private and public hospitals. Women reported that they are often retraumatised after being an inpatient, trauma history being a dominant factor for 80% of those reporting. A responsive health system is one that is gender sensitive and supports patients who have trauma history, optimising recovery.

"I'm a survivor of child abuse……the presence of male patients while I was so vulnerable…still gives me nightmares"

We believe that embedding a culture of safe gender sensitive practice within the Mental Health System will better enable the human response to women's needs without further disadvantage. When women are admitted involuntarily (as most inpatients are), the majority of them have a history of trauma or victimisation as a result of past physical or sexual abuse and assault[7]. A literature review by the Department of Health (2011) indicated that between 49 and 90 percent of women admitted to psychiatric inpatient units have experienced childhood sexual abuse, intimate partner abuse or family violence[8]. These experiences can increase their vulnerability, especially when their safety and privacy is compromised in mixed-sex environments.

The Right to be Safe Report 2018[9] further reinforces that safety issues are not being resolved in the current environments and that women-only corridors are not being adhered to. This lack of

[5] Women's Safety Matters 2018 WMHNV Publication www.wmhnv.org.au/publications
[6] WMHNV Hospital Safety Report 2017 www.wmhnv.org.au/publications
[7] DHS, Tailoring Services to Meet the Needs of Women (1997, p. 23)
[8] Department of Health, Literature Review for Service Guideline on Gender Sensitivity and Safety (2011, p. 14)
[9] The Right to be Safe Report 2018 Mental Health Complaints Commission

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compliancy for the basic human right to privacy in inpatient services nationally (right for privacy when sleeping, bathing and accessing space for family /children visiting - WHO Quality Rights[10] is concerning because it further undermines the quality and safety of women - when they are at their most vulnerable.

Female consumers are at a definite disadvantage in the acute psychiatric system, constituting lower numbers and being made exposed to male consumer's violence, aggression, and sexual advances/attacks simply by the need to access services for their mental health and wellbeing.

We need urgent and continuous interventions throughout the psychiatric system to allow female consumers to feel safe and experience a healing environment when unwell.

- 65% of women were not given the option of care in a female only corridor
- 57% said that male patients could access female only corridors and other female only spaces
- 32% found working locks were installed on their bedroom/bathroom doors
- 67% were not given the right to lock their bedroom/bathroom doors when occupying them

WMHNV Hospital Experience Report 2017

Our research clearly illustrates the need for provision of separate treatment spaces for women in hospital. Since mixed treatment spaces became the norm in the 1960s, many women have resisted hospital admissions for fear of abuse by male consumers[11]. The integration of hospital wards in the 1960s was initiated as a progressive policy even though some psychiatric staff were opposed to this change because they feared for women's safety. One argument put forward to justify putting men in with women in highly volatile psychiatric wards was that the presence of women would ameliorate the behaviour of the men. The fears staff had back then for women's safety were well founded. And fifty years on woman are still not safe in psychiatric wards.

Whilst mixed gender units have too often been identified as not meeting women consumer's safety needs; the efficacy of Women-Only corridors were also called into question by our Hospital Experience Survey 2017[12].

A decade after the Network's last hospital survey, these issues are not dissimilar to the Burdekin Report 1993 which highlighted women only spaces as being a way to create safe and sensitive environments for healing.

- Women say they find it destructive when staff don't act on their reports of feeling unsafe
- Women feel vulnerable when staffing levels are inadequate
- Women feel a lack of dignity and insecurity when they have to share bedrooms or have shared bathrooms
- Women feel that there is ambiguity about how staff need to respond to support their care

WMHNV Hospital Experience Report 2017

The majority of inpatient units today provide some separation of the sexes, but too often this is a stop-gap measure rather than a real solution. Greater visibility of staff is one of the most effective ways in which a safe environment can be provided. A basic first step would be training nurses to run groups and engaging actively with patients on the floor. Nursing should be more than just 'observing' from the safety of the nurses station and writing notes.

[10] WHO Quality Rights Toolkit 2012
[11] Victorian Mental Illness Awareness Council 2013
[12] WMHNV Hospital Experience Survey Report 2017 https://wmhnv.org.au/publications

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Gender sensitive care entails much more than recognising a person's sexual orientation. For women, it might include an understanding of living within a patriarchal environment; the impact of social and ethnic mores; access to financial resources; educational opportunities and encouragement to pursue meaningful work. All of these elements help shape the way a woman presents for care in a psychiatric unit and how she responds to treatment. When these elements are integrated into the physical environment and also the care offered on a unit, women will be seen as individuals with specific, valid and unique needs, rather than as a homogeneous whole.

The Network promotes safe and effective mental health services for women by working with services and empowering women to tell their story about their experiences. To be a change agent for safe, gender sensitive and healing environments for all women who experience mental health care, we advocate for women sensitive and safe policy and practice.

50% of respondents to the WMHNV recent survey[13] indicated that hospital management do not actively promote and respond to gender sensitivity and safety issues as leaders for their staff. 48% indicated that women-only corridors and spaces are not being used effectively for the safety and wellbeing of women in Victorian mental health facilities.

"I was admitted to a hospital that had a women's only corridor but no-one ensured the rule was followed and
as a result it wasn't really a women's corridor since the men were able to walk in whenever they wanted and not get in trouble".

A great deal of government funding was directed towards changing hospital infrastructure to create female only spaces, gendered areas, safety tools such as swipe wristbands for gendered spaces, and locks on bedroom doors. It seems that there is currently a lack of consistency in adherence to using these processes and quality improvements for the purpose they were designed. If the state is reluctant to use woman only space for purpose as intended we need to move to women only wards to mitigate bed pressures resulting in inadequate quarantine of men away from vulnerable women.

Recommendation 1: Ensure that female only spaces are facilitated and utilised for the purpose they were designed inclusive of these key pillars of implementation:

- as a basic principle, men are not placed in female only corridors irrespective of male bed pressures, women are given priority of a female bed when accessed as acute in their own right, not compared to common practice of assessing males as a higher risk than females.
- local policies and staff training provide clear and practical guidance to implement safe bed allocations in this regard
- regular gender sensitivity and safety audits are established and required for all mental health services, to ensure that best practice is being implemented (e.g. Physical spaces and safety tools are utilized, and are effective and functional)
- that hospital management are trained in gender-sensitive and safe practice, understand best practice and the research underpinning it, and actively promote and role model these approaches.

[13] WMHNV Royal Commission Consultation Survey Report 2019

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Recommendation 2: that policy direction and funding of hospitals including all new capital works be linked to safety of female inpatients – inclusive of dedicated women only corridors in wards and therapeutic areas. As this has proven difficult to maintain, it may be necessary to move to female only wards.

TRAUMA INFORMED CARE & PRACTICE[14] IS CENTRAL TO RECOVERY

Gender sensitive and trauma informed care is a framework that needs to be 'applied throughout policy and mental health care'[15]. The Network encourages government and all mental health services across Victoria to ensure consumers, especially women, are not only safe but can rely on a sensitive response to their individual gender needs.

Traumatic life events are a driver of service need - policies and service providers must address and respond to trauma appropriately to ensure best outcomes for individuals and families using these services[16]. Abuse and trauma across the life course may have a cumulative deleterious effect on health and wellbeing (National Women's Health Policy 2020).

For Victorian women aged between 15 and 44 years, intimate partner violence is the leading cause of preventable death, disability and illness. Specific groups of women are particularly at risk of violence due to the interplay of a number of complex factors, including Aboriginal and Torres Strait Islander women, women with a disability and culturally and linguistically diverse women. Having the confidence, knowledge and ability to seek support and access appropriate services is also difficult for many women (National Women's Health Policy 2020).

Further, for Aboriginal and Torres Strait Islander women born in 2010–2012, life expectancy was estimated to be 9.5 years lower than non-Indigenous women (73.7 years compared with 83.1). The impacts of intergenerational trauma, systemic racism and a lack of cultural safety remain significant barriers to health system access[17].

Further, culturally and linguistically diverse women can be doubly disadvantaged in a system unadapted to the specific cultural needs of different ethnic groups. Muslim women in particular are confronted with challenging circumstances when sharing public facilities with male consumers (Women's Mental Health Network 2015).

At least one in five women suffer rape or attempted rape in their lifetime. Sexual harassment and stalking are highly gendered experiences; women are overwhelmingly the victims and men the perpetrators. The high prevalence of sexual violence to which women are exposed and the correspondingly high rate of Post-Traumatic Stress Disorder (PTSD) following such violence renders women the largest single group of people affected by this disorder (WHO 2016, Duggan 2016).

Trauma-informed care and practice (TICP) involves a shift to understanding the impact of trauma on a person's life, their health and mental health. Many people who have experienced trauma can be

[14] Chief Psychiatrist's guideline and practice resource: family violence 2018
[15] Chief Psychiatrist's guideline and practice resource: family violence 2018
[16] Trauma-informed care in child/family welfare services 2016 L. Wall et al 2016 CFCA No.37
[17] Department of Health. My Life, My Lead – Opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health: Report on the national consultations. December 2017. Canberra: Australian Government, 2017

triggered through a range of circumstances and behaviours. Inpatient units and bed-based services in particular can be spaces that can be re-traumatising for people. A 'Trauma Informed Care Practice' approach includes understanding a person's potential triggers and providing sensitive support when this occurs.

Currently there are no targeted services to identify and pick up those mental health issues which are emerging from trauma history or Family Violence, even when associated with childhood abuse and trauma. Further, all services should acknowledge the 'amplification of trauma that occurs at end of life and support trauma-informed aged care services' and that we need to 'increase access to, and support for, peer support and trauma informed care in emergency departments and front-line health services' (National Women's Health Policy 2020).

Mental health workers would benefit from **targeted training** in trauma history care models - emphasising education about caring for those who have stolen generational history (either child of parent identifying as stolen generation or an adult with lived experience), Family Violence and history of child abuse. Staff should also be aware of any recent history of admissions that could be traumatic.

Recommendation 3: that state funding for services, programs and bed allocations be based on key indicators that drive women sensitive service focus.

Recommendation 4: that an immediate injection of targeted funding be provided by state governments to mental health services across acute, subacute, rehabilitation and community care for the promotion of women-sensitive programs (inclusive of Prisons and Forensic facilities).

Recommendation 5: that mental health workforce curriculum be reviewed to ensure quality of care training includes trauma informed care and gender sensitive practice.

Recommendation 6: that the state health service- agreements ensure that systems include trauma-informed care services inclusive of aboriginal issues such as stolen generation trauma, cultural needs and aged care.

Recommendation 7: that mental health workers be employed in all Family Violence related services, including immediate addition to staff in Family Violence Safety Hubs.

Recommendation 8: ensure that all mental health staff are trained to respond to a lived experience of 'stolen generational trauma'.

Recommendation 9: that a state-wide mental health framework is developed on trauma informed care inclusive of stolen generational context and newly arrived lived experience of conflicts in war.

Further reinforced by the WMHNV consultation[18] which explored traumatisation after hospital admission. Of the 50% of respondents for whom the question was relevant, 36% indicated they felt traumatised, with 29% of these feeling strongly traumatised after hospital admission.

[18] WMHNV Royal Commission into Mental Health in Victoria Survey Report 2019

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"I'm a survivor of child abuse –

and that was the cause of my mental health problems. Being locked up, stripped, forced to have powerful drugs all triggered abuse memories and made me more suicidal.

The presence of male patients while I was so vulnerable, with nothing but hospital pyjamas that left me feeling exposed, was also terrifying.

Admissions & drugs never helped me—they made me worse."[19]

The need for trauma-informed service delivery, and staff trained and competent in trauma-informed care, is highlighted by these responses, and is consistently reflected in other research findings of the Network. The majority of women who have admissions into acute mental health facilities have trauma histories. Many of these have experienced family violence and/or sexual abuse, the trauma of which has led to mental health difficulties. Their experience of mental ill health can then often make them more vulnerable to further abuse and traumatisation. Safety (both felt and actual), respect, and a sense of choice/control, are integral to healing from trauma. Service delivery must facilitate each of these core recovery needs in every way possible.

2. PROMOTE MORE RESEARCH AND A GENDER LENS ON ANY SOCIAL DATA COLLECTION AND ANALYSIS PRACTICE

MENTAL HEALTH POLICY AND PROGRAMS HAVE LIMITED EVIDENCE-BASE

There is inadequate gender-disaggregated research and evidence from consumer's lived experiences as women navigate complex webs of service provision. The WHO identifies a need to 'integrate a gender role analysis with a structural analysis of the determinants of health because gender roles intersect with critical structural determinants of health including social position, income, education and occupational and health insurance status.'

The Network identifies that the lack of public reporting of sex disaggregated **data** has a direct effect on the logic of women sensitive programs.

If evidence is gathered as well as reported with a gender lens then the existing evidence in formulating policy is improved and better health outcomes for women will be achieved.

Recommendation 10: that policy making and reporting by state and national departments reflect gender analysis practice and improved application of gender disaggregated data collection[20].

Recommendation 11: that funding for mental health care be linked to indicators that reflect gender budgeting.

Recommendation 12: that state treasury funding practice is informed by gender budgeting methodology to ensure key accountabilities for program delivery is equitable and women focused.

Recommendation 13: that state funds are dedicated to sex disaggregated data collection and reporting as best practice for government and peak research bodies to ensure a gender lens on the needs analysis that informs policy and program development.

[19] WMHNV Royal Commission into Mental Health in Victoria Survey Report 2019
[20] Gender Transformative Practice ARROW 2014

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3. PRIORITISE WOMEN LIVING IN REGIONAL AND RURAL AREAS

IMPROVED ACCESSIBILITY OF REGIONAL/RURAL MENTAL HEALTH SERVICES IS REQUIRED

Women need to be able to **access** health services that are connected and coordinated to bring the complete suite of early intervention understanding to an intersectionality of health issues such as homelessness, ageing, gender identity discrimination and stigma, cultural need, family violence and trauma history.

91% of respondents indicated they would like to see more funding for regional/rural mental health services[21]. In regard to issues where response could be improved in regional/rural services, 70% of respondents highlighted family violence and trauma history. This again accentuates the need for trauma-informed care in both staff training and in service delivery practice.

"…there is no early intervention or post-vention support if you live in smaller regional towns. I would like to see PARCS there for all regional hospitals that don't offer mental health - being dragged off 2 hours away to be discharged with no help to get home puts women and their children at risk."

Rurality is a risk for family violence, and prevalence of family violence is higher in regional/rural areas. The Strengthening Hospital Responses to Family Violence (SHRFV) project is a great initiative that came out of the Royal Commission into Family Violence, and needs to be extended and sustained within mental health services at hospitals.

Accessibility to specialist mental health services is a constant challenge for rural people. There is a lack of psychiatrists, and of visiting outreach mental health services. Women also highlight the lack of therapeutic treatment programs, group programs, and support groups in regional/rural areas, as compared to metropolitan areas (for example Outpatient Eating Disorder, Perinatal Depression, or Dual Diagnosis programs).

Recommendation 14: there needs to be a significant increase in funding to mental health services in regional/rural settings to reduce the impact of obstacles to accessibility. Particular focus should be given to:

- establishing ongoing affordable group treatment and psycho-social programs to enhance recovery
- increased incentives to attract mental health professionals to re-locate into regional/rural areas
- increased transport options, including expansion of the Royal Flying Doctor Wellbeing Service and community bus programs
- increased funding for Telehealth, and expanded accessibility to this option for health service providers and their patients
- the establishment of specialist trauma recovery treatments programs in regional areas, and specialist trauma professional development training for public and private mental health professionals who may be accessed by clients with trauma histories
- establish clear referral pathways and information for clients with trauma histories to locate Medicare-accredited Psychologists/Social Workers with specialist skills in in working with trauma, family violence, and sexual abuse.

[21] WMHNV Royal Commission Consultation 2019

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4. ADVOCATE THE NEED FOR GENDER SENSITIVE SAFE PRACTICE EDUCATION TO BE AN INTEGRAL AND CONTINUAL PART OF HEALTH PROFESSIONALS' TRAINING

Current **workforce** attitudes have been identified as part of the stereotypical issue underpinning women's rights[22], the intersectionality of mental ill health can amplify the barriers for accessing other services too- therefore the Network strongly endorses all health professionals participating in core gender sensitive training.

Staff training focused on safety and gender sensitivity is key to responding positively to women's individual needs, however ongoing implementation and monitoring are equally important.

The Network has over the years identified that women have been disadvantaged in psychiatric wards because they are faced with abusive and violent male behaviour which in many cases prevents a healing environment. The same may be said for people who identify as LGBTIQ. This cohort can face abuse and humiliation at the hands of other consumers and sometimes staff as well as insensitive service provision.

Attitudes of staff can often translate into a good or bad experience of hospital for the consumer. Better trained nurses and clinicians means enhanced awareness of issues women and LGBTIQ consumers face and make for a better hospital experience for them. A good experience of hospital will lessen a consumer's fear of being admitted again. A bad experience is likely to make a consumer to never want to set foot in a psychiatric ward again.

Gender sensitive practice should be an ongoing and core part of all service delivery business[23].

Further, the WMHNV consultation reported 52% of respondents indicating that the training of mental health workers is inadequate, and 95% indicated that gender-sensitive and safe practice education needs to be core training for all mental health workers. Some respondents indicated that training is too clinical and label-focused, and not sufficiently holistic or person-centered.

"I find the clinical system more intent on labelling and pushing the person out. Their skills in understanding the experience and what might help recovery limited and not trauma informed.
When you mix skills like in a PARC I find the training and knowledge is better."

Gender is one of the key social determinants of mental health, and yet it receives little specific focus in the mandatory training of mental health professionals. The same is true of training that informs staff of the differential issues and experiences of women in the context of life and mental health, and underlying factors that drive and sustain inequality.

The WMHNV calls for training to be incorporated for both a trauma-informed lens, and a gender lens. It needs to enable staff to understand the gendered factors that influence a woman's experience of mental ill-health and recovery, and the best practice strategies and processes that can support women's recovery and safety.

[22] Building Gender - Sensitive Safe Practice Final Project Report 2013
[23] Service guideline on gender sensitivity and safety 2011 VIC

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Recommendation 15: that all health workforce training to include gender sensitive safe practice as its core[24].

Recommendation 16: that mental health workforce curriculum be reviewed to ensure quality of care training includes trauma informed care and gender sensitive practice.

Case Study: An example of effective workforce planning, development or training

The Women's Mental Health Network Victoria (WMHNV) has developed an effective training program for staff working in mental health, and drug and alcohol services. The program, Building Gender-Sensitive and Safe Practice Training Program, is based on the Service guideline on gender sensitivity and safety: promoting a holistic approach to wellbeing (ref).

Building Gender Sensitive and Safe Practice Training Program is an interactive training program and resource that is designed to support mental health services and practitioners to consider the needs, wishes and experiences of people in relation to their gender and sexual identity, and to ensure access to high-quality care based on dignity and respect.

The training program aims to support staff and management to:

- ensure a gender sensitive and safe approach to work
- build organisational; capacity for gender sensitive and safe practice
- embed the Service guideline on gender sensitivity and safety: promoting a holistic approach to wellbeing into everyday practice
- discuss and review what gender sensitive and safe practice looks like.

In addition to this training license, the WMHNV has been active in the curriculum development space delivering gender sensitive practice education sessions for some undergraduate programs and interested academics - building capacity in the mental health sector for multiple entry points.

For further information regarding this example, please refer to the Women's Mental Health Network's website: www.wmhnv.org.au.

Recommendation 17: that the state fund WMHNV to rollout to acute and community areas their licensed gender sensitive safe practice training for the mental health sector in context of the service guidelines.

5. CHAMPION AND GUIDE ALL WORKFORCE TRAINING TO INCLUDE GENDER SENSITIVE SAFE PRACTICE AS ITS CORE

Gender sensitive practice and trauma informed care should be core pillars of education for the mental health workforce and beyond. The Network endorses a national and state workforce policy approach that encompasses a gender-sensitive and trauma informed care education program. By focusing all workforce education on gender equality, it is not just left to a few champions within health services to fund a response.

Recommendation 18: that the state funds an agreement with WMHNV to develop gender sensitive safe practice training development to ensure any relevant education / workforce can build capability to respond (inclusive of all health workers, GP division, allied health, sector partners such as Ambulance, Police and any other.

[24] Women's Safety Matters WMHNV 2018

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6. BUILD AN ALLIANCE FOR GENDER SENSITIVE SERVICES ACROSS AUSTRALIA

TENSION BETWEEN MEDICAL MODELS, SOCIAL MODELS AND MENTAL HEALTH

The Network members believe all women in Australia have the **right** to quality and safe mental health services. The current policy agendas in mental health, both Federal and State, has resulted in a process of redesign of Australia's mental health system, added into this are changes in areas of primary care and disability. The result has created an operational environment that is wrapped in volatility, uncertainty, complexity and ambiguity[25].

How does the social model of disability collide with notions of mental illness?

The social model sees[26] 'disability' is the result of the interaction between people living with impairments and an environment filled with physical, attitudinal, communication and social barriers. It therefore carries the implication that the physical, attitudinal, communication and social environment must change to enable people living with impairments to participate in society on an equal basis with others.

The biomedical model posits that mental disorders are brain diseases and emphasizes pharmacological treatment to target presumed biological abnormalities.

The collision is partly because the medical model dominates the mental health world; that says people have an illness that needs to be treated. We know that untreated mental illness can lead to unwanted, disastrous consequences for the person with the mental illness and those around them. The fact that psychotic illnesses such as schizophrenia can rob a person of the capacity to engage with the wider world and loved ones; that they lose touch with a shared reality, is something not usually experienced by someone with a physical disability. Some of the barriers the mentally ill experience, are internal not external. This collision of the internal vs external isn't addressed by a social model. The fact that the mind is impaired and not the body sets up a different set of parameters and needs.

Seeing oneself as disabled is also contentious. Some people who have a mental illness don't want to engage with a social model of disability because they don't want to say they are disabled. And some mental illnesses are transient and episodic which creates the problem of how are we to understand what their disability actually is. Do they in fact have a disability? Others have a chronic and ongoing mental illness which is totally debilitating. The individualised recovery model, which is currently in vogue in mental health, is an optimistic one where it is thought recovery is very possible with the right supports and encouragement. That one can recover is in opposition to the notion of permanent disability. Yet episodic mental illness can also be highly debilitating.

It seems a more complex model is needed to embrace the nuances of mental illness. The fact that we still refer to mental illness, which is a use of medical language, is in stark contrast to the social model of disability. And there are people who identify as both having a mental illness and being disabled with physical, sensory and other impairments.

How does this tension affect women accessing services?

The National Disability Insurance Scheme (NDIS) includes people with psychosocial disability. Psychosocial disability is an internationally recognised term under the United Nations Convention on

[25] Mental Health Policy Environment Strategic Thinking for WMHNV 2017,internal document
[26] Social Model Of Disability, People with a Disability Australia, retrieved May 2019 https://pwd.org.au/resources/disability-faqs/social-model-of-disability/

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the Rights of Persons with Disabilities, used to describe the experience of people with impairments and participation restrictions related to mental health conditions. These impairments can include a loss of ability to function, think clearly, experience full physical health, and manage the social and emotional aspects of their lives.

Psychosocial disability relates to the 'social consequences of disability' - the effects on someone's ability to participate fully in life as result of mental ill-health. Those affected are prevented from engaging in opportunities such as education, training, cultural activities, and achieving their goals and aspirations. Not everyone with a mental illness will have a level of impairment that will result in a psychosocial disability. There is tension between the concept of recovery for people with psychosocial disability and the wording in the National Disability Insurance Scheme Act 2013 which states the impairment or impairments are, or are likely to be, permanent[27].

The critical issue is the intersection of the recovery model in mental health (which claims great efficacy), and the contrary notion that someone has to declare they have no chance of recovery, that they have a permanent disability in order to access certain services such as the NDIS.

How can service providers be better connected and linked up?

Consumers who are not **aligned** or identified with key contact services need to have clear pathways to access to the whole process, as what package they may receive from the NDIS could depend on how they ask for services and the negotiating skills of whoever may be advocating for them. That is if they receive a package at all. We need services for those who do not qualify but still have unmet needs in everyday life functioning.

Some of the key areas for concern are:

- concern about services being completely siloed with no overlap
- NDIS will not act as a bridging service for various organisations or consumer groups.
- In the shrinking funds environment how does the NDIS intend to intersect with mental health? Can it address mental health issues when they present?
- If someone has no one to advocate for them how will they find their way into the NDIS? There will be chasms to fall through.
- Provision of psychology services to facilitate consumer understanding and dealing with their mental illness and its related causes

Lack of hubs of case-workers like in Psychiatric Disability Rehabilitation Support Services (PDRSS) make it difficult for allied mental health organisations to contact and access consumers for forums, surveys and other activities that may be of interest to them; for example the Women's Mental Health Network forums held when PDRSS was active averaged 30-50 attendees, many consumers were only able to attend accompanied by a worker. Today we have difficulty getting anywhere near that number of consumers engaged without extensive, time-consuming, and arduous promotion of events. Even then numbers can be limited and we are not necessarily reaching the most vulnerable.

We need a return to the 'drop-in' model at community services for women consumers. Since the fall of the PDRSS sector consumers are isolated, have no sense of community, are more limited in meeting fellow consumers except when unwell and vulnerable in hospital, and have less ability to support each other in and out of hours.

[27] Towards a Social of Madness and Distress: Exploring what Services Users Say, Beresford, Nettle & Parring. Joseph Rowntree Foundation, 2010.

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We need a dedicated **social network** system for consumers to safely meet and support each other plus a connect point for other services and NGO's that may have something to offer consumers.

We recommend that the more work needs to be done to address the tension between having a permanent disability and the uneven trajectory of Mental Illness as well as aiming for Recovery goals; without this, many from the Mental Health arena, and particularly women, will fall through the gaps.

The Network recommends that an Alliance with all states rolling out the NDIS be established so that these key issues can be better explored and noted with the key stakeholders – consumers.

This may take place through collaborative consultation with academics, community groups and consumer groups who are leading the way towards gender sensitive mental health care in Victoria.

Recommendation 19: that the State commit to a Coordinating Hub with regard to Implementation of NDIS.

Recommendation 20: that the state commit to a networking point for safe consumer-consumer contact and access to consumers for NGO's and related allied services.

Recommendation 21: that all NDIS staff be trained in awareness of mental ill health and how to support those women with a lived experience accessing this system.

Recommendation 22: that all state plans linked the Victorian 10 Year Mental Health Plan be better a connected in ways that incorporate Recovery Goals without prejudice.

Recommendation 23: fund the gap in community mental health services for people not eligible for the National Disability Insurance Scheme (NDIS).

Recommendation 24: build an alliance for gender sensitive services across all service systems to ensure they are consistent and effective in assessing mental health concerns.

7. CONTINUE TO BUILD MENTAL HEALTH AWARENESS BY WIDESPREAD NETWORKING, SOCIAL MEDIA CAMPAIGNS AND TARGETING OF THE MEDIA

We collaborate for a **responsive** mental health system that is accessible, easily navigated and brings about healing.

Our research has shown that women consumers and carers who live in rural and regional Victoria need better access to information, especially when it comes to local services[28].

Similarly, we need to reduce stigma and shame in rural communities where the people providing services to consumers and carers may be personally known to each other either in business or socially.

Stigma, its resulting exclusion, isolation and loneliness, all actively work against Recovery for those with a lived experience of mental ill health.

Mental ill health is often an issue kept in the closet; we need champions for female consumers, similar to those rising up in AFL programs and so forth. Champions that have a lived experience of mental ill health and are not afraid to bring attention to themselves for the cause.

[28] WMHNV Communications Framework Project 2015

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Myths about mental illness and female stereotyping could be addressed by social media campaigns like the 'You Can't Ask That' program on the ABC[29]. Myths and associated stigma could also be highlighted and debunked in a range of short and effective campaigns like posters at bus stops, on Billboards, inside trains, and on toilet doors.

We could have cross-pollination advertising and education campaigns of intersectionality issues in our community like Violence against Women, increase in homelessness for women over 55 years old, and related mental ill health. TV ads like the Scope disability organisation's "See the person" promotion have had impact too. Co-production of advertising campaigns with consumers and other stakeholders have the potential not just to reduce stigma, but also educate the public about mental ill health and the issues facing consumers in their day to day life struggles.

Bring the public on board with the fight against mental illness, by humanising it instead of seeing it just in sensationalist media extremes of suicide and homicide rates.

Depression, Anxiety and Bi-Polar have become somewhat romanticised by film and are more accepted as a daily occurrence after normalising promotions from organisations like Beyond Blue. However, other serious psychoses such as Schizophrenia are seen as dangerous and unwanted by society. Similarly, a predominantly negative female diagnosis of Borderline Personality Disorder often casts females in a hysterical and maladaptive light.

We should be celebrating survivors of mental ill health such as the psychoses, those struggling with the emotional dysregulation and inflation inherent in BPD, as heroes battling terrible odds. Cancer patients are recognised for long, arduous and at times terminal fights to stay alive and have some quality of life. We should recognise the fight for some psychiatric patients even to get out of bed on a daily basis.

In Mental Illness, instead we have headlines like 'Coward kills Cop' rather than 'Man shoots police in defence'. A more positive approach would encourage community support as opposed to isolation and help enable positive broader social movements for fundraising and research. We need a proactive dedicated state-funded media department pulling up The Press on negative reporting and redressing that reporting actively with positive follow up stories/explanations of events in the public eye. The media department could source stories of lived experience of carers and consumers to promote education about mental illness and health, reduce stigma, and increase the understanding and appreciation of struggles faced by consumers and carers whilst showcasing Recovery and their successes.

Service and funding fragmentation impacts women negatively

Mental health services are difficult to navigate. Health services remain **siloed** and this creates difficulty for consumers to navigate a service that may meet their needs. As a result, women have become invisible as their mental health issues emerge and go undetected, often leading to acute ill health.

Women need to be able to access health services that are connected and coordinated to bring the complete suite of early intervention understanding to an intersectionality of health issues such as homelessness, ageing, gender identity discrimination and stigma, cultural need, family violence and trauma history. If services are to be well connected then staff must have the right skills to be able to support mental health. Services which are women sensitive acknowledge that women's needs are

[29] Acknowledge to the ABC TV program 'You Can't Ask That' 2019 series

different to men. Targeted funding to support programs and services that can cater for the gender difference ensures services are more accessible as their point of difference is clear.

We believe that a restored health system is achieved if reform targets the capability within the health system to identify and effectively manage the increasing complexity and health needs of women experiencing mental ill health across all age stages.

Recommendation 25: improve access to assistive technologies and support for older women with disabilities or with restrictive functional capacity.

Recommendation 26: invest in and improve access to services information to ensure women especially in regional, rural and remote areas[30], can identify services relevant to their needs.

Recommendation 27: establish a state funded media department to reinforce positive media on mental health matters.

8. EMPOWER AND INFORM WOMEN CONSUMERS VIA TRAINING AND FORUMS

For most of its history, the Network has relied on volunteers to carry out its important work. Over the past seven years we have been successful in securing project-specific grants to advance our cause. Philanthropic trusts such as The Reichstein Foundation have allowed us to employ staff from time to time. We have demonstrated what even a modestly funded organisation of committed individuals can do for those it represents.

Case Study: An example of effective consumer participation

The Women's Mental Health Network Victoria (WMHNV) supports programs that capture the lived wisdom of consumers and staff.

> "Female-only spaces are so, so important …all I ever needed was somewhere 'safe' to retreat to …"[31]

The Network promotes forums that provide consumers, carers and health professional a unique experience of sharing and collaboration. Forum key aspects are conducting consultations for advocacy purpose and increasing access to mental health services by supporting information sharing. This collaboration has assisted the Network to develop the following consumer focused programs:

Women Speak Out Program

No-one can tell their story of mental illness like a woman who has been there. And many women would appreciate the opportunity to share their experience. Our Women Speak Out Program consumer advocacy training helps build the confidence and skills and can enable women to actively participate in public forums or committees and services. Hearing the voice of women consumers can positively impact on how services are delivered, and can result in improved work practices in inpatient and community settings. The Women Speak Out Program will help build a safe and gender sensitive mental health system for all women. The Network partners with individuals and relevant organisations to bring this program to women in the community.

[30] National Women's Health Policy 2020
[31] WMHNV Royal Commissions Survey report 2019

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Case Study: An example of effective consumer participation

Women in Rural and Regional Victoria

A pilot program, Breaking the Silence, has been funded by State Trustees and SNAP Gippsland (now WITHIN Australia), for women in rural and regional Victoria. It aims to help break down stigma and isolation and empower women to contribute to local community efforts to improve mental health. It is planned to put strategies in place to encourage women who undertake the program to support each other after the training has concluded. It is expected that over time the Breaking the Silence program will be rolled out to other parts of rural and regional Victoria. We will continue to build on our learnings and develop this program further.

Recommendation 28: that the state fund WMHNV to promote forums that provide consumers, carers and health professional a unique experience of sharing and collaboration.

Recommendation 29: that the state fund WMHNV to continue the development work on programs that provide women consumers' confidence to be able contribute back into their communities', on a board/committee or return to the workforce.

HOW TO BEST SUPPORT THE NEEDS OF FAMILY MEMBERS AND CARERS OF PEOPLE LIVING WITH MENTAL ILLNESS.

CARERS NEED TO BE INCLUDED

70% of respondents to the WMHNV survey indicated that the Victorian mental health system does not meet the needs of women as carers, as they seek to navigate and advocate for those they care for. Women indicate that they feel mental health professionals often don't seek or value their wisdom or input in regard to the care of their family member, and that the importance of their knowledge/understanding of their family member is not respected, and sometimes overlooked. They also highlight the inadequacy of the NDIS system to meet the needs of those experiencing mental health problems and their carers.

"Even though I am health literate I am disregarded and labelled.
The stigma is incredible and despite being witness to the scariest events and suicide attempts as the first person - no one has ever asked if I am ok.

Also, the impact on work and huge costs associated with trying to help and pay for accommodation, food, travelling to see if they are ok,
it is not something you can talk about to people at work.
I am crying as I write this…utter loneliness and stigma applies more to women and mothers."

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Recommendation 30: increase the consistent use of a family/carer "lens" in mental health services, on every aspect of service delivery, from admission through to post-discharge support by:

- ensuring carers are included and validated in patient care planning, and that their wisdom is integrated in a collaborative and useful way, to enhance the admission and recovery experience
- ensuring carer inclusion is supported through staff training, and through prompting questions in admission, planning and discharge documents, and case conferencing
- addressing the dilemmas and inconsistencies in eligibility and other processes for utilising NDIS funding in the mental health context
- carer's are notified immediately when their relative/friend is subject to an alleged assault on the psychiatric unit.

CONCLUSION

This submission is based on the combined research, evidence and practice experience of our organisation and years of working to provide a voice for women with mental ill health. We want to see a system that works for the people it is intended to support, that upholds and respects peoples' human rights and enables their recovery. It should be a place people can get the support they need in a trauma-informed and gender-sensitive way, with a commitment to principles of human rights, collaboration, access and choice.

Please listen to what consumers, carers and workers have been saying and dealing with for far too long - A broken system! Please provide radical and extensive reforms, not just add-ons that have done more to cripple functioning than improve overall outcomes for consumers. We need decent funding to make change effective, including respecting the rights and space for females in a male dominated system. If we can do it for level crossings…then surely we can invest appropriately for suffering human beings.

We would like to thank the Victorian Government for the opportunity to contribute to this consultation and we would welcome further consultation on any of the matters raised in this submission.