Hobart Women's Health Centre

Submission to

Rethink Mental Health Tasmania

Consultation

February 26 2015

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About Hobart Women's Health Centre

Hobart Women's Health Centre is a universal service available to all women in Tasmania. It seeks to increase the range of services and its reach to women who are vulnerable to inequitable health outcomes due to social or economic determinants. The Centre acknowledges the impact of societal influences such as income, education, gender, sexual orientation, ethnicity, disability and isolation on health outcomes and seeks to reduce the negative effects of these factors on individual women.

The Centre is part of a national network of women's health centres. It is a health promotion charity funded by the Tasmanian Department of Health and Human Services, guided by the World Health Organisation's definition of health; 'Health is a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity'.

The Centre provides a safe, supportive environment for women. It is run by women, for women, and aims to promote positive health outcomes by providing a diverse range of services that take a holistic approach. This approach to women's health has seen the Centre at the forefront of preventative health care in Tasmania.

The vision of the Centre is for Tasmanian women to be informed, supported and active decision makers in their own health and wellbeing. As a result, the Centre has also been a key advocate on issues such as a woman's right to make informed choices about her own body, migrant and refugee women's health, eating disorders, and the arts and health. The Centre consistently advocates on behalf of women with both State and Commonwealth governments on a range of legislation and policies impacting on women's health.

In recent years the Centre has broadened its service delivery component by undertaking outreach activities, offering a state-wide information telephone line and using electronic technologies. It currently provides services to women from 48 different postcode areas.

Hobart Women's Health Centre continues to provide direct services to individual women and to advocate for, and promote, the health and wellbeing of all Tasmanian women. Our knowledge and expertise is based on 26 years' experience working with, and for, the women of this state.

We welcome the opportunity to contribute to the Rethink Mental Health Tasmania consultation.

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A gendered approach

HWHC adopts – as well as advocates for – a *gender-based approach* to health and wellbeing service policy development and delivery. A gender-based approach 'helps us to identify the ways in which the health risks, experiences, and outcomes are different for women and men, boys and girls, and to act accordingly. HWHC is concerned that, in Tasmania, recognition of the need for a gender-based approach to health and wellbeing - and even an understanding of what this means - is seriously deficient.

"Women become defacto mental health workers and it is often multigenerational; my son with a serious Mental Health illness, has a child with a woman with Mental Health illness, they have a child who is affected by their ill health. This means I am often caring for all of them..."

Gender is a social determinant of health because social factors such as powerlessness, access to resources, and constrained roles impact on patterns of health and illness. At a population level, in most countries of the world, women have more limited access to, and less control over, resources, and over their bodies and lives, than do men. Gender determines the differential power and control men and women have over the socioeconomic determinants of their health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific health risks.

Women suffer more negative health consequences of inequalities between the sexes. For example, women generally live longer than men but are more likely to suffer from long-term disability and chronic diseases; historically women have been subject to discrimination and gender role stereotyping leading to social exclusion and poor mental health; and women are far more likely than men to be victims of domestic violence and sexual assault.8 Gender and sex considerations are also clinically relevant in areas such as sexually transmitted infections (including HIV/AIDS), pain, diabetes and heart disease.[1]

Gender and Health Policy - Public Health Association of Australia

The Public Health Association of Australia will continue to advocate for: the inclusion of gender focus in health policies and research; income and pay equity; adequate funding to support implementation of the national women's and male health policies, also advocating the need to incorporate considerations of gender in all health policies.
The mainstreaming of a gender perspective into all national, state, territory and local formulations of policy in areas that impact health, including ageing and aged care; income and family support and Medicare; employment and workplace relations; unpaid family care; childcare reform; judicial and correctional services; transport; and the provision of public and recreational space. [2]

[1] WHO, Gender and Women's Mental Health, http://www.who.int/mental_health/prevention/genderwomen/en/.

[2] http://www.phaa.net.au/documents/policy/20081002newGenderandHealth.pdf

Gender as a social determinant of health – and mental health

Gender is a critical determinant of mental health and mental illness. Gender differences occur particularly in the rates of common mental disorders - depression, anxiety and somatic complaints. These disorders, in which women predominate, affect approximately 1 in 3 people in the community and constitute a serious public health problem.

Unipolar depression, predicted to be the second leading cause of global disability burden by 2020, is twice as common in women. Depression is not only the most common women's mental health problem but may be more persistent in women than men. More research is needed.

Reducing the overrepresentation of women who are depressed would contribute significantly to lessening the global burden of disability caused by psychological disorders. The disability associated with mental illness falls most heavily on those who experience three or more co-morbid disorders. Again, women predominate.[3]

Women are more affected by mental illness than men (Australian Bureau of Statistics, 2008). In considering the impact of mental illness from 12-month prevalence data, women are more likely than men to experience depression (7.1% compared to 5.3%) and anxiety disorders (17.9% compared to 10.8%). One in six recent mothers experience a mild, moderate or severe form of postnatal depression. Though men and women are affected by schizophrenia in approximately equal numbers, women tend to experience later onset and therefore do not receive the same level of services. Up to 90% of eating disorders (anorexia nervosa and bulimia nervosa) occur in women (Australian Bureau of Statistics, 2008).[4]

Determinants of mental ill health in women

The following social determinants of ill health for women are identified in the AWHN *Women and mental health position paper* 2012[5]

Violence against women – continues to be a major contributor to mental ill health.

Violence is associated with high levels of depression and anxiety (Mullen et al., 1988), eating disorders and substance abuse, with up to 50% of women who have experienced violence suffering from these disorders (Danielson et al., 1998). A number of studies have demonstrated associations between childhood abuse and increased delusions and hallucinations in adulthood (Beck and van der Kolk, 1987; Lysaker et al., 2001). Read and Argyle found that 77% of psychiatric inpatients with histories of physical and/or sexual abuse experienced hallucinations, delusions or thought disorders. In 54% of these cases, the content of psychotic symptoms was related to child abuse (Read and Argyle, 1999).[6]

[3] WHO, Gender and Women's Mental Health, http://www.who.int/mental_health/prevention/genderwomen/en/.

[4] AWHN, Women and Mental Health, Position paper 2012 http://www.awhn.org.au/files.php?cat=1

[5] ibid

[6] ibid

Childhood abuse of girls

A gender imbalance in the experience of some forms of child abuse (e.g., sexual abuse) has also been identified (Stoltenborgh et al., 2011), making women in particular vulnerable to experiencing negative consequences stemming from child abuse. One potential negative consequence that has been identified is an increased rate of mental illness in adulthood for women survivors (Thompson et al., 2004), in particular depression, anxiety and post-traumatic stress disorder (World Health Organization, 2011).[7]

Women poverty and homelessness

There is a vicious cycle of poverty and homelessness in relation to women with mental illness. Lack of access to economic resources such as employment, education, adequate housing and adequate financial resources is usually perpetuated for women with mental illness, therefore preventing poverty alleviation and financial security development (World Health Organisation, 2003). These socio-economic factors influence women's health behaviours, psychological well-being and safety.

Women drug and alcohol abuse[8]

Alcohol and drug abuse are both contributors to ill health and barriers to accessing services*. However, there are common delays in the diagnosis of women's alcohol abuse and a lack of treatment programs that focus on meeting the needs of young and mid-life women. There is a marked lack of professional education and research into women's alcohol abuse disorders.* [9]

Hobart Women's Health Centre's holistic approach – a model in prevention and early intervention

The Hobart Women's Health Centre is committed to continuous improvement. However we believe we offer some interesting insights into a more holistic approach to health especially in prevention and early intervention. This model will not fit all situations but it is a model which could form the basis of improvements in other services.

Firstly as a women- only Centre it is a place where vulnerable women feel safe. We do not have set criteria for women seeking assistance and we accept that health and wellbeing can be impacted by the social determinants of health such as poor housing, education, low income and abusive relationships. We are non judgemental and seek the women's permission for any intervention and aim to offer her options. More importantly we give her time and we listen. In clinical terms our methods might be described as triage. We do not have the capacity for ongoing counselling – generally we offer three sessions. We aim to assist women to find pathways through the service maze and refer or link women to appropriate services, often working intensively over the short, medium to longer term. For this reason our team may be working with housing providers, medical practitioners, job search agencies, legal services, immigration, unions, the police or any number of other agencies and charities. Although this is initially labour intensive, we know from the feedback we receive that it saves a great deal of anxiety and represents a very effective early intervention.

[7] ibid
[8] ibid
[9] ibid

HWHC – We listen to woman and take a gender-approach to health and wellbeing
(Comments below refer to clients of the Centre with high and complex needs)
…These clients are women who are, or are vulnerable to being homeless, suffering ill-health and social isolation. The issues these women present are complex and inter- related. Our usual process is to offer either counselling and support for women for 3 – 4 sessions and then find suitable case managers or other services to assist. We will of course still welcome them to our Centre subsequently as with all women. Each one of these women has a special and unique reason why this Centre suits her needs. But what they all have in common is their needs are such that many services cannot help them, they won't go to what might seem the most obvious service because of some past experience or fear, real or perceived, they will be judged or worse. What we offer is a warm non judgemental place where women are listened to. We take a holistic view of health.
These are women who fall through the gaps. Not through any fault of other services but the system which funds organisations for one or a limited range of activity. We think we see them partly because the sector is over loaded. *HWHC Counsellor – observations*

One of the most common concerns we hear are the difficulties in seeking the "right service", accessing those services in a timely manner and the limitations when the woman has complex needs or co-morbidity.

Barriers to accessing services for individuals include: transport, cost, eligibility especially for Acute/ crisis support from CATT(Adult Mental Health), waiting lists, service cutbacks and stigma around accessing mental health services.

There are very long waiting periods for young women under 18 i.e. CAMHS. Often the crisis or need may have passed by the time the support is available or the mental illness has significantly worsened placing huge stress on the individual, their families and other services less well equipped to respond and support.

Case study
Young woman with a history of mental illness and drug and alcohol use visited HWHC in a distressed state seeking emergency respite. The woman reported feeling very unsafe and reluctant to return to her home due to a number of specific and generalised fears. After contacting Adult mental health, the staff member was advised to phone the Crisis Assessment & Triage Team (CATT). The CATT advised that the woman was not eligible for respite as her problems we due to 'behavioural issues' rather than a mental health disorder. The young woman became increasingly distressed, loud and panicked when she was advised that she would not be eligible for respite and that no CATT members were available to come to HWHC to assess her for some time (at least not until late afternoon, 3-4 hours away or perhaps not even the same day). The CATT advised we call the police. This information was not relayed to the young woman who was becoming more agitated and it was highly likely an appearance from the police would lead to her escalating further. The young woman clearly did not have the skills available at that time to regulate her emotions and was in a very distressed state for around 20 minutes. The young woman also said she was too scared to go to hospital as she reported she had been sexually assaulted during her last stay at DPM. After spending time with a worker and settling, the young woman made the decision to go to accident and emergency to seek admission to DPM. In this situation ideally the CATT would have been better resourced to attend HWHC to assess and support the woman to explore her options.

Many programs at the Hobart Women's Health Centre are designed to improve physical health for example the walking group, fitball and weights class. When we survey participants many clearly identify the mental health benefits – commonly referring to the activities as "the highlight of their week", "the only time they make and see new friends" and "it gets me out of home". Social isolation may exacerbate mental illness, connecting with a community is the first step to social inclusion and mental health. The benefits of physical activities for those with chronic or non-communicable diseases are well known but they are also highly beneficial for many with mental health issues. We know that over 25% of participants self- identify with a disability or mental health issue but we do not ask them to specify. However we know anecdotally women with anxiety and depression and other diagnosed conditions are benefiting from most of our activities including Tai Chi, Yoga, meditation and walking group.

"Until I went to the beach with the walking group I didn't realise how walking by the water could help my constant anxiety. I kept saying 'I have no anxiety, I realised I had no anxiety' I am going to try to go walking near the water by myself sometimes." HWHC walking group participant

Women as Mental Health Carers

It is still the case that women are commonly the primary carers for family members with mental health issues. It is not uncommon for women to care for the previous generation as well as the next generation in one household. Additionally according to Carers Australia

- Carers tend to be economically disadvantaged, with 62 per cent of primary carers in the two lowest income quintiles.
- Carers have lower general wellbeing than others and are more likely to experience poor health, including an above average rating on the depression scale. Carers are also more likely to experience chronic pain or injury associated with caring. [10]

This unpaid care represents considerable savings to governments across Australia. A State policy on mental health must recognise the role played by carers. Carers should be consulted in a meaningful manner to ascertain to the most appropriate supports to continue their role but also to provide respite and when necessary to assist them to relinquish that role.

[10]Carers Australia Federal Election 2013: 'Unpaid Carers: the necessary investment' www.carersaustralia.com.au

Primary Health and clinical services

The discussion paper suggests GPs are well placed to support people in preventing mental health problems, to detect mental health issues at an early stage and to intervene early it assist them to manage their issues. Our experience is there are some doctors who are comfortable in this area but many do not have the time and resources and some express concern about their skills to deal with mental health issues. Sometimes vulnerable patients are unable to express their needs or do not realise they can ask for a Mental Health Plan.

There needs to be more training and support for other health professionals and providers regarding mental health issues and trauma.

> *"I had to go to the hospital to talk about my operation and they did some test and it hurt me. I told them I had bad anxiety – now I can't go back again, I know I have to have the operation but I can't go back in that building again."*
>
> (This woman was later accompanied to an appointment by HWHC staff but it illustrates how mental health can be a barrier to accessing health services which are unrelated to their mental health condition.)

Hobart Women's Health Centre has undertaken a lot of work around eating disorders which of course is classified as a mental health issue. Our experience is many GPs lack awareness of this complex issue and there needs to be more training and information about assessment and treatment although services for eating disorders are in short supply in Tasmania especially for adults.

Hobart Women's Health Centre published ***Sprouting Seeds Tasmanian Eating Disorders information Line Project*** in 2011. After considerable consultation, options for a telephone information line for eating disorders were recommended. The recommendations are yet to be implemented. [11]

More case managers are needed for example, adults living with an eating disorders are expected to manage their own multi disciplinary teams and pass communications one from one health professional to another. This is not appropriate, safe or efficient. The multi disciplinary teams for children and adolescents meet regularly and communicate which is a much better model.

We recommend regular training in recovery oriented practice be made available to clinicians and mandatory for all mental health services. Service/ client outcomes assessed against recovery based principles, supporting recovery efforts, growth and self determination including having consumers and their families on the Boards of community based services.

There are barriers for clinicians in accessing support for their clients: getting appropriate support for women in crisis where there are high and complex issues i.e. mental health,

[11] Hobart Women's Health Centre *Sprouting seeds Tasmanian Eating Disorders information Line Project* 2011 http://www.hwhc.com.au/resources-submissions-reports

drug and alcohol, homelessness. Services eligibility is very difficult when there is co-morbidity (Alcohol and drug/ behavioural/ mental illness).

Ideally extra funding should be made available through Medicare for Better Access Initiative (G.P Mental Health Plan) to extend the number of subsidised counselling sessions from 10 per calendar year to at least 12. People with a mental health plan often feel obliged to continue to see the same clinician for the 10 sessions even if it's not a good fit. People need to be informed they can change clinicians. Although Medicare is not a State responsibility the information around these options could be promoted more widely in the State.

At Hobart Women's Health Centre we have known of several cases where a woman may be placed in involuntary care and she has telephoned the Centre as a service she can trust concerned asking for us to collect mail or check on pets. We have had requests to bring in nightwear and underclothes. Some of these requests cannot be met by our service but we try to do what we can. When a person has been hospitalised the pathways to care on release are not easily accessed or available – this can be simply because of the time of day or day of the week the release occurs.

Mental Health and law enforcement

This is not an area of expertise for Hobart Womens Health Centre but we have listed some comments from consumers and carers as a contribution to the discussion. We are aware of the role the police play in crisis situations and many have a high level of skills in calming distraught clients. It appears they are called when other services are unavailable or unable to attend, especially if drugs and alcohol are involved and when the client is homeless.

***It is Mad versus Bad**. Many people with Mental Health are treated like criminals. The CAT team will not respond to bad behaviour, or people with a history of alcohol & drug misuse*

***Police have become Mental Health workers.** They cannot hold without charge leading to criminal record implications for accessing shelter*

Out of hours court is usually taken up by mental health. There needs to be a nurse to do assessments.

Stigma and fear

Mental health and illness are still largely misunderstood in the community and this is a barrier to acceptance and access to assistance**.** Despite changes in institutional care and the development of improved medications and treatment misconceptions persist.

> *I'd never tell anyone in an interview that I have suffered from clinical depression; they'd find some excuse not to employ me.* *HWHC participant*

> *I went to my doctor and told him about how badly my ex boyfriend had treated me and how angry it made me feel, how it set me back and affected my anxiety and depression – he just asked if I was going to hurt him. Why do they think we are all violent?* *HWHC participant*

> Whenever they have things like the siege in Sydney or that woman in Victoria who was shot the other day – I just think – that's how the media see it and that's what people think of us. And why did they have to kill that woman?

More population-wide educational, promotion and prevention strategies need to be implemented to improve perceptions of mental health issues and the valuable contributions everyone can make to society. Policies for inclusion need to take into account the sometimes episodic nature of some illnesses.

Recommendations

- A central access point for mental health with highly trained staff as the first contact.
- Comprehensive current database of services and referral points to services with an outline of the parameters of their work should be created and maintained, and available on line. This would therefore be easily available for the Mental Health Line and other government services as well as community services. A booklet, adapted for consumers, organised in the basis of local government areas would be useful especially for those without internet access.
- Adult Mental Health Crisis Assessment Response should be extended to ensure timely support and easier access for people living with severe and complex mental illness and for their families.
- Develop more coordinated services to meet the needs of mental health clients who have drugs and alcohol dependency issues.
- Early intervention and prevention programs outreaching to local communities at universal services e.g. Neighbourhood Houses, Child and Family Centres LINCs Community Health Centres to help de-stigmatize mental illness, and education regarding healthy/ unhealthy relationships (D.V. and sexual abuse/ assault).
- Early intervention and prevention programs in schools and increased funding to school social workers and psychologist for intensive individual support to children showing early signs of stress and trauma. More timely and stream lined linkages between school supports and other services in the community to support families and children before trauma or crisis develop.
- Additional counselling, specialist advocacy support and early intervention programs in workplaces for women who have experienced workplace bullying and harassment,
- Additional funding to support children and women who have experienced domestic violence including FVCSS and CHYPP programs and shelters.
- Implement the recommendations of the *Sprouting Seeds Tasmanian Eating Disorders information Line Project* 2011 and increase and coordinate case management services for Eating disorders sufferers.
- Population-wide educational, promotion and prevention strategies need to be implemented