THE VICTORIAN PEAK BODY FOR GENDER EQUITY, WOMEN'S HEALTH AND THE PREVENTION OF VIOLENCE AGAINST WOMEN

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Gender Equity Victoria (GEN VIC) Submission to the Victorian Mental Health Royal Commission

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About Gender Equity Victoria (GEN VIC)

Gender Equity Victoria (GEN VIC) is the peak body for gender equity, women's health and the prevention of violence against women in Victoria. Our vision is for equality, wellbeing and freedom from violence for every woman and girl, in every community of Victoria. We exist to advocate, influence and collaborate to improve outcomes in gender equity, women's health and in the prevention of violence against women.

GEN VIC represents organisations across Victoria who advance gender equity and hold values that align with feminist principles. Our current membership reaches every region and community in Victoria.

GEN VIC recognises gender as a key determinant of one's position or status in society, and therefore one of the most powerful drivers of health inequities. By addressing the role of gender inequity in women's health and the prevention of violence against women, GEN VIC aims to ensure the equality, wellbeing and freedom from violence for every woman and girl, in every community of Victoria.

GEN VIC performs a number of key functions in that we:

- ensure women's voices are integral to policy, legislation and services
- deliver and support coordinated and evidence-informed women's health promotion activities and
- facilitate collaboration and partnerships.

Introduction

In the last two decades, there has been an increased public awareness of the impacts of mental health on individuals and families. This awareness has contributed to greater clinical diagnosis and understanding of the prevalence of mental health conditions and the impact that mental health has on the wellbeing of the general population (Schomerus et al., 2012). The Victorian Royal Commission into Mental Health has the potential to contribute greatly to this growing awareness. In this submission, GEN VIC argues that this potential will be realised if the commission uses a social model of health to address gaps in mental health prevention, early intervention and response (VicHealth, 2018). The social model of health emphasises that social inequities are a key driver of our physical and mental health and wellbeing. These social determinants of health inequities are the social conditions in which people are born, grow, live, work, play and age – and the social, economic and political processes that influence how health and wellbeing is distributed across society (VicHealth, 2018).

How we understand health inequities matters to how we address mental health. Clinical, psychiatric approaches to mental health play a critical role in diagnosis and response. However, when used in isolation from a social approach, clinical approaches can restrict our understanding of the everyday social norms, practices and institutions that shape our access to wellbeing, particularly for women and marginalised communities. We know that women are nearly twice as likely as men to suffer from mental illness (Yu, 2018). We know that suicide rates among Aboriginal and Torres Strait Islander women aged 15-19 are nearly six times higher than the corresponding rates for non-Aboriginal young women (Suicide Prevention Australia, 2016). We also know that transgender young people in Australia aged 14-25 are experiencing depression and anxiety at approximately ten times the rate of adolescents in the Australian general population, with 78% of trans young people have engaged in self-harm (Strauss et al., 2017).

This evidence suggests that access to mental health and wellbeing is not distributed equally across Victoria. Health inequities are differences in health status between population groups that are socially produced, systematic in their unequal distribution across the population, avoidable and unfair. The evidence is clear that optimal mental health is influenced by one's gender identity, age, race, socio-economic background, ability and sexuality. To successfully address gendered issues of equity and access in mental health we need to account for the social determinants of health and adopt an intersectional approach to prevention, treatment and service delivery.

An intersectional approach to mental health recognises that individual's experience may be compounded by other forms of disadvantage and discrimination including, but not limited to racism, ableism, homophobia, transphobia, ageism and classism (Chen, 2017). The key focus of this submission is on primary prevention of mental health, in particular the role of gender equity, women's sexual and reproductive health and the prevention of violence against women. However, we urge the commissions to consider the structural barriers around housing, education, employment and welfare that are gendered in their impacts and fundamentally shape the mental health of women and girls across Victoria. All people should have a fair opportunity to attain their full health potential, and no one should be disadvantaged from achieving this potential.

Structure of submission

This submission applies an intersectional, gendered approach to mental health and wellbeing. With a key focus on primary prevention, the evidence provided primarily relates to terms of reference one and two but helps inform a gendered, social approach to terms of reference three to five. The submission draws on the existing evidence-base to support three key approaches to mental health, wellbeing and illness:

- A gendered approach
- An intersectional approach
- A primary prevention approach

1. The relationship between gendered inequities and mental health

The social conditions in which people are born, live and work are the most important determinants of good health or ill health. Gender is one of the key social determinants of health (WHO, 2008). Gender equity, together with freedom from violence and discrimination, and access to economic and social resources, profoundly shape people's experiences, access to support and services and their mental health outcomes (Women's Health Victoria, 2019). There is a significant and growing evidence-base to link gender inequality to high rates of ill-mental health amongst women.

Globally, women are nearly twice as likely as men to suffer from mental illness. There is an increasing amount of country specific studies which have in the United States indicated correlation between wage gap and gender disparities in mood disorders (Platt, Prins, Bates, & Keyes, 2016). In the United Kingdom, studies have shown that domestic violence and abuse toward women relate to the greater prevalence of mental illness among women (Walby & Allen, 2004). For women in Australia, mental disorders represent the leading cause of disability and the highest burden of non-fatal illnesses (Duggan, 2016). Across the five year period, women were around twice as likely as men to meet the criteria for having a probable serious mental illness. While the proportions of both males and females meeting the criteria for a probable serious mental illness have risen between 2012 and 2016, the increase has been much more marked among females (from 22.5% in 2012 to 28.6% in 2016, compared to a rise from 12.7% to 14.1% for males) (Mission Australia, 2016, p.15).

We know that gendered disparities start young and impact on all areas of the mental and physical health of young people. Young women report the highest rates of mental disorder of any population group (30% for women aged 16 to 24) (Duggan, 2016). The mental health of Victorian women, girls and gender diverse communities have to be understood in the context of gender inequity, violence against women and access and equity in sexual and reproductive health across Victoria.

Gender Inequity

The unequal distribution of power and resources between women and men in the workplace and beyond is underpinned by norms, practices and institutions that impact on ill-mental health for girls, women and gender diverse and gender non-conforming communities.

Currently, women constitute 50.9% of the Victorian population (ABS, 2017a). Yet, women are underrepresented in leadership positions, over represented in paid and unpaid care work and the median salary for in the Victorian public sector is $76, 487 for women, compared to $86,684 for men (VPSC, 2017, p. 31). Across Victoria this inequality has been legitimated through unconscious bias in the hiring process, through stereotypes of women at work, inflexible work arrangements and, has over time, been normalised.

Gender inequality is also a key driver of violence against women and violence that women face throughout their lifetime fundamentally impacts on their mental and physical health. These impacts take place in a range of settings. Settings are the places and social contexts in which people engage in daily activities, and in which environmental, organisational and personal factors interact to affect health and wellbeing. They can be defined geographically (e.g. cities, villages, islands) or organisationally (e.g. schools, workplaces, hospitals) (VicHealth, 2015).

Norms of masculinity and femininity impact on health

Active participation in social, economic, cultural and family settings is fundamentally shaped by gendered norms. A Vic Health study found that when it comes to exercise and mental health there are a range of barriers that stop women from obtaining their optimum health. For example, more boys than girls report that their parents let them walk or ride to places, or visit local parks on their own (Vic Health, 2017). Young women report feeling concern about the presence of males when exercising and worry about being judged, humiliated and harassed (Vic Health, 2017, p.74). This is pertinent to mental health because a growing body of evidence suggests that exercise is helpful in supporting good mental health (Vic Health, 2017, p.74).

Likewise mental health is strongly linked to physical health and overall quality of life. According to Women's Health Victoria's submission to the productivity commission (Women's Health Victoria, 2019), having a mental health condition increases the risk of every major chronic disease. Heart disease, high blood pressure, arthritis, back pain, diabetes, asthma, bronchitis, emphysema and cancer are all much more likely to occur among people with anxiety and depression and the gender differences are significant. Women with mental health conditions are much more likely to have asthma than women across Australia as a whole (70% more likely), while men are 49% more likely to have asthma with a mental health condition. As more women live with mental health conditions than men, overall, women are 23% more likely to be living with both a mental and physical health condition than men.

Violence Against Women

Violence against women comes in a number of forms and settings. Women are substantially more likely than men to have experienced sexual harassment in their lifetime 85% and 56%

respectively (AHRC, 2018) and we know that one-third of women (33%) have been sexually harassed since the age of 15, compared to fewer than one in ten (9%) men. Women are also significantly more likely than men to experience sexual assault, intimate partner violence, family violence, stalking and sexual harassment outside of the workplace (ABS, 2017b). Within the workplace, sexual harassment at work is one part of a continuum of violence and shares the same causes or 'drivers' as violence against women. At home, exposure to male violence: In Australia, two in every five women (41%) have experienced violence since the age of 15 years. Around one in three (34%) has experienced physical violence and almost one in five (19%) has experienced sexual violence.

The negative impacts of violence on women's health include poor mental health, in particular anxiety and depression, as well as alcohol and illicit drug use and suicide (VicHealth, 2017). An Australian study found that approximately 77% of women who have experienced three or four types of gender-based violence had anxiety disorders, 56% had post-traumatic stress disorder and 35% had made suicide attempts (Rees et al., 2011). A Victorian study found that 42% of women who died from suicide between 2009 and 2012 had a history of exposure to interpersonal violence, with 23% having been a victim of physical violence, 18% suffering psychological violence, and 16% experiencing sexual abuse (MacIsaac et al., 2018).

The following excerpt is taken from Women's Health Victoria's submission to the productivity commission:

Case study: Housing, family violence and mental health

Family violence is the single biggest cause of homelessness in Victoria. More than one third of women accessing homelessness services do so because they're fleeing family violence (Centre for Homeless Persons, 2012). The relationship between family violence and homelessness is complex, as it is often underpinned by a range of factors such as gender inequality, socioeconomic disadvantage and mental illness, as well as poor access to income support and housing (Centre for Homeless Persons, 2012). Women who have experienced domestic violence or abuse are at a significantly higher risk of experiencing a range of mental health conditions including post-traumatic stress disorder (PTSD), depression, anxiety, substance abuse, and thoughts of suicide (Department of Health, 2006). Compounding this, homelessness and inappropriate housing expose people to a wide range of risk factors for their mental and physical health and wellbeing. These include violence and abuse, harmful alcohol and other drug use, poor nutrition and sleep, severe social isolation, lack of amenities for self-care, disease, and even exposure to the elements. All of these are major stressors that are highly likely to compromise mental and physical wellbeing and pose additional challenges for providing continuing care (Department of Health, 2006). In contrast, safe, secure and stable accommodation is protective of health, including mental health (Thomson, Petticrew, & Morrison, 2001). Appropriate accommodation not only removes the risks associated with unsuitable accommodation or homelessness, but also provides a base from which a person with mental illness can focus on their recovery.

Change the Story (Our Watch, ANROWS, & VicHealth, 2015), Australia's national framework for the primary prevention of violence against women and their children, demonstrates that

disrespect towards women is one of the underlying drivers of high levels of violence against women. The framework makes it clear that there are particular manifestations of gender inequality that are most consistently associated with higher levels of violence against women. These gendered drivers are located in institutional, social, economic and political systems as well as the norms and practices of everyday life and our interpersonal relationships.

Change the story outlines the following key drivers:

- Condoning of violence against women
- Men's control of decision-making and limits to women's independence in public life and relationships
- Rigid gender roles and stereotyped constructions of masculinity and femininity
- Male peer relations that emphasise aggression and disrespect towards women.

The normalisation of gender inequity fosters an environment where violence and sexual harassment can flourish and which has specific impacts on the mental health of women.

Sexual and Reproductive Health

Reproductive autonomy is critical to the wellbeing of women. Women's Health Victoria's submission to the Productivity Commission outlines a number of sexual and reproductive health factors that influence wellbeing amongst women and gender diverse communities (Women's Health Victoria, 2019). Depression and anxiety are common in women with common reproductive health conditions like polycystic ovarian syndrome (PCOS). These conditions emerge during adolescence, though may not be diagnosed until much later. It has been shown that the longer it takes to receive a diagnosis of PCOS, the more likely women are to be depressed or anxious (Jean Hailes, 2018). While the rate is changing, it is estimated that 70% of Australian women with PCOS remain undiagnosed, and there is a lack of consistency in assessment and management of the condition (AFP, 2012).

Transgender communities are faced with significant barriers in regards to their sexual and reproductive health (SRH). These barriers include not only lack of access to health services and insurance but also stigma and discrimination, harassment, violence, and violations of rights (Gruskin et al., 2018). The SRH of transgender people can only be addressed with attention to the social, cultural, legal, historical, and political contexts in which people are situated, with social, psychological, medical, and legal gender affirmation as a key priority shaping any interventions into sexual and reproductive health.

Recommendations:

- Acknowledge the gendered social determinates of poor mental health for women, men and gender diverse people. Addressing inequity is key to changing the mental health rates and attempts at change should be linked to existing frameworks and strategies that are already in place. For example, *Change the Story,* the Victorian primary prevention strategy, *Free from Violence*, and the Victorian gender equality strategy, *Safe and Strong.*

- Support the implementation of gender equality legislation including the implementation of positive duties for public entities, and procured services, to promote gender equality. Increasing the longevity and impact of the legislation will impact on the mental health of women and marginalised communities.
- Build on existing expertise in the development of training and resources to accompany gender equity programs. The provision of training and the development of resources should draw on the existing expertise of the women's health services (WHS) and build on the current role they play in building the capacity of local organisations to advance gender equity. Victorian WHSs are already at the forefront of gender equity workplace development and can help embed the legislation within already existing processes, including the provision of specialist regional training and the implementation of any new procurement processes, Gender Action Plans and Gender Impact Analysis that will be encouraged under Victorian Gender Equality Legislation and which will impact on the mental health of women.
- Given the particular needs and experiences of women, a support service with expertise in women's mental health should be resourced to support and coordinate consumer input from women, such as the Victorian Women's Mental Health Network.
- To prevent the onset of early stressors for young girls and gender diverse communities, support and resource relationship and sexual and reproductive health education across the state.
- Challenge gender stereotypes and adopt multilevel strategies to change the norms and practices that directly harm women's health.
- Improve the evidence base for non-medicalised interventions. As part of this process, strengthen women's role in the research process and funding for women's health.
- Ensure collection of data disaggregated by sex, socioeconomic status, and other social stratifiers by individual research projects as well as through larger data systems at regional and national levels, and the classification and analysis of such data towards meaningful results and expansion of knowledge for policy.

2. An intersectional approach to mental health

Gender, as a social determinant of mental health, cannot be addressed without recognition that other forms of inequality intersect with gender. An intersectional approach means recognising that an individual's experience of gender inequality may be compounded by other forms of disadvantage and discrimination including, but not limited to racism, ableism, homophobia, ageism and classism. An intersectional approach is key to addressing mental health, wellbeing and illness. The following evidence speaks to the necessity of an intersectional approach to mental health.

Aboriginal and Torres Strait Islander

Aboriginal and Torres Strait Islander women are more likely than non-Aboriginal women to have left school at an earlier age, to be unemployed, to have experienced violence and to be the main carer for the family. Aboriginal and Torres Strait Islander women are hospitalised for self-harm at twice the rate of non-Aboriginal women and hospitalisation rates generally increase with level of disadvantage and degree of remoteness (AIHW, 2014). Suicide rates among Aboriginal and Torres Strait Islander women aged 15-19 are nearly six times higher

than the corresponding rates for non-Aboriginal young women (Suicide Prevention Australia, 2016).

Aboriginal and Torres Strait Islander women are a group of women who also face the worst of the welfare and prison system. In Australia, the number of incarcerated women has increased by 50% in the past five years (compared with 37% for men) (ABS, 2018). Aboriginal and Torres Strait Islander women are 21.2 times more likely to be incarcerated than non-Aboriginal women (ALRC, 2018). In Victoria, the number of women in prisons has increased by 137.8% and for Aboriginal women the rate is 406.7% (Flatout, 2019). Beyond Blue (2015) reports that the most common mental health condition in incarcerated Aboriginal women is PTSD which is often misdiagnosed or not diagnosed.

A complex range of social, economic and environmental factors influences the health and wellbeing of Aboriginal and Torres Strait Islander women. Aboriginal women play a critical role as leaders and advocates for their families and communities (Australian Institute of Health and Welfare, 2014). Centering their voices and engaging in community specific, community led initiatives is key to improving the mental health of Aboriginal women. In addition, any approach to the mental health of Aboriginal and Torres Strait Islander communities must take into account the social, economic and cultural issues that stem from colonisation and a lack of self-determination.

Trans and gender diverse communities

Gender as a binary harms us. Depressive symptoms, suicidality, interpersonal trauma exposure, substance use disorders, anxiety, and general distress have been consistently elevated amongst transgender and gender non-conforming populations, including those who do not identify with gender binary constructs (man or woman) (Valentine & Shipherd, 2018).

Sexuality is also a key factor in mental health rates. Lesbian and bisexual women, people with intersex characteristics and trans women are at increased risk of suicidal behaviour, being almost four times as likely as their cis/heterosexual peers to have tried to self-harm or suicide (Suicide Prevention Australia, 2016). Lesbian and bisexual women, people with intersex characteristics and trans women are at increased risk of suicidal behaviour, being almost four times as likely as their cis/heterosexual peers to have tried to self-harm or suicide (APO, 2016).

In relation to sexual and reproductive health, biological sex also plays a key role in mental wellbeing. Not only do people with wombs experience specific mental health conditions linked to their reproductive capacity such as post-natal anxiety and depression, the brain structure and response to stress also differ (Yu, 2018).

Migrant and refugee women

Migrant and refugee women are less likely than Australian-born women to use preventative and primary health and social support services (and as such are overly represented in acute and crisis care) and less likely to have access to evidence-based and culturally relevant information to facilitate decision-making around their health (MCWH, 2016). Mental health (anxiety, depression and post-traumatic stress disorder) (Kirmayer et al., 2011) and

reproductive health are also areas of increased risk for these women (Keygnaert et al., 2014). Residency and visa status determines different health access entitlements, rendering the Australian health system difficult to navigate and can restrict access to health services for some visa-holders (MCWH, 2015).

Migrant and refugee women also face interpersonal and institutional racism. Interpersonal racism, that is racism that is personally mediated via the expression of prejudicial attitudes and discriminatory behaviour, is a psychosocial stressor that adversely affects a broad range of health outcomes and health risk behaviours as documented in several recent meta-analyses (Priest, Perry, Ferdinand, Kelaher, & Paradies, 2017). Priest, Perry, Ferdinand, Kelaher, & Paradies (2017) investigated the impact of discrimination among children and adolescents from Indigenous and migrant backgrounds. They found that perceived direct racial discrimination had significant, negative effects on later depressive symptoms and on later loneliness. Addressing racism is key to address the mental ill-health of migrants and refugees.

Age

Australia has an ageing population that raises fundamental questions about national economic and social well-being (Commonwealth of Australia, 2010). An aging population has implications for mental health and these implications are gendered. According to the national body, Women in Super, the super necessary to live a comfortable standard of living in retirement is currently estimated at $545,000 for a single and $640,000 for a couple. Yet women in 2013/14, had an average balance of $138,150. In 2017, average superannuation balances for women at retirement (aged 60-64) are now 42.0% lower than those for men (Clare, 2017). Not only do women retire with less super, women over 55 are the fastest growing group facing homelessness. This group also have the lowest sense of safety in public in the OECD which has implications for the physical activities that women partake in and the future mental health rates of older women. Additionally, loneliness poses a significant health problem for a sizeable part of the population (Beutel et al., 2017). Loneliness is a predictor for depression, anxiety and suicidal ideation. One systematic review concluded the absence of supportive social relationships for older people had an impact on the health of older people that was equivalent to smoking heavily, and that being without social connections in older age was worse than drinking alcohol at unsafe levels. Moreover, social isolation was found to be more harmful than not exercising, and twice as harmful as obesity (Holt-Lundstad, Smith, & Layton, 2010). Social isolation and loneliness, particularly in older women and older LGBTIQ communities needs to be accounted for in public health initiatives and taken into account in the urban planning and architecture of our cities.

Class and socio-economic status

Globally we know that socio-economic status matters to mental health outcomes. Using data collected by the Global Burden of Disease datasets, Yu (2018) looked at the data in relation to Gender Inequality Index (GII), the GINI Index, and Gross Domestic Product (GDP) in 122 countries. Yu (2018) found that a significant correlation exists between gender inequality and mental health disparities. Gender disparities in depressive disorders are associated with a country's wealth. These findings can help to inform society, policy-makers, and clinicians to improve the overall health level globally (Yu, 2018).

A steady job or being engaged in the community is important to good health. Australia's unemployment rate is low, but this hides low workforce participation, and a serious problem with underemployment. Casual workers are often not getting enough hours, and more and more Australians are employed on short-term contracts. Women are overrepresented in casual, precarious work and the full-time average weekly ordinary earnings for women are 14.1% less than for men (ABS 2019, Average Weekly Earnings). In addition to disparities in earnings there is a disparity in terms of the unpaid care work that women partake in, in the home. The unequal distribution of unpaid care work reinforces gender stereotypes, such as the 'male breadwinner model' and gender inequality in unpaid care work contributes to the gender inequalities in the labour market (Workplace Gender Equality Agency, 2016)

Gendered inequities in the labour market and precarious employment has a profound impact on mental health (Mavromaras, Sloane, & Wei, 2015; Winefield, Delfabbro, Winefield, Duong, & Malvaso, 2017). It also impacts on physical health. Australia's Health Tracker by Socioeconomic Status, tracks health risk factors, disease and premature death by socioeconomic status. It shows that over the past four years, 49,227 more people on lower incomes have died from chronic diseases – such as diabetes, heart disease and cancer – before the age of 75 than those on higher incomes (Harris & Calder, 2017).

Recommendations:

- A gendered intersectional approach will help deliver the best mental health outcomes and improve access to and the navigation of Victoria's mental health system for people of all ages, including through providing culturally appropriate and safe services for marginalised communities.
- Adopt an intersectional approach to mental health, wellbeing and illness and identify opportunities to integrate intersectionality into public mental health practice, policy and research.
- Centre the voices of those communities, many who have experienced the 'worst aspects' of historical and current mental health systems, both in their own experiences or from the experiences of those that they have cared for.
- Prioritise the voices of individuals and communities impacted by high rates of mental illness. Foreground lived experience in the prevention and response to mental health and wellbeing.
- Echoing the calls of organisations such as Drummond Street Services, Women with Disabilities, Multicultural Centre for Women's Health, use co design, consultation, inclusion of consumers and carers and reporting mechanisms which can increase trust and ensure any mental health service acknowledges the real and distressing experiences many mental health system users have had.
- Resource specialist organisations such as Switchboard Victoria, Transgender Victoria, Multicultural Centre for Women's Health, Djirra, Women with Disabilities Victoria to organise community run programs and spaces and inspire organisations to be more inclusive and culturally appropriate and sensitive.
- In relation to rural and regional communities, utilise the existing women's health services to assist with the regional implementation of public mental health strategies to accommodate regional variability.

- Individuals are embedded within communities and need safe, accessible community spaces and resourcing. These spaces are all the more important for marginalised communities. Recognise mental health in local council plans and the Victorian public health and wellbeing plan (2019-2023) and resource community spaces accordingly.
- Equitable working conditions are key to achieving optimum mental health. Work with government, private and non-government sectors to address unequal access to opportunities, remuneration, recourse and collective bargaining in the workplace.

3. Primary Prevention of Mental Illness

In line with the perspectives of our members and the submissions by other prevention bodies, a primary prevention approach to mental illness is key to addressing the high rates of mental distress amongst women and marginalised communities. Primary prevention is a whole of community approach that emphasises the importance of the factors that are linked to the social causes of mental ill-health. Where possible, a primary prevention approach will help prevent mental distress and illness from starting or preventing an escalation of mental illness as soon as possible.

Prevention involves addressing inequity in the social determinants of health, inequities that have been discussed in varying degrees in this submission. Prevention involves recognising an individual or communities position in society impacts on their health. The lower the socioeconomic position of an individual, the worse their health. Social equity is key to achieving optimum mental health (Marmot, 2018). For this reason, primary prevention involves combining psychological approaches to mental health with social approaches to building more socially, economically and politically equitable societies. In particular, we need to address the essential structural dimensions of gender inequality (Sen & Östlin, 2008)

Recommendations:

- Adopt a whole of system intersectional approach to the prevention, early intervention and responses to mental health conditions. Investing in gender equality is evidence-based, cost-effective and a pre-requisite to achieve optimum mental health and wellbeing across Victoria.
- In line with the submissions of our members, addressing gender inequality will prevent mental illness, support people to recover from mental illness, early in life, early in illness and early in episode, through Victoria's mental health system, and in close partnership with other services, in particular Victoria's infrastructure of women's health services.
- Make the settings of daily life more supportive of population health. Invest in local health promotion and healthy settings initiatives which aim to modify the conditions of a setting itself (physical, social, economic, instructional, organisational, administrative, management, recreational or otherwise) and/or the structural conditions underlying it, in addition to influencing the people within it. This recommendation is in contrast to the many health promotion programs focused solely on modifying individual behaviors within settings.
- Incorporate concern with workforce planning and capacity and capability building to respond to changes in regional social and economic demographics. In addition,

provide evidence-based materials, and fund regional based training that includes unconscious bias and sexual harassment in the workplace, disclosure protocols around family violence and harassment in the workplace and resources.

- Ensure collection of data disaggregated by sex, socioeconomic status, and other social stratifiers by individual research projects as well as through larger data systems at regional and national levels, and the classification and analysis of such data towards meaningful results and expansion of knowledge for policy.

4. References

ABS. (2017a). Victoria records highest population rise of all States and Territories. Retrieved October 3, 2018, from http://www.abs.gov.au/ausstats/abs@.nsf/MediaRealesesByCatalogue/C508DD213FD43EA7CA258148000C6BBE?OpenDocument

ABS. (2017b). Personal Safety Survey. Retrieved January 31, 2019, from http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4906.0~2016~Main%20Features~About%20the%20Personal%20Safety%20Survey%20~2

ABS. (2018). Corrective Services. Retrieved May 21, 2019, from https://www.abs.gov.au/ausstats/abs@.nsf/mf/4512.0

Australian Family Physician. (2012). RACGP - Polycystic ovary syndrome - An update. Retrieved May 20, 2019, from https://www.racgp.org.au/afp/2012/october/polycystic-ovary-syndrome/

Australian Human Rights Council. (2018). *Everyone's business: Fourth national survey on sexual harassment in Australian workplaces*. Retrieved from https://www.humanrights.gov.au/our-work/sex-discrimination/publications/everyone-s-business-fourth-national-survey-sexual

AIHW. (2014). Suicide and hospitalised self-harm in Australia: trends and analysis, Table of contents - Australian Institute of Health and Welfare. Retrieved May 21, 2019, from https://www.aihw.gov.au/reports/injury/suicide-hospitalised-self-harm-in-australia/contents/table-of-contents

ALRC. (2018). Pathways to Justice–Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples. Retrieved May 21, 2019, from https://www.alrc.gov.au/publications/indigenous-incarceration-report133

APO. (2016). Suicide and suicidal behaviour in women – issues and prevention: a discussion paper. Retrieved May 21, 2019, from https://apo.org.au/node/56174

Australian Institute of Health and Welfare. (2014). Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people, Table of contents. Retrieved April 23, 2019, from Australian Institute of Health and Welfare website: https://www.aihw.gov.au/reports/indigenous-australians/effective-strategies-to-strengthen-mental-health-w/contents/table-of-contents

Beutel, M. E., Klein, E. M., Brähler, E., Reiner, I., Jünger, C., Michal, M., … Tibubos, A. N. (2017). Loneliness in the general population: Prevalence, determinants and relations to mental health. *BMC Psychiatry*, *17*(1), 97. https://doi.org/10.1186/s12888-017-1262-x

Beyond Blue. (2015). *The Family Business: Improving the understanding and treatment of Post Traumatic Stress Disorder among incarcerated Aboriginal and Torres Strait Islander Women*. Retrieved from Beyond Blue website: https://www.beyondblue.org.au/docs/default-source/research-project-files/bw0284-the-family-business-final-report.pdf?sfvrsn=6

Chen, J. (2017). *Intersectionality Matters: A guide to engaging immigrant and refugee communities in Australia.* (pp. 1–34). Retrieved from Multicultural Centre for Women's Health website: http://mcwh.com.au/downloads/Intersectionality-Matters-Guide-2017.pdf

Centre for Homeless People. (2012). *Family Violence and Homelessness*. Retrieved from https://chp.org.au/wp-content/uploads/2015/06/Family-violence-fact-sheet-FINAL.pdf

Clare R. (2017), Superannuation account balances by age and gender, December 2017, ASFA Research and Resources Centre, viewed 21 February 2019, https://www.superannuation.asn.au/ArticleDocuments/359/1710_Superannuation_account_balances_by_age_and_gender.pdf.aspx

Department of Health. (2006). Accommodation. Retrieved May 21, 2019, from https://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-p-mono-toc~mental-pubs-p-mono-bas~mental-pubs-p-mono-bas-alt~mental-pubs-p-mono-bas-alt-acc

Duggan, M. (2016). *Investing in women's mental health: strengthening the foundations for women, families and the Australian economy* (p. 70). Retrieved from Australian Health Policy Collaboration website: https://www.vu.edu.au/sites/default/files/AHPC/pdfs/investing-in-womens-mental-health.pdf

Flatout, (2019) *Under the Rader Presentation*. Retrieved June 27 2019, from https://prezi.com/view/radijDY7TplcO5IYBUZB/

Gruskin, S., Everhart, A., Olivia, D. F., Baral, S., Reisner, S. L., Kismödi, E., Ferguson, L. (2018). "In transition: Ensuring the sexual and reproductive health and rights of transgender populations." A roundtable discussion. *Reproductive Health Matters*, *26*(52), 1490624. https://doi.org/10.1080/09688080.2018.1490624

Harris, B., & Calder, R. (2017). Low-income earners are more likely to die early from preventable diseases. Retrieved June 25, 2019, from The Conversation website: http://theconversation.com/low-income-earners-are-more-likely-to-die-early-from-preventable-diseases-87676

Jean Hailes. (2018). PCOS. Retrieved May 20, 2019, from Jean Hailes For Women's Health website: https://jeanhailes.org.au/health-a-z/pcos

Keygnaert, I., Guieu, A., Ooms, G., Vettenburg, N., Temmerman, M., & Roelens, K. (2014). Sexual and reproductive health of migrants: Does the EU care? *Health Policy (Amsterdam, Netherlands)*, *114*(2–3), 215–225. https://doi.org/10.1016/j.healthpol.2013.10.007

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J.,Canadian Collaboration for Immigrant and Refugee Health (CCIRH). (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *CMAJ: Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, *183*(12), E959-967. https://doi.org/10.1503/cmaj.090292

MacIsaac, M. B., Bugeja, L., Weiland, T., Dwyer, J., Selvakumar, K., & Jelinek, G. A. (2018). Prevalence and Characteristics of Interpersonal Violence in People Dying From Suicide in Victoria, Australia. *Asia Pacific Journal of Public Health*, *30*(1), 36–44. https://doi.org/10.1177/1010539517743615

Marmot, M. (2018). Inclusion health: Addressing the causes of the causes. *The Lancet*, *391*(10117), 186–188. https://doi.org/10.1016/S0140-6736(17)32848-9

Mavromaras, K., Sloane, P., & Wei, Z. (2015). The scarring effects of unemployment, low pay and skills under-utilization in Australia compared. *Applied Economics*, *47*(23), 2413–2429. https://doi.org/10.1080/00036846.2015.1008762

Mission Australia, Black Dog Institute (2017) Youth mental health report: Youth Survey 2012-16. Mission Australia. Sydney. Available (direct download) from: https://www.missionaustralia.com.au/publications/research/young-people/706-five-year-mental-health-youth-report

Our Watch, ANROWS, & VicHealth. (2015). *Change the story: A shared framework for the primary prevention of violence against women and their children in Australia*. Retrieved from https://www.ourwatch.org.au/What-We-Do/National-Primary-Prevention-Framework

Platt, J., Prins, S., Bates, L., & Keyes, K. (2016). Unequal depression for equal work? How the wage gap explains gendered disparities in mood disorders. *Social Science & Medicine*, *149*, 1–8. https://doi.org/10.1016/j.socscimed.2015.11.056

Priest, N., Perry, R., Ferdinand, A., Kelaher, M., & Paradies, Y. (2017). Effects over time of self-reported direct and vicarious racial discrimination on depressive symptoms and loneliness among Australian school students. *BMC Psychiatry*, *17*(1), 50. https://doi.org/10.1186/s12888-017-1216-3

Rees, S., Silove, D., Chey, T., Ivancic, L., Steel, Z., Creamer, M., … Forbes, D. (2011). Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function. *JAMA*, *306*(5), 513–521. https://doi.org/10.1001/jama.2011.1098

Schomerus, G., Schwahn, C., Holzinger, A., Corrigan, P. W., Grabe, H. J., Carta, M. G., & Angermeyer, M. C. (2012). Evolution of public attitudes about mental illness: A systematic review and meta-analysis: Evolution of public attitudes. *Acta Psychiatrica Scandinavica*, *125*(6), 440–452. https://doi.org/10.1111/j.1600-0447.2012.01826.x

Sen, G., & Östlin, P. (2008). Gender inequity in health: Why it exists and how we can change it. *Global Public Health*, *3*(sup1), 1–12. https://doi.org/10.1080/17441690801900795

Strauss, P., Cook, A., Winter, S., Watson, V., Wright Toussaint, D., & Lin, A. (2017). *Trans Pathways: the mental health experiences and care pathways of trans young people.* [Summary of Results]. Retrieved from Telethon Kids Institute website: https://www.telethonkids.org.au/our-research/brain-and-behaviour/mental-health-and-youth/youth-mental-health/trans-pathways/

Suicide Prevention Australia. (2016). *Suicide and suicidal behaviour in women – issues and prevention: a discussion paper*. Retrieved from https://apo.org.au/node/56174

Thomson, H., Petticrew, M., & Morrison, D. (2001). Health effects of housing improvement: systematic review of intervention studies. Retrieved May 21, 2019, from https://www.ncbi.nlm.nih.gov/pubmed/11473906

Valentine, S. E., & Shipherd, J. C. (2018). A systematic review of social stress and mental health among transgender and gender non-conforming people in the United States. *Clinical Psychology Review*, *66*, 24–38. https://doi.org/10.1016/j.cpr.2018.03.003

VicHealth. (2017). *Physical activity across life stages-Youth (12-17) physical activity insights*. Retrieved from Victorian Health Promotion Foundation website: https://www.vichealth.vic.gov.au/media-and-resources/publications/life-stages

VicHealth. (2015). *Health Equity Summary Report*. Retrieved from Victorian Health Promotion Foundation website: https://www.vichealth.vic.gov.au/-/media/ResourceCentre/PublicationsandResources/Health-Inequalities/Fair-Foundations/Summary/Health-Equity_Summary-Report_Settings.pdf?la=en&hash=B2A5E839976105CC913F69857DB532203613C37E

VPSC. (2017). *State of the Public Sector In Victoria 2016-2017* (p. 90). Retrieved from Victoria Public Sector Commission website: https://vpsc.vic.gov.au/wp-content/uploads/2018/02/State-of-the-Public-Sector-In-Victoria-2016-2017-Final-Web-version-ISSN-2204-9096.pdf

Walby, S., & Allen, J. (2004). Domestic violence, sexual assault and stalking: Findings from the British Crime Survey. *Home Office Research, Development and Statistics Directorate*, 146.

Winefield, A. H., Delfabbro, P. H., Winefield, H. R., Duong, D., & Malvaso, C. (2017). The Psychological Effects of Unemployment and Unsatisfactory Employment on Young Adults: Findings from a 10-Year Longitudinal Study. *The Journal of Genetic Psychology*, *178*(4), 246–251. https://doi.org/10.1080/00221325.2017.1342594

Women's Health Victoria. (2019). The social and economic benefits of improving mental health-Women's Health Victoria's submission to the Productivity Commission Inequity. Retrieved from: https://whv.org.au/resources/whv-publications/submission-inquiry-social-and-economic-benefits-improving-mental-health

Yu, S. (2018). Uncovering the hidden impacts of inequality on mental health: A global study. *Translational Psychiatry*, *8*(1), 98. https://doi.org/10.1038/s41398-018-0148-0