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Submission to

Victorian Royal Commission into Family Violence

May 2015

Introduction

The Australian Women's Health Network thanks the Victorian Royal Commission into Family Violence for the opportunity to make a submission in this important and ground breaking work.

The Australian Women's Health Network

The Australian Women's Health Network (AWHN) provides a national voice for women's health issues, with woman centred analysis of health care models and research. AWHN adopts a social view of health within a health promotion framework, drawing on a variety of interventions with an aim to prevent women's illness, disease and injury, and to promote women's independence, health and wellbeing. Further information about the organisation and how to become a member can be found on the AWHN website.

In its membership AWHN has representatives from across Australia in all States and Territories with a membership base of 137 organisations and individuals. Many of these members are part of Australia's strong, independent and thriving women's health sector with skills and experience in health promotion and primary prevention.

In 2014 AWHN developed the ***AWHN Health and the Primary Prevention of Violence Against Women*** position paper with the assistance of a review panel made up of AWHN members.

This paper articulates the AWHN position on the primary prevention of violence against women for their improved health and well-being. The paper:

- proposes a position on primary prevention (as distinct from secondary and tertiary interventions)
- identifies good practice principles for primary prevention programs and factors for success for programs, based on practice across different settings
- provides a review and analysis of the implications of the Commonwealth, State and Territory Plans to prevent violence against women
- presents a resource for public education, debate and community consultation activities related to primary prevention.

The position paper draws on Australian and international peer reviewed work based on empirical evidence, however, because prevention of violence against women is a relatively new field of research, it also draws on the extensive grey literature on the topic.[1]

This submission draws heavily from this position paper.

In addition, this submission draws from the ***AWHN Women and Mental Health Position Paper*** 2012 and ***AWHN Women's Health: Meaningful Measures for population health planning*** 2013.

These three papers are attached.

[1] Grey literature is all that material which is not subject to peer review, i.e. peer reviewed journals and books (Alberani, Peitrangeli & Mazza, 1990). This may include reports, newsletters, pamphlets, web sites and other print and digital media sources.

The author of this submission is Marilyn Beaumont, AWHN National Board Chair since 2012. Her experience in the women's health sector includes as a registered general and psychiatric nurse with marginalised populations including homeless women and women in the corrections services and as CEO of Women's Health Victoria (WHV). During her period with WHV, advocacy on the health costs of intimate partner violence and the need for them to be considered in health impact assessments, and in particular Victorian burden of disease estimates, provided the impetus for the ground breaking research funded by VicHealth/Department of Human Services known as ***Health Costs of Violence – Measuring the burden of disease caused by intimate partner violence.*** She also led WHV in the testing of primary prevention tools through collaboration with VicHealth and LinFox from 2007 to 2012 with the development of the ***Take a Stand Partnership Program.*** This Program helps prevent violence against women before it occurs by working with businesses to change attitudes and behaviours that support violence against women.

QUESTION 1: Are there other goals the Royal Commission should consider?

AWHN is seeking the Royal Commission's consideration of making recommendations on:

- **a definition for primary prevention of violence against women and the elements of a primary prevention initiative**
- **the workforce needs for primary prevention.**

Royal Commission goals are stated in the Issues Paper as follows:

> In keeping with its Terms of Reference, the Royal Commission aims to make recommendations which:
>
> - foster a violence-free society
> - reduce and aim to eliminate family violence
> - prevent the occurrence and escalation of family violence
> - build respectful family relationships
> - increase awareness of the extent and effects of family violence
> - reinforce community rejection of the use of family violence
> - ensure the safety of people who are or may be affected by family violence, by:
>   - facilitating early intervention before violence occurs
>   - providing fast, effective responses to those who report family violence
>   - providing effective protections to adults and children who have been affected by
>   - family violence in the past, and remain at risk of family violence
> - support adults and children who have been affected by family violence
> - hold those who have been violent accountable for their actions
> - help people who use or may use family violence to change their behaviour

- develop and improve the means by which solutions to family violence are implemented and assessed.

AWHN welcomes the strong intention to prevent violence before it occurs which the first six dot points above reiterate. These being first, followed by responses to violence after it occurs, was heartening.

Primary prevention is a public health approach that aims to prevent violence from occurring in the first place. It is advocated as an effective means of working towards the elimination of all forms of violence against women. Primary prevention must focus on changing the culture/s that operate to make gender based violence acceptable. This is sometimes referred to as culture, or cultural change.

This requires high level leadership, a concerted long term commitment and action across all sections of society and all levels of government.

AWHN submits that there isn't a gap in the Royal Commission's goals, but experience has shown that work in the area of prevention of family violence falls short of primary prevention. It most often falls back to secondary or tertiary interventions without those responsible for this even being conscious that that is what they are doing. It is a particularly hard conversation to challenge their work as not being primary prevention.

According to the report from the United Nations (UN) Expert Group meeting in 2012, primary prevention remains a poorly understood concept across sectors and between stakeholders. It is often conflated with early intervention or the response to existing violence, or else limited to awareness raising or social marketing campaigns (UN Women, 2012). Education programs or sessions are frequently used in primary prevention, however, short, one-off education programs that are **not linked with a comprehensive program do not meet the criteria for being primary prevention**.

It is important to recognise that primary prevention in the field of preventing violence against women is a new and emerging field and practitioners may face challenges as they learn from experience.

One of these challenges is to ***m*aintain a focus on primary prevention rather than be drawn into tertiary and/or secondary prevention**. Because tertiary work is more visible and tangible, funding bodies may try to combine response and prevention in one program. The response sector has historically struggled to provide safety and support for women who are victims of violence and it is vital that resources should not be taken from these services, and that they should not have to compete for limited funding with the primary prevention sector.

Prevention requires specific skills which are different to those required for crisis response, and it is important that the workforce for each has a clear understanding of its roles and responsibilities and works together co-operatively. While the reason for running primary prevention programs is to eliminate violence against women, the focus of programs must be on the underlying causes. That is, the power imbalance, gender inequality between men and women and associated cultures of disrespect and abuse. These are the factors that give rise to, or create the conditions that lead to gender based violence. These conditions include the structural barriers of gender inequality and gender role socialisation, and the social norms that ignore, condone or support violence against women.

Whilst recognising that secondary and tertiary interventions and responses to violence when it occurs are important to minimise harm, we seek substantial outcomes from the Royal Commissions work which clearly relates to the intention, in the particular goals, to foster a violence-free society and reduce and aim to eliminate family violence, that is, to prevent violence.

To achieve the goal of preventing violence against women it is imperative that funding for evidence based ***primary*** prevention programs and research is not only maintained, but also expanded as new knowledge and understanding emerges.

QUESTION TWO: The Royal Commission wants to hear about the extent to which recent reforms and developments have improved responses to family violence, and where they need to be expanded or altered.

Responses to family violence have included a heightened awareness and public discourse around the need to prevent violence before it occurs often through community events. However, most of the reform, as such, relates to a more effective and timely response to the occurrence of violence.

Whilst significant work has been done within Victoria, possibly more than other jurisdictions including nationally, there has not been a comprehensive and funded reform focus on the cultural change necessary to achieve and sustain the extent of cultural change necessary for gender equality.

Culture has been described as a way of making sense of the world through shared understandings and constructed meanings – about the cultivated stories, myths, symbols and rituals that make sense of what groups have done, are doing and will do (Giddens, 1979). Because culture is continually emergent, negotiated and in play, change is possible. The strategies that are used to bring about culture change may include education, community mobilisation, social marketing, events (such as White Ribbon day or International Women's Day breakfasts and other community events), structural and policy changes and a myriad of other approaches. It is important to note that any one of these strategies implemented on a stand-alone basis does not meet the criteria for being primary prevention.

The work of primary prevention of violence against women is about changing the attitudes and behaviours that lead to some men abusing power by socially, emotionally or physically controlling or being violent against women. These are the factors that give rise to, or create the conditions that lead to gender based violence and abuse. These conditions include the structural barriers of gender inequality and gender role socialisation, and the social norms that ignore, condone or support violence against women (Quadara and Wall, 2012).

A major area of expansion of family violence response reform is needed within mainstream primary, secondary and tertiary health services. This submission outlines two areas for increased focus:

A. **Health services as workplace settings for prevention**
B. **Integrate the evidence into clinical practice about the health impact of violence against women and their children, in particular, in pregnancy and the relationship between violence and women's mental illness.**

A. Health services as workplace settings for prevention

The understanding that the workplace is an important setting for prevention programs is evident in policy and programs. The previous Victorian Labor Government policy *A Right to Respect Victorian Plan to Prevent Violence Against Women 2012-2020*, stated that the workplace is an important setting

for the prevention of violence against women, first because women experience high levels of violence *within* the workplace, and second because workplaces are effective contexts for addressing violence occurring *outside* the workplace setting. Workplaces are also important because of their unique potential to reach and support vulnerable or isolated groups who may have limited access to other settings. The research indicates that a holistic model for workplace-based prevention of violence against women, which encompasses all of the above, would be best practice.

One of the most convincing rationales for workplace-based prevention suggested by the VicHealth Framework was that workplaces are organisational contexts through which social norms are shaped and can be changed.

Primary, secondary and tertiary health services are workplaces that have been slow to be involved as settings for violence prevention. They are major employers of a significant proportion of their local communities, are well distributed across the state and play a very important role in rural areas.

This distribution includes being within communities where the data shows a high level of reported family violence. Health service staff are members of these communities. It must therefore be assumed that there is an equivalent proportion of health service staff living in these communities who live in domestic violence situations.

This submission makes two key points about health workplaces as settings for prevention.

1. **Health professionals and support staff should be involved in organised workplace based training to: identify their own violence supportive behaviour; gain the skills and confidence to speak up when they hear or see attitudes or behaviours that support violence against women; and, implement policy and strategies which identify workplace support for workers who are experiencing or witnessing violence.**
2. **This should be in addition to the activity to prevent violence in the workplace from other staff and patients and their families.**

B. Integrate the evidence into clinical practice about the health impact of violence against women and their children, in particular, during pregnancy and also the relationship between violence and women's mental illness.

1. Health impact of violence and health sector clinical practice

VicHealth *Health Costs of Violence Measuring the Burden of Disease Caused by Intimate Partner Violence* (2004, p 21) report provides a summary of known health outcomes of intimate partner violence as follows:

Fatal impacts

- Femicide
- Suicide
- Life-threatening sexually transmitted infections (eg HIV)
- Death of mother or infant during or following childbirth

Non-fatal impacts

Physical injuries:

- Bruising
- Lacerations or tears
- Fractures

Reproductive health:

- Sexually transmitted diseases
- Urinary tract infections
- Human papilloma (wart) virus
- Abnormal pap tests
- Termination of pregnancy
- Complications of pregnancy (eg inadequate weight gain, infections during pregnancy, miscarriage, haemorrhage, low birth weight)

Mental health:

- Attempted suicide
- Self-harming behaviours
- Depression
- Anxiety
- Eating disorders
- Traumatic and post-traumatic stress symptoms
- Other psychiatric disorders such as phobias and dissociative and somatisation disorder (involving the physical expression of psychological symptoms)

Behaviours and practices affecting health:

- Harmful tobacco and alcohol use
- Illicit and licit drug use (eg tranquillisers and sleeping pills)

Other:

- Sleep problems
- Gastrointestinal and digestive disorders
- Chronic pain disorders (eg headaches, neck pain)

The research behind the VicHealth (2004) report demonstrated that while women experiencing intimate partner violence were high users of generalist primary, secondary and tertiary health services there was frequently a poor outcome from this service seeking. In addition, there is evidence of prescribed drug addiction arising from this service seeking.

The report challenged the health sector to become one of the driving forces for change in the bid to reduce violence against women. Over the ten years since the report was published this has not occurred. The health impact of violence against women has not been translated into health professional graduate and post graduate education programs or into clinical practice in generalist primary, secondary and tertiary health services.

It is interesting to note in the previous Victorian Coalition Government's ***Victoria's Action Plan to address Violence against women and their children*** 2012 (p12) that while the signatories to the policy demonstrated a cross government commitment, the Minister for Health was not one of the signatories. This policy did begin to highlight the role of the health sector by outlining further workplace based initiatives for action as follows:

- Further extend Family Violence Risk Assessment and Risk Management Framework in Health Sector – to Mental Health and Drug and Alcohol providers, Hospitals, GPs, Ambulance staff and to Emergency Management personal support and recovery staff.
- Strengthen hospital responses to family violence – develop a project to review and improve quality processes which strengthen hospitals' responses to family violence and optimise their relationship with the integrated family violence system.

Systemic change is required within health services. Whether domestic violence is identified by routine enquiry or by other approaches to case-finding, it is essential that health care providers are resourced through training, policies and protocols to respond in ways which have been identified by survivors as helpful and empowering.

Without diminishing the importance of general understanding and application of knowledge in practice across health service provision, two particular priority areas are outlined.

2. Women and pregnancy

Australian Domestic and Family Violence Clearinghouse Issues Paper 6 published in 2002, identified:

> …that pregnancy may be one of the few times when chronically abused women are permitted to go to the doctor. As almost all Australian women have regular contact with the health system when they are pregnant and for up to a year afterwards, it is a unique opportunity for beneficial intervention in the lives of women who are victimised. It is vitally important that the Australian health system, and birthing services in particular, are safe, confidential places where women receive effective support and high quality care if they disclose abuse. How prepared the Australian health system is to respond to these challenges is questionable. There is evidence in Australia and overseas which suggests that between four and eight or nine in every hundred pregnant women are abused during their pregnancy and/or after the birth. It also shows that when women are abused, they are less likely to have planned the pregnancy or to want it. Further, evidence from overseas indicates that there is a significant proportion of abused women among those seeking to terminate their pregnancies.
>
> However, most health care providers are unfamiliar with the violence support system/services, unsure how to access them and unaware of the special referral processes necessary to support abused women or monitor men who abuse. These services are not specific to pregnant or postpartum women.
>
> Health services, especially birthing services, have a unique opportunity to intervene beneficially.

There is significant opportunity to develop better practise in primary prevention of violence against women and intervention where there is evidence of violence in services around sexual and reproductive health and in the ante natal period.

3. Women and mental illness

The ***AWHN Women and Mental Health Position Paper 2012*** addresses violence against women (p.15).

There are many hypotheses concerning the multiple interactions of biological, social, cultural, economic and personal contexts impacting on women's mental health. Violence against women, childhood abuse, poverty, homelessness and substance abuse are key social determinants of mental illness in women. Life events, including biological life-cycle events such as childbirth and menopause, may trigger the onset of a mental illness, and individual characteristics may influence the development and severity of symptoms (Zubin et al., 1992). Early childhood experiences play a significant role in determining future mental health and rates of childhood sexual abuse are higher in women than men (approximately 3:1) (MacMillan et al., 2001). In particular, physical, emotional, and sexual abuse in childhood may predispose women to the development of mental illness later in life. Intimate partner violence has also been associated with a high prevalence of major depression (63%) and post-traumatic stress disorder (PTSD) (40%) in women (Campbell and Lewandowski, 1997).

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).

The National Plan to Reduce Violence against Women and their Children 2010–2022 sets out six national outcomes for all governments to deliver during the next 12 years. **However, the lack of explicit mental illness follow-up or linkage with mental health services (or indeed any mainstream health service connection) is a shortcoming in this National Plan that urgently needs to be addressed. This shortcoming should be addressed in the Victorian response. In addition, investment should be made in further research in this area.**

QUESTION THREE: Which of the reforms to the family violence system introduced in the last ten years do you consider most effective? Why? How could they be improved?

As a national organisation, AWHN has gathered information from service providers all over the country to inform this submission. Although we cannot comment on the particular Victorian reforms, we would however make two key points:

1. Primary prevention is not considered to be part of the family violence system which is about the response to violence. The majority of primary prevention practitioners work in agencies well outside this system.
2. To be defined as primary prevention the strategies must challenge the attitudes and behaviours that are violence supportive whilst changing the structural supports that maintain gender inequality. Education programs, awareness raising and community mobilisation are all important, but alone do not constitute primary prevention. A comprehensive, multi-level, integrated approach is needed for primary prevention. Primary prevention should actively address multiple and intersecting forms of discrimination and disadvantage that place women and girls at risk of violence (UN Women, 2012). Primary prevention of gender based violence must focus on changing the culture/s that operate to make gender based violence acceptable and is sometimes referred to as culture or cultural change.

QUESTION FOUR: If you or your organisation have been involved in programs, campaigns or initiatives about family violence for the general community, tell us what these involved and how they have been evaluated.

As a national organisation AWHN has gathered information gathered information from service providers all over the country to inform this response.

Women's health and health promotion approaches during the current decade have demonstrated that primary prevention programs can be carried out in 'settings', or the places where people in communities live, work, play and age (Peersman, 2001). A settings approach makes it possible to target specific groups with appropriate programs – in (among others) sports clubs, schools, workplaces and faith settings, as well with specific population groups including children, young people, people with physical and intellectual disabilities, Indigenous and culturally and linguistically diverse people.

VicHealth has led the way in piloting violence prevention programs across a range of settings. In 2012, ***The Respect, Responsibility and Equality program: A summary report on five projects that build new knowledge to prevent violence against women*** was published which provided an overview of five

settings based programs that built capacity to promote equal and respectful relationships in various settings. A number of AWHN member agencies and individuals were involved in this work.

To implement a primary prevention approach the use of a social/ecological model for change has been advocated. The social/ecological model has been proposed for both understanding violence and for prevention activities. The model suggests that rather than being a simple phenomenon, violence is the result of the complex interplay of individual, relationship, social, cultural and environmental factors. The model works at three levels, individual/relationship, community/organisational and societal, each of which is interdependent with the other.

The social/ecological model suggests that the problem of violence against women is essentially one of culture and environment, rather than one of deficits in individuals. Solutions involve changing social norms and behaviours, and require the active involvement of all levels of the community. The premise of this model is that violence is a function of the abuse of power and control, and it aims to bring about social change to create an ethical setting where individuals are not exploited, power is not abused and all members of a community are involved (Maton, 2000). It has been argued that this model has the capacity for social transformation of individual and community values and norms. Change depends on interventions occurring at multiple levels, ranging from individuals through to society, and from society down to the individual (Dyson and Flood, 2008). In this model:

- The **societal level** seeks to understand the cultural values and beliefs that shape the other two levels of the social ecology and change institutional and cultural support for, and weak sanctions against, gender equality and rigid gender roles. The role of governments is emphasised in providing an 'enabling' environment through policy and legislative reform to promote gender equality and women's empowerment.
- The **community/organisation level** works on the formal and informal social structures that impact on individuals such as norms concerning gender equality, masculine peer norms and organisational values.
- The **individual/relationship level** focuses on developmental and personal factors that shape responses to stressors in the environment such as rigid gender roles, weak support for gender equality, attitudes of masculine entitlement and superiority, and male dominance and control of wealth in relationships, as well as on promoting respectful relationships (World Health Organisation, 1986, Victorian Health Promotion Foundation, 2007).

QUESTION FIVE: If you or your organisation has been involved in observing or assessing programs, campaigns or initiatives of this kind, we are interested in your conclusions about their effectiveness in reducing and preventing family violence.

The AWHN *Health and the Primary Prevention of Violence Against Women* position paper reiterates the use and application of good practice principles outlined by VicHealth in 2007 as follows:

1. Good practice in primary prevention

In 2006 the UN Secretary General reported to the General Assembly on the *In-Depth Study on All Forms of Violence against Women*. The report articulated general principles, based on international

evidence, for good practice in prevention. These principles can be applied to all programs and are mapped out in AWHN's position paper against the levels of the ecological model:

Societal level: prioritising the prevention of violence against women in all policies and programs; allocating specific resources within all sectors for prevention activities, and seeking political support for sustained, long-term investment in prevention (UN General Assembly, 2006). Community and media programs should also be supported by government laws and policies that promote gender equality (World Health Organisation, 2009).

Community/Organisation Level: developing prevention strategies that address the root causes of violence against women, particularly the persistence of gender-based stereotypes; outlining clear objectives, defining what prevention strategies are seeking to change and how; and putting in place a process of monitoring and evaluation. Working with a cross-section of stakeholders, including government bodies, NGOs, workers' and employers' organisations and local community leaders, to build inclusive and effective strategies; and promoting women's safety, including by altering physical environments where necessary.

Individual/relationship level: engaging men and boys proactively in strategy development and implementation for the prevention of male violence against women; highlighting the fact that violence against women is unacceptable and its elimination is a public responsibility; ensuring that prevention efforts are holistic, take into account multiple discrimination and connect wherever possible with other key issues for women (UN General Assembly, 2006).

Evidence from the VicHealth projects (2012) demonstrate that prevention programs need to be developed using a consistent, evidence based framework. When planning a prevention initiative it is vital to consider how this work can complement and reinforce similar approaches occurring at other levels. In this way multiple settings and sectors can work coherently to build the necessary momentum to effect long term cultural change. For example, an education program in a sports club or school may have a primary focus on the individual/relationship level of the social ecology, but it can draw upon examples of respect in the wider community by using 'teachable moments'[2] from the media or current affairs to encourage participants to think more broadly than their own immediate lives and relationships.

Many small and medium sized programs are currently in progress in communities across Australia; as these programs develop a growing body of knowledge is emerging from practice. The combined effect of this will create a groundswell of momentum and lead to the kind of long term cultural change that is required for the ultimate elimination of violence against women and the creation of a society in which all people are equal, and respectful relationships and behaviours are the norm.

2. Principles for community mobilisation

In addition to the comprehensive principles for prevention (discussed above), other sources have articulated principles for community mobilisation and prevention education.

The World Health Organisation (2007) identified principles for conducting community based primary prevention education. These include: the use of participatory methods for effectively engaging participants; fostering an enabling social environment to increase the likelihood that positive

[2] Teachable moments are those times when a significant event occurs that can be used to 'educate' groups or individuals. For example, incidents of blatant disrespect or of gender inequality in the media or current affairs can be used as the basis for facilitated discussion to focus on what could have been done differently. Teachable moments are suggested as a strategy for Soccer's *Coaching Boy's into Men* program.

behaviour change will be sustained; employing and training facilitators with high quality skills; providing long term follow-up to support and sustain changes brought about by the program; and combining education with wider advocacy and community mobilisation activities.

A community mobilisation approach that reaches each level of the ecology has been advocated by Michau (2005). This includes:

A proactive approach: primary prevention assumes that it is not enough to provide services for women experiencing violence, or to promote prevention without challenging communities to examine the assumptions which perpetuate it. The root causes of violence against women must be addressed through gender based analysis of why violence occurs – such as the imbalance of power between women and men and rigid gender roles.

A holistic approach: violence prevention should be relevant and recognise the multifaceted and interconnected relationships between individuals and institutions. The complex histories, cultures and relationships that shape a community must be acknowledged and accommodated. To generate momentum for change a wide cross section of community members must be engaged, not just women or one sector, such as police or the health care system.

A process of social change: changing attitudes, values and norms is a process, not a one off event. Projects should be based on an understanding about a systematic process of change, implemented by skilled facilitators who can guide a community on a journey of change.

Repeated exposure to ideas: individuals should be exposed to regular reinforcing messages from a range of sources over a sustained period of time. This means a co-ordinated approach across sectors with faith, school, sports, and arts communities, the media, and workplaces all communicating the same messages about violence against women being unacceptable under any circumstances, and respect and equality being desirable in relationships.

Community ownership: organisations can play a role in facilitating change, but it is in the hearts and minds of the individuals and groups in a community where change must occur. Therefore, it is those individuals and groups who must engage with and lead change.

3. Principles for prevention education

Violence prevention education programs are directed at children, young people and adults in a range of settings. Research in the USA noted a paucity of evidence concerning prevention education programs with young people that demonstrate disrupting sexually violent behaviours. Tharp et al. argue that programs have forgone 'the standards of evidence and the principles of prevention to move a program more quickly into practice' (Tharp et al., 2011, p. 3384). To identify principles for prevention, these authors turned to prevention programs in areas such as delinquency, substance abuse, sexual risk and school failure, which they claim have demonstrated effectiveness. The principles identified include that programs should be comprehensive, use varied teaching methods, be theoretically driven, promote positive relationships, be appropriately timed in development, socio-culturally relevant, and employ well trained staff to ensure adequate implementation and are of sufficient 'dosage' to create behaviour change (Tharp et al., 2011).

In Australia work has also been done on developing principles for violence prevention. For example, the Social Justice and Social Change Research Centre at the University of Western Sydney identified six standards for education programs to prevent sexual assault, which extend to both community and school based programs (Carmody et al., 2009). The same year VicHealth also developed principles for respectful relationships education (Flood et al., 2009). Rather than go into detail about each authors'

principles, here, they are synthesised, as they are remarkably similar. Both reports suggest that programs must:

- be comprehensive
- be theoretically driven and address cultural and developmental concerns
- engage educators who are well trained and skilled in prevention education techniques, and use a positive, enabling approach
- use participatory approaches to effectively engage participants, and
- be subject to rigorous evaluation.

Research has demonstrated that to be effective, programs with school aged students should be part of a whole school approach[3] that promotes an ethos of equality, respect and non-violence throughout the school community, supported by policies (Flood et al., 2009, Dyson, 2008, Dyson et al., 2011). School programs should also be supported by community interventions that work to effect change in individuals and whole communities by addressing gender norms, and media interventions such as public awareness campaigns that challenge gender norms and attitudes through awareness raising activities.

Didactic approaches are unlikely to be effective in education programs. A number of alternative approaches to education shift the power focus away from the educator towards empowering learners. Critical pedagogy, founded by Paolo Friere, is concerned with the idea of a just society in which people have economic, political and cultural control over their lives (Aliakbari and Faraji, 2011). According to Freire (2005) traditional education works on a model that assumes information can be 'banked' by educators who hold 'knowledge' into students who are empty vessels and recipients of information; in this model, teachers are authorities and students (regardless of their age) are obedient to their authority (Friere, 2005). Individual learning styles differ, and varied approaches are appropriate to maximise learning in any group. Much learning is non-formal and essentially a social process. 'Learning is not just a psychological process, but is intimately related to the world and affected by it. People take on the knowledge, values, beliefs and attitudes of the society in which we live' (Jarvis, 1987, p. 11). Action learning is one form of critical pedagogy that is about learning from concrete experience and critical reflection, through group discussion, trial and error, discovery and learning from one another. It is a process by which groups of people work towards change on real issues or problems (Zuber-Skerritt, 2001).

Based on the principles for primary prevention programs identified above for community and education programs, the following questions are proposed to guide practitioners planning a program to assess whether it meets the criteria for being primary prevention:

- Does it address sexist norms and promote gender equality?
- Is it comprehensive, contextualised and relevant to the setting and the individuals in it?
- Does it focus on structural as well as individual contributors to the problem?
- Does it have a clear program logic that is theoretically and empirically informed?

[3] A whole school approach is advocated as part of health promoting schools. This involves not only working with students and on the curriculum, but also addressing the health issue in school policies, the overall ethos and environment in the school and by engaging the wider school community including staff members, parents, students and relevant local community agencies.

- Does it emphasise a positive, strengths based developmental process?
- Is it (or will it be) evaluated?

4. Principles for awareness raising campaigns

Awareness raising campaigns are an important component of a comprehensive primary prevention approach. They should aim to change attitudes, behaviours and beliefs that normalise and tolerate gender based violence. Awareness-raising campaigns are recognised as the efficient and effective means of communicating information to the general public. Awareness raising should take a top down, bottom up approach, fostering communication and information exchange in order to improve mutual understanding as well as mobilising communities and the whole society to bring about the necessary change in attitudes and behaviour (European Institute for Gender Equality, 2013). They should have: a strong basis in human rights and gender analysis; clear, appropriate, comprehensive definitions of violence; take a women/victim-centred approach; hold men/perpetrators accountable for the violence they inflict; emphasise equality and anti-discriminatory practice; and recognise the diversity of women and men.

In Australia, VicHealth undertook a review of awareness raising campaigns and identified a number of principles for implementing such programs. These include:

- Pretesting, and 'on the ground' activities to avoid undesirable and unintended consequences of awareness campaigns (e.g. normalising abuse). Preparation for increased awareness also needs to include interagency responses and referral networks, so that responses to the campaign can be appropriately addressed.
- Need for a campaign to be based on social marketing and health promotion theory, and for it to be developed using formative research with thorough pretesting.
- Developed from a theoretical base and/or had been developed using research or pre-testing. The authors also noted that few campaigns had been evaluated (Donovan and Vlais, 2005).

5. A Strengths Based approach

A strength based approach calls for programs to be positive, inclusive and enabling. Health promotion theory suggests that to be effective, programs must be 'salutogenic' (Antonovsky, 1996). Traditional, disease focused approaches to health use a 'pathogenic' model that sit at one end of a continuum of approaches to health and well-being while salutogenesis sits at the other. Salutogenesis argues that health can be an asset held by individuals and groups which can promote positive well-being (Glasgow Centre for Population Health, 2011). In the salutogenic, or asset based approach, one type of intervention aims to strengthen resources such as self-management, community networks, and another aims to create meaning – interventions to increase perceptions of control (Harrop et al., 2006). An asset based approach makes visible and values the skills, knowledge, connections and potential in a community. It promotes capacity, connectedness and social capital (Glasgow Centre for Population Health, 2011). In primary prevention programs, it is important that they are positive, strengths based and that participants are engaged as partners in the change process, not as potential victims or perpetrators. This means not focussing too much on the negative aspects of abuse and disrespect, but focusing on promoting equal and respectful relations between women and men. It also means recruiting women and men as partners in prevention so that they take responsibility for identifying changes and making them happen.

QUESTION SIX: What circumstances, conditions, situations or events, within relationships, families, institutions and whole communities, are associated with the occurrence or persistence of family violence?

AWHN's submission outlines the link between violence against women and health and between gender inequality and violence against women.

Gender-based violence is a complex social problem with serious health consequences. Recognition of the social nature of violence against women is central to efforts to eliminate it. A strong link has been established between gender based violence and the systemic inequalities rooted in structural power imbalances between men and women (UN General Assembly, 2006).

There is a strong association between sexist peer norms, low status of women and violence against women (Dyson and Flood, 2008; Flood, 2011; UN Division for the advancement of women, 2008; Victorian Health Promotion Foundation, 2010). Violence supportive attitudes and behaviour can be found almost anywhere, and recognised as: lack of support for gender equality; belief in the inferior status of women in relation to men; sexual harassment and coercion; bullying, abusive or controlling behaviours, or group disrespect (demonstrated by rude, aggressive behaviour, consumption of pornography, sexualising women, group consumption of alcohol, and rape supportive attitudes).

In 2013 AWHN produced the ***AWHN Women Health: Meaningful measures for population health planning*** resource which demonstrates the places where health and gender inequality intersect. This resource arose from the view that what gets counted matters and the evidence that Australian health policy and planning has tended to overlook the social determinants of women's health and continues to remain 'blind' to prevailing gender hierarchies and their resulting systematically inequitable distribution of power, prestige and resources between women and men. It provides a snapshot of the social determinants of women's health. These are the social and economic circumstances of women's lives (such as their socio-economic disadvantage). Such circumstances result from the inaccessibility to women of key requisites for a healthy life which can also be meaningfully measured (such as economic and social participation). In turn, this can expose women to health behaviours and/or risk factors for poor health (such as stress or self-harm) that can result in a myriad of health problems (such as mental health issues) – all of which can be meaningfully measured.

In addition, the resource throws a spotlight on the underpinning drivers of women's socio-economic positioning. These are the deeply entrenched structural mechanisms that stratify society along gender lines, and produce and maintain gender hierarchies in relation to power, prestige and access to resources that are the key requisites for a healthy life.

Although this resource was developed with and for population health planners and health status data collectors, it contains a visual, conceptual framework to demonstrate how we need to focus on the structural inequalities if we are to achieve better health outcomes for women.

If we are to achieve the Royal Commissions goal of reducing or elimination violence against women there must be a better measure of progress than currently exists. AWHN's ***Women Health: Meaningful Measures*** conceptual framework may be useful in the Royal Commissions deliberations about how we measure progress in achieving the goal.

We note and welcome the recent release by the Victorian Minister for the Prevention of Family Violence Fiona Richardson MP about work to develop a family violence index. The release identifies that it is intended that this bring together data from across the fields of crime, justice, health, education and our community to create a single indicator of family violence.

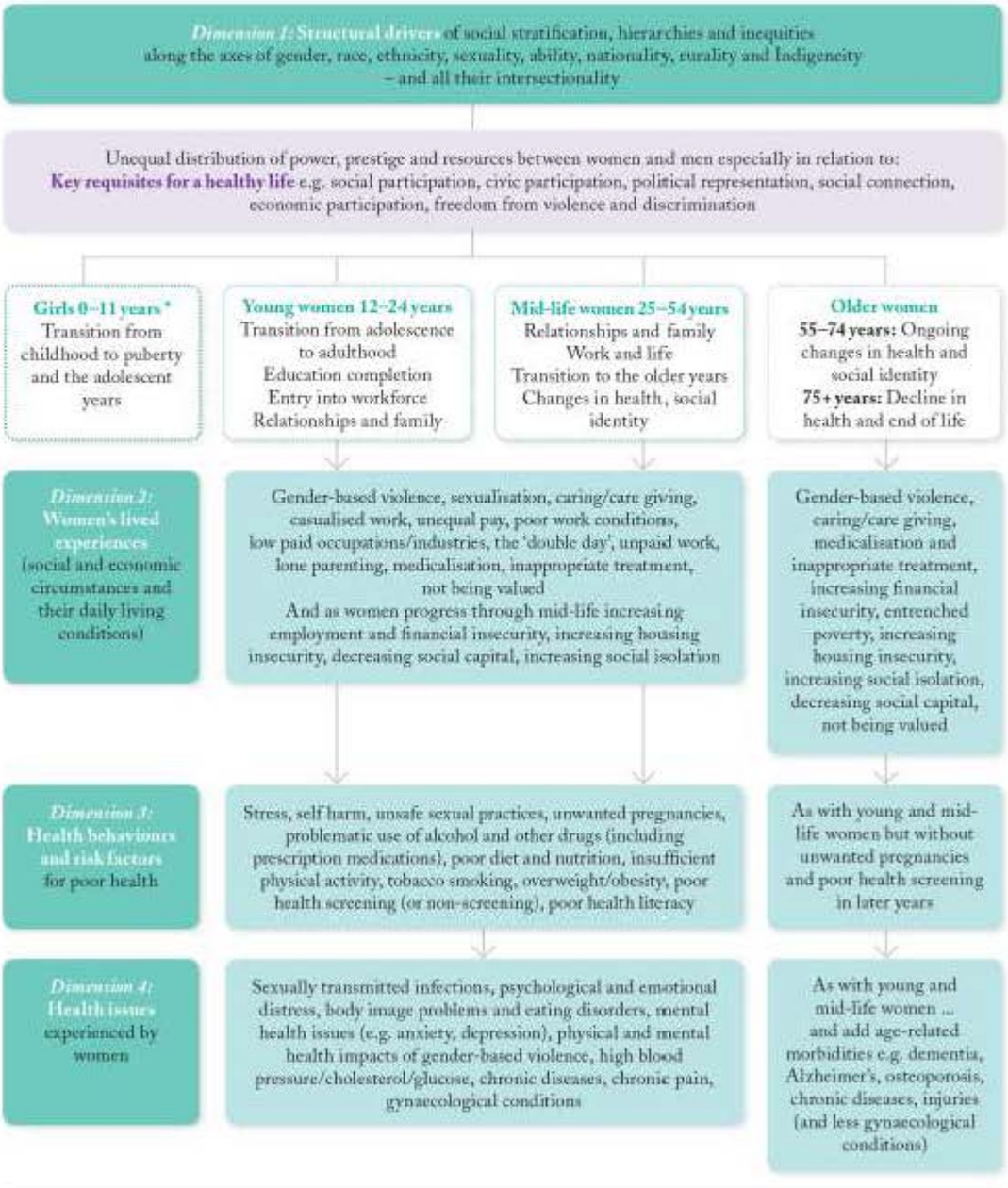
Relevant measures, statistics and data for the Index may include things such as:

- the reporting rates of instances of crime,
- the number of police referrals to family violence services,
- the number of perpetrators convicted,
- the number of working days lost by employees affected,
- the rate of homelessness caused by family violence,
- the number of presentations to the justice system,
- the variation of community attitudes towards acts of violence,
- the number of affected women and children presenting to hospital.

AWHN would like to take the opportunity offered in the making of this submission to bring to the attention of the Royal Commission the dimensions of the conceptual framework to measure women's health which we believe adds to the work to develop effective measures of family violence.

2.3 The conceptual framework: Four dimensions

The conceptual framework for women's health comprises four dimensions that make explicit the totality and interlinked complexity of women's health. A life course approach and the key requisites for a healthy life are also part of the conceptual framework.



* Girls aged 0–11 years are shown in this conceptual framework for women's health to indicate that the structural drivers are at work throughout the life course. The conceptual framework, however, focuses on the causal linkages between the four dimensions and their effects on young women, mid-life women and older women.

QUESTION SEVEN: What circumstances and conditions are associated with the reduced occurrence of family violence?

Gender equality is a specific and accountable goal at all levels of government and society.

Unconscious bias and violence supportive behaviours are recognised and openly discussed.

Respectful relationships between women and men are taught and reinforced through generations.

QUESTION EIGHT: Tell us about any gaps or deficiencies in current responses to family violence, including legal responses. Tell us about what improvements you would make to overcome these gaps and deficiencies, or otherwise improve current responses.

No comment.

QUESTION NINE: Does insufficient integration and co-ordination between the various bodies who come into contact with people affected by family violence hinder the assessment of risk, or the effectiveness of (early intervention, crisis and ongoing) support provided, to people affected by family violence? If so, please provide examples.

No comment.

QUESTION TEN: What practical changes might improve integration and co-ordination? What barriers to integration and co-ordination exist?

No comment.

QUESTION ELEVEN: What are some of the most promising and successful ways of supporting the ongoing safety and wellbeing of people affected by violence? Are there gaps or deficiencies in our approach to supporting ongoing safety and wellbeing? How could measures to reduce the impact of family violence be improved?

No comment.

QUESTION TWELVE - If you, your partner or a relative have participated in a behaviour change program, tell us about the program and whether you found it effective. What aspects of the program worked best? Do you have criticisms of the program and ideas about how it should be improved?

No comment.

QUESTION THIRTEEN - If you, your partner or a relative have been violent and changed their behaviour, tell us about what motivated that change. Was a particular relationship, program, process or experience (or combination of these) a key part of the change? What did you learn about what caused the violent behaviour?

No comment.

QUESTION FOURTEEN - To what extent do current processes encourage and support people to be accountable and change their behaviour? To what extent do they fail to do so? How do we ensure that behaviour change is lasting and sustainable?

No comment.

QUESTION FIFTEEN - If you or your organisation have offered a behaviour change program, tell us about the program, including any evaluation of its effectiveness which has been conducted.

No comment.

QUESTION SIXTEEN - If you or your organisation have been involved in observing or assessing approaches to behaviour change, tell us about any Australian or international research which may assist the Royal Commission. In particular, what does research indicate about the relative effectiveness of early intervention in producing positive outcomes?

No comment.

QUESTION SEVENTEEN Are there specific cultural, social, economic, geographical or other factors in particular groups and communities in Victoria which tend to make family violence more likely to occur, or to exacerbate its effects? If so, what are they?

No comment.

QUESTION EIGHTEEN: What barriers prevent people in particular groups and communities in Victoria from engaging with or benefiting from family violence services?

How can the family violence system be improved to reflect the diversity of people's experiences?

Four areas for closer attention are recommended in this submission:

1. The existence of pets and animals in the relationship where violence occurs can be used as threat of killing them if the woman leaves, or if the woman leaves there is no suitable accommodation for her, her children (if any) and the pets and animals.
2. There is a hidden issue that we understand occurs, from stories told by women and the experience of the submission writers family, of women being required to have sex with their male partners mates. The shame of being required to do this and not understanding that this constitutes rape which is violence keeps the woman silent.
3. The harms associated with children's and young people's exposure and consumption of pornographic material is already a significant problem. Pornography has become both more mainstream and more hardcore. Technology has played a significant role in these shifts. The issues of sexualised violence and support of violent sexual norms which arise needs further work to understand and greater attention to address this development. Excellent work in this area is occurring, such as by the Domestic Violence Resource Centre Victoria and Maree Crabbe in ***Reality & Risk: Pornography, young people and sexuality***. This is a community education project which seeks to respond to the social and personal implications of increasingly pervasive and hardcore pornography and its impact on young people's perceptions of men and women, and sexuality. A brief article on some of the issues addressed by the project can be found at: http://www.dvrcv.org.au/eroticising-inequality/
4. As outlined in the previous Victorian Labor Government policy *A Right to Respect Victorian Plan to Prevent Violence Against Women 2012-2020,* workplaces are an important context for reaching women and men who have limited contact with place-based community networks and organisations, which in itself can be a risk factor for violence against women. Women may seek assistance for experiences of violence (whether occurring inside or outside the workplace setting) through workplace support mechanisms and collegial networks. For newly-arrived immigrant or refugee women, and women experiencing rape in marriage, the workplace may be the only contact with systems of support beyond their own families – and therefore an essential resource for addressing family violence.

These variations on the understanding of violence should also be much more explicitly part of community discussion.

QUESTION NINETEEN: How can responses to family violence in these groups and communities be improved? What approaches have been shown to be most effective?

No further comment.

GENERAL QUESTIONS

QUESTION TWENTY: Are there any other suggestions you would like to make to improve policies, programs and services which currently seek to carry out the goals set out above?

AWHN submits that there should be a coordinated primary prevention of violence system that has the following elements:

1. **Establish primary prevention programs in 'settings',** or the places where people in communities live, work, play and age. This makes it possible to target specific groups with appropriate programs – in (among others) sports clubs, schools, workplaces and faith settings, as well with specific population groups including children, young people, and people with physical and intellectual disabilities, Indigenous and culturally and linguistically diverse people. Some examples of settings approaches are further explicated in AWHN's position paper.
2. **Establish a program of work across three levels which are interdependent** with each other: individual/relationship, community/organisational and societal.
3. **Takes a positive, community building, or strengths based approach** rather than focus on negatives. A strengths-based approach calls for programs to be positive, inclusive and enabling. Such an approach makes visible and values the skills, knowledge, connections and potential in a community. It promotes capacity, connectedness and social capital. This approach has the potential to engage men and women in the community as partners in bringing about the changes needed to eliminate violence against women. Many small and medium sized primary prevention programs using this approach are currently in progress in communities across Australia. As greater numbers of ordinary people become involved in prevention programs the combined effect has the potential to create a groundswell of momentum that will lead to the kind of long term cultural change that is required to create a society in which all people are equal, and respectful relationships and behaviours are the norm.
4. **Evaluation of primary prevention programs** should incorporate the knowledge that the work of primary prevention is not an exact science and evaluating the effectiveness of prevention programs can be difficult. Criteria for effectiveness depends on the findings of a well conducted, rigorous evaluation which focuses on outcomes in terms of not only knowledge and attitudes, but also on sustained behaviour change. The kind of high level measures that

are often identified for primary prevention, for example, changes in community attitudes, are almost impossible to link to particular programs. Few studies have had the capacity to follow participants in a program longitudinally to understand what changes and which programs work (World Health Organisation, 2002, Quadara and Wall, 2012, Casey and Lindhorst, 2009).

Evaluation is a developing science and the increased demand for evidence based programs has increased pressure on the community sector to include evaluation as part of program plans, which rarely include adequate funding for external evaluation. Earlier generations of evaluation focused on the evaluator as 'objective scientist' who stands outside of a program to judge its worth, or describe strengths or weaknesses. VicHealth has developed a capacity building approach to the evaluation of primary prevention programs. This will support community organisations to include internal evaluation, see, for example, Kwok (2013) and Flood (2013).

Evaluation capacity building has been defined as efforts to equip community sector practitioners with the skills to conduct evaluations and to integrate evaluation findings into practice (Flood, 2013). This approach was used in the five projects of the *Respect, Responsibility and Equality* programs funded by VicHealth between 2008 and 2011. According to Kwok (2013), primary prevention practice effects change incrementally and evaluation of programs should also be incremental. She identifies three key points which have emerged from the capacity building approach to evaluation:

- **First**, primary prevention evaluations must be *process* oriented – based on the understanding that the work is aimed at determinants level change. Primary prevention is about a means not an end and evaluations must be means directed.
- **Second**, evaluations must be prepared to explain the link between the program initiatives and the potential to influence determinants level change (that is, gender equality and respectful behaviours). They should be able to demonstrate that changes have occurred through realistic and measurable indicators.
- **Third**, evaluations are about practice that holds promise for longer term change. Promising practice is not necessarily practice that achieves a reduction in the problem, rather it is practice that is shown to potentially influence the root causes of the problem, in this case, the social norms that make violence against women acceptable in the first place (Kwok, 2013).

5. **Knowledge transfer and exchange** is a process which brings together researchers and the individuals, groups and communities which have a stake in participating in, or using, research or evaluation findings to exchange ideas, evidence and expertise. In other words, research informs (evidence based) practice and practice in turn informs research to ensure a continuous cycle. It is a critical part of the research process and can take the form of:
    - building links to ensure that research informs and is informed by policy and practice.
    - developing and maintaining relationships between researchers and those who have a stake in informing or using the results of the research.
    - disseminating research outcomes in ways that are accessible and comprehensible to the relevant stakeholders.

    Anecdotally there are many other projects in progress and completed, but almost no academic literature that analyses or reports on outcomes[15]. Added to this there are limited community

reports that add to learning from empirical experience. Although a plethora of prevention programs have been funded over the past decade the lack of effective knowledge transfer and exchange is a major flaw that must be addressed.

QUESTION TWENTY-ONE: The Royal Commission will be considering both short term and longer term responses to family violence. Tell us about the changes which you think could produce the greatest impact in the short and longer term.

A sound foundation has been laid for the future development of primary prevention of violence against women in Australia. This is not to suggest that all the answers are available and there is a great deal more to learn.

Primary prevention of violence against women

AWHN Health and the Primary Prevention of Violence Against Women 2014 position paper highlights the importance of a collaborative, coordinated integrated approach to address violence against women. Many of the actions required should operate both within and outside of Victoria. Recommendations are made for both State and Commonwealth Governments.

Based on the findings outlined in the position paper, the AWHN recommends there should be:

1. A definition for primary prevention of violence against women and the elements of a primary prevention initiative.
2. Development of an understanding of and investment in the workforce needs for primary prevention.
3. Recognition that no single initiative will prevent violence against women. Dedicated funding must be provided to the primary prevention sector to ensure activities can be delivered across the range of settings where people live, work and play to continue and expand the work of preventing and eliminating all forms of violence against women.

Further, we recommend that:

4. All community projects funded by the State and Commonwealth Governments are evaluated (using either an external evaluation approach or a capacity building internal evaluation approach as discussed in this submission) and that reports of these evaluations are made freely available to the primary prevention sector to build the evidence base and to ensure ongoing learning. There should also be an appropriately funded, substantive meta-evaluation of whole of population change.

It is the role of government to ensure gender equity is enshrined in all Commonwealth and State laws, policies and practices. We therefore recommend:

5. All government policies should be reviewed regularly using a gender lens and when necessary updated to ensure that gender equality is enshrined in all its practices.
6. A communication strategy should be undertaken to promote gender equality laws and policies to ensure they are understood and adhered to by government, business and non-government sector organisations.

7. Governments and political parties at all levels should comply with and model gender equality in all appointments and committees.

It is commendable that Australia has a long term national prevention plan in place; however, preventing violence against women is both an urgent and long term task that should not be subject to changes of government. The AWHN therefore recommends:

8. That Governments should publish regular updates on the progress of Commonwealth, state and territory prevention of violence against women plans. Reports from community programs funded under these plans should also be made available to ensure effective knowledge exchange occurs to inform ongoing practice.

There is a considerable focus on educating young people in equal and respectful relationships in the Commonwealth plan to prevent violence against women. The AWHN therefore recommends:

9. Respectful relationships education programs be incorporated into all Victorian schools' curricula from kindergarten through year 12.
10. All school programs are developed using the good practice principles detailed in AWHN's position paper and our response to question 5, using a whole school (health promoting) approach.
11. Long term funding be provided to continue improving and expanding primary prevention approaches across settings. This should include a long term commitment to evaluation.

Based on the published roles and functions of OurWatch, the AWHN recommends:

12. Awareness raising programs developed and conducted by OurWatch should be evidence based, and draw on the good practice principles for community programs that are identified in AWHN's position paper and our response to question 5.
13. OurWatch should develop a nationally agreed framework (including detailed definition of, and principles for primary prevention) to guide program development and implementation. This should be used to assess applications at all levels for funding primary prevention programs. Criteria for assessing primary prevention are suggested in AWHN's position paper.

The media can play an important role in the primary prevention of violence against women. The EVAs (Eliminating Violence Against Women Awards) in Victoria has established that collaborations between non-government organisations (NGO) and media representatives can be productive.
We therefore further recommend:

14. OurWatch and governments work collaboratively with media outlets regardless of the platform to develop voluntary standards for reporting and advertising that reflects gender equality and respectful representations of women and men.

In relation to primary prevention practitioners, two key bodies stand out as having the knowledge and experience in both the social determinants of health and primary prevention, VicHealth and the women's health sector Australia wide. VicHealth has provided the evidence base upon which programs can be developed and the women's health sector has well developed skills in health promotion and primary prevention. The AWHN therefore recommends:

15. At a minimum, primary prevention programs should promote gender equality and respectful relationships, as well as challenging violence supportive behaviours, environments and structures that are the social determinants of violence against women.

16. Primary prevention programs be planned using the good practice principles identified in AWHN's position paper.
17. Because gender inequality and the social determinants of health are critical factors underpinning violence against women, a gendered lens should be applied to the planning of primary prevention programs to ensure the underlying factors of gender and power are incorporated into all program plans.

The VicHealth 2004 report challenged the health sector to become one of the driving forces for change in the bid to reduce violence against women. Over the ten years since this report there is little evidence of this occurring within mainstream primary, secondary and tertiary health services. The health impact of violence against women has not been translated into health professional graduate and post graduate education programs nor into clinical practice in generalist primary, secondary and tertiary health services. Systemic change is required within health services. Health care providers should be resourced through training, policies and protocols to respond in ways which have been identified by women and their children who have experienced family violence as helpful and empowering.

AWHN therefore recommends that a major area of expansion of family violence response reform is within mainstream primary, secondary and tertiary health services. Two areas for increased focus are:

A. Health services as workplace settings for prevention.
B. Integrate the evidence into clinical practice about the health impact of violence against women and their children, in particular, during pregnancy and the relationship between violence and women's mental illness.

AUSTRALIAN WOMEN'S HEALTH NETWORK

HEALTH AND THE PRIMARY PREVENTION OF VIOLENCE AGAINST WOMEN

Position Paper 2014

Australian Women's Health Network

Health and the Primary Prevention of Violence against Women

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About AWHN

The Australian Women's Health Network is an advocacy organisation that provides a national voice on women's health, based on informed consultation with members. Through the application of a social view of health, it provides a woman-centred analysis of all models of health and medical care and research. It maintains that women's health is a key social and political issue and must be allocated adequate resources to make a real difference.

It aims to foster the development not only of women's health services but of stronger community-based primary health care services generally, which it sees as essential to improve population health outcomes. It advocates collaboration and partnership between relevant agencies on all issues affecting health. To this end, AWHN coordinates the sharing of information, skills and resources to empower members and maximise their effectiveness. The coalition of groups that comprises the organisation aims to promote equity within the health system and equitable access to services for all women, in particular those women disadvantaged by race, class, education, age, poverty, sexuality, disability, geographical location, cultural isolation and language.

This position paper is available for free download at: www.awhn.org.au

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Definitions

Domestic violence (also family violence, intimate partner violence) may be physical and involve actual physical harm, threatened harm against a person, or someone/something they care for. It may be emotional, and may involve belittling, name calling, and intimidation. It may also take the form of limiting a woman's freedom. For example financially, by keeping a woman dependent on a partner to the extent that it is necessary to ask for money and justify all expenditure; or socially, such as being insulted or bullied in front of others; or being isolated from friends or family or controlling where she can go or who she can see. It does not have to occur in the home to be classified as domestic violence and can take a number of forms, including stalking and cyber-stalking.

Equality: The Oxford English dictionary defines equality as the state of being equal, especially in status, rights, or opportunities. **Gender equality:** suggests that women and men should receive equal treatment and not experience disadvantage on the basis of their gender. This principle is enshrined in the United Nations Universal Declaration of Human Rights.

Equity: Equity is a term which describes fairness and justice in outcomes. It is not about the equal delivery of services or distribution of resources; it is about recognising diversity and disadvantage to ensure equal outcomes for all.

Family or intimate partner violence refers to violence that occurs between people in relationships, including current or past marriages, domestic partnerships, familial relations, or people who share accommodation such as flat mates and boarders. It can affect people of any age, and from any background, race, religion or culture.

Gender: Although these terms 'sex' and 'gender' are often used interchangeably, they have very different meanings. 'Sex' refers to the biological and physical characteristics that define maleness and femaleness. 'Gender' refers to the socially constructed roles, behaviours, activities, and attributes that any given society considers appropriate for men and women; gender defines masculinity and femininity (World Health Organisation, 2014).

Gender-based violence, or violence perpetrated by men against women, takes many forms. In addition to physical violence by intimate partners, known assailants or strangers, the definition of gender-based violence includes violence that results from unequal power relations based on gender differences.

Health: is defined as '…a complete state of physical, mental and social well-being, not merely the absence of disease or infirmity' (World Health Organisation, 2013).

Sexism: is discrimination based on gender and the attitudes, stereotypes, and the cultural elements that promote this discrimination. Given the historical and continued imbalance of power, where men as a class are privileged over women as a class, an important, but often overlooked component of sexism is that it involves prejudice plus power.

Sexual violence can occur between intimate partners, relations, acquaintances or between strangers. It takes many forms including sexual harassment, verbal abuse, leering, threats or indecent exposure.

Sexual harassment is any unwanted or unwelcome sexual behaviour, which makes a person feel offended, humiliated or intimidated. It is not interaction, flirtation or friendship which is mutual or consensual. Sexual harassment is a type of sex discrimination which disproportionately affects women. Despite being outlawed for over 25 years, sexual harassment remains a problem in Australia.

Violence against women is a term that encompasses all forms of gender-based violence.

Background

The rates of physical violence experienced by men and women since the age of 15 are comparable. For both, the perpetrator is far more likely to be male, however the contextual settings strongly differ[1]. Violence against men more often occurs in public while violence against women more frequently occurs in the home.

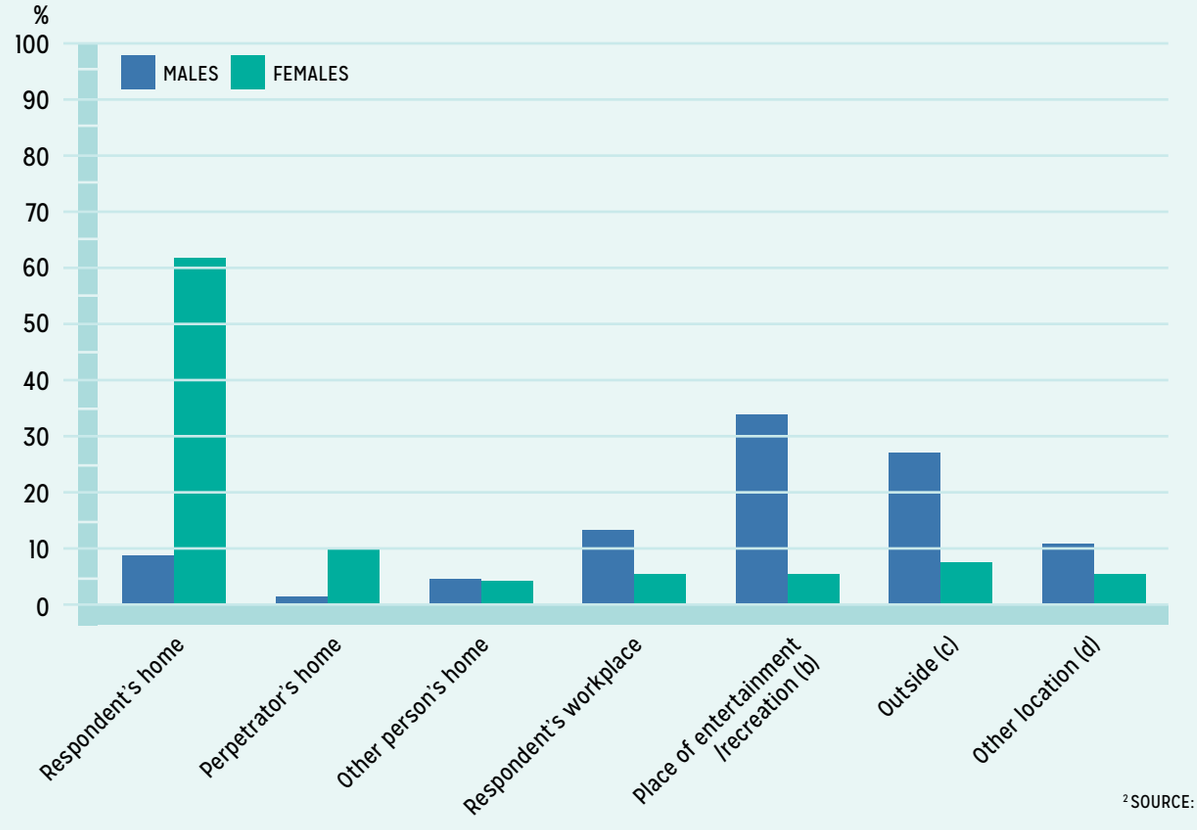
The Australian Bureau of Statistics (2012) found that men aged 18 years and over were more likely to have experienced violence by a stranger (36% of all men) compared to men who had experienced violence by a known person (27% of all men). The most likely type of known perpetrator was an acquaintance or neighbour (10%).

In contrast, women aged 18 years and over were more likely to have experienced violence by a known person (36% of all women) compared to women who had experienced violence by a stranger (12% of all women). The most likely type of known perpetrator was a previous partner (15% of all women). Almost every week, a woman in Australia is killed by a partner or ex-partner (Mouzos & Makkai, 2004).

The differing contexts and perpetrators of violence against women and men often leads to the violence against women being considered a private issue. There is a failure to interrogate the reasons why some men see violence against their partners or ex-partners as an appropriate response or form of engagement.

This is why, according to the United Nations Population Fund (UNFPA), gender based violence is 'The most pervasive, yet least recognized human rights abuse in the world'

OF MEN AND WOMEN WHO EXPERIENCED PHYSICAL ASSAULT BY A MALE (a), Location of the most recent incident



[2] SOURCE:

[1] Australian Bureau of Statistics (2006) Personal Safety, Australia. www.abs.gov.au/ausstats/abs@nsf/Lookup/4102.0main+features30Jun+2010
[2] Australian Bureau of Statistics (2012) PersonalSafety, Australia. www.abs.gov.au/ausstats/abs@nsf/Lookup/4906.0Chapter3002012

Executive summary

This position paper focuses on the primary prevention of violence perpetrated by men against women. It develops a position on primary prevention (as distinct from secondary and tertiary interventions). It also identifies examples of good practice across settings, and factors for success for primary prevention programs. The paper has been developed as a resource for public education, debate and community activities related to the primary prevention of violence against women.

Intimate partner violence is prevalent, serious and preventable; it is also a crime. Among the poor health outcomes for women who experience intimate partner violence are premature death and injury, poor mental health, habits which are harmful to health such as smoking, misuse of alcohol and non-prescription drugs, use of tranquilisers, sleeping pills and anti-depressants and reproductive health problems.

The cost of violence against women to individuals, communities and the whole of society is staggering and unacceptable. Every week in Australia at least one woman is killed by her current or former partner, and since the age of 15, one in three women has experienced physical violence and one in five has experienced sexual violence. The annual financial cost to the community of violence against women was calculated by Access Economics in 2002/3 to be $8.1 billion (Victorian Health Promotion Foundation, 2004), a figure which is likely to increase unless the incidence of violence against women can be reduced and ultimately eliminated.

Gender based Violence

> ***Gender-based violence**, or violence perpetrated by men against women, takes many forms. In addition to physical violence by intimate partners, known assailants or strangers, the definition of gender-based violence includes violence that results from unequal power relations based on gender differences.*

The term gender based violence encompasses a range of abuses that result in, or are likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, whether they occur in public or private life (United Nations, 1993). Research has established that rather than being a few isolated acts, violence against women is a pattern of behaviour that violates the human rights of women and girls, limits their participation in society and damages their health and well-being (García-Moreno et al., 2013).

Gender-based violence is a complex social problem with serious health consequences. Recognition of the social nature of violence against women is central to efforts to eliminate it. A strong link has been established between gender based violence and the systemic inequalities rooted in structural power imbalances between men and women (United Nations General Assembly, 2006). The terms gender based violence and violence against women will be used interchangeably in this paper. When referring specifically to domestic violence the terms intimate partner violence and family violence may also be used.

In Australia nearly one in three women over the age of 15 years reports being subjected to violence at some time and one in five has experienced sexual violence. Intimate partner violence contributes to 9% of the total burden of disease for women aged 15 to 44 years (Victorian Health Promotion Foundation, 2004).

The social determinants of health are the conditions in which people are born, grow, live, work and age. These are shaped by the distribution of money, abuses of power and the distribution of resources at global, national and local levels, as well as by gender (Australian Women's Health Network, 2012).

Prevention

There is a strong association between sexist peer norms, low status of women and violence against women (Dyson and Flood, 2008, Flood, 2011, UN Division for the advancement of women, 2008, Victorian Health Promotion Foundation, 2010). Violence supportive attitudes and behaviour can be found almost anywhere, and recognised as: lack of support for gender equality; belief in the inferior status of women in relation to men; sexual harassment and coercion; bullying, abusive or controlling behaviours, or group disrespect (demonstrated by rude, aggressive behaviour, consumption of pornography, sexualising women, group consumption of alcohol, and rape supportive attitudes). The goal of prevention is to make these attitudes and behaviours visible and change them through the promotion of equal and respectful relationships.

Primary prevention is a public health approach that aims to prevent violence from occurring in the first place. It is advocated as an effective means of working towards the elimination of all forms of violence against women. Primary prevention must focus on changing the culture/s that operate to make gender based violence acceptable. This is sometimes referred to as culture, or cultural change.

Primary prevention programs can be carried out in 'settings', or the places where people in communities live, work, play and age (Peersman, 2001). A settings approach makes it possible to target specific groups with appropriate programs – in (among others) sports clubs, schools, workplaces and faith settings, as well with specific population groups including children, young people, and people with physical and intellectual disabilities, Indigenous and culturally and linguistically diverse people. Some examples of settings approaches are further explicated in this position paper.

A social/ecological model has been proposed for both understanding gendered violence and for prevention activities. The Victorian Health Promotion Foundation (VicHealth) has a model which suggests that rather than being a simple phenomenon, violence is the result of the complex interplay of individual, relationship, social, cultural and environmental factors. The model works at three levels which are interdependent with each other: individual/relationship, community/ organisational and societal (Victorian Health Promotion Foundation, 2007).

Rather than focus on negatives, primary prevention must take a positive, community building, or strengths based approach. A strengths-based approach calls for programs to be positive, inclusive and enabling. Such an approach makes visible and values the skills, knowledge, connections and potential in a community. It promotes capacity, connectedness and social capital (Glasgow Centre for Population Health, 2011). This approach has the potential to engage men and women in the community as partners in bringing about the changes needed to eliminate violence against women. Many small and medium sized primary prevention programs using this approach are currently in progress in communities across Australia. See, for example, a report on programs from the Victorian Health Promotion Foundation (2012). As greater numbers of ordinary people become involved in prevention programs the combined effect has the potential to create a groundswell of momentum that will lead to the kind of long term cultural change that is required to create a society in which all people are equal, and respectful relationships and behaviours are the norm.

Policy Context

Australia has Commonwealth, State and Territory plans that focus on both responding to and preventing violence against women. All states and territories are signatory to the Commonwealth plan to Prevent Violence against Women and their Children, yet not all of the individual plans align with the Commonwealth in terms of primary prevention. There is a lack of transparency and clarity about how the different plans are being implemented and progressing. The Commonwealth has funded a number of community based programs since 2009 yet no effective knowledge transfer[3] about the learnings that have come out of these programs has taken place to inform practice.

[3] Australian Knowledge transfer and exchange is the process of sharing useful, evidence based learnings, expertise and skills with others. It involves a broad range of activities which are mutually beneficial to a range of stakeholders, including in this case researchers, practitioners and policy makers

Recommendations

To Federal, State and Territory Governments

Based on the findings of this position paper the Australian Women's Health Network recommends that Governments:

1. Recognise that no single initiative will prevent violence against women. Dedicated funding must be provided to the primary prevention sector to ensure activities can be delivered across the range of settings where people live, work and play to continue and expand the work of preventing and eliminating all forms of violence against women.
2. Continue to provide specific funding for the tertiary response sector at a level to ensure women who are subjected to intimate partner violence and sexual assault have adequate and appropriate services available to provide them with safety and support.

This position paper has highlighted the importance of a collaborative, coordinated integrated approach to address violence against women. We believe that a national body is required to ensure the successful implementation of the recommendations contained on this paper. We therefore recommend that:

3. Responses to violence against women be guided by a national advisory structure of all relevant stakeholders. This would include governments, the Foundation, ANROWS, AWAVA, women's health and other community organisations. The national advisory body would be responsible for developing a collaborative multi-year workplan between member stakeholders.

Further, we recommend that:

4. All community projects funded by the Commonwealth Government are evaluated (using either an external evaluation approach or a capacity building internal evaluation approach as discussed on page 29 of this position paper) and that reports of these evaluations are made freely available to the primary prevention sector to build the evidence base and to ensure ongoing learning. The multi year workplan discussed in Recommendation 3 should also be accompanied by an appropriately funded, substantive meta-evaluation of whole of population change.

It is the role of government to ensure gender equity is enshrined in all Commonwealth and State laws, policies and practices. We therefore recommend:

5. All government policies should be reviewed regularly using a gender lens and when necessary updated to ensure that gender equality is enshrined in all its practices.
6. A communication strategy should be undertaken to promote gender equality laws and policies to ensure they are understood and adhered to by government, business and non-government sector organisations.
7. Governments and political parties at all levels should comply with and model gender equality in all appointments and committees.

It is commendable that Australia has a long term prevention plan in place; however, preventing violence against women is both an urgent and long term task that should not be subject to changes of government. The AWHN therefore recommends:

8. That Governments should publish regular updates on the progress of Commonwealth, state and territory prevention of violence against women plans. Reports from community programs funded under these plans should also be made available to ensure effective knowledge exchange occurs to inform ongoing practice.

There is a considerable focus on educating young people in equal and respectful relationships in the Commonwealth plan to prevent violence against women. The AWHN therefore recommends:

9. Respectful relationships education programs be incorporated into all schools' curricula from kindergarten through year 12.
10. All school programs are developed using the good practice principles detailed on page 24 of this position paper, using a whole school (health promoting) approach.
11. Long term funding be provided to continue improving and expanding primary prevention approaches across settings. This should include a long term commitment to evaluation.

To the Foundation to Prevent Violence against Women and their Children

Based on the published roles and functions of the Foundation detailed on pages 34 & 35 of this position paper, the AWHN recommends:

12. Awareness raising programs developed and conducted by the Foundation should be evidence based, and draw on the good practice principles for community programs identified on page 24 of this position paper.

13. The Foundation develops a nationally agreed framework (including detailed definition of, and principles for primary prevention) to guide program development and implementation. This should be used to assess applications at all levels for funding primary prevention programs. Criteria for assessing primary prevention are suggested on page 24 of this position paper.

The media can play an important role in the primary prevention of violence against women. The EVAs[4] in Victoria has established that collaborations between NGO and media representatives can be productive. We therefore further recommend:

14. The Foundation works collaboratively with media outlets regardless of the platform to develop voluntary standards for reporting and advertising that reflects gender equality and respectful representations of women and men.

To Primary Prevention Practitioners

Two key bodies stand out as having the knowledge and experience in both the social determinants of health and primary prevention, VicHealth and the women's health sector Australia wide. VicHealth has provided the evidence base upon which programs can be developed and the women's health sector has well developed skills in health promotion and primary prevention. The AWHN therefore recommends:

15. At a minimum, primary prevention programs should promote gender equality and respectful relationships, as well as challenging violence supportive behaviours, environments and structures that are the social determinants of violence against women.

16. Primary prevention programs be planned using the good practice principles identified in section 2.6 of this position paper.

17. Because gender inequality and the social determinants of health are critical factors underpinning violence against women, a gendered lens should be applied to the planning of primary prevention programs to ensure the underlying factors of gender and power are incorporated into all program plans.

[4] The Eliminating Violence Against Women Media Awards

HEALTH AND THE PRIMARY PREVENTION OF VIOLENCE AGAINST WOMEN

1. Introduction

Australia has a strong, independent and thriving women's health sector with skills and experience in health promotion and primary prevention. This position paper articulates the Australian Women's Health Network (AWHN) position on the primary prevention of violence against women for their improved health and well-being. The paper:

- proposes a position on primary prevention (as distinct from secondary and tertiary interventions).
- identifies good practice principles primary prevention programs and factors for success for programs, based on practice across different settings.
- provides a review and analysis of the implications of the Commonwealth, State and Territory Plans to prevent violence against women;
- presents a resource for public education, debate and community consultation activities related to primary prevention.

The position paper draws on Australian and international peer reviewed work based on empirical evidence, however, because prevention of violence against women is a relatively new field of research, it also draws on the extensive grey literature on the topic.[5] The paper starts with a discussion of gender, the social nature of violence against women and the kinds of behaviour and attitudes that support, foster or condone gender based violence. In section two, it focuses on prevention of violence against women, in particular the public health approach, including primary prevention and the ecological model. Section three discusses evaluation approaches and identifies good practice principles for primary prevention. Section four examines the policy context for preventing violence against women in Australia, analyses the national, state and territory prevention plans, and discusses two recent initiatives, the Foundation and the Centre for Excellence to Prevent Violence against Women. Finally it draws on the findings to make recommendations for primary prevention policy and practice in Australia.

1.1 Gender and power

Although these terms 'sex' and 'gender' are often used interchangeably, they have very different meanings. 'Sex' refers to the biological and physical characteristics that define maleness and femaleness. 'Gender' refers to the socially constructed roles, behaviours, activities, and attributes that any given society considers appropriate for men and women; gender defines masculinity and femininity (World Health Organisation, 2014). Gender can be conceived as a system of social power relations which permeates the structures, processes and practices of all aspects of public and private life (Australian Women's Health Network, 2012).

Mainstream social and cultural practices within societies strengthen notions that gender roles for women and men are natural biologically determined differences. Gender is deeply embedded in the legal, religious and cultural structures and norms that are taken-for-granted in the everyday arrangements of people's lives. Gender relations are multi-dimensional, interweaving relationships of power, economic arrangements, emotional relationships, systems of communication and meaning (Connell, 2003).

Power can be conceived in two main ways: as power-over and power-to. A power-over model is characterised by three main features: that power is possessed, flows from above to below, and is primarily repressive (Sawicki, 1991). In this model, those who possess power oppress those who do not have it, and there are few options for the oppressed to remedy their oppression other than revolution. Another model of power is that it is not a possession, but as something that circulates in networks between individuals (Foucault, 1980). In this model, power is neither positive nor negative, but simply exists. This understanding of power does not suggest that it cannot be used to oppress, but recognises the possibility of resistance, and of agency – the capacity for individuals to take action and bring about change – that is not present in hierarchical notions of power.

From this standpoint, power can be seen as operating between individuals and groups who share a common understanding about unspoken social 'rules' for the conduct of gender relations and it may be used to enforce as well as to resist violence. The elimination of violence against women is predicated on the the idea that deeply held cultural norms and values can be changed.

[5] Grey literature is all that material which is not subject to peer review, i.e. peer reviewed journals and books (Alberani, Peitrangeli & Mazza, 1990). This may include reports, newsletters, pamphlets, web sites and other print and digital media sources.

1.2 Violence against women

Gender-based violence is a complex social problem which grows from deeply-held beliefs, value systems, stereotypes and power relationships. In addition to the physical, emotional and social harms resulting from gender based violence, there are also multiple, serious, complex sequalae for its victims.

Globally, 30% of women have experienced physical and or sexual intimate partner violence and 7% have been sexually assaulted by someone other than a partner (García-Moreno et al., 2013). In Australia nearly one in three women over the age of 15 years report being subjected to violence at some time and one in five have experienced sexual violence (National Council to Reduce Violence Against Women and their Children, 2009).

Gender based violence is not a new phenomenon; recognition of the extent of the problem is, however, relatively new. It is only in recent decades that meaningful measures have been developed to understand the true scope and impact of intimate partner violence (Australian Women's Health Network, 2013). For example, evidence of the scope, impact and human costs of violence against women was not established until 2004 when VicHealth published its report *The health costs of violence: Measuring the burden of disease caused by intimate partner violence. The study that led to this report established that in Australia intimate partner violence* contributed to 9% of the total burden of disease for women aged 15 to 44 years (Victorian Health Promotion Foundation, 2004). The availability of measures to understand the health implications of violence against women, and the subsequent actions to address the problem through improved services and the development of prevention programs, represents a quantum leap in knowledge and understanding about violence against women as a serious health issue and demonstrates that 'what gets measured gets done' (Australian Women's Health Network, 2013). It is this knowledge and understanding that underpins the current groundswell of primary prevention activity.

The evidence has demonstrates that, rather than being a few isolated acts, violence against women is a pattern of behaviour that violates the human rights of women and girls, limits their participation in society and damages their health and well-being (García-Moreno et al., 2013). The complexity of the problem means that both the response system and prevention efforts must be multi-sectoral and inter-disciplinary, and must operate in all the structures of government, community and interpersonal relations.

Despite a desire to explain the phenomenon by seeking a cause, no single cause adequately accounts for violence against women; it cannot be attributed solely to individual psychological factors or socioeconomic conditions (United Nations General Assembly, 2006). Explanations for violence that focus primarily on individual behaviours and personal histories, such as alcohol abuse or a history of exposure to violence, overlook the broader impact of systemic gender inequality and women's subordination (UN Women, 2012).

Although violence against women is a centuries old phenomenon, it was not until 1993 that the issue of violence against women was accepted as a human rights violation at the Vienna World Conference on Human Rights and defined as:

> *…any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life (United Nations, 1993).*

Gender equality between women and men is recognised as a principle in international law, articulated in many United Nations documents from the 1948 Universal Declaration of Human Rights onwards. They are also enshrined in Australian law. Recognition of the social nature of violence against women is central to efforts to eliminate it.

1.3 The impact of violence against women

Violence against women has serious health and social consequences, and the figures concerning this are stark. Since the age of 15 years 40% of all Australian women have experience some form of gender based violence. Twenty one percent of women have experience physical assault and 17% have experienced sexual assault. One in six women have experienced violence by a current

or former partner at some time in her life. In addition, since the age of 15 years one third of all Australian women have experienced sexual harassment in the form of inappropriate comments about their body or sex life, one quarter have experienced unwanted sexual touching and one in five have been stalked (Australian Bureau of Statistics, 2006).

The direct health consequences of gender based violence (GBV) to women, include depression, anxiety and phobias, suicidal behaviours, physical injury, a range of somatic disorders and a variety of reproductive health problems (Victorian Health Promotion Foundation, 2008). Women who have been exposed to violence report poorer overall physical health than those who have not, and there is evidence that the health impact of violence can persist long after the abuse has stopped (Victorian Health Promotion Foundation, 2004, García-Moreno et al., 2013).

In addition to the immediate physical and mental health harm experienced by women there are also long-term effects. According to VicHealth:

> *Domestic violence has a long-term impact on its victims and survivors, including their income and financial stability, housing security, and parenting, and on their children's safety during contact with abusive ex-partners (Walsh (2008) cited in Victorian Health Promotion Foundation, 2008)*

Intimate partner homicide also accounts for one fifth of all homicides in Australia. Female deaths account for four out of five of these homicides, typically these women are killed in the context of a long history of domestic violence (Victorian Health Promotion Foundation, 2010). There are also serious consequences for children, families and the wider community. The experience of growing up in a violent home can be devastating and increases children's risk of mental health, behavioural and learning difficulties. Boys who witness domestic violence are at a greater risk of becoming perpetrators as adults (Victorian Health Promotion Foundation, 2008).

In addition to the serious human costs of violence against women the financial cost to the community are enormous. This takes into account the cost of public and private services to victims, perpetrators and children, the costs in terms of lost productivity (including sick leave, 'presenteeism'[6], access to employment support services, replacing staff and lost unpaid work) (Victorian Health Promotion Foundation, 2008). Other costs include counselling, changing schools, child protection services, increased use of government services, and juvenile and adult crime (Victorian Health Promotion Foundation, 2004).

1.4 What is violence supportive behaviour?

As discussed above, gender based violence is a complex social phenomenon that is supported and maintained in society as a result of a range of overt and covert actions that are normalised to the point where they are taken for granted and often pass unnoticed. The strong association between sexist peer norms, low status of women and violence against women must be addressed in any violence prevention project, and to do this, the attitudes and behaviours that foster or maintain the practice must be made visible and changed.

Research with male perpetrators has identified a range of particular predisposing attitudes and behaviours. These include a general approval of interpersonal violence by men, acceptance of rape myths, belief that relations between men and women are adversarial, and generalised hostility towards women. This may include distorted ideas about social situations, such as taking a woman's lack of interest in sex as a personal insult, thinking that women dress deliberately to tease men, or that women actually enjoy rape once they are forced to submit (Hagemann-White et al., 2010). Adherence to any of these beliefs or values by a person of any gender contributes to a violence supportive environment.

Certain settings[7] appear to support sexual violence, for example, studies in university fraternities, military institutions and sporting organisations[8] suggest that attitudes that position men as needing to dominate in sexual relations, link masculinity with extreme forms of heterosexual performance, sexist, heterosexist and homophobic attitudes, use of pornography, and general norms of women's subordinate status all support a climate of violence against women (Boswell and Spade, 1996, Sanday, 1996, Dyson and Flood, 2008). For example, in sport, Rosen (2003) reported an association between 'group disrespect' (the presence of rude and

[6] This term has been coined to describe distraction, lack of concentration and underperformance at work. In other words being physically present at work but in all other ways absent.

[7] The term 'setting' is used in health promotion practice to describe the places where people live, work and play. A settings approach will be discussed in more detail below.

[8] The majority of this research has occurred in the USA.

aggressive behaviour, pornography consumption, sexualised discussion, and encouragement of group drinking) and the perpetration of intimate partner violence, at both individual and group levels.

Other factors in these settings that have been associated with some men becoming abusive or violent include:

- Male bonding: The codes of mateship and loyalty in tightly knit male groups may intensify sexism and encourage individuals to allow group loyalties to override their personal integrity.
- Settings which encourage male aggression: for example, contact sports that naturalise and glorify violence through teaching athletes physical aggression and dominance, extreme competitiveness, physical toughness and insensitivity to others' pain.
- Sexualisation and subordination of women: some critics point to women's roles in sports, either as sexualised props for men's performance (for example, as cheerleaders or carers), or as supporters and carers, as being implicated in sexist norms.
- Celebrity status and entitlement: the high-profile status and celebrity treatment of professional athletes has been seen to potentially feed a sense of entitlement and lack of accountability for actions off the field.
- Drug abuse: excessive consumption of performance enhancing and illicit drugs and alcohol has been identified as a potential risk factor for sexual assault.
- 'Groupie' culture: players' sexual involvement with women who seek out their sexual company, combined with a status of entitlement, may shape athletes' assumptions about women, sexuality, and consent (Dyson and Flood, 2008, Benedict, 1998, Melnick, 1992).

These attitudes and behaviours can be seen in a wide range of other male dominated settings.

Context-specific mechanisms further shape the prevalence of violence-supportive attitudes and violent behaviour among men. One is *group socialisation*: in joining particular groups such as sporting teams, the military or fraternities men are actively inducted into the existing norms and values of these contexts. Another mechanism is *self-selection*: men with pre-existing violence-supportive attitudes and behaviours and an orientation towards behaviours such as heavy drinking may join groups with similar norms (Dyson and Flood, 2008).

Research with men in US college settings has shown that they tend to overestimate the amount of sex their male peers have, and the degree to which their peers support coercive behaviour with women. At the same time they underestimate the importance of consensual sex to their friends (Casey and Lindhorst, 2009, Berkowitz, 2002). In another study Berkowitz (2003) argues that a small but vocal minority of men who endorse rape supportive attitudes create the perception that sexual objectification and coercion of women are normal in male peer networks and create a climate of disrespect for women. Fabiano et al. (2003) also found that most men reported privately that they placed high value on consent in sexual activity. This may suggest that the majority of men (or women) do not adhere privately to sexist or other violence supportive attitudes, however, their silence condones and therefore supports violence against women.

Other settings normalise violence supportive attitudes and behaviours in different ways. For example, faith based communities may be sites where gender based violence is inadvertently fostered or condoned. This may be based on custom and tradition rather than the teaching of a particular religion. For example, by emphasising women's subordinate status in comparison with that of men, or blaming a woman for her husband's abusive behaviour because she is not suitably submissive. The report of a primary prevention program in faith based communities in Melbourne argues that it is important for leaders in these communities to speak out against violence and promote equal and respectful gender relationships as part of their pastoral role (Holmes, 2012). The UN expert meeting on the role of faith based communities in prevention acknowledged the sensitivity, complexity and diversity of engaging faith communities in prevention (Grape, 2012).

Workplaces are also sites where women may experience violence, or where violence supportive attitudes prevail, and gender hostility and sexual harassment in workplaces may be normalised. In an Australian study, over 60% of women surveyed reported experiencing some form of violence and 75% reported experiencing unwanted or unwelcome sexual behaviour at work (Chung et al., 2012). This may involve explicitly sexual

verbal and non-verbal behaviours, insulting behaviours that are based on gender, unwanted sexual attention and sexual coercion. In the workplace employers and managers have a responsibility to ensure the workplace is safe and non-discriminatory; those who do not do this are displaying violence supportive attitudes and behaviours (Chung et al., 2012). There is also ongoing evidence that women in Australia experience gender based discrimination in the workplace, as demonstrated by the gap in women's pay relative to men's and under-representation in positions of decision making and seniority (Chung et al., 2012). Workplaces that do not address this differential are exercising violence supportive practices.

Schools are yet another site where violence supportive attitudes and behaviours may thrive. In 2008 the *National Survey of Secondary Students and Sexual Health* reported that 38% of young women in years 10, 11 and 12 had experienced unwanted sex, a 10% increase since the previous survey in 2002. Students cited being too drunk, or pressure from their partner, as the most common reasons for having unwanted sex (Smith et al., 2009).

Adolescence and young adulthood are times when young men are testing ways of enacting their masculinity, which can be highly contingent and situational depending on peer groups and role models. Blye (2003) described this as a process of young men jostling between competing forms of masculinity. For example, men may use sexist jokes as a kind of bonding exercise; it is through joking friendships that men are able to negotiate the tension they feel over a need for intimate friendships with other men. This phenomenon was also observed by Corboz, Flood & Dyson (forthcoming) in research with elite Australian football players. Sometimes these confused performances of masculinity described by Blye above can lead to overt sexism and consequently be violence supportive.

In summary, violence supportive attitudes and behaviour can be found in any setting, and recognised as lack of support for gender equality, belief in the inferior status of women in relation to men, sexual harassment and coercion, bullying, abusive or controlling behaviours, group disrespect (demonstrated by rude, aggressive behaviour, consumption of pornography, sexualising women, group consumption of alcohol, and rape supportive attitudes). While many of the attitudes and behaviours discussed in this section have been identified by researchers in specific settings, they also occur in other settings so should not only be limited to the setting in which they are discussed.

Violence supportive attitudes and norms are also shaped by other social influences including popular media. A wide range of studies have documented relationships between tolerance for physical or sexual violence and exposure to particular imagery in pornography, television, film, advertising and electronic games (Flood & Pease, 2006).[9]

[9] www.awe.asn.au/drupal/sites/default/files/Why_Violence_Against_Women_and_Girls_Happens.pdf

2. Prevention of gender based violence

2.1 A public health model for prevention

Public Health has been defined as an organised response to the protection and promotion of human health (Peersman, 2001). It is concerned with the health of entire populations, which may be a local neighbourhood or an entire country. Public health programs are delivered through education, promoting health lifestyles, and disease and injury prevention. This is in contrast to the medical approach to health which focuses on treating individuals after they become sick or injured. Public Health embraces a definition of health which has been recognised since 1958 as '…a complete state of physical, mental and social well-being, not merely the absence of disease or infirmity' (World Health Organisation, 2013).

Public Health has developed a three level model of prevention to address a range of health issues that affect both populations and individuals. In this model, *Tertiary prevention* aims to work with people who are already affected by disease to improve function and minimize the impact of the disease and delay complications and repeat events associated with it. *Secondary prevention* aims to reduce the progression of disease through early detection, such as screening and pre-symptomatic stages, early detection and early intervention associated with the onset of disease.

Primary prevention aims to limit the incidence of disease by addressing the causes or determinants of potential ill-health. This may be by reducing exposure to risk factors as well as by promoting protective factors, such as the emergence of pre-disposing social or environmental conditions that can cause disease (National Public Health Partnership, 2006). In the disease prevention model described here there is some overlap between secondary and primary prevention, for example, when the cause of the problem cannot be eliminated the focus turns to modifying behaviour using a combined approach.

The public health model for prevention has been adapted for preventing violence against women. Thus, primary prevention is explained as preventing violence from occurring in the first place; secondary prevention as providing early intervention, for example, with perpetrators; and tertiary prevention as providing safety and support for victims after violence has occurred (World Health Organisation, 2002, Dyson and Flood, 2008, Martin et al., 2009, Flood, 2011).

2.2 The Social Determinants of Health

An understanding of the social determinants of health is critical for primary prevention programs. These are the conditions in which people are born, grow, live, work and age (World Health Organisation, 2013) that are shaped by the distribution of money, power and resources at global, national and local levels as well as by gender and accompanying abuses of these. This is also sometimes also known as the 'social hierarchy' (Australian Women's Health Network, 2012).

The Ottawa Charter identifies the fundamental conditions and resources for health as including peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity (World Health Organisation, 1986). The social conditions that influence violence against women include: the ways in which gender roles and relationships are constructed and defined; how power and material resources are distributed; social norms about violence and violence against women; and access to resources and systems of support (Women's Health West, 2012).

Well-being describes a concept of health in which equity, freedom from violence and discrimination, and access to the resources necessary to live a full and satisfying life are paramount (World Health Organisation, 1948). Women who experience intimate partner violence also experience inequalities on a range of social health measures. For example, as a result of violence they may experience lack of access to secure housing, as well as insecure work and income support. Thus, violence against women not only affects health but also well-being.

There is a strong link between violence against women and the systemic inequalities rooted in structural power imbalances between men and women (United Nations General Assembly, 2006). A gendered analysis can expose the ways in which the social determinants of health affect women and men differently (including those from marginalised or disadvantaged communities). Such an analysis must form the basis of primary prevention programs to eliminate gender-based violence.

2.3 Primary Prevention of Violence against Women

The work of primary prevention of violence against women is about changing the attitudes and behaviours that lead to some men abusing power by socially, emotionally or physically controlling or being violent against women. These are the factors that give rise to, or create the conditions that lead to gender based violence and abuse. These conditions include the structural barriers of gender inequality and gender role socialisation, and the social norms that ignore, condone or support violence against women (Quadara and Wall, 2012).

According to the report from the UN Expert Group meeting in 2012, primary prevention remains a poorly understood concept across sectors and between stakeholders. It is often conflated with early intervention or the response to existing violence, or else limited to awareness raising or social marketing campaigns (UN Women, 2012). Education programs or sessions are frequently used in primary prevention, however, short, one-off education programs that are not linked with a comprehensive program do not meet the criteria for being primary prevention.

Health promotion is a public health discipline which strives to address the social, political and economic determinants of health in order to achieve a complete state of physical, mental and social well-being for individuals and communities, and to empower people to take charge of their own health. It provides an alternative to medicalised understandings of health, and goes beyond addressing individual lifestyle strategies (Peersman, 2001). For health promotion, health is seen as a resource for everyday life, not the objective of living, it is a positive concept which emphases social and personal resources, as well as physical capacities (World Health Organisation, 1986).

Culture has been described as a way of making sense of the world through shared understandings and constructed meanings – about the cultivated stories, myths, symbols and rituals that make sense of what groups have done, are doing and will do (Giddens, 1979). Because culture is continually emergent, negotiated and in play, change is possible. The strategies that are used to bring about culture change may include education, community mobilisation, social marketing, events (such as White Ribbon day or International Women's Day breakfasts and other community events), structural and policy changes and a myriad of other approaches. It is important to note that any one of these strategies implemented on a stand-alone basis do not meet the criteria for being primary prevention.

To be defined as primary prevention the strategies must challenge the attitudes and behaviours that are violence supportive whilst changing the structural supports that maintain gender inequality. Education programs, awareness raising and community mobilisation are all important, but alone do not constitute primary prevention; a comprehensive, multi-level, integrated approach is needed for primary prevention. Primary prevention should actively address multiple and intersecting forms of discrimination and disadvantage that place women and girls at risk of violence (UN Women, 2012). Primary prevention of gender based violence must focus on changing the culture/s that operate to make gender based violence acceptable and is sometimes referred to as culture or cultural change.

Primary prevention programs can be carried out in 'settings', or the places where people in communities live, work, play and age (Peersman, 2001). A settings approach makes it possible to target specific groups with appropriate programs – in (among others) sports clubs, schools, workplaces and faith settings, as well with specific population groups including children, young people, and people with physical and intellectual disabilities, Indigenous and culturally and linguistically diverse people.

VicHealth has led the way in piloting prevention programs across a range of settings. In 2012, *The Respect, Responsibility and Equality program: A summary report on five projects that build new knowledge to prevent violence against women* was published which provided an overview of five settings based programs that built capacity to promote equal and respectful relationships in various settings. These included:

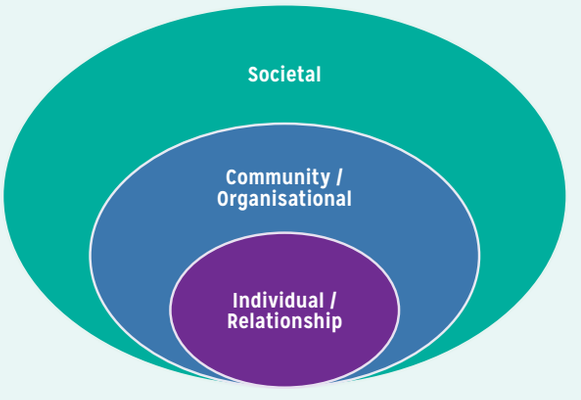
- Workplace setting: *Working Together Against Violence*, a Women's Health Victoria program in a male dominated corporate workplace.

- Maternal and child health: *Baby Makes 3*, Whitehorse Community Health Service program for parents in their transition to first time parenthood.
- Faith based communities: *Northern Interfaith Respectful Relationships* program, led by Darebin City Council to build capacity among faith leaders to foster respectful and violence free relationships between men and women.
- Youth sector: *Partners in Prevention*, led by the Domestic Violence Resource Centre Victoria to build capacity of practitioners to promote equal and respectful relationships.
- Local government sector: *Respect and Equity*, a program in one local government to address the underlying causes of violence against women from planning and policy to service provision.

2.4 The Ecological Model

To implement a primary prevention approach the use of a social/ecological model for change has been advocated. The social/ecological[10] model has been proposed for both understanding violence and for prevention activities.[11] The model suggests that rather than being a simple phenomenon, violence is the result of the complex interplay of individual, relationship, social, cultural and environmental factors. The model works at three levels: individual/relationship, community/organisational and societal, each of which is interdependent with the other.

FIGURE 1: AN ECOLOGICAL APPROACH TO UNDERSTANDING VIOLENCE AGAINST WOMEN
SOURCE: VicHealth (2207)



The Ecological Model suggests that the problem of violence against women is essentially one of culture and environment, rather than one of deficits in individuals. Solutions involve changing social norms and behaviours, and require the active involvement of all levels of the community. The premise of this model is that violence is a function of the abuse of power and control, and it aims to bring about social change to create an ethical setting where individuals are not exploited, power is not abused and all members of a community are involved (Maton, 2000). It has been argued that this model has the capacity for social transformation in individual and community values and norms. Change depends on interventions occurring at multiple levels ranging from individuals through to society, and from society down to the individual (Dyson and Flood, 2008). In this model:

- The **societal level** seeks to understand the cultural values and beliefs that shape the other two levels of the social ecology and change institutional and cultural support for, and weak sanctions against, gender equality and rigid gender roles. The role of governments is emphasised in providing an 'enabling' environment through policy and legislative reform to promote gender equality and women's empowerment.
- The **community/organisation level** works on the formal and informal social structures that impact on individuals such as norms concerning gender equality, masculine peer norms and organisational values.
- The **individual/relationship level** focuses on developmental and personal factors that shape responses to stressors in the environment such as rigid gender roles, weak support for gender equality, attitudes of masculine entitlement and superiority, and male dominance and control of wealth in relationships, as well as on promoting respectful relationships (World Health Organisation, 1986, Victorian Health Promotion Foundation, 2007).

[10] Commonly called the ecological model, the term will be simplified and used in this way throughout this paper.

[11] In this paper it will only be discussed in terms of primary prevention.

2.5 VicHealth Framework to guide primary prevention

While primary prevention work is happening across Australia, in the past decade the scope of this work has been strongest in Victoria, led by the Victorian Health Promotion Foundation (VicHealth).[12] VicHealth is one of a very small number of health promotion foundations established internationally, and the only one in Australia, with the explicit purpose of promoting health and well-being. VicHealth works in partnership with government, organisations, communities and individuals, and since the early part of this century has taken the lead in researching and developing programs to prevent violence against women.

VicHealth's *Preventing Violence Before it Occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria* (The Framework) demonstrates that efforts to prevent violence against women should be based on three interrelated themes. Promoting equal and respectful relationships between men and women; promoting non-violent social norms; and reducing the effects of prior exposure to violence and improving access to resources and systems of support (Victorian Health Promotion Foundation, 2007).

As well as mainstream efforts, the VicHealth Framework identifies particular population groups and actions for prevention activities. Population groups include children, young people, women and men, disadvantaged neighbourhoods, Indigenous communities, rural communities, culturally and linguistically diverse communities and women with disabilities. Preventative actions include research, monitoring and evaluation, direct participation programs, organisational and workforce development programs, community strengthening, communications and social marketing, advocacy and legislative and policy reform.

Settings and sectors for action include community services, corporate, faith communities, education, workplaces, cultural institutions and networks, arts, sport and recreation, media and popular culture, local government, health, cyberspace and new technologies, justice, academic and military/like institutions (Victorian Health Promotion Foundation, 2007).

VicHealth also identifies medium term outcomes. For example, at the *individual/relationship* level these may include improved access to support and resources, equitable gender relations and improved skills in non-violent conflict resolution. *Organisational outcomes* might include organisations that model and facilitate equal, respectful and non-violent gender relations. *Community outcomes* could lead to environments that value and support norms which are non-violent, which build connections between people and take action to address violence if it does occur. *Societal outcomes* might include strong legislative and regulatory frameworks for gender equality and healthy relationships between men and women. VicHealth also argues that these outcomes would in turn lead to long term benefits for individuals, communities and society as a whole. (Victorian Health Promotion Foundation, 2007).

VicHealth has developed a guide to primary prevention of violence against women based on the ecological framework (Victorian Health Promotion Foundation, 2007), an extract of which is reproduced below.

2.5.1 Key determinants of violence and theme for action

PROMOTING EQUAL AND RESPECTFUL RELATIONSHIPS BETWEEN MEN AND WOMEN		
Individual determinants	**Community/organisation contributors**	**Societal contributors**
▪ Rigid gender roles/weak support for gender equality ▪ Masculine sense of entitlement ▪ Male dominance and control of wealth in relationships	▪ Masculine peer and organisational cultures ▪ Culturally specific norms regarding gender and sexuality	▪ Institutional and cultural support for, or weak sanctions against gender inequality and rigid gender roles.

[12] VicHealth is a statutory authority with a tripartite governance structure (including government, community and VicHealth representatives) which was established by the Victorian Parliament as part of the Tobacco Act 1987.

2.5.2 Key contributing factors and themes for action

PROMOTING NON-VIOLENT NORMS/REDUCING THE EFFECTS OF PRIOR EXPOSURE TO VIOLENCE		
Individual determinants	**Community/organisation contributors**	**Societal contributors**
▪ Attitudinal support for violence against women ▪ Witnessing or experiencing family violence as a child ▪ Exposure to other forms of interpersonal or collective violence ▪ Use and acceptance of violence as a means of resolving inter-personal disputes	▪ Neighbourhood, peer and organisational cultures which are violence supportive or have weak sanctions against violence ▪ Community and peer violence	▪ Approval of, or weak sanctions against violence or violence against women ▪ Ethos condoning violence as a means of settling interpersonal, civic or political disputes ▪ colonisation
IMPROVING ACCESS TO RESOURCES AND SYSTEMS OF SUPPORT		
Individual determinants	**Community/organisation contributors**	**Societal contributors**
▪ Social isolation and limited access to systems of support ▪ Income, education and occupation ▪ Relative labour force status ▪ Alcohol or illicit drug use ▪ Poor parenting ▪ Poor mental health ▪ Relationship and marital conflict ▪ Divorce/separation	▪ Weak social connections and social cohesion and limited collective activity among women ▪ Strong support for privacy of the family ▪ Neighbourhood characteristics (service infrastructure, unemployment, poverty)	▪ Support for the privacy and autonomy of the family ▪ Unequal distribution of material resources (unemployment, education)

2.6 Good practice in primary prevention

In 2006 the UN Secretary General reported to the General Assembly on the *In-Depth Study on All Forms of Violence against Women*. The report articulated general principles, based on international evidence, for good practice in prevention. These principles can be applied to all programs and are mapped here against the levels of the ecological model:

Societal level: prioritising the prevention of violence against women in all policies and programs; allocating specific resources within all sectors for prevention activities, and seeking political support for sustained, long-term investment in prevention (United National General Assembly, 2006). Community and media programs should also be supported by Government laws and policies that promote gender equality (World Health Organisation, 2009).

Community/Organisation Level: developing prevention strategies that address the root causes of violence against women, particularly the persistence of gender-based stereotypes; outlining clear objectives, defining what prevention strategies are seeking to change and how; and putting in place a process of monitoring and evaluation. Working with a cross-section of stakeholders, including government bodies, NGOs, workers' and employers' organizations and local community leaders, to build inclusive and effective strategies; and promoting women's safety, including by altering physical environments where necessary

Individual/relationship level: engaging men and boys proactively in strategy development and implementation for the prevention of male violence against women; highlighting the fact that violence against women is unacceptable and its elimination is a public responsibility; ensuring that prevention efforts are holistic, take into account multiple discrimination and connect wherever possible with other key issues for women (United Nations General Assembly, 2006).

Prevention programs need to be developed using a consistent, evidence based framework. When planning a prevention initiative it is vital to consider how this work can complement and reinforce similar approaches occurring at other levels. In this way multiple settings and sectors can work coherently to build the necessary momentum to effect long term cultural change. For example, an education program in a sports club or school may have a primary focus on the individual/relationship level of the social ecology, but it can draw upon examples of respect in the wider community by using 'teachable moments'[13] from the media or current affairs to encourage participants to think more broadly than their own immediate lives and relationships.

Many small and medium sized programs are currently in progress in communities across Australia; as these programs develop a growing body of knowledge is emerging from practice. The combined effect of this will create a groundswell of momentum and lead to the kind of long term cultural change that is required for the ultimate elimination of violence against women and the creation of a society in which all people are equal, and respectful relationships and behaviours are the norm.

2.6.1 Principles for community mobilisation

In addition to the comprehensive principles for prevention (discussed above), other sources have articulated principles for community mobilisation and prevention education.

The World Health Organisation (2007) identified principles for conducting community based primary prevention education. These include: the use of participatory methods for effectively engaging participants; fostering an enabling social environment to increase the likelihood that positive behaviour change will be sustained; employing and training facilitators with high quality skills; providing long term follow-up to support and sustain changes brought about by the program; and combining education with wider advocacy and community mobilisation activities.

A community mobilisation approach that reaches each level of the ecology has been advocated by Michau (2005). These include:

A proactive approach: primary prevention assumes that it is not enough to provide services for women experiencing violence, or to promote prevention without challenging communities to examine the assumptions which perpetuate it. The root causes of violence against women must be addressed through gender based analysis of why violence occurs – such as the imbalance of power between women and men and rigid gender roles.

A holistic approach: violence prevention should be relevant and recognise the multifaceted and interconnected relationships between individuals and institutions. The complex histories, cultures and relationships that shape a community must be acknowledged and accommodated. To generate momentum for change a wide cross section of community members must be engaged, not just women or one sector, such as police or the health care system.

A process of social change: changing attitudes, values and norms is a process, not a one off event. Projects should be based on an understanding about a systematic process of change, implemented by skilled facilitators who can guide a community on a journey of change.

Repeated exposure to ideas: individuals should be exposed to regular reinforcing messages from a range of sources over a sustained period of time. This means a co-ordinated approach across sectors with faith, school, sports, and arts communities, the media, and workplaces all communicating the same messages about violence against women being unacceptable under any circumstances, and respect and equality being desirable in relationships.

Community ownership: organisations can play a role in facilitating change, but it is in the hearts and minds of the individuals and groups in a community where change must occur. Therefore, it is those individuals and groups who must engage with and lead change.

2.6.2 Principles for prevention education

Prevention education programs are directed at children, young people and adults in a range of settings. Research in the USA noted a paucity of evidence concerning prevention education programs with young people that demonstrate disrupting sexually violent behaviours.

[13] Teachable moments are those times when a significant event occurs that can be used to 'educate' groups or individuals. For example, incidents of blatant disrespect or of gender inequality in the media or current affairs can be used as the basis for facilitated discussion to focus on what could have been done differently. Teachable moments are suggested as a strategy for Soccer's *Coaching Boy's into Men* program.

Tharp et al. argue that programs have forgone 'the standards of evidence and the principles of prevention to move a program more quickly into practice' (Tharp et al., 2011, p. 3384). To identify principles for prevention, these authors turned to prevention programs in areas such as delinquency, substance abuse, sexual risk and school failure, which they claim have demonstrated effectiveness. The principles identified include that programs should be comprehensive, use varied teaching methods, be theoretically driven, promote positive relationships, be appropriately timed in development, socio-culturally relevant, and employ well trained staff to ensure adequate implementation and are of sufficient 'dosage' to create behaviour change (Tharp et al., 2011).

In Australia work has also been done on developing principles for violence prevention. For example, the Social Justice and Social Change Research Centre at the University of Western Sydney identified six standards for education programs to prevent sexual assault, which extend to both community and school based programs (Carmody et al., 2009). The same year VicHealth also developed principles for respectful relationships education (Flood et al., 2009). Rather than go into detail about each authors' principles, here they are synthesised, as they are remarkably similar. Both reports suggest that programs must:

- be comprehensive
- be theoretically driven and address cultural and developmental concerns
- engage educators who are well trained and skilled in prevention education techniques, and use a positive, enabling approach
- use participatory approaches to effectively engage participants, and
- be subject to rigorous evaluation.

Research has demonstrated that to be effective, programs with school aged students should be part of a whole school approach[14] that promotes an ethos of equality, respect and non-violence throughout the school community, supported by policies (Flood et al., 2009, Dyson, 2008, Dyson et al., 2011). School programs should also be supported by community interventions that work to effect change in individuals and whole communities by addressing gender norms, and media interventions such as public awareness campaigns that challenge gender norms and attitudes through awareness raising activities.

Didactic approaches are unlikely to be effective in education programs. A number of alternative approaches to education shift the power focus away from the educator towards empowering learners. Critical pedagogy, founded by Paolo Friere, is concerned with the idea of a just society in which people have economic, political and cultural control over their lives (Aliakbari and Faraji, 2011). According to Freire (2005) traditional education works on a model that assumes information can be 'banked' by educators who hold 'knowledge' into students who are empty vessels and recipients of information; in this model, teachers are authorities and students (regardless of their age) are obedient to their authority (Friere, 2005). Individual learning styles differ, and varied approaches are appropriate to maximise learning in any group. Much learning is non-formal and essentially a social process. 'Learning is not just a psychological process, but is intimately related to the world and affected by it. People take on the knowledge, values, beliefs and attitudes of the society in which we live' (Jarvis, 1987, p. 11). Action learning is one form of critical pedagogy that is about learning from concrete experience and critical reflection, through group discussion, trial and error, discovery and learning from one another. It is a process by which groups of people work towards change on real issues or problems (Zuber-Skerritt, 2001).

Based on the principles for primary prevention programs identified above for community, and education programs, the following questions are proposed to guide practitioners planning a program to assess whether it meets the criteria for being primary prevention:

- Does it address sexist norms and promote gender equality?
- Is it comprehensive, contextualised and relevant to the setting and the individuals in it?
- Does it focus on structural as well as individual contributors to the problem?
- Does it have a clear program logic that is theoretically and empirically informed?
- Does it emphasise a positive, strengths based developmental process?
- Is it (or will it be) evaluated?

[14] A whole school approach is advocated as part of health promoting schools. This involves not only working with students and on the curriculum, but also addressing the health issue in school policies, the overall ethos and environment in the school and by engaging the wider school community including staff members, parents, students and relevant local community agencies.

2.6.3 Principles for awareness raising campaigns

Awareness raising campaigns are an important component of a comprehensive primary prevention approach. They should aim to change attitudes, behaviours and beliefs that normalise and tolerate gender based violence. Awareness-raising campaigns are recognised as the efficient and effective means of communicating information to the general public. Awareness raising should take a top down, bottom up approach, fostering communication and information exchange in order to improve mutual understanding as well as mobilising communities and the whole society to bring about the necessary change in attitudes and behaviour (European Institute for Gender Equality, 2013). They should have a strong basis in human rights and gender analysis; clear, appropriate, comprehensive definitions of violence; take a women/victim-centred approach; hold men/perpetrators accountable for the violence they inflict; emphasise equality and anti-discriminatory practice and recognise the diversity of women and men.

In Australia, VicHealth undertook a review of awareness raising campaigns and identified a number of principles for implementing such programs. These include:

- Pretesting, and 'on the ground' activities to avoid undesirable and unintended consequences of awareness campaigns (e.g. normalising abuse). Preparation for increased awareness also needs to include interagency responses and referral networks, so that responses to the campaign can be appropriately addressed.
- Need for a campaign to be based on social marketing and health promotion theory and for it to be developed using formative research with thorough pretesting.
- Developed from a theoretical base and/or had been developed using research or pre-testing. The authors also noted that few campaigns had been evaluated (Donovan and Vlais, 2005).

2.6.4 A Strengths Based approach

A strength based approach calls for programs to be positive, inclusive and enabling. Health promotion theory suggests that to be effective, programs must be 'salutogenic' (Antonovsky, 1996). Traditional, disease focused approaches to health use a 'pathogenic' model sit at one end of a continuum of approaches to health and well-being while salutogenesis sits are the other. Salutogenesis argues that health can be an asset held by individuals and groups which can promote positive well-being (Glasgow Centre for Population Health, 2011). In the salutogenic, or asset based approach, one type of intervention aims to strengthen resources such as self-management, community networks, and another aims to create meaning – interventions to increase perceptions of control (Harrop et al., 2006). An asset based approach makes visible and values the skills, knowledge, connections and potential in a community. It promotes capacity, connectedness and social capital (Glasgow Centre for Population Health, 2011). In primary prevention programs, it is important that it is positive, strengths based and that participants are engaged as partners in the change process, not as potential victims or perpetrators. This means not focussing too much on the negative aspects of abuse and disrespect, but focusing on promoting equal and respectful relations between women and men. It also means recruiting women and men as partners in prevention so that they take responsibility for identifying changes and making them happen.

2.6.5 Challenges to Primary Prevention

It is important to recognise that primary prevention in the field of preventing violence against women is a new and emerging field and practitioners may face challenges as they learn from experience.

One of these challenges is to maintain a focus on primary prevention rather than be drawn into tertiary, secondary prevention. Because tertiary work is more visible and tangible, funding bodies may try to combine response and prevention in one program. The response sector has historically struggled to provide safety and support for women who are victims of violence and it is vital that resources should not be taken from these services, and that they should not have to compete with for limited funding with the primary prevention sector.

Prevention requires specific skills which are different to those required for crisis response, and it is important that the workforce for each has a clear understanding of its roles and responsibilities and works together co-operatively. While the reason for running primary prevention programs is to eliminate violence against women, the focus of programs must be on the underlying causes. That is, the power imbalance, gender inequality between men and women and associated cultures of disrespect and abuse. These are the factors that give rise to, or create the conditions that lead to gender based violence. These conditions include the structural barriers of gender inequality and gender role socialisation, and the social norms that ignore, condone or support violence against women.

To achieve the goal of preventing and eliminating violence against women it is imperative that funding for evidence based primary prevention programs and research is not only maintained, but also expanded as new knowledge and understanding emerges.

3. Evaluating primary prevention programs

In the context of social programs, evaluation is a means of documenting what has happened, identifying what worked, what didn't work, assessing short and medium term outcomes and longer term impact. Process evaluation tells the 'story' behind the program as it develops. Outcome evaluation focuses on the effects of the program; the extent to which its goals and objectives were met, and any unexpected outcomes. Impact evaluation reports on the long term results of a program, analysing, for example, the long-term maintenance of change resulting from a program.

The work of primary prevention is not an exact science and evaluating the effectiveness of prevention programs can be difficult. Criteria for effectiveness depends on the findings of a well conducted, rigorous evaluation which focuses on outcomes in terms of not only knowledge and attitudes, but also on sustained behaviour change. The kind of high level measures that are often identified for primary prevention, for example, changes in community attitudes, are almost impossible to link to particular programs. Few studies have had the capacity to follow participants in a program longitudinally to understand what changes and which programs work (World Health Organisation, 2002, Quadara and Wall, 2012, Casey and Lindhorst, 2009).

Evaluation is a developing science and the increased demand for evidence based programs has increased pressure on the community sector to include evaluation as part of program plans; which rarely includes adequate funding for external evaluation. Earlier generations of evaluation focused on the evaluator as 'objective scientist' who stands outside of a program to judge its worth, or describe strengths or weaknesses. VicHealth has developed a capacity building approach to the evaluation of primary prevention programs. This will support community organisations to include internal evaluation, see, for example, Kwok (2013) and Flood (2013).

Evaluation capacity building has been defined as efforts to equip community sector practitioners with the skills to conduct evaluations and to integrate evaluation findings into practice (Flood, 2013). This approach was used in the five projects of the *Respect, Responsibility and Equality* programs funded by VicHealth between 2008 and 2011. According to Kwok (2013) primary prevention practice effects change incrementally and evaluation of programs should also be incremental. She identifies three key points which have emerged from the capacity building approach to evaluation:

- **First**, primary prevention evaluations must be *process* oriented – based on the understanding that the work is aimed at determinants level change. Primary prevention is about a means not an end and evaluations must be means directed.
- **Second**, evaluations must be prepared to explain the link between the program initiatives and the potential to influence determinants level change (that is, gender equality and respectful behaviours). They should be able to demonstrate that changes have occurred through realistic and measurable indicators.
- **Third**, evaluations are about practice that holds promise for longer term change. Promising practice is not necessarily practice that achieves a reduction in the problem, rather it is practice that is shown to potentially influence the root causes of the problem, in this case, the social norms that make violence against women acceptable in the first place (Kwok, 2013).

3.1 Knowledge transfer and exchange

Knowledge transfer and exchange is a process which brings together researchers and the individuals, groups and communities which have a stake in participating in, or using research or evaluation findings to exchange ideas, evidence and expertise. In other words, research informs (evidence based) practice and practice in turn informs research to ensure a continuous cycle. It is a critical part of the research process and can take the form of:

- building links to ensure that research informs and is informed by policy and practice.
- developing and maintaining relationships between researchers and those who have a stake in informing or using the results of the research.

- disseminating research outcomes in ways that are accessible and comprehensible to the relevant stakeholders.

Anecdotally there are many other projects in progress and completed, but almost no academic literature that analyses or reports on outcomes[15]. Added to this there are limited community reports that add to learning from empirical experience. Although a plethora of prevention programs have been funded over the past decade the lack of effective knowledge transfer and exchange is a major flaw that must be addressed. It is hoped that the Centre for Excellence and Foundation for the Prevention of Violence against Women (see below) established in 2013 may go some way to addressing this gap in knowledge

[14] What 'counts' as evidence is often limited to peer reviewed publications. There is a time delay – often of years – between the completion of research or evaluation, writing up results, submitting them to academic journals, peer review and final publication.

4. Policy Context

4.1 National, State and Territory Plans

The National, State and Territory Plans to address violence against women are summarised below. The plans all focus to some extent on the three levels of prevention (discussed on pages 16 and 17 of the paper). Response, service co-ordination and integration take a central position in most of the plans. Each plan has been analysed to understand the extent to which they address primary prevention and the three levels of the social ecology discussed on page 27. Although the various plans contain detailed strategies or action plans, the main focus of the summary here is on the extent to which the plans meet the criteria for primary prevention.

Plans were sourced from web searches, some were readily available on the relevant Government Department's web site, others were harder to find. In 2012 a progress report on the National Plan was submitted to the Australian Women against Violence Alliance (AWAVA). The report outlined primary prevention measures that had been implemented, including The Line social marketing campaign, respectful relationships programs in schools and community settings targeting young people, especially boys and community based in sporting organisations.

No other evaluation or update on the progress of the National Plan was found in searches of the Australian Government web site, of the departments responsible for implementation and co-ordination of the plan, or of the internet. In 2013 there were two significant developments related to the National Plan, the announcement of a Foundation for the prevention of violence against women and the National Centre for Excellence. The progress report to AWAVA also notes that the National Centre of Excellence (NCE) as a key strategy to deliver the Plan's goal of improving the evidence base and its application towards enhancing policy, programs and practice (FaHCSIA, 2012).

4.2 Summary of National and State Government Plans

Policy	Time frame	Goals/outcomes	Analysis
National Plan to Prevent Violence against Women and their Children	2010 – 2022	1. Communities are safe and free from violence 2. Relationships are respectful 3. Indigenous communities are strengthened 4. Services meet the needs of women and their children experiencing violence 5. Justice responses are effective 6. Perpetrators stop their violence and are held to account.	▪ Outcomes one & two meet the criteria for primary prevention. ▪ Outcome one addresses all levels of the social ecology. ▪ Outcome two emphasises the importance of working in schools with young people. ▪ Community programs have been funded as part of the plan but no evidence is yet available. ▪ In 2013 it was planned to include respectful relationships education in the national curriculum, identify primary prevention benchmarks and to work with the media to shape the broader conversation about violence against women.

Policy	Time frame	Goals/outcomes	Analysis
Queensland state plan: *For our sons and our daughters*	2009 - 2014	▪ All people, regardless of gender, age, sexual orientation or personal circumstance, are safe to live free from domestic and family violence in Queensland.	▪ No mention of primary prevention, the focus is on tertiary strategies. ▪ Schools program Social and Emotional Learning in Queensland to 'support children to develop positive behaviour and constructive social relationships' mooted but no details available. ▪ Although Queensland is a signatory to the National Plan and is active in a range of secondary and tertiary programs, a search of the Queensland Government web site revealed no annual reports for the current strategy, which expires in 2014.

Policy	Time frame	Goals/outcomes	Analysis
ACT Strategy: ***Our Responsibility: Ending Violence against Women and Children***	2011-2017	▪ Women and children are safe because an anti-violence culture exists in the ACT ▪ Increase safety and security for women and children in public spaces ▪ Promote and support public discussions about violence against women and children ▪ Build respectful relationships initiatives, identify gaps and new target groups for education.	▪ Meets the criteria for primary prevention. ▪ Recognises violence against women as a human rights issue and an impediment to equality. ▪ Addresses all levels of the social ecology

Policy	Time frame	Goals/outcomes	Analysis
New South Wales: ***Stop the Violence, End the Silence: NSW domestic and family violence action plan***	2010 (no end date)	Prevention goals: ▪ Increase community awareness that such violence is not acceptable ▪ Sustained, evaluated prevention strategies targeting the whole community and particular 'at risk' communities ▪ Mainstreaming preventative strategies across key government agencies.	▪ Primary prevention embedded in the plan. ▪ Stresses an integrated approach. ▪ Has immediate, medium and long term goals. ▪ Alludes to the ecological model

Policy	Time frame	Goals/outcomes	Analysis
Victoria: ***Action plan to address violence against women & children: everyone has a responsibility to act***	2012 – 2015	▪ Addresses prevention, early intervention and response through an integrated system ▪ Educating to change attitudes and behaviours and to promote respectful non-violent relationships and engaging organisations and communities to promote gender equity and stop violence ▪ Fostering relationships, organisations, communities and cultures that are gender equitable and non-violent.	▪ Contains a clear definition of primary prevention and acknowledgement of the ecological model. ▪ Anecdotally an evaluation of the plan is planned, however evidence of this this was not found on the DHS web site. ▪ A strong primary prevention plan.

Policy	Time frame	Goals/outcomes	Analysis
South Australia: ***A Right to Safety: the next phase of South Australia's Women's Safety strategy***	2011 – 2022	Prevention section has three main areas of focus: ▪ Promoting communities not to tolerate violence against women ▪ Promoting respectful relationships ▪ Promoting gender equality.	▪ Uses the VicHealth *Framework for primary prevention* and meets the criteria for primary prevention. ▪ Ecological approach not specified, however, the three outcomes address the individual, relationship, community and societal levels of the ecology.

Policy	Time frame	Goals/outcomes	Analysis
Western Australia: ***Family and domestic violence prevention strategy to 2022***	2013-2022	▪ *Prevention and early intervention* states 'individual attitudes and behaviours within the community reflect that family and domestic violence in any form is not acceptable' ▪ Encourage schools and other educational institutions to implement Respectful Relationships Education Programs through integration into the mainstream curriculum ▪ Continue to raise awareness and support attitudinal change towards family and domestic violence through a range of social marketing campaigns targeted at diverse communities ▪ Build capacity and engagement with media outlets to promote appropriate and respectful reporting of family and domestic violence (Government of Western Australia, 2012).	▪ This strategy does not specify the use of, or define primary prevention or the ecological model; it has no mention of gender equality, and therefore, does not address the root causes of violence against women. ▪ Because it lacks these qualities, this plan, whist it addresses some components does not for the purposes of this paper meet the criteria for primary prevention.

Policy	Time frame	Goals/outcomes	Analysis
Tasmania: *Primary Prevention Strategy to Reduce Violence against Women and Children*	2012 – 2022	▪ Strongly aligned with the national plan ▪ Rejects outcomes 5 and 6 from the National Plan as being secondary and tertiary responses that should be addressed through the criminal justice system ▪ The implementation plan states that it will address social norms and practices relating to violence, gender roles and relations and access to resources and systems of support, and provides actions, and indicators for change for each stated action ▪ Each of the actions in the implementation plan address the broader factors that underpin the phenomenon of gender-based violence.	▪ Clearly defines primary prevention and the ecological model ▪ No evidence that it is being applied in practice.

Policy	Time frame	Goals/outcomes	Analysis
Northern Territory		No specific plan, links with the National Plan and VicHealth resources and AWHN National Women's Health Strategy.	

4.3 National Centre for Excellence

The National Centre for Excellence (NCE) was established in mid-2013, represents a key commitment under the National Plan and a specific component of the first three year plan 2010 – 2013. The main function of the NCE is to build the evidence concerning domestic violence and sexual assault, and it has responsibility for developing a national research agenda and program.

Prior to 2013 the Commonwealth Government funded two gender based violence clearinghouses to disseminate research and inform practice: the Australian Domestic Violence Clearinghouse and the Australian Centre for the Study of Sexual Assault. With the creation of the National Centre for Excellence (NCE) two key bodies responsible for research and knowledge transfer in the national plan are now defunded. According to the NCE web site the core functions of the two clearinghouses will continue under its aegis, and a phased approach to the transition will see the existing clearinghouses continue to provide certain functions and services while the NCE prepares for a transition late in 2014.

The NCE is located in Sydney; its functions are specified in the 2012 National Implementation Plan (discussed above) as being to:

- Lead national efforts to enhance the research base in the areas of domestic [and family] violence and sexual assault across research, education and service delivery organisations to support the National Plan;
- Focus on translating evidence into information to support ongoing improvement in the work of practitioners;
- Help inform policy development and service delivery responses; and
- Prioritise, coordinate and focus research efforts across the different outcomes of the National Plan, as well as taking account of priorities identified in other national research agendas.

Late in 2013 the NCE undertook a stakeholder engagement process to inform the development of a national research agenda and identification of research priorities for perpetrator intervention programs. The report of the stakeholder engagement process states that primary prevention remains an under researched area in relation to domestic and family violence, with the main research focus being on interventions (or tertiary prevention).

Initial funding of $1 million was provide to establish the NCE; from mid-2013 the Centre will receiving annual funding of $3 million, with the Australian Government providing $1.5 million annually and the remaining

$1.5 million being provided by state and territory governments on a cost shared basis (Department of Social Services, 2013).

In May 2014 the Federal Government re-launched the NCE under a new name, as Australia's National Research Organisation for Women's Safety (ANROWS).

4.4 Foundation for the Prevention of Violence against Women.

In July 2013 the Foundation to Prevent Violence against Women and their Children (the Foundation) was launched by the Commonwealth and Victorian Governments. The Foundation is a national, independent, not for profit, awareness-raising non-government organisation (NGO). It will engage the community in action to prevent violence against women and their children. The purpose of the Foundation is to harness community energy to reject inequality and violence against women, and drive a change in attitudes and behaviour (West et al., 2013). The role of the Foundation is to build on the National Plan, particularly in relation to primary prevention. Its objectives are to:

- Raise awareness and engage the community in taking action to prevent violence against women and their children;
- Drive a broad-based change in attitudes that condone or excuse violence against women and their children, and promote respect between women and men, including young people and children;
- Work with communities in which women and their children can be especially vulnerable to violence. This includes indigenous communities, culturally and linguistically diverse (CALD) communities and women and children with disabilities;
- Protect children through preventing violence against women, recognising the linkages between violence against women and child safety and well-being;
- Build a platform to bring together and support existing best practice primary prevention and other community organisations to collaborate in reducing violence against women and their children; and
- Establish an innovative and sustainable agency.

During the last half of 2013 community consultations were carried out around Australia with a range of stakeholders. The consultant's report on the national consultation process proposes that the Foundation should:

- Develop a national awareness raising strategy/ campaign to increase understanding across the country of the nature, dimensions, contributors and impacts of violence against women and their children, including a media/communications strategy;
- Develop a national primary prevention plan with implementation guidelines linked to the National Plan, National Framework for Protecting Australia's Children 2009-2020 and other relevant strategies/ frameworks; and
- Map key legislative and other systemic factors and develop a priority action plan to guide the changes required to assist in the prevention of violence.

At the time of writing this paper it was announced that the Foundation and the Victorian health Promotion Foundation (VicHealth) had formed a partnership to build, at the national level, on existing work to prevent violence against women. The first priority of the partnership is the development of national framework to provide a shared understanding of what needs to be done and ANROWS will be an equal partner in the frameworks development. (VicHealth, 2014).

5. Recommendations for a way forward

A sound foundation has been laid for the future development of primary prevention of violence against women in Australia. VicHealth has developed the evidence base and frameworks upon which to build primary prevention programs and the women's health sector across Australia has well developed skills for delivering such programs. This is not to suggest that all the answers are available and there is a great deal more to learn. With the backing of governments and the new non-government structures of the Foundation and Centre for Excellence, the stage is set for the work to continue and for ongoing improvement in knowledge and skills to occur. Based on the findings of this position paper, the Australian Women's Health Network (AWHN) proposes the following recommendations for a way forward in Australia to work towards the goal of eliminating violence against women.

To Federal, State and Territory Governments

Based on the findings of this position paper the Australian Women's Health Network recommends that Governments:

1. Recognise that no single initiative will prevent violence against women. Dedicated funding must be provided to the primary prevention sector to ensure activities can be delivered across the range of settings where people live, work and play to continue and expand the work of preventing and eliminating all forms of violence against women.
2. Continue to provide specific funding for the tertiary response sector at a level to ensure women who are subjected to intimate partner violence and sexual assault have adequate and appropriate services available to provide them with safety and support.

This position paper has highlighted the importance of a collaborative, coordinated integrated approach to address violence against women. We believe that a national body is required to ensure the successful implementation of the recommendations contained on this paper. We therefore recommend that:

3. Responses to violence against women be guided by a national advisory structure of all relevant stakeholders. This would include governments, the Foundation, ANROWS, AWAVA, women's health and other community organisations. The national advisory body would be responsible for developing a collaborative multi-year workplan between member stakeholders.

Further, we recommend that:

4. All community projects funded by the Commonwealth Government are evaluated (using either an external evaluation approach or a capacity building internal evaluation approach as discussed on page 29 of this position paper) and that reports of these evaluations are made freely available to the primary prevention sector to build the evidence base and to ensure ongoing learning. The multi year workplan discussed in Recommendation 3 should also be accompanied by an appropriately funded, substantive meta-evaluation of whole of population change.

It is the role of government to ensure gender equity is enshrined in all Commonwealth and State laws, policies and practices. We therefore recommend:

5. All government policies should be reviewed regularly using a gender lens and when necessary updated to ensure that gender equality is enshrined in all its practices.
6. A communication strategy should be undertaken to promote gender equality laws and policies to ensure they are understood and adhered to by government, business and non-government sector organisations.
7. Governments and political parties at all levels should comply with and model gender equality in all appointments and committees.

It is commendable that Australia has a long term prevention plan in place; however, preventing violence against women is both an urgent and long term task that should not be subject to changes of government. The AWHN therefore recommends:

8. That Governments should publish regular updates on the progress of Commonwealth, state and territory prevention of violence against women plans. Reports from community programs funded under these plans should also be made available to ensure effective knowledge exchange occurs to inform ongoing practice.

There is a considerable focus on educating young people in equal and respectful relationships in the Commonwealth plan to prevent violence against women. The AWHN therefore recommends:

9. Respectful relationships education programs be incorporated into all schools' curricula from kindergarten through year 12.
10. All school programs are developed using the good practice principles detailed on page 24 of this position paper, using a whole school (health promoting) approach.
11. Long term funding be provided to continue improving and expanding primary prevention approaches across settings. This should include a long term commitment to evaluation.

To the Foundation to Prevent Violence against Women and their Children

Based on the published roles and functions of the Foundation detailed on pages 34 & 35 of this position paper, the AWHN recommends:

12. Awareness raising programs developed and conducted by the Foundation should be evidence based, and draw on the good practice principles for community programs identified on page 24 of this position paper.
13. The Foundation develops a nationally agreed framework (including detailed definition of, and principles for primary prevention) to guide program development and implementation. This should be used to assess applications at all levels for funding primary prevention programs. Criteria for assessing primary prevention are suggested on page 24 of this position paper.

The media can play an important role in the primary prevention of violence against women. The EVAs[16] in Victoria has established that collaborations between NGO and media representatives can be productive. We therefore further recommend:

14. The Foundation works collaboratively with media outlets regardless of the platform to develop voluntary standards for reporting and advertising that reflects gender equality and respectful representations of women and men.

To Primary Prevention Practitioners

Two key bodies stand out as having the knowledge and experience in both the social determinants of health and primary prevention, VicHealth and the women's health sector Australia wide. VicHealth has provided the evidence base upon which programs can be developed and the women's health sector has well developed skills in health promotion and primary prevention. The AWHN therefore recommends:

15. At a minimum, primary prevention programs should promote gender equality and respectful relationships, as well as challenging violence supportive behaviours, environments and structures that are the social determinants of violence against women.
16. Primary prevention programs be planned using the good practice principles identified in section 2.6 of this position paper.
17. Because gender inequality and the social determinants of health are critical factors underpinning violence against women, a gendered lens should be applied to the planning of primary prevention programs to ensure the underlying factors of gender and power are incorporated into all program plans.

[16] The Eliminating Violence Against Women Media Awards.

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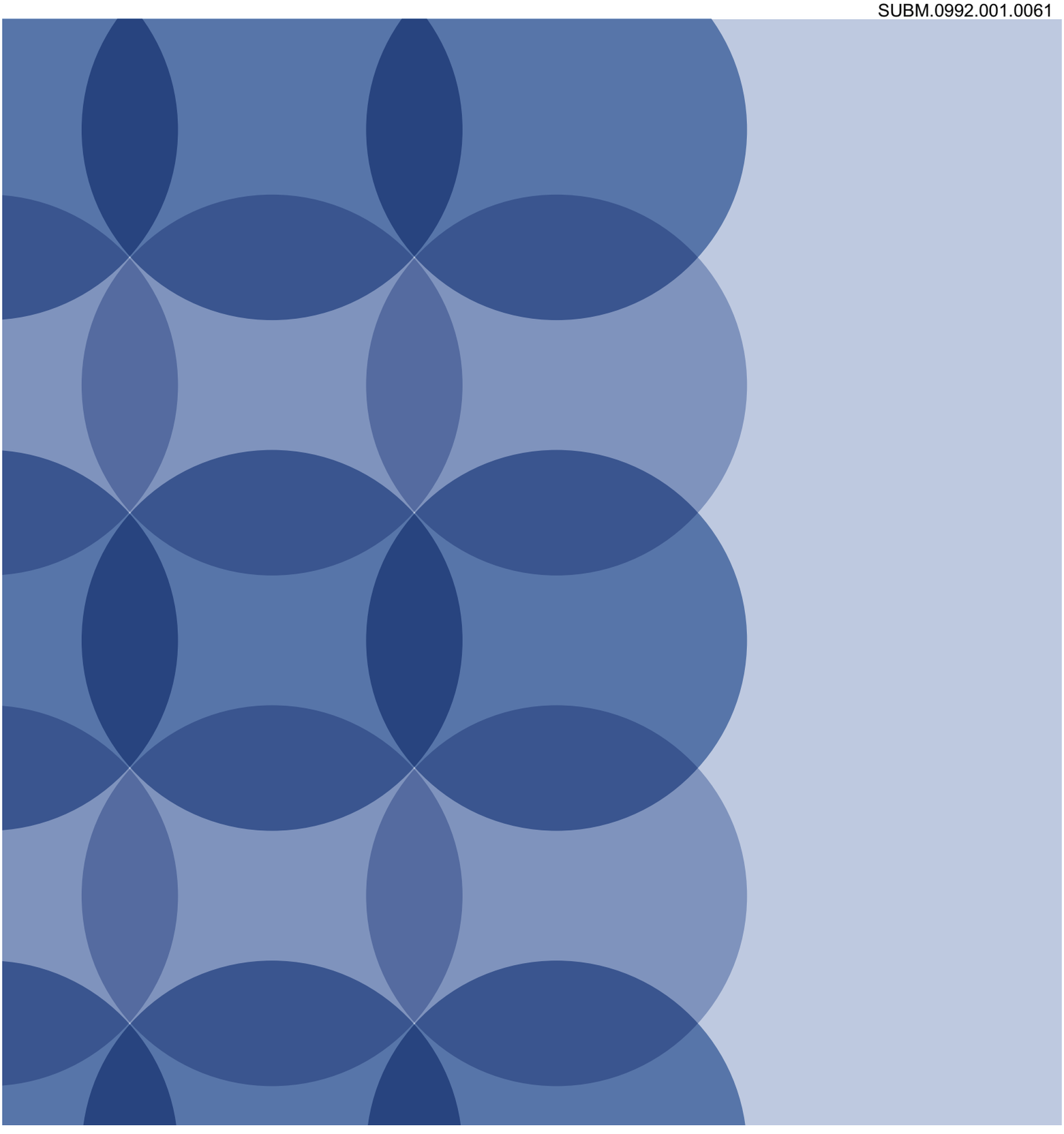

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WOMEN AND MENTAL HEALTH

Position Paper 2012

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Women and Mental Health

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Executive summary

Mental ill health is a major health concern for Australians, with almost half of the population either directly or indirectly experiencing the impact of mental illness. Women are disproportionately affected by mental illness. In Australia, anxiety and depression are the leading causes of disease burden for women.

Women's mental health policy context

It is of great concern that despite the prevalence of mental disorders among women, there has been very little focus on the special needs of women with mental ill health. Most policies, framework documents, and other important discussion papers that advise governments on strategic funding do not adopt a gendered approach. This has meant that women with mental illness have not received the level of support and services, research and education needed to ensure the best possible outcomes. The National Women's Health Policy (NWHP) (Department of Health and Ageing, 2010) addresses inequities in women's health and women's mental health. However, this approach is rarely reflected in other areas of relevant policy development. In recent times the moderate level of mental health reform has been driven by the need to improve outcomes for adolescents, dominated by the needs of young men. While this is an important objective, the youth mental health reform strategies have inadvertently contributed to further inequities in services and support provision for women with mental illnesses. This document outlines the Australian Women's Health Network position on women's mental health and makes recommendations for action on policy, systems, and service delivery development to improve mental health outcomes for women in Australia.

Determinants of mental ill health in women

There are distinctly different determinants of mental disorders in women and men. Important social factors causing mental ill health include violence against women, perpetrated against them both as children and adults. As a result of traumas women can experience profound mental disorders such as depression, anxiety, post-traumatic syndrome and Borderline Personality Disorder. Other issues such as homelessness, poverty, and substance abuse can be associated with violent relationships and further complicate mental ill health patterns. Recent data shows that women are experiencing increasing rates of alcohol, ecstasy and related drug abuse, which in turn can cause mental illnesses such as psychosis or depression. However, there are very few women-focused alcohol and drug abuse recovery programs.

Biological factors, including reproductive hormone fluctuation across the life-cycle, have not received much attention with respect to impact on mental health. Premenstrual dysphoria, postnatal depression or psychosis, and perimenopausal depression are examples of specific reproductive hormone changes that are implicated in the development of mental illness. Women experiencing these conditions or other physical illnesses, such as polycystic ovarian syndrome, need increased levels of access to co-located psychological/psychiatric services than are currently available. Women experiencing psychiatric disorders such as Borderline Personality Disorder are often misdiagnosed, and there is currently very little adequate treatment available. This is an important area requiring research investment. Psychiatry services need to adopt a gendered focus, with significant consideration given to the safety and privacy provided for women, particularly in inpatient units. Community psychiatry teams also need to provide more gender-focused programs for women.

Research and education

There is a notable lack of well-coordinated, integrated research in the area of women's mental health and mental illness. Women-focused, evidence-based treatment approaches are needed to underpin future strategic planning for developing and funding support and services to assist women with mental illnesses. Public and professional education strategies concerning mental health and mental illness are required in order to decrease stigma associated with mental disorders in women and to assist women in accessing appropriate resources.

In conclusion, there is a fundamental and urgent requirement for mental health reform that addresses the specific needs of women and includes strategies that simultaneously support the prevention of mental illnesses and increase the overall well-being of women living with existing mental health conditions. By focussing more on women's mental health issues the quality of life for many Australians in the broader community will be greatly improved.

Recommendations

Women's mental health in the current policy context

It is recommended that:

1. all mental health policies adopt a gendered approach (p. 14);
2. current and proposed National Mental Health Plans are linked together and informed by the *National Women's Health Policy* (2010), to ensure the inclusion of a clear focus on women's mental health (p. 14);
3. the Commonwealth Department of Health and Ageing provide leadership to mental health services in gendering action across the social determinants of health through the mental health strategy, *A Ten Year Roadmap for National Mental Health Reform* (p. 14); and
4. the strategic priorities of existing youth programs are expanded to offer greater mental health promotion opportunities and develop more clinical services that are specifically designed for young women with Borderline Personality Disorder and Depression/ Anxiety Disorders (p. 14).

Violence against women

It is recommended that:

5. the Council of Australian Governments maintains its commitment to and investment in the *National Plan to Reduce Violence Against Women and Their Children Strategy* 6.3: Intervene early to prevent violence by ensuring that:
   - » research into perpetrator interventions is undertaken;
   - » best practice guidelines and national standards are developed;
   - » specific evidence-based best practice domestic violence programs are developed, tested and rolled out; and
   - » the identification of "effective post-intervention services and programs to sustain long term behavioural change and reduce re-offending" (p. 16).
6. the Federal Government commissions a report into the impact of violence against girls and women and the development of mental illness (p. 16);
7. the Federal Government establishes a research project into the development of Borderline Personality Disorder in women, with the goal of developing new effective interventions (p. 16);
8. linkages between mental health service provision outcomes and the goals of the *National Plan to Reduce Violence against Women and their Children* are strengthened through the introduction of specific key performance indicators against which all such services are required to report (p. 16);
9. the Medicare Local Network initiates the establishment of collaborative partnerships between community mental health agencies, primary health practitioners, and women's health and domestic violence organisations, in order to establish longer-term follow up which focuses on the mental health of women and children who have experienced violence (p. 16).

Childhood abuse of girls

It is recommended that:

10. Health Workforce Australia develops and delivers training programs for primary care clinicians to improve their skills in recognising abuse-related mental illness symptoms in women and assist them with appropriate psychotherapeutic techniques (p. 17);
11. the Federal Government strengthens its investment in the *National Plan to Reduce Violence against Women and their Children 2010-2022* strategies and ensures the plan is effectively monitored to fulfil its stated aims and goals (p. 17).

Women, poverty and homelessness

It is recommended that:

12. commonwealth initiatives to decrease homelessness employ a gendered perspective and are linked to mental health services (p. 17).

Alcohol use

It is recommended that:

13. australian alcohol abuse research incorporate a focus on different age groups and gender to assist in the development of evidence-based treatment approaches to meet the needs of women of all ages (p. 18).

Illicit drug use

It is recommended that:

14. drug recovery services provide women-focused programs to address the rising number of women with mental health disorders which are impacted upon by illicit drug abuse (p. 18).

Mental health aspects of physical illness

It is recommended that:

15. federal, state and territory governments invest in the development of more co-located psychological and psychiatric services within women's health services (p. 19);

16. Health Workforce Australia develops and delivers further education to health practitioners about the mental health aspects of physical illnesses (p. 19); and

17. greater investment is made in providing gender-sensitive supportive care with a focus on the psychological impact of chronic, long-term physical illnesses (p. 19).

Reproductive life-cycle phases and possible mental health issues for women

It is recommended that:

18. further investment be made in developing evidence-based best practice in the relationship between women's health, mental health, menopause and the mid-life stage (p. 20);

19. federal and state governments conduct targeted professional and public education campaigns concerning the interaction between reproductive hormones and an individual's mental state (p. 20); and

20. the federal government strengthens investment in data collection, analysis and dissemination of knowledge regarding the use of psychotropic medications in pregnancy (p. 20).

Special issues for women with mental illnesses

It is recommended that:

21. the federal government fund the Mental Health Council of Australia to develop and conduct a gendered public education campaign to reduce the stigma attached to mental disorders (p. 21);

22. as a matter of urgency Health Workforce Australia provides to general clinicians specific clinical training programs outlining the recognition of the symptoms and signs in women of Borderline Personality Disorder (p. 21); and

23. subsequent to appropriate workforce development, a public education campaign be undertaken by the Mental Health Council of Australia that employs social media communication strategies to promote recognition of the symptoms and signs of Borderline Personality Disorder and what help is available (p. 21).

Holistic approaches

It is recommended that:

24. federal and state governments jointly fund the expansion and establishment of more women's health centres that provide comprehensive women-sensitive mental health services (p. 23); and

25. the federal government investigates the practical requirements for removing barriers to women's equity of access to a comprehensive range of women-sensitive mental health services, including equitable provision of psychological and psychiatric services to women. This investigation should include barriers arising from out-of-pocket/co-payment costs, caps on Medicare rebates, transportation, and geographic location of service availability (p. 23).

Psychiatry inpatient units – safety and privacy issues

It is recommended that:

26. all existing and new psychiatric inpatient facilities are redesigned or designed to provide significant areas of gender segregation and ensure safety plus privacy for female inpatients (p. 24);
27. education programs on gender sensitivity are mandatory for all clinical staff in inpatient psychiatry facilities (p. 24); and
28. the Council of Australian Governments provides leadership to initiate reforms which require that sexual and other assaults in psychiatric facilities be reported and treated in the same way as those occurring in the general community (p. 24).

Community mental health services and gender-sensitive practice

It is recommended that:

29. federal, state and territory governments develop gender-sensitive practice guidelines, with specific input from women as consumers, carer advocates and mental health clinicians, and ensure their implementation in all mental healthcare settings. Expertise in the development of gender-sensitive practice guidelines and training is readily available within the women's health sector (p. 25); and
30. the use of peer support is encouraged in state government-funded community mental healthcare clinics and Psychiatric Disability Support Sector services, with ongoing education of women provided through consumer advocacy organisations, such as Mental Illness Fellowship Australia, SANE Australia, and Beyond Blue (p. 25).

Research and education

It is recommended that:

31. a national women's mental health research institute is established with the aim of building a nationally integrated evidence base through coordinating and facilitating an Australia-wide program of research to improve outcomes for women with mental illnesses (p. 26).

Specific development of treatments tailored for women with mental llnesses

It is recommended that:

32. National Health and Medical Research Council research priority be given to developing new treatments for women with specific mental illnesses (p. 26).

Definitions

Addiction: A state of dependence resulting from habitual use of drugs/alcohol, characterised by compulsion and patterns of use despite negative consequences.

Anorexia nervosa: An eating disorder characterised by starvation or techniques such as binge eating and purging to induce weight loss. It is motivated by a perception of being or becoming overweight and can be life threatening.

Anxiety: A psychological and physiological future-oriented state characterised by negative affect in which a person focuses on the possibility of uncontrollable danger or misfortune.

Anxiety disorders: A group of psychiatric disorders characterised by persistent fear and anxiety that interfere with a person's ability to function day-to-day.

Bipolar disorder: A mood disorder that is characterised by periods of mania or hypomania, depression and 'mixed episodes' (a mixture of manic and depressive symptoms).

Borderline Personality Disorder (BPD): A psychological condition which produces extreme emotional pain, adverse effects on the lifestyle of sufferers, and usually a significant negative impact on relationships with others. It is characterised by a pervasive pattern of instability of interpersonal relationships, self-image, and marked impulsivity beginning by early adulthood and present in a variety of contexts.

Bulimia nervosa: An eating disorder characterised by recurrent episodes of binge eating and a sense of lack of control over eating during this time, with self-induced vomiting, fasting or excessive exercise.

Child abuse: Non-accidental behaviour by parents, caregivers, other adults or older adolescents that is outside cultural norms, resulting in substantial risk, causing physical or emotional harm to a child or young person. Behaviour may be intentional or unintentional and include physical abuse, sexual abuse, neglect, emotional maltreatment or witnessing of family violence.

Cognitive behaviour therapy (CBT): A broad term used to apply to structured psychological therapy approaches in which people learn to develop more effective ways of thinking about and/or responding to symptoms, or situations, which cause distress. These therapies may be delivered either one-to-one or in an educational group course, most often in weekly sessions for a period of a few months. There are a number of CBT protocols for different problems, and CBT approaches often go by more specific names such as cognitive therapy; rational emotive therapy; exposure therapy; relaxation training; and mindfulness-based cognitive therapy.

Cognitive remediation: Structured courses for improving memory, attention and other mental functioning, through regular practice of these skills with targeted exercises. These may be done either on computer or on paper, and are often accompanied by therapist coaching to implement these skills in everyday life. Typically, cognitive remediation involves practice several times a week for a number of weeks. It is also referred to as cognitive training, or cognitive rehabilitation.

Delusions: Fixed and false beliefs held with strong conviction, usually associated with neurological or mental illness. Types of delusions include a false belief that the person is being persecuted or has special powers.

Depression (Major Depression): A mental illness characterised by two main symptoms: persistent low, sad, depressed mood and/or the inability to derive enjoyment or pleasure from life. These symptoms are accompanied by a combination of the following: disturbed sleep and appetite, reduced motivation, cognitive impairment, high anxiety, excessive guilt, hopelessness, helplessness and suicidality. Depression has a profound negative impact on the individual's functioning and quality of life.

Dialectical Behaviour Therapy (DBT): A type of cognitive behaviour therapy which helps people to develop skills in regulating emotional distress, dealing with challenging interpersonal situations, and coping with impulsive behaviour. It has been most widely used as an approach for Borderline Personality Disorder, but has also been applied to other problems such as eating disorders. It typically involves regular attendance at an educational group in which skills are learnt, in combination with weekly one-to-one therapist support, over one year or more.

Disinhibited Behaviour: A state of reduced control over one's behaviour, impulses and emotions.

DSM-IV-TR: A manual published by the American Psychiatric Association (APA) that includes all currently recognised mental health disorders. It provides a common language and criteria for the classification of mental disorders.

Eating disorders: A group of conditions defined by insufficient or excessive food intake affecting physical and mental health.

Estrogen: A female hormone produced by the ovaries that causes growth and development of the female sexual organs.

Haemodialysis: A treatment used to remove toxic elements from the blood. It is the most common method used to treat advanced and permanent kidney failure.

Hallucinations: Experiences of sensory events that do not exist in the surrounding environment; these events are characterised by sight, touch, smell, taste, and hearing, and are commonly associated with schizophrenia.

Health Burden: The total significance of disease for society beyond the immediate cost of treatment.

Menopause: The phase of permanent cessation of the female menstrual cycle, characterised by fluctuation of female hormones, leading to cessation of menses.

Major Depression: This is a clinical disorder characterised by persistent, prolonged sadness, loss of interest or pleasure in nearly all activities which can be accompanied by changes in appetite or weight, sleep, decreased energy, feelings of guilt or worthlessness, difficulty thinking or concentrating, having recurrent thoughts of death or suicide and attempting suicide.

Mood disorder: A group of psychiatric disorders, including depression and bipolar disorder, characterised by a pervasive disturbance of mood.

Perimenopausal Depression: Depression occurring either for the first time, or a relapse of pre-existing depression, during the menopause phase. It is characterised by dysphoric mood, with predominant anger, irritability, hostility, increased tension and anxiety, occurring usually between the ages of 45 and 55.

Polycystic Ovary Syndrome (PCOS): A disorder which is characterised by an imbalance of a woman's sex hormones. This syndrome can cause changes to the menstrual cycle such as absent or irregular periods, or small cysts on the ovaries, which can be linked to infertility.

Post-natal Depression: A prolonged period of severe depression in women following childbirth, characterised by anxiety, irritability and insomnia. The cause is linked to a combination of sudden hormonal changes and psychological and environmental factors.

Post-natal Psychosis: Also referred to as puerperal psychosis. Characterised by the sudden onset of psychotic symptoms following childbirth. The cause is linked to a combination of sudden hormonal changes and psychological and environmental factors.

Post-Traumatic Stress Disorder (PTSD): An anxiety disorder related to an extremely traumatic event comprising intense fear, horror and hopelessness such as rape, torture, war, child abuse and fatal illness. Symptoms of PTSD include distressing thoughts, nightmares, psychological distress, and physical symptoms such as sweating and rapid heartbeat when the memories of the trauma are triggered. Sleep disturbance, irritability, and impaired concentration can also be associated with the disorder.

Premenstrual Dysphoric Disorder (PMDD): A severe form of premenstrual syndrome (PMS) characterised by adverse clinical and psychological conditions. Symptoms include: depressed mood, irritability, poor concentration, anxiety, and physical symptoms such as breast tenderness, headaches, joint and muscle pain.

Premenstrual Syndrome (PMS): A collection of physical and emotional features related to cyclical changes of hormones. Symptoms include dysphoria, negative self-concept, irritability and reduced coping abilities.

Private Healthcare: Operates independently of government oversight and receives funding mainly from patients and their insurance policies.

Progesterone: A naturally occurring hormone produced by the ovaries which helps to regulate the monthly menstrual cycle.

Psychoneuroendocrinology: The clinical study of hormone fluctuations (neuroendocrine) and their impact on mental state and behaviour.

Psychosis: A term used to describe a mental state characterised by the presence of delusions, hallucinations and/or thought disorder: also referred to as positive symptoms. Negative symptoms such as loss of motivation can also occur. These symptoms can be accompanied by other secondary features during a psychotic episode such as depression, anxiety, sleep disturbance, social withdrawal and impaired role functioning.

Psychotropic medications: Also referred to as psychotherapeutic medications, these medications are used to treat mental illnesses and impact function affecting perception, mood and cognition.

Public Healthcare: Operates inside the bounds of government control and receives funding through compulsory tax contributions.

Schizophrenia: A severe psychotic disorder that affects multiple brain structures, has a lifelong course, and can lead to social, cognitive and behavioural impairments. It is characterised by delusions and hallucinations as the most common features.

Sexual assault: any behaviour of a sexual nature that makes a person feel uncomfortable, frightened or threatened. It can take various forms, some of which are criminal offences.

Substance abuse: A maladaptive pattern of substance use leading to clinical impairment resulting in failure to fulfil role obligations at work, school or home, as well as physical and social implications.

Woman-centred: A term that describes healthcare that respects the values, culture, choices, and preferences of the woman and her family, within the context of promoting optimal health outcomes. Woman-centredness is designed to promote satisfaction with the care experience and to improve well-being for women, their families and healthcare professionals and is an essential component of healthcare quality improvement (Childbirth Australia, 2012).

Woman-sensitive practice: An approach to work practices that recognises gender as a significant social determinant , acknowledging the different experiences, expectations, pressures, inequalities and needs of women (Department of Health, 2011).

Introduction

More women than men are affected by mental illness in Australia. There is a high prevalence of disorders such as anxiety and depression in women, due to the combined social and biological determinants of mental ill health. There is an urgent need for a gendered focus if mental health reform is to be effective: currently this focus is lacking. The time is long overdue to differentiate between women's and men's needs and treatments in Australia.

While it is not possible to address all aspects of women's mental health within the scope of this paper, the following points are prioritised as key areas requiring urgent action:

- Mental health reform has occurred at a rapid pace in Australia over the past 10 years, but despite evidence-based advocacy there is a notable lack of focus on women's mental health as a specific area.
- Current research into women's mental health/mental disorders is patchy and poorly funded.
- There is a great need to develop a tailored approach to treatment options and access to services through understanding the special needs of women with mental illnesses.
- Violence, poverty, substance abuse and gender inequity impact significantly on women's mental health.
- Good mental health for women includes the absence of mental illnesses plus involvement in community activities; supportive relationships; self-esteem and self-efficacy; access to education and employment; an increased sense of belonging; improved physical health; and enhanced long-term well-being.

Women's mental health

One out of every five Australians experience some form of mental illness each year, and women are more affected than men. Given the 'ripple effect' of the impact of mental illness on family, friends and community, it is probable that one in two Australians are affected directly or indirectly by mental illness. In 2007, almost half (45%) of all Australians had experienced a mental disorder at some point in their lifetime (Australian Bureau of Statistics, 2008).

Mental illness is the third largest contributor to the total disease impact (13.2%), which is 374,541 years of healthy life lost (Disability Adjusted Life Years), the largest overall cause of disability (27%) and carries the highest incidence of disease for adult women (Begg et al., 2007). However, only 6.0% of the national recurrent health expenditure is directed toward mental illness (Australian Institute of Health and Welfare, 2010). It has been estimated that in Australia mental illness symptoms result in an annual loss of $AU2.7 billion in employee productivity (Hilton et al., 2010).

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).

The definition of 'mental health' according to the World Health Organisation factsheet 220 (2010) is "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community". In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community. The term 'mental illness' encompasses all of the diseases of the mind, including depression; schizophrenia; bipolar disorder; severe anxiety disorders, including post-traumatic stress disorder; substance addictions; autism; severe childhood developmental disorders; dementia; and dysfunctional personality disorders. It is synonymous with mental ill health or mental disorders.

Gender is an important determinant of the presentation, type, and outcomes of mental ill health. There are many biological, psychological, economic, social, political and cultural attributes associated with being female that impact on women's mental health. There are specific issues for women experiencing mental illness which have not received attention in a coordinated, gender-sensitive manner, leading to poor outcomes. Women's mental health is crucial to their well-being, the daily enjoyment of life, the capacity to thrive and to contribute to society. Women's mental health is fundamental to the well- being of families and communities, through the caring, nurturing and educative roles that women perform on a daily basis.

Women's mental health in the current policy context

Recently there has been an increased focus by government on mental health, with many policy and discussion papers operating at state, territory and national levels. Overall, there is a conspicuous lack of gender focus in general mental health plans. The only current policy document incorporating a specific focus on the mental health needs of women is the 2010 National Women's Health Policy (NWHP). However, unlike the first NWHP, 'Advancing Women's Health in Australia', funding or an implementation plan did not accompany the current NWHP. There has also been a complete absence of linkages between this and other Government policies since its release, with the result that the 2010 NWHP has been unable to influence subsequent action.

In 1992, the Commonwealth Government committed to the development of the first National Mental Health Plan. Since then there have been three further National Mental Health Plans, with the current Fourth National Mental Health Plan being endorsed by health ministers

in December 2008, to guide mental health action from 2009-2014. As well as the National Mental Health Plans, there are many other policy and discussion papers from mental health bodies which operate at state, territory and national levels.

The Council of Australian Governments (COAG) met in February 2006 and agreed on a National Action Plan on Mental Health (2006-2011) (Council of Australian Governments, 2006). Almost $2 billion of funding was announced in 2006, to be invested in mental healthcare over the next five years. The Plan included a number of important initiatives, but there was no specific focus on promoting women's mental health or meeting the needs of women with mental illness, except for small investments in postnatal depression services in some Australian States and scattered carer respite funding which assists women, who are the main carers for people with mental illnesses. This lack of dedicated funding for women with mental illnesses is of great concern and occurred despite the strong evidence-based submissions demonstrating the efficacy of applying a gendered approach to mental health reform.

The Fourth National Mental Health Plan provides an agenda for collaborative government action in mental health for the period of 2009-2014 (Department of Health and Ageing, 2009). It sets out five important priority areas, which include social inclusion and recovery, prevention and early intervention, service access and coordination, continuity of care, and quality improvement and innovation. While these areas are generally important for women with mental illnesses, there is no specific attention given to women in any of the areas. The particular needs of women who have experienced sexual abuse in mental health services are mentioned in three sentences, with no further details (Department of Health and Ageing, 2009). The need for women-focused, specific, tailored mental health service delivery, support and education is not addressed in this, or indeed any, current mental health reform documents.

Since 2006, there has been a growing emphasis on early intervention and prevention services in mental health. In particular, significant funding has been invested in the Early Psychosis Prevention and Intervention Centre model (EPPIC), (Senate Community Affairs Committee Secretariat, 2011). The EPPIC model predominantly provides services for young men and, to date, the early intervention and prevention model has adopted a gender-blind approach. The growing emphasis on funding a model that does not focus on women's mental health means that potentially women, particularly middle-aged and older, may not receive adequate mental health care.

In 2010 the NWHP was launched, stating that mental health and well-being was the second National Health priority for women (Department of Health and Ageing, 2010). The 2010 NWHP goals were to:

- highlight the significance of gender as a key determinant of women's health and well-being;
- acknowledge that women's health needs differ according to their life stages;
- prioritise the needs of women with the highest risk of poor health;
- ensure that the health system is responsive to all women, with a clear focus on illness prevention and health promotion; and
- support effective and collaborative research, data collection, monitoring, evaluation, and knowledge transfer to advance the evidence base on women's mental health.

The 2010 NWHP clearly recognises the importance of good mental health for women and documents the serious, complex issues faced by women with mental disorders. The 2010 NWHP includes important sections on the increased female prevalence of depression and anxiety disorders, women's mental health across their lifespan, and consideration of mental health needs for marginalised women. However, even the 2010 NHWP does not include enough detail about other important issues for women with mental illnesses, such as the provision of safer inpatient facilities, increased gendered mental health/illness research, and greater funding for the development and delivery of services that are specifically tailored to meet the needs of women with mental illnesses.

The latest proposed mental health strategy is *A Ten Year Roadmap for National Mental Health Reform*, a draft of which was released for consultation in January 2012 (Department of Health and Ageing, 2012). An online survey tool was used to gather feedback for a period of three weeks, ending in February 2012. Consultations have been completed and the 'Roadmap' is currently under review by the Department of Health and Ageing, with the expectation that it will be finalised and released in early 2013.-

The 'Roadmap' details a commitment by governments to a long-term national reform plan for mental health to guide future action and investment across Australia over the next 10 years. This document comprises five key areas and includes a major focus on youth mental health, EPPIC and other factors that increase consumer empowerment. The plan is oblivious to the importance of gender and of women's specific mental health needs. Moreover, since the release of the 'Roadmap' there has been criticism of it by various mental health bodies for being too simplistic and general. There have also been many negative comments about the narrowness of feedback using the online tool and the short length of time given for public response.

The focus on youth mental health in recent times, including the EPPIC model, has led to the provision of services mainly for males with severe mental illnesses. Data from the EPPIC services show that in general there are significantly more young men receiving treatment as compared with women (Department of Health, 2007). This is not surprising, since it is a transnationally replicated finding that women present with severe mental illnesses up to five years later than men (Seeman, 2000). Another important youth mental health program that is receiving a very large amount of national mental health funding is the Headspace initiative. Commencing in 2004, a number of sites were established throughout Australia to enable young people aged between 12 and 25 years to access help for mental health issues, in youth-friendly settings. Accompanying the clinical work is a major media campaign designed to provide information to the young general public. Early and specific intervention for young women with eating disorders, Borderline Personality Disorder, depression and anxiety is better addressed through the Headspace program. Headspace needs to develop more programs specifically designed to meet the needs of young women. Overall, the increased focus on youth mental health in policy, funding and general media attention has predominantly been gender blind. This has led to much-needed improvement in mental health services for young men, but has not been matched by an equal and increased focus on women's mental health. Furthermore, since the past eight years of mental health reform activity has led to greater investment in youth mental health, but because mental health funding resources are finite, this has meant that the needs of older women with severe mental illness, and their male counterparts, are largely ignored.

Recommendations:

1. All mental health policies should adopt a gendered approach.
2. Current and proposed National Mental Health Plans are linked together and informed by the *National Women's Health Policy* (2010), to ensure the inclusion of a clear focus on women's mental health.
3. The Commonwealth Department of Health and Ageing provide leadership to mental health services in gendering action across the social determinants of health through the mental health strategy, *A Ten Year Roadmap for National Mental Health Reform*.
4. The strategic priorities of existing youth programs are expanded to offer greater mental health promotion opportunities and develop more clinical services that are specifically designed for young women with Borderline Personality Disorder and Depression/Anxiety Disorders.

Determinants of mental ill health in women

There are many hypotheses concerning the multiple interactions of biological, social, cultural, economic and personal contexts impacting on women's mental health. Violence against women, childhood abuse, poverty, homelessness, and substance abuse are key social determinants of mental illness in women. Life events, including biological life-cycle events such as childbirth and menopause, may trigger the onset of a mental illness, and individual characteristics may influence the development and severity of symptoms (Zubin et al., 1992). Early childhood experiences play a significant role in determining future mental health, and rates of childhood sexual abuse are higher in women than men (approximately 3:1) (MacMillan et al., 2001). In particular, physical, emotional, and sexual abuse in childhood may predispose women to the development of mental illness later in life. Intimate partner violence has been associated with a high prevalence of major depression (63%) and post-traumatic stress disorder (PTSD) (40%) in women (Campbell and Lewandowski, 1997).

Violence against women

Violence against women is now recognised as one of the most widespread violations of human rights. Approximately one in five women in Australia are subjected to physical or sexual violence during their lifetime, which has devastating effects on their health and well-being, as well as on their families and communities. Domestic violence and sexual assault are the most common forms of violence experienced by women.

The National Council to Reduce Violence against Women and Their Children (2011) demonstrated that:

- one in three Australian women have experienced physical violence since the age of 15;
- almost one in five women have experienced sexual violence; and
- nearly all Australians (98%) recognise that violence against women and their children is a crime (Council of Australian Governments, 2011).

Violence against women is one of the least visible but most widespread forms of violence worldwide. Most violence against women takes place in the home, and in the majority of cases the assailant is a current or previous partner, male family member or friend. The World Health Organisation published a report in 2002 titled *'World Report on Violence and Health,'* which documents the serious and long-term impacts of violence, a leading worldwide public health issue (World Health Organisation, 2002). In Australia, intimate partner violence is the leading contributor to death, disability and illness in Victorian women aged 15 to 44 years (VicHealth, 2004). The *National Plan to Reduce Violence against Women and their Children 2010–2022* is a framework for action by the Commonwealth, state and territory governments to reduce violence against women and their children (Council of Australian Governments, 2011). The National Plan sets out six national outcomes for all governments to deliver during the next 12 years. The outcomes will be delivered through four three-year action plans, the first of which runs from 2010 to 2013.

The central goals of the National Plan are to reduce violence against women and their children; to improve how governments work together; increase support for women and their children; and create innovative ways to bring about change. The Plan combines approaches to the prevention of violence through raising awareness as well as integrating mainstream and specialist services to assist women who have experienced violence. The *National Plan to Reduce Violence against Women and their Children* is a multifaceted approach to the problem of violence against women, with clear, measureable outcomes. However, the lack of explicit mental illness follow-up or linkage with mental health services is a shortcoming in this National Plan that urgently needs to be addressed.

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).

Recommendations:

5. The Council of Australian Governments maintains its commitment to and investment in the *National Plan to Reduce Violence Against Women and Their Children Strategy* 6.3: Intervene early to prevent violence by ensuring:
   - » research into perpetrator interventions is undertaken;
   - » best practice guidelines and national standards are developed;
   - » specific evidence-based best practice domestic violence programs are developed, tested and rolled out; and
   - » the identification of "effective post-intervention services and programs to sustain long term behavioural change and reduce re-offending";
6. the Federal Government commissions a report into the impact of violence against girls and women and the development of mental illness (p. 19);
7. the Federal Government establishes a research project into the development of Borderline Personality Disorder in women with the goal of developing new effective interventions (p. 20);
8. linkages between mental health service provision outcomes and the goals of the *National Plan to Reduce Violence against Women and their Children* are strengthened through the introduction of specific key performance indicators against which all such services are required to report; and
9. the Medicare Local Network initiates the establishment of collaborative partnerships between community mental health agencies, primary health practitioners, women's health and domestic violence organisations to establish longer term follow-up which focuses on the mental health of women and children who have experienced violence.

Childhood abuse of girls

The prevalence rates of reported child abuse in Australia are estimated to be between 2% and 36% (Price-Robertson et al., 2010). This is an amalgamation of estimated 2–12% of child neglect; 11% emotional abuse; witnessing family violence to be between 12% to 23%, and child sexual abuse to be between 4% and 16% for males and 7% and 36% for females (Price-Robertson et al., 2010). Of course, these statistics are an underestimate since not all abuse is reported.

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).

Between 2% and 5% of the population are affected by Borderline Personality Disorder (BPD). DSM-IV-TR states that BPD is diagnosed predominantly in females (about 75%) (American Psychiatric Association, 2000). Women with documented childhood abuse were the main subjects in a robust study which showed that such women were four times more likely to be diagnosed with BPD than those without abuse or neglect in childhood (Johnson et al., 1999). In Australia to date there has been little investment in the research of this condition, with limited specific treatment options.

Child abuse survivors may have difficulty expressing their feelings and needs because these were ignored during their abuse. Survivors may also find it difficult to trust professionals: consequently many do not seek help until adulthood (Sanderson, 2006). This can result in survivors only seeking help when the symptoms of mental illness worsen, or otherwise seeking help only to address somatic symptoms because the need to address the underlying psychological symptoms are not recognised or because sufferers do not want to discuss them. Despite these barriers to help-seeking, women are more likely to seek help from, and disclose mental health problems to, primary care clinicians when compared to men (World Health Organization, 2011).

With 43% of women in primary care settings reporting childhood abuse and neglect histories (Walker et al., 1999), clinicians such as general practitioners (GPs), psychologists and other mental health clinicians (such as psychiatrists, social workers, counsellors, psychotherapists, mental health nurses and other professional mental health clinicians) who work in primary care practices in their respective fields will likely come in contact with women survivors. A significant number of healthcare clinicians have little or no training in working psychotherapeutically with women who have a history of abuse. Traditional medical teaching recommends that abuse histories should not be revisited if the trauma was long past, and to a great extent this is still current practice. Up-skilling of the primary care sector in the recognition of abuse related mental illness symptoms and in using appropriate psychotherapeutic techniques is needed to assist women with abuse-related symptoms.

Prevention is clearly the best approach: the current *National Plan to Reduce Violence against Women and their Children 2010–2022* contains a number of preventative strategies including policies related to violence in family law, Indigenous safety and well-being, homelessness, and the provision of income support, family payments and crisis payments. The Plan includes a focus on young people's attitudes towards violence and risk-taking behaviours such as binge drinking. Helping young people better understand and develop respectful relationships will have long-term impacts on the level of violence against women. There is also some investment in research to build an evidence base through the Australian Domestic and Family Violence Clearinghouse and the Australian Centre for the Study of Sexual Assault (Council of Australian Governments, 2011).

Recommendations:

10. Health Workforce Australia develops and delivers training programs for primary care clinicians to improve their skills in recognising abuse-related mental illness symptoms in women and assisting them with appropriate psychotherapeutic techniques; and
11. The Federal Government strengthens its investment in *National Plan to Reduce Violence against Women and their Children 2010–2022* strategies and ensures the plan is effectively monitored to fulfil its stated aims and goals.

Women, poverty & 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 who struggle with economic resources do not have money to feed and clothe themselves or their families, which in turn leads to increased levels of depression, anxiety and lower self-esteem (Australian Bureau of Statistics, 2003, McClelland and Scotton, 1998). There is also evidence to suggest that children living in low socio-economic status households have higher levels of anxiety, depression, substance abuse and poor adaptive functioning, which have a cumulative effect on long-term mental health outcomes (Bradley and Corwyn, 2002, McMunn et al., 2001).

Research has suggested that homelessness is linked with sexual abuse, mental illness and substance abuse, with higher rates of all three in the homeless population than the general population (Australian Institute of Health and Welfare, 2007). Women comprise 44% of the homeless population in Australia (Chamberlain and MacKenzie, 2009). Women most often become homeless as a result of abuse, violence and mental illness.

Recommendation:

12. Implementation of Commonwealth initiatives to decrease homelessness which employ a gendered perspective and are linked to mental health services.

Women and alcohol/ drug abuse

Gender differences exist regarding the rates of use, types of substances abused, and related behaviours.

Alcohol Use

In Australia women generally consume less alcohol than men (Australian Institute of Health and Welfare, 2008). However, alcohol consumption and high-risk drinking is increasing among females, particularly young women (de Visser et al., 2006). Increased alcohol consumption is associated with increased rates of depression, anxiety and suicidality (Bolton et al., 2010). In 2004, around 77% of males and 71% of females aged 14 years and over consumed alcohol at levels which involve some risk of long-term alcohol-related harm. Overall, one in ten Australians consumed alcohol at levels that are considered risky or high risk for alcohol-related harm in the long term. For males, the peak occurred at ages 20–29, where 6% drank at high-risk levels and 9% drank at medium-risk levels. For females, the peak also occurred at ages 20–29, where 3% drank at high-risk levels and 12% drank at medium-risk levels. Females aged 14–19 years were more likely to drink alcohol at medium-risk and high-risk levels for long-term harm compared with males of the same age. A dramatic increase from 8% to 16% in high-risk drinking by mid-life women (aged 35–59 years) in Australia from 1995 to 2010 has also been observed (Australian Institute of Health and Welfare, 2005).

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.

Recommendation:

13. Australian alcohol abuse research incorporate a focus on different age groups and gender to assist the development of evidence-based treatment approaches to meet the needs of women of all ages.

Illicit drug use

Approximately 11% of the Australian population use marijuana/cannabis, and males generally used marijuana/ cannabis more frequently compared with females.

Among males and females, those aged 30–39 years in 2004 were most likely to use marijuana/cannabis every day, compared with those in other age groups (Australian Institute of Health and Welfare, 2005).

Ecstasy and recreational drugs use has increased in Australia over the past five years, with 20% of people aged 20–24 years having used ecstasy and related drugs. There is now very little difference between men and women in the use of these drugs (Australian Institute of Health and Welfare, 2008). However, specific recovery programs for women with substance abuse problems are limited, since the focus is male-centric due to the past greater number of men with substance abuse disorders.

The use of illegal drugs and alcohol by women can be associated with experiences of trauma, including physical, sexual and psychological traumas (Willis and Rushforth, 2003). Drug abuse, including the abuse of prescription drugs, can be practiced by both men and women as a way to cope with mental illness (Forsythe and Adams, 2009).

Recommendation:

14. Drug recovery services provide women-focused programs to address the rising number of women with mental health disorders which are impacted upon by illicit drug abuse.

Meeting the mental health needs of women

Mental health aspects of physical illness

Women's experiences of both mental and physical illness are different from that of men's. Women tend to live longer than men but in general take more medications and have more contact with health services. Physical illness in women is a major risk factor for mental illness. Depression and anxiety are prevalent in women suffering from common medical conditions such as diabetes, cancer, ischaemic heart disease and chronic kidney disease, and the prevalence of these conditions is increasing rapidly in our ageing population. For example, Type 2 diabetes affects one in four people over the age of 50.

The impact of mental illness in women with any additional physical illness is magnified, and depression in particular can substantially affect self-care. The management of medical disease often creates a significant added challenge for women, which is likely to affect their physical health adversely.

For example, a woman with diabetes and depression may be less likely to measure her blood glucose level routinely or attend regular specialist appointments, putting her at risk of further complications such as kidney disease, blindness, or heart attacks. In women receiving haemodialysis, for example, mortality is increased in those with depression or lack of attention to self-care.

Mental illness should be routinely screened for when women are treated for major illnesses such as those mentioned above. For women with physical illnesses, access to mental health clinicians with specific knowledge of their illness is highly beneficial. Ready access to psychological, psychiatric and other supportive care services that are both gender-sensitive and integrated into medical care is important. For example, breast cancer support nurses with knowledge of both the specific breast cancer treatments and the emotional impact of the disease, and disease-specific volunteer-based support services, such as Breacan in Victoria, have developed women-sensitive support systems across the continuum of care (See recommendations 23, 24).

Recommendations:

15. Federal, state and territory governments invest in the development of more co-located psychological and psychiatric services within women's health services;
16. Health Workforce Australia develops and delivers further education to health practitioners about the mental health aspects of physical illnesses; and
17. Greater investment is made in providing gender-sensitive supportive care with a focus on the psychological impact of chronic, long-term physical illnesses.

Reproductive life-cycle phases and possible mental health issues for women

One way of describing a woman's life-cycle is through stages of reproductive aging, which include the reproductive phase, menopause transition, and post-menopause. Hormone levels vary across these stages, as does susceptibility to certain illnesses. Reproductive-related disorders are specifically related to fluctuations in reproductive hormones, that is, oestrogen and progesterone. Examples are premenstrual syndrome, postnatal depression, and perimenopausal depression. This particular area of women's mental health, known as Psychoneuroendocrinology, has been hampered by a lack of research examining the impact of reproductive hormone fluctuations on women's mental health. From a societal view, this area has a poor history of being dominated by pejorative concepts about women being 'ruled by their hormones' and being incapable of high-level functioning as a result. In more recent times, greater knowledge about the sex steroid impact on the brain, plus improved access and understanding about different types of hormone contraception and treatments, is enabling women to seek attention for mental disorders that have a connection with reproductive hormones.

Premenstrual syndrome can affect many women, but 5–10% of women experience severe symptoms, are functionally incapacitated in the week before menses, and are thus diagnosed with premenstrual dysphoric

disorder (PMDD). The impact of PMDD is estimated to be equivalent to that of major depression, with resultant negative effects on the woman and her family, and in terms of the cost to healthcare and lost productivity. Unfortunately, there has been considerable stigma attached to this condition and for some time it has been under-recognised, thereby disadvantaging women who experience severe PMDD.

Postnatal depression and postnatal psychosis affect up to 15% of women in the year after delivery. The ramifications for the woman and the development of her baby can be very serious. Antenatal screening for depression and anxiety is being conducted in many parts of Australia. However, for women with pre-existing depression or psychosis, there is very little evidence-based data on the appropriate use of psychotropic medication in pregnancy. Particularly, in the case of antipsychotic medications, there is no systematically collected existing database to guide the safe use of these medications during pregnancy. A small Register, the 'National Register of Antipsychotic Medications in Pregnancy', has recently been established (Kulkarni et al., 2008), and in Victoria there is a Perinatal Psychotropic Medication Information Service (Royal Women's Hospital, 2012). This type of data collection needs to be enhanced and coordinated to provide an important service for the whole nation.

Perimenopausal depression is increasingly recognised as being distinctly different from major depression. Major depression is typically characterised by episodes of prolonged sadness with associated sleep and appetite changes. In contrast, perimenopausal depression is characterised by irritability, low but fluctuating mood, and often occurs in conjunction with typical menopausal symptoms such as hot flushes. Perimenopausal depression is a serious condition that requires early recognition, and often women experiencing this type of depression do not respond to standard antidepressant treatment. A combination of hormonal and tailored antidepressant treatment with a healthy lifestyle approach appears to provide the best outcomes (Cohen et al., 2006). It is clearly important to recognise that most women do not experience perimenopausal depression and therefore do not require special mental health attention. However, for the small percentage that experience severe debilitating depression, new approaches must be made available through clinician and public education. Special menopause clinics in this area would enable earlier and appropriate intervention. Joint mental and physical health assessments and management options need to be available across Australia for middle-aged women.

Disorders which alter the normal hormonal cycle in women also affect mental health, such as polycystic ovary syndrome (PCOS). PCOS is common and is associated with high rates of depression, bipolar disorder and other mental illnesses. Infertility and obesity are related PCOS issues and can greatly impair a woman's quality of life. Hormone or psychotropic medications or a combination of both can aid this condition. Psychological therapies such as cognitive behaviour therapy and healthy lifestyle approaches can also be helpful.

Overall, there is a limited evidence base upon which to inform mental healthcare, and limited recognition of the high prevalence and burden of these conditions.

For the individual woman there needs to be greater access to clinicians with expert knowledge of the interplay between reproductive status and mental health. Currently, hormonal and psychotropic treatments are available through separate siloed specialties and services. Access to multidisciplinary expertise needs to be made available.

At a societal level, awareness of these conditions and treatments needs to be increased both in the general public and in medical circles. Cooperation between services needs to be encouraged, and further research into effective treatments conducted.

Recommendations:

18. Further investment be made in developing evidence-based best practice in the relationship between women's health, mental health, menopause, and mid-life;
19. Federal and state governments conduct targeted professional and public education campaigns regarding the interaction between reproductive hormones and an individual's mental state; and
20. The federal government strengthens investment in data collection, analysis and dissemination of knowledge about the use of psychotropic medications in pregnancy.

Meeting the needs of women with mental illnesses

Special issues for women with mental illnesses

Current diagnostic systems

A major challenge in psychiatry is that mental illnesses are not able to be objectively diagnosed. Unlike other areas of medicine, there are no specific diagnostic laboratory tests for depression, bipolar disorder, schizophrenia, and other disorders. This leads to subjective diagnoses which can vary according to the experience, culture and gender of the clinician and consumer. In particular, being a female patient can bias the clinician's diagnostic process in a particular direction. This is one of the factors noted in the over-representation of women diagnosed with mood disorders such as major depression or bipolar disorder.

A particularly problematic disorder to correctly diagnose is Borderline Personality Disorder (BPD). As stated earlier, this mental disorder is predominantly diagnosed in women and has an aetiological association with childhood or later trauma. The symptoms of BPD include deep feelings of insecurity in which the woman has difficulty coping, fear of abandonment and loss; continually seeking reassurance; expressing inappropriate anger towards others who they consider to be responsible for how they feel; and a fragile sense of self and one's place in the world. Further BPD symptoms are persistent impulsiveness, which includes abusing alcohol and other drugs; spending excessively; gambling; stealing; driving recklessly, or having unsafe sex.

Women with BPD often have confused, contradictory feelings, manifested by frequent questioning and changing of emotions or attitudes towards others, and towards aspects of life such as goals, career, living arrangements or sexual orientation. The most serious and life-threatening symptom of BPD is self-harm: the woman may cause herself pain by cutting, burning or hitting herself; overdosing on prescription or illegal drugs; binge eating or starving; or repeatedly putting herself in dangerous situations or attempting suicide (Paris, 2007). Unfortunately, there are no clearly defined treatments for this condition, although some good results are seen with Dialectical Behavioural Therapy, which is a specifically developed therapy that combines cognitive behavioural techniques with mindfulness techniques derived from Buddhist philosophy. BPD in its severe form is stigmatised, possibly due to the breadth of symptoms and lack of specific interventions. Removing the stigma from this condition is urgently required to assist women who suffer from BPD.

Recommendations:

21. That the federal government fund the Mental Health Council of Australia to develop and conduct a gendered public education campaign to reduce the stigma attached to mental disorders;
22. As a matter of urgency, provision to general clinicians by Health Workforce Australia of specific clinical training programs concerning the recognition in women of the symptoms and signs of Borderline Personality Disorder; and
23. Subsequent to appropriate workforce development, a public education campaign be undertaken by Mental Health Council of Australia that employs social media communication strategies to promote recognition of the symptoms and signs of Borderline Personality Disorder and what help is available.

Gender blindness in current treatments

Psychological and psychiatric treatments by and large have not been specifically developed for women. In fact, psychotropic medication dosages and guidelines are often derived from clinical trials that have been conducted in predominantly male subjects (Kulkarni, 2010). Traditionally, women have been the major recipients of psychotherapy, but many traditional forms of psychotherapy have not included a current-day female perspective and rely on theoretical frameworks that are deeply patriarchal.

As described earlier, an important basis for the development of mental illnesses in women is that a significant number of women experience traumatic childhoods. Therefore it is important that, where appropriate, techniques such as Dialectical Behavioural Therapy (DBT) (Loebel et al., 1992) or other types of psychotherapy for the management of mental disorders are used that take the abuse background into proper consideration.

The treatment of persistent symptoms for a number of different mental illnesses with Cognitive Behavioural Therapy (CBT) is a useful adjunctive therapy (van der Gaag et al., 2011). In working with women, specific empowerment issues may need to be addressed (Notman and Nadelson, 2006). Cognitive remediation techniques are useful for work-skilling programs for women. Women with longer term schizophrenia may have specific difficulties with entering or re-entering the workforce, and special attention needs to be paid to improving skills for women in areas such as computer technology. It is rare for schizophrenia recovery programs to focus on parenting skills, but for women with schizophrenia who may have lost custody of their children due to their illness, parenting-related matters constitute a key area of recovery work.

Psychotherapeutic and educational techniques such as grief work and female empowerment strategies aimed at coming to terms with mental illness, loss, and understanding the social construction of femininity are some of the newer approaches that address gender-specific issues.

Holistic approaches

Women with mental illnesses often experience disjointed, incomplete and uncoordinated care. There are many barriers and hurdles in the mental health care systems that can be very confusing for women with mental illnesses and their families. Poor communication exists between primary health care practitioners, inpatient psychiatry units, community mental health facilities and non-government support services. Different treatment approaches with varied goals for the patient can result from the complex mental health service systems that currently exist. In particular, the links between physical healthcare and mental healthcare can be tenuous at best, with poor communication between different treating teams.

The Better Access to Mental Healthcare initiative introduced new mental health Medicare items on 1 November 2006. These items enable people with diagnosed mental disorders to access services from a range of mental health service providers, including psychologists. The purpose of the Better Access Initiative was to improve this situation by increasing community access to mental health professionals and team-based mental healthcare, with general practitioners encouraged to work more closely and collaboratively with psychiatrists, clinical psychologists, registered psychologists and appropriately trained social workers and occupational therapists (Council of Australian Governments, 2006). However, the initiative, which received considerable funding, has not improved access to mental healthcare for many people. In a thorough review published in 2011, Byles and colleagues found that a large proportion of women who reported mental health problems made no Medicare mental health claims and that socio-economically disadvantaged women were less likely to use the services. They concluded that uptake of assistance through the Better Access Initiative by women with mental health needs was low, highlighting continuing socio-economic inequity (Byles et al., 2011).

The Better Access Initiative included a Medicare Rebate for ten sessions in a calendar year with a clinical psychologist, plus a further six sessions under 'exceptional circumstances' as decided by the referring doctor. The Initiative meant that clinical psychologists could choose to bulk bill for the sessions or charge extra. Many clinical psychologists chose to charge extra for their services, which meant that socio-economically disadvantaged women with mental illnesses did not take up the scheme because of the out-of-pocket extra payments, the limited nature of the session numbers, and the type of treatments offered. In considering future approaches to mental healthcare for women, it is clear that a combined health/mental health approach, that is, an amalgamation of both physical health and mental health care, is vital to ensure the best outcomes for women.

More community based women's health centres staffed by expert health and mental health professionals, with a special focus on women's mental health and health needs, are required. It is very important to achieve a geographical balance as very few suitable services exist outside capital cities. Clinical psychology and psychiatry input in such centres is an important aspect of mental healthcare for women, and affordable access to woman-centred mental healthcare is needed. Affordable woman-centred mental healthcare can be obtained by extending existing models of women's health centres or women's refuge centres to include a comprehensive range of mental health services tailored to meet women's needs. In order to encourage better access for women to receive psychological mental healthcare, there needs to be a cap on the extra out-of-pocket payments that can be charged in addition to the Medicare Rebate in these special women's centres. In this way, women can receive help for a spectrum of issues ranging from improving their general mental well-being through to treatments for severe mental illnesses while also having their physical healthcare needs met, within the same community centre.

Recommendations:

24. Federal and state governments jointly fund the expansion and establishment of more women's health centres that provide comprehensive women-sensitive mental health services; and

25. the federal government investigates the practical requirements for removing barriers to women's equity of access to a comprehensive range of woman-sensitive mental health services, including equitable provision of psychological and psychiatric services to women. This investigation should include barriers arising from out-of-pocket/co-payment costs; caps on Medicare rebates; transportation; and geographic location of service availability.

Service delivery for women with mental illnesses

Psychiatry inpatient units – safety and privacy issues

Since the 1960s, psychiatry inpatient units in Australia have housed male and female patients together. Mixed gender wards are common practice in this country in both the private and public sectors, leading to a number of incidents of assault, predominantly against female inpatients.

The problems of abuse, trauma and violence have worsened due to changes in the way that mental health services are currently delivered. Overall, with well-developed community psychiatric services, the threshold for admission to psychiatric inpatient units has been raised, the length of stay has shortened, and rates of readmission have increased (Quirk and Lelliott, 2001). As a result, the level of disturbed, violent and aggressive behaviour of patients admitted to psychiatry wards has increased. More severely ill people with increasingly disinhibited behaviours (sometimes due to substance use) are hospitalised in mixed gender wards for short periods of time. A survey of women treated in public hospital psychiatry inpatient units in Victoria in 2006 (Clarke, 2008) found that of the 75 female inpatients who responded to the questionnaire, 58.5% identified as feeling unsafe in mixed wards; 61% experienced harassment, intimidation or abuse in response to a general question; 13% of women specifically identified frightening experiences of males entering their bedrooms; 19% of women specifically identified witnessing significant aggression; 11% of women specifically identified experiencing sexual harassment; and 5% of women specifically identified sexual assault.

In 2006, the National Patient Safety Agency in the UK published a detailed analysis of patient safety incidents related to mental health between November 2003 and September 2005. One of the specific areas examined was sexual safety: 122 incidents relating to sexual safety were reported. These included allegations of rape, with the alleged perpetrator being another patient in 40% of cases, and a staff member in 60% of cases; consensual sex; exposure; sexual advances; and inappropriate/sexual touching. Many key messages and recommendations came from this report in relation to sexual safety. Of great significance was that in 2006 the UK adopted a policy of gender segregation on psychiatric wards, with significant fines for breaches of this policy. It is very clear that inpatient psychiatry units need to change the building structures, as well as staff attitudes, to provide safety and privacy for women needing hospitalisation. Guidelines such as the 'Gender-Sensitive Practice Guidelines' recommend major improvements in both building design and staff education to reduce violence against women in psychiatric care settings (Department of Health, 2011).

Recommendations:

26. That all existing and new psychiatric inpatient facilities be redesigned or designed to provide significant areas of gender segregation and ensure safety and privacy for female inpatients;
27. Education programs on gender sensitivity be rendered mandatory for all clinical staff in inpatient psychiatry facilities; and
28. The Council of Australian Governments provide leadership to initiate reforms which require that sexual and other assaults in psychiatric facilities be reported and treated in the same way as those occurring in the general community (p. 30).

Community mental health services and gender sensitive practice

Gender sensitive practice in the community setting includes viewing women's lives in the context of their lived circumstances, acknowledging the power difference between facilitators and participants to avoid disempowering women, remaining aware of gender stereotypes and the objectification of women, and making services available, accessible, affordable and appropriate (Women's Centre for Health Matters, 2009). Women with mental illnesses are increasingly being managed out of the hospital setting, as community psychiatry has become the standard mode of service provision. In order to reduce gender disparities in

mental health treatment, gender-sensitive services must be adopted and implemented. These services must meet women's needs for dedicated care, privacy, empowerment and understanding at all levels, from primary to specialist care in all outpatient facilities, including the non-government sector that provides considerable support for people with persistent mental disorders (Judd et al., 2009).

A recent review of peer support literature (Pound et al., 2011) found that there are a variety of peer support models which best meet the needs of women. The models complement care in the community sector, and can have different ways of functioning. The key characteristics that define best practice peer support include an emphasis on experiential knowledge, reciprocity, providing opportunities to learn and take on new roles, sharing responsibility, building friendship or interpersonal relationships, and being non-hierarchical and voluntary. There are excellent examples of this model in use in the Australian Capital Territory (ACT) and other parts of Australia. Overall, the use of peer support in community settings with competent facilitators, including leaders as peers and also for supervision and support for peer leaders, has been found to be a useful community mental health support modality for women (Mead and MacNeil, 2006).

Recommendations:

29. Federal, state and territory governments develop gender-sensitive practice guidelines, with specific input from women as consumers, carer advocates and mental health clinicians, and ensure their implementation in all mental healthcare settings. Expertise in the development of gender-sensitive practice guidelines and training is readily available within the women's health sector; and

30. The encouragement of the use of peer support in state government-funded community mental healthcare clinics and Psychiatric Disability Support Sector services, with ongoing education of women provided through consumer advocacy organisations such as Mental Illness Fellowship Australia, SANE Australia, and Beyond Blue.

Research and education

To date there are very few dedicated women's mental health research centres in Australia, with small groups across the nation conducting research into specific aspects of women's mental illnesses. There is an urgent need for a greater, co-ordinated focus on women's mental health research across Australia in order to develop more tailored approaches to the prevention of women's mental illness, focussing on promoting well-being and understanding the social context of women's mental health issues. Better integration of research, which includes the use of advances in biotechnology within social and psychological domains, will enable more understanding of the biological, psychological and social factors that impact detrimentally on women's mental health.

This in turn will lead to new and better treatment options being developed and an evidence base for mental health reform for women with mental disorders.

As the population ages, the growing burden of disease will increasingly impact on health resources. Research is required to maximise the effectiveness of policies and services, as well as to allocate resources to cost-effective interventions specifically designed to meet the needs of women. There is an urgent need for gender-focused research to ensure that clinicians, policy makers and mental health services can improve the quality of their services for women with mental illnesses. Building a solid, nationally integrated evidence base derived from high quality research into the bio-psychosocial causes of, and special therapeutic approaches to, women's mental illnesses is an important and much needed investment in the project of improving the future for women with mental disorders.

Recommendation:

31. A national women's mental health research institute is established with the aim of building a nationally integrated evidence base through coordinating and facilitating an Australia-wide program of research to improve outcomes for women with mental illnesses.

Specific development of treatments tailored for women with mental illnesses

Managing women with schizophrenia requires new approaches that have a clear gender focus. In this way, more specific, tailored treatments for women with mental illness can be developed and implemented to provide better outcomes. Developing better clinical approaches for women with mood disorders that take specific aspects of hormone fluctuations into account and are able to provide information about this for women is another area of research that is required. Borderline Personality Disorder is a severe mental illness with both high mortality and morbidity, and yet there is very little investment in the research of this disorder, and there is no specific treatment approach.

Recommendations:

32. National Health and Medical Research Council research priority be given to developing new treatments for women with specific mental illnesses.

Recently, a 'Ten Year Roadmap' for national mental health reform has been drafted to continue on from the Fourth National Mental Health Plan, but it does not employ a gender lens or a plan to implement research to develop specific approaches for women with mental illnesses. This vision for mental health reform in Australia does not provide the substantial research investment required to evaluate its key directions which include Promoting Good Mental Health and Well-being and Preventing Mental Illness and Suicide; Early Detection and Intervention; Consumers and Carers at the Heart of Services and Support; Supporting People to Participate in Society; and Making Services Work for People – Access, Quality, Integration and Coordination (Department of Health and Ageing, 2012). The gender-blind approach of this Plan mirrors that of previous Mental Health Plans. It is crucial that gender analysis is made the foundation of this document if outcomes for women are to be improved: a general focus will not achieve this aim.

Mental health promotion and education

The benefit of promoting mental health and well-being for populations and communities is receiving greater attention. Emphasising the importance of the quality of societal and community life has a significant impact for the individual as well as the community. Mental health promotion and education aims to support people to achieve and maintain good mental health, as well as improving the well-being of communities. The most popular methods of health promotion also apply to mental health promotion and include mental health education, and social marketing, aimed at behavioural change in the individual and broader community/societal changes.

In this era of increased social media usage by the general population, there is abundant potential to increase the general awareness of mental health issues for women through broad health promotion. Although there are a number of popular women's mental health websites, there are still too few mental health promotion programs that are focused on women's mental health issues. Women's mental health promotion and education is a key factor in promoting gender-sensitive practice. In particular, mental health promotion for women needs to develop a strong focus on available resources for assistance. Expert mental health promotion must focus on mental health from a gendered perspective, such as in the areas of postnatal depression, depression in general, and psychosis awareness. It is important to use the existing mental health promotion outlets and to build new sites in order to increase mental health promotion for women. The aim of these would be to educate the entire population on the broad determinants of mental health and ill health; the different manifestations of mental disorders in women and awareness of their possible impacts; and the resources available to help women with mental illness.

While social media is one mode of delivering information and education, there is a clear need for a variety of mental health promotion and support strategies to be provided. As discussed earlier, there is an urgent need to fund a greater number of community health centres for women than presently exist, which would include a range of mental health services developed and delivered to cater for a spectrum of mental health issues. In this setting, important educational material can be disseminated concerning mental health, the social determinants of mental ill health, and access to resources and support networks.

Conclusion

Although mental health reform has occurred at a rapid pace in Australia over the past ten years, there is a notable lack of focus on women's mental health as a specific target area. Promoting women's mental health and well-being requires greater understanding of negative societal factors such as violence, poverty, substance abuse and gender inequity. Prevention of mental illness in women involves social reform, since violence, poverty and substance abuse can impact adversely on well-being. In combination with biological and psychological factors, adverse social factors lead to the development of mental illness. The specific combination and impact of the bio-psychosocial factors causing mental disorders in women is poorly understood, and the current research into women's mental health and mental disorders is uneven and poorly funded. There is a great need to research the impact of social factors on mental health and to develop a tailored approach to the prevention of mental illness in women. Women who experience mental disorders urgently require gender specific treatment options and access to safe, private services that answer the special needs of women with mental illnesses. The dual challenges of preventing mental disorders in women and effectively treating women's mental illness with sensitivity are key areas that require urgent and combined attention from the community, health, social policy, legal, research and education sectors. Mental health reform in Australia must give specific attention to the integrated bio-psychosocial factors that impact on the mental health and well-being of women, as well as focussing on specially tailored treatments for women with mental disorders.

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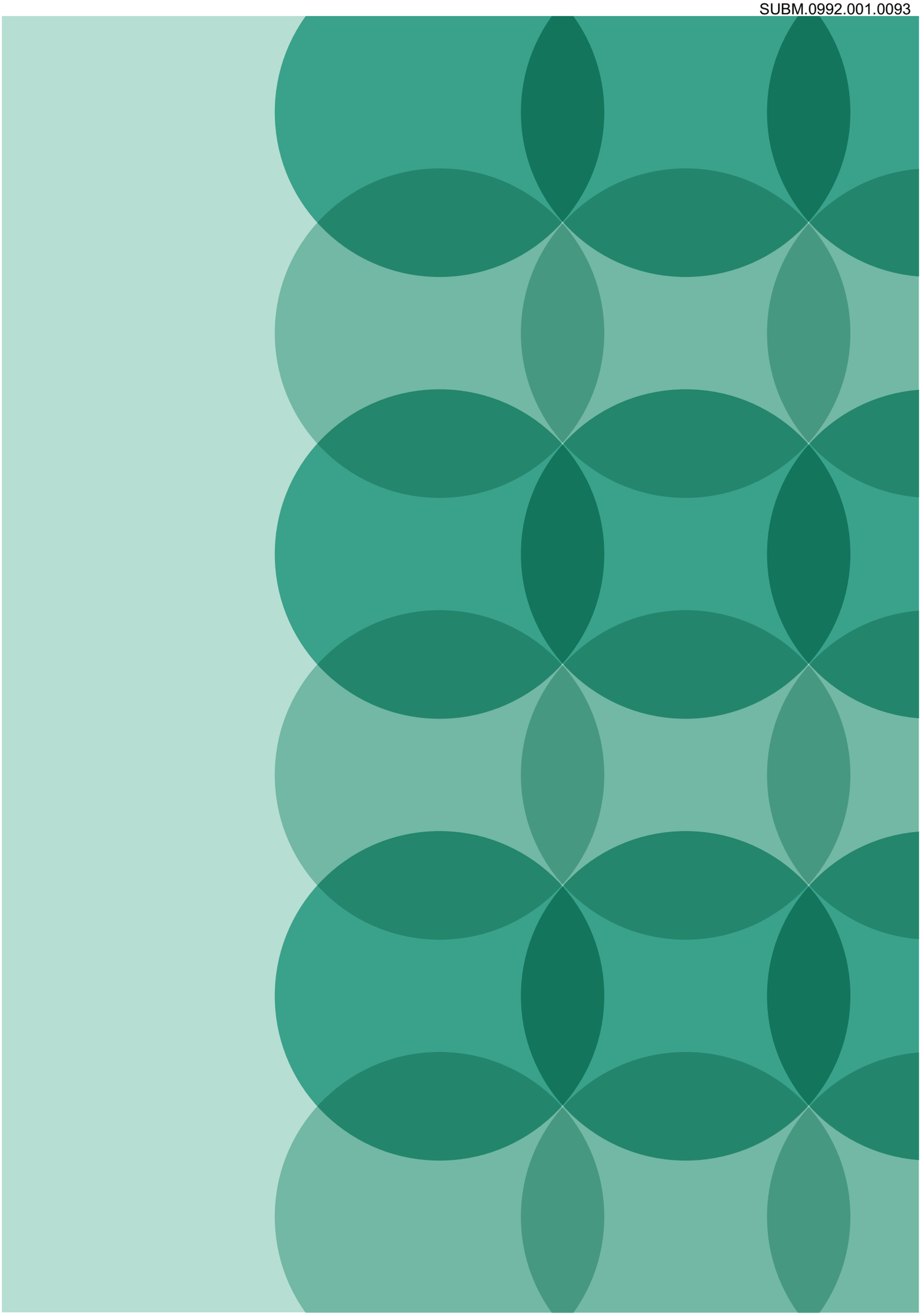

AUSTRALIAN WOMEN'S HEALTH NETWORK

WOMEN'S HEALTH: MEANINGFUL MEASURES
FOR POPULATION HEALTH PLANNING

2013

Australian Women's Health Network

Women Health: Meaningful measures for population health planning

A publication of the Australian Women's Health Network, based on a commissioned paper written by WLK Consulting, with support from the Women Health: Meaningful measures for population health planning Advisory Group, August 2013.

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This position paper is available for free download at: www.awhn.org.au

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Executive summary

The Australian Women's Health Network (AWHN) identified the need to develop meaningful measures of women's health as an outcome of a series of position papers published in 2012 on women's health and wellbeing and women and health reform. The *Women's Health: Meaningful Measures in Population Health Planning* project was subsequently proposed to Minister for Health, Tanya Plibersek; with funding received for the project shortly after from the Department of Health and Ageing. With limited resources for the project, a think tank was convened on 31 July 2013 in Canberra as the most effective way to draw together the expertise required to meet the aims of the project.

What are meaningful measures? Meaningful measures provide a snapshot of the social determinants of women's health. These are the social and economic circumstances of women's lives (such as their socio-economic disadvantage). Such circumstances result from the inaccessibility to women of key requisites for a healthy life which can also be meaningfully measured (such as economic and social participation). In turn, this can expose women to health behaviours and/or risk factors for poor health (such as stress or self harm) that can result in a myriad of health problems (such as mental health issues) – all of which can be meaningfully measured.

In addition, meaningful measures throw a spotlight on the underpinning drivers of women's socio-economic positioning. These are the deeply entrenched structural mechanisms that stratify society along gender lines, and produce and maintain gender hierarchies in relation to power, prestige and access to resources that are the key requisites for a healthy life.

Meaningful measures are needed because Australian health policy and planning has tended to overlook the social determinants of women's health and continues to remain 'blind' to prevailing gender hierarchies and their resulting systematically inequitable distribution of power, prestige and resources between women and men. In Australia there exists a current opportunity to mainstream meaningful measures through various population health policy and planning activities of Medicare Locals, local governments (councils), and state and territory governments. There exists an opportunity, too, to influence an environment that can authorise the uptake of meaningful measures through state, territory and federal government departments of health (and their ministers) and peak health organisations, for example. The work arising from *Women's Health: Meaningful Measures in Population Health Planning* project (namely, this resource) is addressed to these primary intended users.

For the think tank, participants were asked to prepare a brief presentation against a set of questions. These were:

1. In targeting better health outcomes for women, what is critical to measure and make visible within each of the following levels of determinants that affect health outcomes?
   - individual level
   - intermediary factors, and
   - structural factors
2. What data sources could be accessed by population health planners within the areas to be measured?
3. What data gaps make this difficult?

Facilitation of agreement on a core set of meaningful measures first led to the development of a robust conceptual framework that shows four causally interlinked dimensions of women's health:

- the underlying structural mechanisms that stratify society along gender lines and produce and maintain gender hierarchies in relation to power, prestige and access to resources (including the key requisites for a healthy life);
- the social determinants of women's health (or women's social and economic circumstances, their daily living conditions, their lived experiences);
- women's exposure to health behaviours and/or risk factors for poor health; and
- the various health issues experienced by women, which must be understood in the context of the other dimensions.

The four dimensions of the conceptual framework are aligned with contemporary research on the social determinants of health, in particular the work of the World Health Organization's (WHO's) Commission on the Social Determinants of Health (CSDH)

(http://www.who.int/social_determinants/en/). CSDH makes an analytical distinction between the structural factors of health inequities (considered to be the most upstream of all determinants) and the social and economic conditions of daily life (cast as the more intermediary social determinants of health).

Aligned with CSDH, the conceptual framework for women's health conveys the message that any action to improve women's health cannot limit itself to the social determinants but must tackle the structural mechanisms that produce and maintain the inequitable distribution of power, prestige and resources between men and women in the first place.

The conceptual framework for women's health also includes a life course approach to show how the causal relationships between the structural drivers and the second, third and forth dimensions of women's health are experienced by women throughout the life course and in different ways.

Meaningful measures then emerged from the conceptual framework. Meaningful measures reflect the most critical elements of the conceptual framework necessary for health policy makers and planners to comprehend – *at a minimum* – so that their work does not continue to overlook the social determinants of women's health and/or remain 'blind' to the structural drivers of gender hierarchies and inequities that shape women's daily living conditions and their health outcomes.

The final agreed set of meaningful measures is presented in this report together with links to available data sources where these are currently known to exist. Fresh data sources will no doubt come into existence as data custodians, such as the Australian Bureau of Statistics, continue to expand their output of gender-based statistics. This means that the meaningful measures arising from the *Women's Health: Meaningful Measures in Population Health Planning* project are not static but rather a work-in-progress. This report concludes with a set of implementation steps to ensure the continued development of meaningful measures of Australian women's health.

1.0 Background and context to the work

1.1 About the Australian Women's Health Network

The Australian Women's Health Network (AWHN) is a community-based, non-profit consultative organisation with members in every state and territory across Australia who share the purpose of working to improve the health and well-being of Australian women.

AWHN works with policy makers, service providers and community to advance a national voice on women's health through disease prevention, health promotion advocacy and information sharing. AWHN recognises the social, economic, cultural and political factors that impact on women's lives and health.

AWHN has member networks in all states and territories of Australia, across all dimensions of the social determinants of health. AWHN's membership profile ensures broad reach as the majority of the organisation members are themselves member-based organisations, which between them have an estimated 12,000 individuals that AWHN communicates with on a regular basis. This includes rural and remote women, women with disabilities, Aboriginal and Torres Strait Islander (ATSI) women, migrant and refugee women, older women, young women, lesbian, bisexual, transgendered, same sex attracted and intersex women. Further information about AWHN can be found at www.awhn.org.au.

In 2012, AWHN produced the *AWHN Women and Health and Well-being* and *Women and Health Reform Position Papers* (www.awhn.org.au) which argued broadly for recognition of a number of principles essential to establishing a firm basis upon which to redress health inequities for women. The need for the development of meaningful measures of women's health was identified in these papers and promoted through advocacy for action on their recommendations. The *Women's Health: Meaningful Measures in Population Health Planning* project was proposed to Minister for Health, Tanya Plibersek following discussion on these recommendations, and subsequently received funding assistance from the Commonwealth Government with a Health Systems Capacity Development grant through the Department of Health and Ageing.

A think tank was convened on 31 July 2013 in Canberra as the most effective way to draw together the expertise required to meet the aims of the project, particularly given the very limited resources available. The total funding received for the project was $10,000 and it needed to be completed in a short time frame (from May to September 2013) with significant population planning currently underway.

The objective and target outcomes of AWHN's *Women's Health: Meaningful Measures in Population Health Planning* project were as follows:

Objective

Recognising that gender is a key determinant of health and is often invisible in data collections and analysis for health planning, the objective of the *Women's Health: Meaningful Measures in Population Health Planning* project was to create agreed national key performance indicators for women's health for inclusion in population health planning data collection and analysis.

Target Outcomes

1. Enhanced population health planning through recognition:
   - » that gender accounts for the fundamental differences between men's and women's health;
   - » of the importance of gendered social relations, social factors and conditions of living in determining health and illness outcomes; and
   - » that gender is an overarching social determinant of health.
2. Enhanced population health data which underpins prioritising service delivery initiatives and needs analysis for action.
3. Improved health and well-being for women through the inclusion of these key performance indicators in all Commonwealth, State/Territory and Local Government funded entity population health planning.

1.2 Why focus on meaningful measures?

'What gets measured is what gets done'. This is a key message of the *Women's Health: Meaningful Measures in Population Health Planning* project. Put simply, what gets measured is more likely to be prioritised by health policy makers and planners. Health measures enable evidence and facts to be gathered and used for sound health policy and planning: they contribute to setting the health agenda – nationally, regionally and locally. Once priorities are set, decision-makers can be held to account for their actions (or non-actions) on them. They can also monitor efforts against them through health measures and improve future actions on them. That is why it is important to have *meaningful* measures of women's health for population health planning – measures that truly reflect women's lived realities. The think tank was an opportunity to explore such measures – as well as any gaps in data collection and analysis.

What kinds of evidence and facts do meaningful measures of women's health collect?

Meaningful measures provide a snapshot of the social determinants of women's health. These are the social and economic circumstances of women's lives (such as their socio-economic disadvantage). Such circumstances result from the inaccessibility to women of key requisites for a healthy life which can also be meaningfully measured (such as economic and social participation). In turn, this can expose women to health behaviours and/or risk factors for poor health (such as stress or self harm) that can result in a myriad of health problems (such as mental health issues) – all of which can be meaningfully measured.

In addition, meaningful measures throw a spotlight on the underpinning drivers of women's socio-economic positioning. These are the deeply entrenched structural mechanisms that stratify society along gender lines, and produce and maintain gender hierarchies in relation to power, prestige and access to resources that are the key requisites for a healthy life.

Research that exemplifies 'what gets measured is what gets done' includes the Victorian Health Promotion Foundation's (VicHealth's) report on the health costs of violence against women, *The health costs of violence: Measuring the burden of disease caused by intimate partner violence* (VicHealth 2004). This report shows that intimate partner violence was the leading contributor to death, disability and illness for Victorian women aged 15–44 years. Since the publication of the report, this meaningful measure has set the agenda for health policy and planning in Victoria at the statewide and local levels.

Meaningful measures therefore support and resource health policy makers and planners to undertake their work in ways that are encompassing of women's experiences and genuinely inclusive of the populations they plan for. More about women's socio-economic circumstances and the underlying mechanisms that stratify society along gender lines can be found in section 2.2 'The social determinants of health and the structural drivers of inequities' of this report.

Why do we need such an emphasis on meaningful measures of women's health?

Australian health policy and planning has tended to overlook the social determinants of women's health and continues to remain 'blind' to prevailing gender hierarchies and their resulting systematically inequitable distribution of power, prestige and resources between women and men. The traditional way of bringing data together does not always take into account the impacts of the social determinants and structural drivers on women *because* they are women; for example, the effects of women's financial insecurity on their health at different stages in the life course. As noted by one think tank participant, the public health field is poised for an analytical breakthrough of this barrier. The *Women's Health: Meaningful Measures in Population Health Planning* project is a contribution to this work.

In Australia there exists a current opportunity to mainstream meaningful measures through various population health policy and planning activities. The primary intended users of the work (namely, this resource) arising from the *Women's Health: Meaningful*

Measures in Population Health Planning project are:

1. entities mandated to conduct population health planning based on evidence and meaningful measures, for example:
   - 61 Medicare Locals;
   - local governments (councils); and
   - state and territory governments.
2. entities that can build an authorising environment for the uptake of meaningful measures of women's health, for example:
   - state, territory and federal government departments of health (and their ministers);
   - public health sector organisations like such as the Australian Institute of Health and Welfare;
   - entities responsible for data capture and distribution such as the Australian Bureau of Statistics and the Australian Women's Health Longitudinal Study; and
   - peak health organisations, such as the Public Health Association of Australia, National Mental Health Commission, and National Heart Foundation.

1.3 The think tank on meaningful measures

On 31 July 2013, AWHN convened a think tank in Canberra of experts in population health planning, data collection and analysis to explore meaningful measures of women's health.

In preparation for the day, participants were asked to prepare a 1–2 page presentation against a set of questions. The questions were:

1. **In targeting better health outcomes for women, what is critical to measure and make visible within each of the following levels of determinants that affect health outcomes?**

   Individual level
   - Lifestyle factors, particularly: diet, physical activity, smoking, alcohol and drugs; genetics; social connection; freedom from violence and discrimination; and access to income, opportunities for social participation and citizenship.

   Intermediary factors
   - Social and community factors, including the influence of: neighbourhoods; criminal incidents; unemployment levels; discrimination and racism; social exclusion and cultural influences.
   - Living and working conditions, including: educational attainment; access to health services; housing; employment conditions; unemployment; sanitation; air and water quality.

   Structural factors
   - General socio-economic factors impacting on health and well-being, including: levels of poverty and wealth and how income is distributed (i.e. the social gradient); cultural richness; educational opportunities; legal and political environments, policies and infrastructure.

2. What data sources could be accessed by population health planners within the areas to be measured?

For example, the Australian Institute of Health and Wellbeing Health Performance Framework includes the following:

Health status

- Mortality and life expectancy
- Prevalence of health conditions
- Human functions – disability and impairment
- Well-being

Determinants of Health

- Bio-medical – genetic, blood pressure, cholesterol, weight
- Community and socio-economic status – social capital, income, housing, education, employment
- Environmental – physical (urban design, open space, pools, gyms, community centres, libraries), chemical (air quality), biological (food, water)
- Health behaviours – smoking, alcohol, nutrition, immunisation, sexually transmitted infections, exercise, sun

Health system performance

- Accessibility
    i. Availability
    ii. barriers e.g. disability, low socio-economic status, cultural and linguistic diversity, ATSI, transport
- Continuity of care, effectiveness, efficiency and sustainability, responsiveness
- Safety from health care, falls etc.

3. What data gaps make this difficult?

For example, data is usually disaggregated by sex but insufficiently correlated with income to explain the nature of the social-health gradient by sex. Income is a key determinant of health for women. Women have far less access to economic resources than men and their health is a reflection of that social-health gradient.

Violence against women is the single biggest cause of poor physical and mental health among women but we have little longitudinal data about the long-term effects of violence against women on women's economic well-being and security, as well as health and well-being.

During the think tank, participants discussed the common themes and points of differences in the approaches and concepts used for their presentations. Facilitation of agreement on a core set of meaningful measures during the think tank first led to the development of a conceptual framework for women's health. Meaningful measures then emerged from the conceptual framework.

The conceptual framework and the meaningful measures are presented and discussed in the following sections of this report.

2.0 A conceptual framework for women's health

2.1 The ingredients for a conceptual framework

During the think tank, participants agreed that the most critical factor in identifying meaningful measures is the existence of a robust conceptual framework that can encapsulate Australian women's health in all its totality and interlinked complexity. Much of the discussion was subsequently spent sketching the contours of a conceptual framework, the final version of which can be found on p. 13 of this report. As the collective thinking unfolded, a distinction emerged between an uppermost causal level of structural drivers of gender hierarchies and inequities and a second-order level of social and economic circumstances expressed as women's lived experiences of the structural drivers.

The resulting conceptual framework is aligned with contemporary research on the social determinants of health, in particular the work of the World Health Organization's (WHO's) Commission on the Social Determinants of Health (CSDH) (http://www.who.int/social_determinants/en/). CSDH makes an analytical distinction between the structural factors of health inequities (considered to be the most upstream of all determinants) and the social and economic conditions of daily life (cast as the more intermediary social determinants of health). CSDH presents the different levels of causality in a framework for action on the social determinants of health – one that clearly shows the priority given to the structural determinants of health inequities in shaping a population's health:

A key aim of the framework is to highlight the difference between levels of causation, distinguishing between the mechanisms by which social hierarchies are created, and the conditions of daily life which then result. [...] The vocabulary of 'structural determinants' and 'intermediary determinants' underscores the causal priority of the structural factors (Solar and Irwin 2010: 4 and 6).

It is noted that VicHealth is also currently using CSDH's latest research on the social determinants of health by adapting and applying it to the Australian context, although the focus of VicHealth's work is not specifically on women's health. In addition, implementation of the conceptual framework for women's health should support country reporting against international conventions, such as the United Nation's *Convention on the Elimination of all Forms of Discrimination against Women* (CEDAW).

Think tank participants further recommended that the conceptual framework incorporates a life course approach, such as that utilised by the Ministry of Health in New South Wales. A life course approach has the benefit of focusing attention on the operation of the structural drivers of gender hierarchies and inequities throughout women's lives – from childhood and adolescence, to the young adulthood years, to the mid-life years, and to the older years and end-of-life – in recognition that this operation of structural drivers will be experienced and lived differently by women depending on their stages in the life course.

The following section describes in more detail the distinction between an uppermost causal level of structural drivers of women's health and a second-order level of social and economic conditions expressed as women's lived experiences of the structural drivers; and explains why this distinction is so important for a conceptual framework for women's health.

The conceptual framework is then presented and described in section 2.3 *'The conceptual framework: Four dimensions'.*

2.2 The social determinants of health and the structural drivers of inequities

2.2.1 The social gradient in health

It is understood globally by public health experts that the most powerful influences on a population's health are the social and economic conditions in which people are born, grow, live, work and age (CSDH 2008: 26).[1] Evidence shows a strong relationship between socio-economic disadvantage, on the one hand, and shortened life expectancies and increased morbidities, on the other. The health of any given population is not evenly experienced but is rather graded by differences in socio-economic circumstances. This is known as the social gradient in health.

The existence of a social gradient in health means that health policy makers and planners (and their partners) must take action on social and economic conditions that shape people's lives if they are to improve the health of everyone – especially those with the poorest outcomes. Effective health policy, for example, involves multi-sectoral effort to reduce levels of social exclusion, financial insecurity and economic disadvantage, thereby improving opportunities for all to be part of the social and economic life of their communities. As Marmot and Wilkinson write, "Societies that enable all citizens to play a full and useful role in the social, economic and cultural life of their society will be healthier than those where people face insecurity, exclusion and deprivation" (Marmot and Wilkinson, 2003: 11).

2.2.2 Gender inequities

Inarguably, action on the social determinants of health is the basis of sound population health planning. But what is less well understood and less widely acknowledged in the public health field is the recognition that the social gradient of health is not gender neutral. The fact remains that within any given population, men and women are unequal in social and economic terms. The social construction of gender – or how we live our biological sex according to prevailing norms, values, expectations and behaviours as men and women – exerts an ever-present force on the unequal distribution of power, prestige and resources *between* the genders, including men's and women's differential access to the key requisites for a healthy life. This unequal distribution of assets stratifies society along gender lines and produces and maintains gender hierarchies and inequities. These in turn shape every facet of women's experiences in ways that are unique to them *as* women – although not always in the same ways (explained further below). Gender-based inequities are, in short, the structural drivers of the social and economic conditions of women's lives; and they influence the circumstances of daily living for women in a myriad of ways, including (but not limited to):

- the role women play in families and households;
- the relationships women have to others as carers and care givers;
- the pathways open to women for secure paid employment;
- the power and control exercised by men over women in private and public life;
- women's capacity to influence the course of public life;
- the voice women have in decision making;
- the ways in which women are valued; and
- the ways in which women are treated – including by the health system.

These unique circumstances of women's daily living – the social and economic conditions of their lived realities – then mean that women are more likely than men to be found lower down the social gradient in health with the accompanying exposures to poorer health that this positioning entails.

Economic participation, for example, is a key requisite for a healthy life. Gender norms and institutions define different employment expectations of men and women such that women are systematically disadvantaged in relation to their access to economic participation relative to men. Dominant beliefs about what counts as women's work are typically manifested in the daily life of women in Australia. This is through:

- the inordinate amount of unpaid work performed by women in households and families;
- women's often fragmented paid work trajectories and career paths;

[1] With health understood as a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity

- women's restriction to lower paid roles, occupations and sectors of employment;
- the poor working conditions often endured by women; or
- all of the above.

Moreover, these unique social and economic conditions reduce women's lifetime earning capacity and increase their exposure to economic disadvantage and/or poverty in adulthood and older age – both of which pose further risks to the health of women as a group compared to men.

With respect to a conceptual framework for women's health, then, explicitly naming the structural drivers that stratify society along gender lines and produce and maintain systemic gender hierarchies and inequities is both necessary and non-negotiable. So too is showing the relationships between these structural drivers and social and economic circumstances of women's lives, the health behaviours and/or risk factors that expose women to ill health, and the resulting health issues experienced by women.

2.2.3 A note on intersectionality

As stated, gender hierarchies and inequities shape every facet of women's experiences in ways that are unique to them as women, although not always in ways that are identical. Women's experiences as women are not always the same because social stratification occurs across multiple axes. Social stratification along the lines of gender always intersects with other lines of social hierarchy, such as racial privilege, ethnic privilege and hetero-normativity – to name but a few. This means that the distribution of power, money and resources can be unequal *within* women as a group, with some women experiencing the effects of compounded inequities because of their positioning through multiple axes of social stratification and systemic hierarchies.

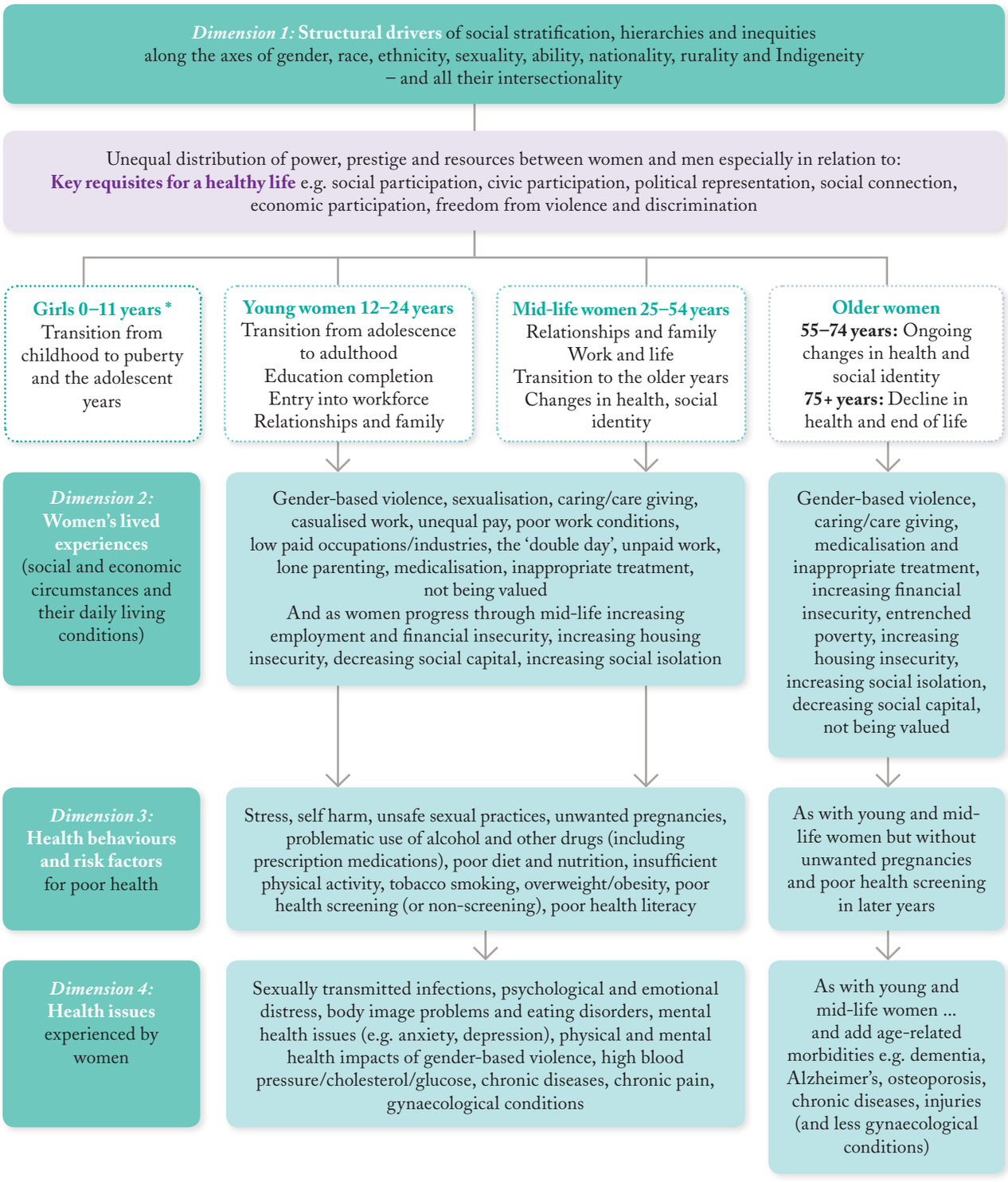
To the example of economic participation above, we can add that prevailing norms about culture and ethnicity typically define different employment expectations of Anglo-Australian women and women from non-English speaking backgrounds. As a result, women from non-English speaking backgrounds are systematically disadvantaged in relation to their access to economic participation relative to Anglo-Australian women. This differential access to economic participation between women is manifested in the concentration of women from non-English speaking backgrounds in lower paid jobs in blue collar occupations, which can expose them to poor work conditions such as long and/or inflexible working hours. Compared to their counterparts in white collar employment, women from non-English speaking backgrounds in blue collar work are consequently more exposed to reduced lifetime earning capacity and hence increased economic disadvantage and/or poverty. They are also more likely to be exposed to the stressors of poor working conditions and hence at increased risk of emotional and/or mental health issues. In short, the specific social and economic circumstances of women from non-English speaking backgrounds mean that these women are more likely than Anglo-Australian women to be found lower down the social gradient in health along with the exposures to poorer health that this positioning entails.

Of course, understanding the lived realities of other groups of women, such as Aboriginal and Torres Strait Islander-identified women, women with disabilities and sexuality and gender diverse women, demands similar attention to the intersectionality of different axes of social stratification and systemic hierarchies. Only then can health policy makers and planners grasp the social and economic circumstances of these women as the result of deep structural drivers of inequities.

With respect to a conceptual framework for women's health, it is therefore imperative that the structural drivers that stratify society along gender lines are shown together with other axes of social stratification that structure social hierarchies and inequities, and which in turn intersect with one another to influence women's social and economic circumstances, their health behaviours and risk factors for poor health, and the health issues that they ultimately experience.

2.3 The conceptual framework: Four dimensions

The conceptual framework for women's health comprises four dimensions that make explicit the totality and interlinked complexity of women's health. A life course approach and the key requisites for a healthy life are also part of the conceptual framework.



* Girls aged 0–11 years are shown in this conceptual framework for women's health to indicate that the structural drivers are at work throughout the life course. The conceptual framework, however, focuses on the causal linkages between the four dimensions and their effects on young women, mid-life women and older women.

2.3.1 The first dimension: Structural drivers of stratification, hierarchies and inequities

This level includes the deeply entrenched structural mechanism that stratifies society along gender lines and produces and maintains systemic gender hierarchies and inequities in relation to power, prestige and access to resources. The key requisites for a healthy life are part of this unequal distribution of assets between the genders. The structural mechanism responsible for this is the social construction of gender, or how we live our biological sex according to prevailing norms, values, expectations and behaviours as men and women. This particular structural mechanism intersects with other powerful drivers of social stratification that operate along the lines of race, ethnicity, sexuality, ability, nationality, rurality and Indigeneity, which each produce and maintain hierarchies and inequities that complicate even further the relation to power, prestige and access to resources for specific groups of women.

In keeping with the Commission on the Social Determinants of Health's causal prioritising of the structural determinants of health inequities, this first dimension of women's health is shown in the uppermost part of the conceptual framework for women's health.

2.3.2 Interlude: the key requisites for a healthy life and the stages of women's life course

Situated between the first and second dimensions of women's health, are the key requisites for a healthy life. The key requisites are part of society's resources that men and women have differential access to because of impacts of social stratification along gender lines. They include:

- social participation;
- civic participation;
- political representation;
- social connection;
- economic participation; and
- freedom from violence and discrimination.

The key resources for a healthy life are located between the first and second dimensions for a reason. Put simply, the structural drivers of stratification, hierarchies and inequities along gender lines mean women have less accessibility to the key requisites for a healthy life compared to men, and it is this inequity that is then 'lived' in women's socio-economic circumstances (the second dimension of women's health).

Also situated between the first and second dimensions are the stages of the life course approach. These are:

- childhood and adolescence (0–11 years);
- the young adulthood years (12–24 years);
- the mid-life years (25–54 years); and
- the older years and towards the end-of-life (55–74 years and 75+ years)

The stages of the life course approach are located between the first and second dimensions to show how the causal relationships between the structural drivers and the second, third and forth dimensions of women's health are experienced by women throughout the life course and in different ways (depending on the stage).

2.3.3 The second dimension: Social and economic circumstances of women

This level includes the social and economic circumstances of women (also known as women's daily living conditions or women's lived realities) that are shaped by the hierarchies and inequities in relation to power, prestige and access to resources as generated by the structural drivers. These social and economic circumstances are what public health conventionally understands as the social determinants of health; and in the conceptual framework for women's health (and in keeping with the latest research on the social determinants of health) these social determinants of health are a second-order priority insofar as they are the product of the deeper, underlying and entrenched structural determinants of health inequities. The conceptual framework for women's health thus conveys the message that any action to improve women's health cannot limit itself to the social determinants but must tackle the structural mechanisms that produce and maintain the inequitable distribution of power, prestige and resources between men and women in the first place.

The social determinants of women's health include a myriad of circumstances experienced by women on a daily basis including:

- employment issues: such as poor working conditions; fragmented paid work trajectories and career paths; unemployment; under-employment; casualisation; unequal pay; and restriction to lower paid roles and 'feminised' occupations/sectors of employment;
- financial insecurity, socio-economic disadvantage and entrenched poverty;
- housing insecurity and homelessness;
- poor social support, social isolation, social exclusion and low social capital (e.g. not having a voice in decision making);
- unpaid work (especially women's role as primary carers of children and care givers to other family members), carrying the load of the 'double day' (i.e. paid work and unpaid work), lone parenting and volunteering;
- gender-based violence (physical, sexual, emotional and financial) including intimate partner violence;
- sexual harassment in the workplace and stalking;
- discrimination and exploitation;
- sexualisation and objectification;
- inappropriate treatment by institutions (such as the legal system or the media) and services (including a health service system that medicalises women); and
- not being valued overall.

2.3.4 The third dimension: Health behaviours and risk factors for poor health

This level includes the exposures to individual health behaviours and/or risk factors for poor health that are connected to women's social and economic circumstances, such as:

- low self-esteem, stress and self-harm;
- poor diet and nutrition, physical inactivity, overweight and obesity;
- tobacco smoking;
- the problematic use of alcohol and other drugs (including prescription medicines);
- unsafe sexual practices and unwanted pregnancies;
- poor health screening practices (or non-screening); and
- poor health literacy.

2.3.5 The fourth dimension: Women's health issues

This level includes the myriad of health issues experienced by women that must be contextualised and understood according to the conceptual framework as a whole; that is, as framed by the preceding structural and socio-economic dimensions of women's health in their interlinked and causal chain of effects. Women's health issues include (and are not limited to):

- high blood pressure, high blood cholesterol and high blood glucose;
- mental health issues (e.g. depression, anxiety);
- body image problems and eating disorders;
- emotional health issues (e.g. stress);
- physical health problems (e.g. chronic pain, arthritis);
- gynaecological conditions;
- sexually transmitted infections;
- physical and mental health impacts of gender-based violence;
- preventable chronic diseases (e.g. diabetes, lung cancer, heart disease); and
- age-related morbidities (e.g. chronic diseases, osteoporosis, injuries from falls, dementia and Alzheimer's).

3.0 The meaningful measures

The conceptual framework presented and described above allows us to understand women's health in its full dimensions. Importantly, it enables us to identify the most critical aspects of women's health to be measured. This identification is important because 'what gets measured is what gets done' (see section 1.2 'Why focus on meaningful measures'?).

Not every aspect of women's health as shown in the conceptual framework need always be measured; salient elements are therefore the *prioritised* areas of the conceptual framework necessary for health policy makers and planners to comprehend – *at a minimum* – so that their work does not continue to overlook the social determinants of women's health and/or remain 'blind' to the structural drivers of gender hierarchies and inequities that shape women's daily living conditions and their health outcomes.

As this report makes clear, meaningful measures are specifically for use by population health planners and decision-makers, and the different emphases they will place on the different meaningful measures given the diversity of the populations they are planning for is acknowledged. The table and its contents are not meant to be an exhaustive set of measures of Australian women's health for health planners and decision-makers.

The following table includes the meaningful measures of Australian women's health that arose from the work of the think tank in prioritising certain elements of the conceptual framework. The table also includes links to available data sources for the meaningful measures, where these are currently known to exist. Fresh data sources will no doubt come into existence as national data custodians, such as the Australian Bureau of Statistics, continue to expand their output of gender-based statistics – particularly in the areas of women's experiences of violence and pay inequities. This means that the table of meaningful measures that follows is not static but rather a work-in-progress, to be continuously developed.

Salient element of women's health	As meaningfully measured by ...	Data source
Demographics and diversity	Age distribution of women as a population group	Australian Bureau of Statistics Census Community Profiles Series, http://www.abs.gov.au/census Department of Immigration and Citizenship, Settlement Reporting Facility, http://www.immi.gov.au/living-in-australia/delivering-assistance/settlement-reporting-facility/
	Countries of birth of women and their age distributions	
	Aboriginal and Torres Strait Island identified women and their age distributions	
	Languages spoken at home and spoken English proficiency	
	Religious affiliation	
	Women with disabilities	Women's Health Victoria, The Index ('Demographics and diversity'), http://www.theindex.org.au/Data/DemographicsDiversity.aspx
	Same-sex attracted women	
Gender equality and women's empowerment	Meaningful measure requires further investigation; two possible options are: » United Nations Development Program's Gender Inequality Index, a composite measure reflecting inequality in achievements between women and men in reproductive health, empowerment and the labour market » OECD's Social Institutions and Gender Index, a composite measure of the root causes of gender inequality; for example, violence against women, access to public space, discrimination against women with respect to political participation	Data source requires further investigation; for the moment there is the Gender Inequality Index (data on Australia available) http://hdrstats.undp.org/en/indicators/68606.html and the Social Institution and Gender Index (Australia yet to be ranked) http://www.genderindex.org

Continued...

Salient element of women's health	As meaningfully measured by ...	Data source
Women in leadership	Ratio of women with seats in parliament compared to men (federal and state/territory)	Parliament of Australia, 'Representation of women in Australian parliaments', http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BN/2011-2012/Womeninparliament#_Toc318895764 Australian Bureau of Statistics, 'Gender indicators' http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4125.0main+features610Aug%202013
	Ratio of women at ministerial portfolios compared to men (federal and state/territory)	
	Ratio of women who are local government councillors compared to men	Contact the Australian Local Government Association, http:/www.alga.asn.au
	Ratio of women in executive and leadership positions in private, Government and Non-Government entities compared to men (and attendant remuneration received)	Equal Opportunity for Women in the Workplace Agency, Census of Women in Leadership, http:/www.wgea.gov.au Australian Bureau of Statistics, 'Gender indicators', http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4125.0main+features610Aug%202013
Social connection	Meaningful measure requires further investigation	Data source requires further investigation
Labour force status	Women's labour force status compared to men	Australian Bureau of Statistics, Census Community Profiles Series, http://www.abs.gov.au/census
	Women's mode of employment (full time or part time) compared to men	
	Women's occupations and industries compared to men	
Financial insecurity	Women's individual income compared to men	Australian Bureau of Statistics, Census Community Profiles Series, http://www.abs.gov.au/census
	Women's superannuation compared to men	Women's Health Victoria, The Index ('Economic and employment conditions'), http://www.theindex.org.au/Data/EconomicEmploymentConditions.aspx
	Current gender wage gap in Australia	economic Security4Women (eS4W) ('Gender pay gap measures') http://www.security4women.org.au
Unpaid work	Amount of time spent caring for dependent children compared to men	Australian Bureau of Statistics, Census Community Profiles Series, http://www.abs.gov.au/census
	Amount of time spent assisting a family member or other person with a disability compared to men	
	Amount of time spent on housework compared to men	
	Voluntary work undertaken by women compared to men	
Housing insecurity	Women experiencing homelessness and the reasons why	Australian Homelessness Clearinghouse ('Research and data') http://www.homelessnessclearinghouse.govspace.gov.au

Continued...

Salient element of women's health	As meaningfully measured by ...	Data source
Lone parenting	Number of female-headed households with dependent children compared to male-headed households	Australian Bureau of Statistics, Census Community Profiles Series, http://www.abs.gov.au/census
Gender-based violence	Population-based surveys on women's experiences of gender-based violence	Australian Bureau of Statistics, Personal safety survey, http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/ =AA3C5529FE728CD3CA25794F0011DD51?opendocument Australian Longitudinal Study on Women's Health, http://www.alswh.org.au
Discrimination based on ethnicity, race, sexual orientation or disability	Meaningful measures for each of these forms of discrimination require further investigation	Data sources for each of these forms of discrimination require further investigation; for the moment, the Human Rights Commission Australia has research reports and publications, https://www.humanrights.gov.au/
Exposure to health behaviours/risk factors for poor health	Women's use of prescription medications Rates of smoking amongst women Rates of alcohol consumption and binge drinking	Australian Longitudinal Study on Women's Health, http://www.alswh.org.au
Morbidity experience	Years lived with disability (YLD) and their causes	Australian Institute of Health and Welfare, Burden of Disease http://www.aihw.gov.au Australian Longitudinal Study on Women's Health http://www.alswh.org.au
Sexual and reproductive health	Breast cancer screening participation rates Cervical cancer screening participation rates Human papilomavirus vaccination participation rates Abortion rates Fertility and infertility rates Communicable diseases Contraceptive use	Women's Health Victoria, The Index ('Sexual and reproductive health'), http://www.theindex.org.au/Data/SexualReproductiveHealth.aspx

4.0 Using the meaningful measures: Case scenario

Societies that enable all citizens to play a full and useful role in the social, economic and cultural life of their society will be healthier than those where people face insecurity, exclusion and deprivation' (Marmot and Wilkinson, 2003: 11).

The following case scenario has been developed as a way of illustrating how the meaningful measures contained in this resource can be used for population health planning.

A population health planner in Melbourne's north is working with a range of partners on developing a strategy to promote the mental health and wellbeing of the local community. Drawing on evidence, they decide that a key action area in the strategy is to focus on enhancing pathways to economic participation for those who want to participate but experience barriers in doing so.

Using the meaningful measures table in this report, the planner builds a profile of the labour force status of men and women in the local area; and sees that a lower proportion of women participate in the formal labour force than men. These facts prompt her to consult with stakeholders (including community women) to find out more about what lies behind this pattern in labour force status.

The planner finds out that the local population has a relatively young profile, with many households that are families with dependent children. Moreover, in these family households, women have the primary role of caring for the children. The extent of this unpaid work means many women have not been able to return to paid employment since starting their families, even though they would like to resume their careers. The women believe that many employers will not offer the flexibility in working conditions they would need to re-enter the workforce. They also talk about how their work at home is not really valued by those around them, but rather expected of them; and that this is having a bearing on their sense of self and their mental health and wellbeing.

The planner finds out that the local population is diverse, too, with a sizeable group of newly-arrived women from non-English speaking backgrounds countries such as China, India and Sudan. She verifies this by using the meaningful measures table in this report to build a profile of newly arrived women. During her consultations with newly arrived women, she learns that discrimination is a common experience. Many have found it difficult to source employment and/or have their educational qualifications from their home countries recognised. Many feel they have not gained acceptance in the local community. The women talk about how all these factors combine to affect their self-esteem, confidence and overall mental health and wellbeing.

The planner reports these needs back to the partners she is working with on the mental health and wellbeing strategy. Together, they formulate a set of specific activities to enhance pathways to economic participation for community women, including:

- advocating for more affordable and accessible child care;
- promoting equal and respectful relationships between women and men that emphasise the value of shared parenting roles (rather than traditionally defined gender roles);
- running community education sessions on the Fair Work Amendment Act 2013 which strengthens employee rights to request flexible work if are caring for dependants;
- communicating messages that assist in empowering local women to ask employers for flexible working conditions; and
- implementing a best-practice micro-finance program involving the provision of short-term no-interest credit, small business training and financial literacy training to assist newly-arrived women from non-English speaking backgrounds to start up local enterprises.

5.0 Implementation steps

1. The AWHN *Women's health: Meaningful measures for population health planning* report will be disseminated through targeted distribution to its primary intended users with assistance sought from the AWHN membership, Australian Medicare Locals Alliance, Australian Local Government Association, Australian Health Ministers' Advisory Council and Commonwealth Department of Health and Ageing.
2. Population health planning experts will be asked to provide feedback to AWHN on their application of the conceptual framework and meaningful measures in this report, with particular reference to the questions below, to support their ongoing refinement:
    - » How have you used the conceptual framework and women's health meaningful measures and was this effective?
    - » Are there specific ways in which the conceptual framework and women's health meaningful measures can be improved? For example, are there other/different meaningful measures that should be considered as seminal to population health planning? Have you identified better examples of data sources for the meaningful measures?
3. Entities responsible for data capture and distribution will be asked to consider the data gaps for the meaningful measures identified in this report and provide feedback to AWHN on how these might be addressed.
4. Reported progress against the steps outlined above will be used by AWHN to support continuing promotion, refinement and improvement in women's health through population health planning.

To assist in the provision of feedback and AWHN's reporting of progress outlined in these implementation steps a questionnaire has been developed for use at Appendix A.

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Appendix A

AWHN Women's health: Meaningful measures for population health planning
FEEDBACK FORM

AUSTRALIAN WOMEN'S HEALTH NETWORK

Reported progress against the *AWHN Women's health: Meaningful measures for population health planning* resource's Implementation Steps (pg. 20) will be used by AWHN to support continuing promotion, refinement and improvement in women's health through population health planning. To assist in this work, population health planning experts and entities responsible for data capture and distribution are asked to answer the relevant questions below.

POPULATION HEALTH PLANNING EXPERTS

1. How have you used the conceptual framework and women's health meaningful measures and was this effective?

2. Are there specific ways in which the conceptual framework and women's health meaningful measures can be improved? For example, are there other/different meaningful measures that should be considered as seminal to population health planning?

3. Have you identified better examples of data sources for the meaningful measures?

ENTITIES RESPONSIBLE FOR DATA CAPTURE AND DISTRIBUTION

4. How might the data gaps for the meaningful measures identified in this report be addressed?

Please send your feedback to AWHN
by email to ceo@awhn.org.au or
by post to PO Box 188, Drysdale VIC 3222.

A Microsoft Word version of this feedback form is available for free download at: www.awhn.org.au