Senate Select Committee on Mental Health Submission 2005

Dr Simone Fullagar
Centre for Work, Leisure and Community Research
Mt Gravatt Campus
GRIFFITH UNIVERSITY
Brisbane 4111
Ph: (07) 3875 5676
Email: s.fullagar@griffith.edu.au
12/05/2006

Gender issues that affect women's mental health

a). The National Mental Health Strategy acknowledges the social nature of risk conditions that affect population wellbeing and the specific issues faced by particular social groups. However, despite the wide ranging evidence in the qualitative and quantitative research literature relating to the prevalence and incidence of mental health problems amongst women across the lifespan there is no gender analysis evident. This is a severe short coming in that the thinking and resultant practices designed to improve mental health for men and women do not consider the gendered patterns, roles and social pressures that affect wellbeing.

Recent qualitative research has been undertaken with women recovering from depression (Fullagar, S, Gattuso, S, Young, I, McGough, J & Hales, W, 'More than prozac: Women recovering from depression', presented at the Australian Women's Health conference, Melbourne, 2005). This research reveals the highly gendered nature of factors contributing to depression (discrimination at work, homophobia, the double shift of home/work, childhood sexual assault, family violence etc) and factors the impede/support recovery (stigma of 'not coping' related to women's identities as mothers/partners/workers, not having emotional distress addressed adequately by GP's, the over medicalised view of mental illness, lack of public mental health services and generalist counsellors, lack of leisure time for self and relief from caring/ dual roles). The 48 women who participated in this research from urban and rural communities clearly identified the significant impact of gender expectations on their mental health (see attached summary of qualitative findings).

n) The absence of a gendered understanding of mental health issues clearly calls for further research to be funded to explore this area further. The importance of qualitative research that engages with the experiences of women and men from a range of social groups is of equal importance, though it is often unrecognised, to the quantified randomised control trial 'gold standard'.

b) & i) The adequacy of various modes of care for people with mental health problems and illnesses is severely constrained by the medical model of mental health and clinical focus of most services. Prevention, health promotion, early intervention and recovery focussed services need to be funded to engage more broadly with community health and recreation/leisure services, approaches and participatory models of service user involvement. For example, a number of women in our research said that they wanted wellbeing focussed programs and services that were not simply

illness oriented (art classes, wellbeing support groups, social interaction and leisure spaces with free childcare etc).

e) There are also instances of human rights abuses occurring within child protection services in Queensland. Mothers with mental illness are having their children removed and placed into care because there is a severe lack of community based mental health support services to provide in-home intensive parenting support. These mothers have often been subject to sexual assault and alternate care arrangements as children themselves. Within these situations the lack of community support services serves construct the ‘risk’ to the child as a consequence of the individual mother’s own mental health status (a relation of blame thus ensues). The mother’s impairment is only part of the broader picture that is more clearly connected to the absence of support that creates a risk condition within communities/society.

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