Women's Community Health Network WA

Toward a Gender Responsive Recovery College Service Model

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Women's Community Health Network WA

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The Women's Community Health Network WA – Who We Are

The Women's Community Health Network WA (WCHN) is the peak body for women's health and community services across Western Australia. Our services work across sexual and reproductive health; mental health; family, domestic and sexual violence; alcohol and/or other drug use; health promotion and prevention; and employment and education. Women's health and community services work with the cultural, social and economic factors that affect the health, safety and wellbeing of women and their children in Western Australia and limit their life choices and chances.

The Women's Community Health Network is committed to knowledge translation and exchange to ensure that best available evidence is utilised in policy and practice. Our health promotion, research and development program delivers projects designed to promote women's health, safety and wellbeing across three key areas – sexual and reproductive health, mental health, and prevention of violence.

The Recovery College Model of Service – the relevance of gender and other social determinants

There is a consensus among the mental health community that recovery is a broad multi-faceted concept; a journey of small and large steps to a meaningful life in the community. A considerable body of research suggests that people with mental illness can realise their full potential in the community, if given the right services and supports.

Recovery Colleges are intended to support the recovery of people in the community living with a mental illness and their carers and families. Recovery Colleges can take on many forms and orientations, and there is no single definitive model. However, they tend to be a physical place offering a variety of educational classes to people with mental illness and others wanting to learn more about mental health in our communities.

Recovery Colleges often focus on equipping students with new skills that can foster their recovery, as well as enhancing their overall capacities and capabilities. Common offerings include classes focused on self-care, life-skills, physical health, employment and information technology.

Recovery Colleges emphasise goal-setting and skill-acquisition, offering a range of choices and options that individual students can tailor to their own unique circumstances.

A key value underlying Recovery Colleges is the meaningful involvement of peers in all aspects of college life[1]. This means that peers are heavily involved in management, governance and course development and delivery.

Recovery Colleges exist in large cities and small towns, often tailored to the local community.

[1] Alessia Anfossi *n.d.* The current state of Recovery Colleges in the UK: final report Nottinghamshire Healthcare, NHS Foundation Trust

Several research studies indicate that Recovery Colleges are popular and well-utilised interventions that can improve quality of life and well-being[2]. One study at the University of Nottingham led to useful checklists and fidelity measures that can be used in college development and evaluation[3].

While the current research on Recovery Colleges is useful, a desktop literature review and WCHN consultations with women in the community[4] reveal that there are still significant gaps in the research. More research is necessary to better document and analyse implementation and impact and more work is needed to ensure that the Recovery College model of service is responsive to the lived experience of gender, particularly as it intersects with cultural background, Aboriginality, disability, sexuality and such things as geographical location and the social determinants of health more broadly.

The potential benefits of Recovery Colleges are clear. They can provide education and empowerment for people in recovery. Most studies show that 'universal' elements in recovery discussed in the literature – hope, optimism, control over one's destiny, importance of one's culture – make sense to most people, and that recovery is based on being able to lead a full cultural and community life without stigma. However, in conversations within women's – particularly Culturally and Linguistically Diverse (CaLD) women and Aboriginal women's – focus groups it is clear that the overall language of recovery can be inadequate and problematic and often does not address the specific issues and circumstances that affect the mental health of women, such as racism, sexism, other forms of oppression and poor understanding of cultural and spiritual needs. Difficult issues affecting women, particularly CALD women and Aboriginal women – including racism, internalised oppression and questions of identity – are rarely raised within recovery literature and within discussions of models of recovery.

In the United Kingdom, the Mental Health Foundation, in collaboration with Survivor Research, explored distress and recovery based on the experience and understandings of African, African Caribbean and South Asian women to formulate approaches to recovery that consider people's identities and experiences as black people and/or as members of black communities[5]. The most important message from the 27 women who told their stories for this study was that their understandings of their recovery are intrinsically linked to the ways in which they made sense of their mental distress.

For some black women, distress arose from the adverse effects of socio-cultural experiences, including racism, sexism and other forms of discrimination in society. Their racial/cultural, gender, sexual and spiritual identities, and a sense of worth in self and community had a direct relationship with their views on mental and emotional wellness and recovery. Mental health services and recovery frameworks often do not account for these experiences and identities, essentially failing to address a significant part of their distress.

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[2] Rachel Perkins, Sara Meddings, Sue Williamsand Julie Repper. Recovery Colleges 10 Years On. Nottinghamshire Healthcare, NHS Foundation Trust

[3] Please see: http://www.researchintorecovery.com/recollect

[4] Undertaken as part of the Mental Health Commission community consultation process in June 2018 to inform the development of a Recovery College model of service in Western Australia.

[5] Kalathil, J (2011) Recovery and Resilience: African, African-Caribbean and South Asian's Women's Narratives of Recovering from Mental Distress. London: Mental Health Foundation and Survivor Research

According to the researchers, regaining a positive sense of self could be a difficult process for Culturally and Linguistically Diverse (CaLD) women, especially if they were regularly receiving messages of inferiority based on something as fundamental as their skin colour, 'race', faith or culture. In this context the recovery process would, of necessity, need to help develop mechanisms to cope with societal oppression. According to the study attaining a shared sense of identity with other CaLD survivors and one's own community and working towards social justice through collective action was part of this process. But most important was having access to 'recovery spaces' where specific socio-cultural aspects of distress, including experiences of racism and trauma, could be safely addressed.

Furthermore, oppressive practices and traumatic experiences, such as sexual and physical abuse, domestic violence, bereavement and loss, and stress from the obligations of fulfilling familial norms were significant in how some CaLD women made sense of mental distress. For some, distress was also part of a personal spiritual crisis or religious experience. Faith and/or personal spiritual grounding were important in their recovery. Meanings of recovery and resilience, for these women, depended on how they had managed to overcome these situations and regain a sense of control over their lives.

Overall, CaLD women were saying that any approach to recovery should account for the context of an individual's distress, acknowledging that the person needs to recover not only from mental distress but from the underlying causes of it. Distress needs to be understood as a legitimate response to life events, socio-political oppression, spiritual crises, trauma and stress. Healing and recovery for CaLD women, and people from minority ethnic communities in general, can only work if this context of a person's life was taken into consideration.

Recognition of women's contexts – with its gender specific and intersectional themes - was evident in some of the Recovery College models of service reviewed for this paper.

Courses included:

- Women's art groups
- Women's well-being social groups
- Women only, trauma focused groups (topics included: definitions of trauma, types and prevalence of trauma experienced by women, the impacts of trauma on women, their families and the community, the recovery process after experiencing trauma)
- Women only, abuse focused groups (usually with a focus on domestic violence and with the aim of alleviating anxiety and decreasing feelings of isolation, providing a theoretical understanding of all aspects of domestic violence, emphasising the importance of identifying and validating the wide range of mixed feelings experienced during the on-going process of recovery)
- Mothers postnatal support groups
- Recovery from Abuse groups (designed to help women to recover from all types of abuse and support them in their recovery journey)
- Young women's recovery and wellbeing groups
- Moving on from abuse groups
- Women's running and other fitness groups
- Women's empowerment groups

Groups that were women only were often defined as: safe places/spaces/environments, promoting empowerment, comfortable and supportive.

Gender matters in the Recovery College service model

From conception the life experiences of girls and women differ from those of boys and men. Some of these pertain to the intrinsic biological differences in female and male reproductive potential, but the more prominent differences are gender-based and reflect disparities in opportunities, responsibilities and roles throughout the life course. These have consequences for all aspects of health. Gender matters in the lives of women and girls. Social inequalities, the impact of negative life experiences (in particular violence and abuse) and gender expectations – shape risks across the life course of women.

In terms of the life course of a female, Western Australian girls begin by being 2.5 times more likely than boys to be sexually assaulted before the age of 9[6]. The sexual abuse of girls is more likely to be perpetrated by family members, to begin at an earlier age and to occur repeatedly than the sexual abuse of boys. The sexual abuse of boys is more likely to be perpetrated by non-family members, to occur later in childhood and to be a single incident.[7] As they grow up, girls are far more likely to be sexually assaulted, with the highest rate occurring in WA in the 10-14 year age group, with the second highest rate found in the 15-19 year age group.[8] Eight out of ten women aged 18 to 24 were harassed on the street in the past year.[9]

Over the course of their lives, 1 in 5 Australian females will experience sexual violence, with 99% by a male perpetrator, compared to 1 in 22 men.[10] ABS 2016 'victims of crime' figures show WA with 5 years of continuous increase in the number of sexual assault victims. The release includes information on family and domestic violence (FDV) related crimes, with FDV-related assault showing a 12% rise in Western Australia (more here).

1 in 4 Australian women have experienced intimate partner violence in their lifetime[11]. In Western Australia, the likelihood of experiencing family and domestic violence related assault is highest in the 25-34 age range, at over 3.5 times the number for men[12]. The latest available data shows that Aboriginal women in WA experience hospitalisation for domestic violence at 27 times the rate of non-Aboriginal women (2002-2015)[13]. Women are five times more likely than men to require medical attention or hospitalisation as a result of intimate partner violence, and five times more likely to report

[6] Australian Bureau of Statistics. Recorded Crime – Victims, Australia 2014 Table 7 [Internet]. 2016 [cited 2017 June 19]. ABS Cat. No. 4510.0. Available from http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4510.02015?OpenDocument

[7] Finkelhor D (1991) *A sourcebook on child sexual abuse, Thousand Oaks CA, USA: Sage; Kelly L, Regan L and Burton S (1991) An exploratory study of the prevalence of sexual abuse in a sample of 16 – 21 year olds, London, UK: University of North London: Child Abuse Studies Unit.*

[8] Australian Bureau of Statistics. Recorded Crime – Victims, Australia 2014 Table 7 [Internet]. 2016 [cited 2017 June 19]. ABS Cat. No. 4510.0. Available from http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4510.02015?OpenDocument

[9] Johnson, M. and Bennett, E. (2015) Everyday sexism: Australian women's experiences of street harassment, The Australia Institute, Canberra.

[10] Cox P. Violence against women: Additional analysis of the Australian Bureau of Statistics' Personal Safety Survey, 2012. (ANROWS Horizons: 01.01/2016 Rev. ed.). [Internet].Australia's National Research Organisation for Women's Safety (ANROWS); 2016 [cited 2017 June 19]. Available from http://media.aomx.com/anrows.org.au/PSS_2016update.pdf

[11] Cox P. Violence against women: Additional analysis of the Australian Bureau of Statistics' Personal Safety Survey, 2012. (ANROWS Horizons: 01.01/2016 Rev. ed.). [Internet].Australia's National Research Organisation for Women's Safety (ANROWS); 2016 [cited 2017 June 19]. Available from http://media.aomx.com/anrows.org.au/PSS_2016update.pdf

[12] Australian Bureau of Statistics, Recorded Crime – Victims, Australia, 2015, Experimental Family and Domestic Violence Statistics Table 3: 45100DO007_2015 [Internet]. 2016 [cited 2017 June 19]. ABS Cat. No. 4510.0. Available from http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4510.02015?OpenDocument

[13] Government of Western Australia, Department of Health, Epidemiology branch. Analysis of WA Hospital Morbidity Data 2015 (customised unpublished data). 2017.

fearing for their lives.[14] While 42% of adults and children seeking homelessness assistance from specialist homelessness services in WA do so as a result of family and domestic violence.[15]

Research has consistently demonstrated poorer health/mental health outcomes amongst women on low-incomes and experiencing poor working conditions[16]. Women more likely to have low paid, part-time and insecure work[17]. Women are disproportionately likely to be poor, with Australian women earning 28% less income than men overall[18]. This lower income over the lifetime is often related to or further exacerbated by breaks from the workforce to accommodate the birth of, and care for children. Women are more likely to be primary carers of children[19], do a larger share of unpaid domestic work[20], and are the heads of 83% of single parent families with dependents[21]. 32% of women in this group are living in poverty (as are there children).

As they grow older, women are more likely to be primary carers of seniors, making up 2 in 3 primary carers of those aged over 65yrs, with most doing so out of family responsibility.[22] The median income of these carers is $520 a week, 42% lower than non-carers.[23] 24% of women aged 65 to 69 provide unpaid childcare to others[24]. On entering retirement, women's superannuation balances average 56% of men's.[25] The year 2015-16 saw a 17.5% increase in the number of women over the age of 55 seeking assistance from homelessness services.[26] This is twice the rate of growth for the general homelessness services population.[27] Women are the majority of adult tenants in public housing.[28]

The main group still suffering persistent poverty in Western Australia remain those who are fully reliant on the pension who are in private rental accommodation, whose after housing costs are much higher than those who own a home or are in public housing. These are overwhelmingly women, especially single women. Over 60% of Commonwealth Rent Assistance recipients are women.[29]

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[14] Mouzos, J. (1999) Femicide: An overview of major findings, No. 124, Australian Institute of Criminology, Canberra, pp. 1-6.

[15] Government of Western Australia, Department for Child Protection and Family Support. Homelessness in Western Australia: March 2016 [Internet]. Government of Western Australia, Department for Child Protection and Family Support; 2016 [cited 2017 June 19]. Available from https://www.dcp.wa.gov.au/servicescommunity/Documents/Homelessness%20strategy%20paper.pdf

[16] Gro, C.J. 2007. Poverty, Mental Health & Women. American Psychological Nurses Association.

[17] Australian Bureau of Statistics. Gender Indicators, Australia, August 2016: Economic Security [Internet]. 2016 [cited 2017 June 19]. ABS Cat. No 4125.0. Available from http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4125.0~August%202016~Main%20Features~Economic%20Security~6151

[18] Richardson D, Denniss R. Income and Wealth Inequality in Australia, Policy Brief No.64 [Internet]. The Australia Institute, 2014 [cited 2017 June 19]. Available from http://www.tai.org.au/system/files_force/PB+64+Income+and+wealth+inequality+FINAL.pdf

[19] Ibid.

[20] Ibid.

[21] Ibid.

[22] Australian Bureau of Statistics. Disability, Aging and Carers, Australia: Summary of Findings, 2015: Carers [Internet]. 2016 [cited 2017 June 19] ABS Cat No 4430.0. Available from http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4430.0Main%20Features402015?opendocument&tabname=Summary&prodno=4430.0&issue=2015&num=&view=

[23] Ibid.

[24] Australian Bureau of Statistics. Reflecting a Nation: Stories from the 2011 Census, 2012-2013: Where and How to Australia's Older People Live? [Internet]. 2013 [cited 2017 June 19]. ABS Cat. No, 2071.0. Available from http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/2071.0Main%20Features602012%E2%80%932013?opendocument&tabname=Summary&prodno=2071.0&issue=2012%962013&num=&view=

[25] Government of Western Australia Department of Local Government and Communities. 2015 Women's Report Card: An indicator report of Western Australia's women's progress. Perth Western Australia; 2015.

[26] Australian Institute of Health and Welfare, *More receiving homelessness support due to family violence* [media release], 15 December 2016, para. 2, accessed 13 January 2016, http://www.aihw.gov.au/media-release-detail/?id=60129557836

[27] Australian Institute of Health and Welfare, *Housing Assistance in Australia 2016 Supplementary Data* Table 6: Number of tenants in social housing by age, sex and program, at 30 June 2015, Canberra, 2016

[28] Ibid.

[29] Australian Council of Social Services 2016. *Poverty in Australia.* NSW: Australian Council of Social Services

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[30]. The high prevalence of mental distress amongst women and girls of all ages is bound up in the totality of women's experiences including family, domestic and sexual violence and; social and economic inequality. Mental illness represents the leading cause of disability and the highest burden of non-fatal illnesses for women in Australia[31]. Young women report the highest rates of mental illness of any population group (30% for women aged 16 to 24)[32]. Women are more likely than men to have (or report symptoms of) the following conditions:

- Anxiety disorders[33]
- Affective disorder such as depression[34]
- Eating disorders –eating disorders are the third most common chronic illness amongst young women in Australia[35]
- Deliberate self-harm[36]
- Perinatal depression – one in five mothers of children aged 24 months or less are diagnosed with depression[37]
- Multimorbid physical illnesses – women are 1.6 times as likely as men to suffer coexisting mental and physical illness. These multimorbidities are associated with increased severity of mental illness and increased disability [38]
- Women are almost twice as likely as men to report post-traumatic stress disorder[39].

Implications for women and girls at risk

Approximately one quarter of women who have experienced gendered violence, present complex trauma involving multiple types of physical and sexual victimisation and mental illness, substance abuse and ongoing victimisation. Thus we need models to enhance the wellbeing and safety of women with complex trauma.

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[30] Australian Women's Health Network 2012. Women and Mental Health – Issue Paper. AWHN

[31] Begg, SJ, Vos, T, Barker, B, Stanley, L & Lopez, AD 2008, Burden of disease and injury in Australia in the new millennium: measuring health loss from diseases, injuries and risk factors, Medical Journal of Australia, vol. 188, no. 1, p. 36

[32] Australian Bureau of Statistics (ABS) 2012, 1310.0 Year Book Australia. Health Viewed 25th February 2016 http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1301.0~2012~Main%20Features~Health%20status~229

[33] Australian Institute of Health and Welfare (AIHW) Johnson S, Bonello MR, Li Z, Hilder L & Sullivan EA. 2014. Maternal deaths in Australia 2006–2010, Maternal deaths series no. 4. Cat. no. PER 61. Canberra: AIHW. Viewed February 25th 2016. http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129548375

[34] Ibid.

[35] National Eating Disorders Collaboration 2012, Eating Disorders in Australia, viewed 16th January 2016, http://www.nedc. com.au/eating-disorders-in-australia

[36] Australian Institute of Health and Welfare (AIHW) Johnson S, Bonello MR, Li Z, Hilder L & Sullivan EA. 2014. Maternal deaths in Australia 2006–2010, Maternal deaths series no. 4. Cat. no. PER 61. Canberra: AIHW. Viewed February 25th 2016. http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129548375

[37] Australian Institute of Health and Welfare (AIHW) 2012a, Experience of perinatal depression: data from the 2010 Australian National Infant Feeding Survey, Information Paper, cat. no. PHE 161, AIHW, Canberra, viewed 16th February 2016, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737422202.

[38] Australian Institute of Health and Welfare (AIHW) 2012b, Comorbidity of mental disorders and physical conditions 2007, cat. no. PHE 155, AIHW, Canberra, viewed 4th November 2015, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737421142.

[39] Australian Bureau of Statistics. *National Survey of Mental Health and Wellbeing: Summary of Results, 2007 [Internet]. 2008 [cited 2017 June 19]. ABS* Cat. No. 4326.0 Available from http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/$File/43260_2007.pdf

Family, domestic and sexual violence has serious impacts for women's health–contributing to a range of negative health outcomes, including poor mental health. Importantly, these health impacts are preventable. The health burden of intimate partner violence can be reduced by supporting women and children's long-term recovery in the aftermath of violence.

There is an accumulation of risk over the life course and the poorest outcomes are for those who experience abuse and violence of different kinds as both children and adults. This accumulation of risk from violence and abuse also needs to be understood in relation to gender and other inequalities. Violence and abuse is a common thread running through the lives of the vast majority of women who experience the poorest mental health outcomes. Experiencing violence and abuse is a risk factor for poor outcomes, but the relationship is not a simple one. The level of risk depends on the nature and degree of abuse and on the other circumstances of the women involved.

Women who have single abusive experiences and have other protective factors in their lives are more likely to survive successfully than those who experience multiple and continuing forms of abuse without as many protective factors. And the risks operate in both directions: women who have serious and ongoing experiences of abuse are more likely to face negative outcomes, and those negative outcomes are highly likely to increase their experience of continuing abuse.

A study of street-based sex workers in Sydney found nearly half would have met the criteria for a PTSD diagnosis at some point during their lives, making this the highest occupational risk for PTSD in Australia[40]. The high rates of PTSD are attributed to multiple traumas, including childhood sexual abuse and violent physical or sexual assaults while working.

Women fleeing domestic violence are at particular risk of PTSD, with an Australian study finding 42% of women in a women's refuge suffering from it[41]. While domestic violence is a form of complex trauma in itself, it is far more likely to be experienced by women who, as children, experienced sexual abuse, severe beatings by parents, and who were also raised in homes with domestic violence[42]. These experiences of complex trauma in childhood and adulthood significantly increase the risk of having complex PTSD in adulthood.

Another of the most at-risk groups is Indigenous Australians, with a study in a remote community finding 97% had experienced traumatic events and 55% met the criteria for PTSD at some point in their lives[43].

Indigenous Australians have high rates of interpersonal trauma that frequently begin early in life and are characterised as severe, chronic and perpetrated by multiple people, often those in authority and well known to the individual. These complex traumas are further compounded by the pervasive transgenerational impacts of colonisation[44].

[40] Please see: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1481550/
[41] Please see: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193378/
[42] Please see: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2801%2905622-7/abstract
[43] Please see: https://www.rrh.org.au/public/assets/article_documents/article_print_1667.pdf
[44] Please see: https://research.acer.edu.au/indigenous_education/24/

Survivors of complex trauma are less likely to be treated for their PTSD despite their symptoms being more pervasive[45].

Aboriginal women

Aboriginal women in Western Australia continue to struggle with the destructive legacy of colonisation. Sexual and physical child abuse, separation from families and communities, loss of cultural identity that occurred during the Stolen Generation caused significant damage to Aboriginal and Torres Strait Islander communities. This has lead to extensive complex trauma within their communities. It is important that a Recovery College model of service recognise Aboriginal healing practices and collaborate with Aboriginal communities. It is also important to recognise the needs of Aboriginal participants in groups being offered. Creating an atmosphere and service model that is comfortable for all participants is fundamental to creating a positive experience for everyone. Being mindful of the way physical, spiritual, intellectual, and emotional needs are presented is imperative.

For example, the community-based healing programs supported by the Aboriginal and Torres Strait Islander Healing Foundation aim to improve the emotional wellbeing of Indigenous people, in particular members of the Stolen Generations, and to provide appropriate training for people delivering the healing.

Programs supported by the Foundation aim to improve mental health in Indigenous communities by providing healing services and access to traditional healing, education about trauma and how to manage grief and loss more effectively, as well as a professional workforce that can better respond to loss, grief and trauma in these communities. Topics dealt with include suicide prevention, depression, violence, incarceration, substance abuse, intergenerational trauma, and pathways to healing.

Women from CaLD Backgrounds

Women from CaLD backgrounds are more likely to experience the double-disadvantage of cultural diversity and gender that can result in their needs and issues being neither recognised nor addressed either adequately or at all. Women from CaLD backgrounds face a myriad of intersectional challenges on a daily basis. They are more likely to be isolated in their homes and hence at risk of long term social exclusion. There is a high risk of disengagement, both by the women and any dependents of such families, which runs the risk of causing long-term societal and individual problems. Mental health issues for women from CaLD backgrounds include the impact of isolation from their extended family, the isolation of ageing, the need for greater social connectedness and the isolating impact of caring for children and home responsibilities[46].

In light of the research evidence about the link between isolation and poor mental health and social functioning, CaLD women who are not currently eligible to settlement services—and who have no means of accessing structured opportunities to participate in broader Australian society—are at risk of poorer health outcomes.

[45] Please see: https://www.cambridge.org/core/journals/psychological-medicine/article/div-classtitleremission-from-post-traumatic-stress-disorder-in-the-general-populationdiv/2A389D6AB903349910C8FFE0D31A5AC8

[46] Federation of Ethnic Communities' Councils of Australia 2012. Supporting Australian Women from Culturally and Linguistically Diverse (CALD) Backgrounds: Women's Policy Statement.

Toward a gender-responsive Recovery College model of service

When we are talking about mental health and alcohol and other drug use it is also important to talk about gender, to make the connection. This is not an attempt to prioritise women over men, but to recognise the gendered pathways to poor mental health and alcohol and other drug use to ensure targeted and tailored responses. This will ensure appropriate, effective and sustainable recovery pathways.

The usefulness of highlighting gendered social patterns and experiences is to encourage gender specific and tailored responses. The premise of client or individual-centred care is that it is more effective and cost-efficient to tailor services and models of care to a person's experiences, circumstances and needs. It is reasonable to use sex-disaggregated data to determine that there are some common themes pertaining to gender that require tailored responses.

It is important that a Recovery College model of service in Western Australia is gender responsive; with significant consideration given to the safety and privacy provided for women and gender informed course content.

Potentially, partnerships and collaborations with community based women's health services could create opportunities for women consumers, carers and service providers to work together to co-design and deliver Recovery College services. Hearing the voice of women consumers can positively impact on how services are delivered.

The Women's Community Health Network strongly supports:

- Gender–sensitive and safe practice (exploring practice through a gender lens)
- Safe Practice: Supporting gender–sensitive and safe care in the service setting (an approach that takes into account the physical, sexual and emotional safety and wellbeing of all consumers)
- Effective communication to support gender–sensitive and safe practice
- Organisational capacity to support gender–sensitive and safe practice
- Initiatives that support service managers and leaders to understand their responsibilities in providing support for gender– sensitive and safe practice.
- Trauma-informed peer support available to women who are trauma survivors (in the Recovery College – peer led – service model this would include: integrating trauma-informed principles into their relationships with the women they support or into the peer support groups they are facilitating. The goal is to provide peer supporters—both male and female—with the understanding, tools, and resources needed to engage in culturally responsive, trauma-informed peer support relationships with women trauma survivors. There are also cultural considerations for working with women who are trauma survivors, including race, ethnicity, spiritual and religious factors, and age and generational concerns. There are concrete ways to bring an understanding of these issues into active peer support relationships with women trauma and abuse survivors).

Designing and delivering Recovery College service models that are responsive to women

Gender mainstreaming is a term used when a service must benefit all genders equally.

Engaging women – from all sectors of the community – as co-designers, is crucial for gender-sensitive Recovery College service models. Effective co-design can bring developers of the Recovery College model of service delivery into direct contact with women and their stories. It is important to recognise that creating a service model with women in mind means recognising that women are not an abstract homogenous group.

Women represent enormous diversity defined by their cultural background, socioeconomic status, where they live, their sexuality, dis/ability and age. To design for women is to be inclusive of all women and girls, including trans-women and intersex women. Co-design embraces the diverse (even conflicting) perceptions of women and gives them the tools to effectively participate in the creation of an effective service model and propose ideas and engage in the testing of scenarios and outcomes.

Women and girls' stories are needed to ensure that the Recovery College service model reflects women's lived experiences and propels a model that supports the recovery of a diversity of women with some crucial lived experiences in common.

Gender responsive is described as:

"Creating an environment through site selection, staff selection, program development, content, and material that reflects an understanding of the realities of women's lives and is responsive to the issues of the clients."[47]

Gender-responsive services for women are person-centered. This means the services acknowledge, address, and respect the vast diversity among women: socioeconomic issues, psychological or physical disabilities, race, ethnicity, sexual orientation, gender identity, cultural identity, religion, and so forth.

Being gender responsive can be as simple as considering the types of examples that are provided in an educational program to ensure they will resonate with female participants. More complex efforts include thinking about the types of services, access, and approaches to determine whether they fit with the priorities, needs, and desires of women participating in a Recovery College.

Another approach is to promote staff cultural competence specific to women and women's experiences within their cultures (ethnic, racial, religious, etc.). Becoming culturally competent takes time, practice, and knowledge. For example, compared to men, women often have more caregiving roles, family responsibilities, higher rates of poverty, and a wider range of mental and physical health needs, leading to more complex overall service needs.

Women's service needs often differ from men's, so it is helpful for programs to consider the following:

- Offering gender-specific groups
- Exploring gender-specific curricula

[47] Covington, S. 2007. *Women and Addiction: A Gender-Responsive Approach*. Clinical Innovator's Series. Center City, MN: Hazelden.

- Addressing women's issues in planning and services

Gender-specific groups

Many women with mental health and or alcohol and other drug issues have experienced trauma, often from males in their lives, and may feel uncomfortable or unsafe in mixed-gender groups. Female trauma survivors typically need to be in all-women groups led by female facilitators.

In co-ed groups, gender dynamics often come into play. For example, women have often been socialized to take care of men, and may tune into the needs of the men in a co-ed group rather than to their own. The women may also be socialized to defer to men and may not share their experiences, feelings, or opinions in a co-ed group. Or men may be used to talking over women, or not validating their experiences. Also, participants of either sex may have underlying issues with the opposite sex that come out in their responses or reactions in co-ed groups.

A skilled facilitator will ensure everyone participates and can intervene or redirect participants when gender dynamics make open, supportive dialogue more difficult.

Gender-specific curricula exist that address the specific needs of women and topics that women may be uncomfortable discussing with men present.

Addressing women's issues in planning and services could include helping a woman secure child care, helping her meet child welfare requirements, offering her a trauma-specific intervention, creating a safety plan in cases of intimate partner violence, and the like.

A Recovery College service model that respects women and takes gender into account is more likely to:

- Help female participants engage and actively participate in their recovery services.
- Help staff feel supported as they put gender-responsive principles into practice.
- Create a welcoming and safe environment for women being served and for female staff.
- Help staff keep positive attitudes about their work and the women they serve.

Using co-design methods to ensure the meaningful participation of women in the design and content of courses being provided at Recovery Colleges is crucial. Co-design involves working together. Looking beyond surface change, co-design identifies some of the partnership and collaborative practices that have the potential to usefully inform the way in which Recovery College services are delivered. The key word is 'together' – a collaborative approach in which every stakeholder has an important role to play.

To meet the good practice principles of sustained and inclusive engagement of people with lived experience and their families in co-design, there needs to be mechanisms to connect and bring the very diverse people affected by mental illness and AOD use together.

It is important that co-design is embedded in Recovery College service models. This may require some kind of a connecting point and network to facilitate co-design and co-production in a region and to:

- Support for relationship networks
- Enable proactive engagement, liaison and communication between potential co-design stakeholders
- Support skill development and capability building in collaboration and co-design
- Support peer to peer mentoring to build knowledge and capacity
- Foster leadership and coordination of local co-design activities
- Enable proactive identification of opportunities for co-design
- Foster creation and promotion of local knowledge

Like any other co-design initiative, it will require people with lived experience to take on responsibility for the work and they should be adequately remunerated for that work and the expertise they contribute.