



# WOMEN AND MENTAL HEALTH

---

Position Paper 2012

# Australian Women's Health Network

## Women and Mental Health

A publication of the Australian Women's Health Network, based on a commissioned paper written by Professor Jayashri Kulkarni, with support from the AWHN Publication Review Panel, August 2012.

This publication may include subsequent alterations/additions which do not necessarily reflect the views of the original commissioned author.

PO Box 188, Drysdale, Victoria 3222

Association number: A02383

[www.awhn.org.au](http://www.awhn.org.au)

© Australian Women's Health Network

This publication may be reproduced in whole or in part for study, research, criticism, training or review purposes subject to the inclusion of an acknowledgement of the source and authoring, and no commercial usage or sale.

ISBN: 978-0-9578645-6-6

Published November 2012

## Acknowledgements

The Australian Women's Health Network gratefully acknowledges funding support provided by the Australian Government to develop this *Health Reform* position paper through the Department of Health and Ageing Community Sector Support Scheme.

AWHN would like to thank Professor Jayashri Kulkarni, the AWHN Publication Review Panel (Dr Gwendolyn Gray; Patty Kinnersly; Maree Hawken; Lucy Cirocco, and Kelly Banister), Marilyn Beaumont, and Dr Andrew Watts of *textedit*.

This position paper is available for free download at:  
[www.awhn.org.au](http://www.awhn.org.au)

# Table of contents

Executive summary .....	4
Recommendations .....	5
Definitions .....	8
Introduction .....	11
Women’s mental health .....	12
Women’s mental health in the current policy context .....	12
Determinants of mental ill health in women .....	15
Violence against women.....	15
Childhood abuse of girls .....	16
Women, poverty and homelessness .....	17
Women and alcohol/drug abuse .....	18
<i>Alcohol use</i> .....	18
<i>Illicit drug use</i> .....	18
Meeting the mental health needs of women .....	19
Mental health aspects of physical illness.....	19
Reproductive life-cycle phases and possible mental health issues for women .....	19
Meeting the needs of women with the mental illnesses .....	21
Special issues for women with mental illness .....	21
<i>Current diagnostic systems</i> .....	21
<i>Gender blindness in current treatments</i> .....	21
<i>Holistic approaches</i> .....	22
Service delivery for women with mental illnesses .....	24
Psychiatry inpatients units – safety and privacy issues .....	24
Community mental health services and gender-sensitive practice .....	24
Research and education .....	26
Specific development of treatments tailored for women with mental illnesses .....	26
Mental health promotion and education.....	27
Conclusion .....	28
References .....	29

# 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 illnesses

### 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.



# REFERENCES



- American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition: DSM-IV-TR®. American Psychiatric Association.
- Australian Bureau of Statistics (2003) *National Health Survey: Mental Health*, cat. no. 4811.0. ABS, Canberra.
- Australian Bureau of Statistics (2008) *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, cat. no. 4326.0. ABS, Canberra.
- Australian Institute of Health and Welfare (2005) *Statistics on drug use in Australia 2004*, cat. no. PHE 62. AIHW, Canberra.
- Australian Institute of Health and Welfare (2007) *Australian Self-harm Statistics – Key Findings: Living is for everyone: suicide prevention in Australia*. AIHW, Canberra.
- Australian Institute of Health and Welfare (2008) *2007 National Drug Strategy Household Survey: First results: Drug statistics series, no. 20*. cat. no. PHE 98. AIHW, Canberra.
- Australian Institute of Health and Welfare (2010) *Australia's health 2010*, no. 12, cat. no. AUS 122. AIHW, Canberra.
- Beck, J. C. & Van Der Kolk, B. (1987) 'Reports of childhood incest and current behavior of chronically hospitalized psychotic women' *Am J Psychiatry* (144) pp. 1474–6.
- Begg, S., Vos, T., Barker, B., Stevenson, C., Stanley, L. & Lopez, A. (2007) *The burden of disease and injury in Australia 2003*, cat. no. PHE 82. AIHW, Canberra.
- Bolton, J. M., Pagura, J., Enns, M. W., Grant, B. & Sareen, J. (2010) 'A population-based longitudinal study of risk factors for suicide attempts in major depressive disorder' *J Psychiatr Res* (44) pp. 817–26.
- Bradley, R. H. & Corwyn, R. F. (2002) 'Socioeconomic status and child development' *Annu Rev Psychol* (53) pp. 371–99.
- Byles, J. E., Dolja-Gore, X., Loxton, D. J., Parkinson, L. & Stewart Williams, J. A. (2011) 'Women's uptake of Medicare Benefits Schedule mental health items for general practitioners, psychologists and other allied mental health professionals' *Med J Aust* (194) pp. 175–9.
- Campbell, J. C. & Lewandowski, L. A. (1997) 'Mental and physical health effects of intimate partner violence on women and children' *Psychiatr Clin North Am* (20) pp. 353–74.
- Chamberlain, C. & Mackenzie, D. (2009) *Counting the homeless 2006*: Victoria, Cat. no. HOU 203. AIHW, Canberra.
- Childbirth Australia (2012) *Woman-Centred Care*. Available: <[http://www.childbirth.org.au/index.php?option=com\\_content&view=article&id=20](http://www.childbirth.org.au/index.php?option=com_content&view=article&id=20)>, accessed 20 September 2012.
- Clarke, H. (2008) *Submission to the Review of Mental Health Act, 1986*. Victorian Women and Mental Health Network, Victoria.
- Cohen, L. S., Soares, C. N., Vitonis, A. F., Otto, M. W. & Harlow, B. L. (2006) 'Risk for new onset of depression during the menopausal transition: the Harvard study of moods and cycles' *Arch Gen Psychiatry* (63) pp. 385–90.
- Council of Australian Governments (2006) *National action plan on mental health 2006–2011*. COAG, Canberra.
- Council of Australian Governments (2011) *National Plan to Reduce Violence against Women and their children 2010–2022*. COAG, Canberra.
- Danielson, K. K., Moffitt, T. E., Caspi, A. & Silva, P. A. (1998) 'Comorbidity between abuse of an adult and DSM-III-R mental disorders: evidence from an epidemiological study' *Am J Psychiatry* (155) pp. 131–3.
- De Visser, R. O., Rissel, C. E., Smith, A. M. & Richters, J. (2006) 'Sociodemographic correlates of selected health risk behaviors in a representative sample of Australian young people' *Int J Behav Med* (13) pp. 153–62.
- Department of Health (2007) *Youth Early Psychosis Status Report*. Mental Health, Drugs & Regions Division, Victoria.
- Department of Health (2011) *Service guideline on gender sensitivity and safety: Promoting a holistic approach to wellbeing*. Mental Health, Drugs & Regions Division, Melbourne.
- Department of Health and Ageing (2009) *The Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009–2014*. DHA, Canberra.
- Department of Health and Ageing (2010) *National Women's Health Policy 2010*. DHA, Canberra.
- Department of Health and Ageing (2012) *A Ten year Roadmap for National Mental Health Reform: Draft no. 4*. DHA, Canberra.
- Forsythe, L. & Adams, K. (2009) *Trends & issues in crime and criminal justice: Mental health, abuse, drug use and crime: does gender matter?* Australian Institute of Criminology, Canberra.
- Hilton, M. F., Scuffham, P. A., Vecchio, N. & Whiteford, H. A. (2010) 'Using the interaction of mental health symptoms and treatment status to estimate lost employee productivity' *Aust N Z J Psychiatry* (44) pp. 151–61.
- Johnson, J. G., Cohen, P., Brown, J., Smailes, E. M. & Bernstein, D. P. (1999) 'Childhood maltreatment increases risk for personality disorders during early adulthood' *Arch Gen Psychiatry* (56) pp. 600–6.
- Judd, F., Armstrong, S. & Kulkarni, J. (2009) 'Gender-sensitive mental health care' *Australas Psychiatry* (17) pp. 105–11.
- Kulkarni, J. (2010) 'Special issues in managing long-term mental illness in women' *Int Rev Psychiatry* (22) pp. 183–90.
- Kulkarni, J., Mccauley-Elsom, K., Marston, N., Gilbert, H., Gurvich, C., De Castella, A. & Fitzgerald, P. (2008) 'Preliminary findings from the National Register of Antipsychotic Medication in Pregnancy' *Aust N Z J Psychiatry* (42) pp. 38–44.
- Loebel, A., Lieberman, J., Alvir, J., Mayerhoff, D., Geisler, S. & Szymanski, S. (1992) 'Duration of psychosis and outcome in first-episode schizophrenia' *American Journal of Psychiatry* (149) pp. 1183–8.
- Lysaker, P. H., Meyer, P. S., Evans, J. D., Clements, C. A. & Marks, K. A. (2001) 'Childhood sexual trauma and psychosocial functioning in adults with schizophrenia' *Psychiatr Serv* (52) pp. 1485–8.

- Macmillan, H. L., Fleming, J. E., Streiner, D. L., Lin, E., Boyle, M. H., Jamieson, E., Duku, E. K., Walsh, C. A., Wong, M. Y. & Beardslee, W. R. (2001) 'Childhood abuse and lifetime psychopathology in a community sample' *Am J Psychiatry* (158) pp. 1878–83.
- McClelland, A. & Scotton, R. (1998). 'Poverty in health'. In: Finher, R. & Nieuwenhuysen, J. (eds.) *Australian Poverty: Then and Now*. Melbourne University Press, Melbourne.
- McMunn, A. M., Nazroo, J. Y., Marmot, M. G., Boreham, R. & Goodman, R. (2001) 'Children's emotional and behavioural well-being and the family environment: findings from the Health Survey for England' *Soc Sci Med* (53) pp. 423–40.
- Mead, S. & Macneil, C. (2006) 'Peer Support: What Makes It Unique?' *International Journal of Psychosocial Rehabilitation* (10) pp. 29–37.
- Mullen, P. E., Romans-Clarkson, S. E., Walton, V. A. & Herbison, G. P. (1988) 'Impact of sexual and physical abuse on women's mental health' *Lancet* (1) pp. 841–5.
- Notman, M. & Nadelson, C. (2006) *Psychoanalytic perspectives*. Lippincott, Williams & Wilkins, Ontario, Canada.
- Paris, J. (2007) 'The nature of borderline personality disorder: multiple dimensions, multiple symptoms, but one category' *J Pers Disord* (21) pp. 457–73.
- Pound, L., Judd, K. & Gough, J. (2011) *Peer support for women living with mental health issues: The views of ACT Women*. Women's Centre for Health Matters.
- Price-Robertson, R., Bromfield, L. & Vassallo, S. (2010) *The prevalence of child abuse and neglect: NCPC Resource Sheet*. National Child Protection Clearinghouse, Melbourne.
- Quirk, A. & Lelliott, P. (2001) 'What do we know about life on acute psychiatric wards in the UK? A review of the research evidence' *Soc Sci Med* (53) pp. 1565–74.
- Read, J. & Argyle, N. (1999) 'Hallucinations, delusions, and thought disorder among adult psychiatric inpatients with a history of child abuse' *Psychiatr Serv* (50) pp. 1467–72.
- Royal Women's Hospital (2012) *Perinatal Psychotropic Medicine Information Service*. Available: <<http://www.ppmis.org.au/>>, accessed 2 October 2012.
- Sanderson, C. (2006) *Counselling Adult Survivors of Child Sexual Abuse*. J.Kingsley.
- Seeman, M. V. (2000) 'Women and schizophrenia' *Medscape Womens Health* (5) p. 2.
- Senate Community Affairs Committee Secretariat (2011) *Inquiry into Commonwealth Funding and Administration of Mental Health Services: EPPIC funding in the 2011–12 Federal Budget*. Community Affairs References Committee, Canberra.
- Stoltenborgh, M., Van Ijzendoorn, M. H., Euser, E. M. & Bakermans-Kranenburg, M. J. (2011) 'A global perspective on child sexual abuse: meta-analysis of prevalence around the world' *Child Maltreat* (16) pp. 79–101.
- Thompson, M. P., Kingree, J. B. & Desai, S. (2004) 'Gender differences in long-term health consequences of physical abuse of children: data from a nationally representative survey' *Am J Public Health* (94) pp. 599–604.
- Van Der Gaag, M., Stant, A. D., Wolters, K. J., Buskens, E. & Wiersma, D. (2011) 'Cognitive-behavioural therapy for persistent and recurrent psychosis in people with schizophrenia-spectrum disorder: cost-effectiveness analysis.' *Br J Psychiatry*. (198) pp. 59–65.
- VicHealth (2004) *The Health Costs of Violence: Measuring the Burden of Disease Caused by Intimate Partner Violence*. VicHealth, Melbourne.
- Walker, E. A., Gelfand, A., Katon, W. J., Koss, M. P., Von Korff, M., Bernstein, D. & Russo, J. (1999) 'Adult health status of women with histories of childhood abuse and neglect' *Am J Med* (107) pp. 332–9.
- Willis, K. & Rushforth, C. (2003) *The Female Criminal – An Overview of Women's Drug Use and Offending Behaviour: Trends and issues in crime and criminal justice, no. 264*. Australian Institute of Criminology, Canberra.
- Women's Centre for Health Matters (2009) *Position paper on gender sensitive mental health service delivery*. Canberra.
- World Health Organisation (2002) *World report on violence and health: summary*. WHO, Geneva.
- World Health Organisation (2003) *Investing in Mental Health*. WHO, Geneva.
- World Health Organization (2011) *Gender and Women's Mental Health: Gender disparities and mental health: The facts*. WHO, Geneva. Available: <[http://www.who.int/mental\\_health/prevention/genderwomen/en/](http://www.who.int/mental_health/prevention/genderwomen/en/)>, accessed 2 October 2012.
- Zubin, J., Steinhauer, S. R. & Condray, R. (1992) 'Vulnerability to relapse in schizophrenia' *Br J Psychiatry Suppl* (18) pp. 13–8.

