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Design by Studio Binocular
Welcome to the Spring edition of newparadigm. With such a diverse range of writers and shifting themes, newparadigm aims to inform, challenge and stimulate debate. Please let us know your thoughts regarding this special edition on Women and Mental Health.

While the first couple of months in my position as Chief Executive Officer of VICSERV have been very busy, I am very much looking forward to meeting with, establishing and maintaining strong relationships with the Board, VICSERV staff, member organisations and—especially during this exciting time—the Victorian State Government. I feel very privileged in taking on this role… and what a great first edition of newparadigm to be involved in!

It is gratifying that women’s rights and women’s mental health issues are more noticeably being recognised as an integral part of the mainstream of public policy making, and promoting awareness and understanding around these issues are seen to have a place on the current agenda. Women and Mental Health is also a fitting theme with the recent welcoming of the Department of Human Services Mental Health Branch report The gender sensitivity and safety in adult acute inpatient units project, which examines issues like those explored in this edition of newparadigm. The report also saw a number of our contributors to this edition—including Heather Clarke, Sabin Fernbacher and Professor Jayashri Kulkarni—appointed as advisory committee members.

I would like to provide a note of thanks to previous editor Matt Clear for his hard work on newparadigm during his time at VICSERV and for his unique vision for a fresh and progressive journal. I would also like to acknowledge the efforts of Elliot Cartledge and Kristie Lennon in bringing this edition to publication and my appreciation extends to the contributors of this edition.

Thank you for your continued readership and support and I encourage you to make contact with us to talk about possibilities for 2009.

Yours Sincerely,

Kim Koop
Chief Executive Officer
How safe are women in Victorian inpatient units?

Women between the age of 20 and 70 were intimidated by the violence and aggression that are often part of inpatient settings in both rural and metropolitan areas. A significant number of women also felt devalued by unwanted sexual overtures or innuendos from male patients towards themselves or other women, and were offended by inappropriate abusive language.

For some years, the Victorian Mental Illness Awareness Council (VMIAC) has been receiving disturbing feedback from female consumers expressing concern about experiencing sexual harassment, abuse or assault from male consumers while being cared for and treated in psychiatric inpatient units. As a consequence, VMIAC successfully applied to the Reichstein Foundation for funding to undertake a twelve-month project investigating the safety of women in Victorian public psychiatric inpatient units. The project, Feeling Unsafe in a Sanctuary, is currently due for completion.

The Reichstein Foundation works in partnership with community organisations and other donors to improve, maintain or restore human rights and social justice and has supported VMIAC in developing a number of projects aimed at improving consumers’ experience of mental health services. The Foundation is highly respected for its support of innovative research and its appreciation of the need for informed understanding of the issues behind positive change.

But why focus particularly on women’s safety in inpatient settings? The literature reviewed as part of the project and the outcomes of discussions with women across metropolitan and rural Victoria, suggest women are disadvantaged in multiple ways by:

- being female in a predominantly paternalistic society,
- living with the threat—or the fact—of domestic violence or sexual abuse or assault,
- the (often unequal) responsibilities of raising children, often as sole parent(s),
- the devastating effects of mental illness that disrupts everyday life and relationships, which may be exacerbated by earlier abuse,
- cultural and social backgrounds and religious beliefs,
- the increased likelihood of experiencing poverty and inadequate housing, and
- substance abuse or addictions that add an extra layer of disadvantage to women’s ability to live lives that are predictable, safe and satisfying.

A literature review, with particular emphasis on research and government initiative documents and reports relevant to women’s safety, drawn from local, state, national and international sources (including policy and service framework documents and journal articles) was undertaken.

More than two decades ago, since the move away from institutionalised psychiatric treatment to community-based care, women have been subject to a legacy of indifference to their special needs. Or, at least, to a paucity of policy and practice guidelines that effectively protect their interests. It is disturbing that while Valerie Gerrand raised the need for effective policies to guide women’s treatment in her 1993 monograph, The Patient Majority, and, so too, did Carolyn Graham in a 1994 report Certified Truths: Women who have been sexually assaulted – their experience of psychiatric services, a comment from Graham’s report might well have been written today. She asserted that ‘many women reported not feeling safe while a patient in a psychiatric hospital, due to an absence of policies and procedures that protected them.’

One woman who participated in our discussion groups said ‘I was terrified’, another said ‘hospital is a frightening place to be’, and another stated ‘psych wards are dangerous places’. Currently, the policy guiding women’s treatment and care rests, primarily, on a document that is more than ten years old. The 1997 document, Victoria’s Mental Health Services: Tailoring Services to Meet Women’s Needs, produced by the Victorian Government Department of Human Services may have been ground-breaking at the time. Today, however, the document falls short of providing a blueprint for ensuring consistent treatment outcomes. There is a need to re-think policy and practice to ensure women are safe and their special needs are met wherever they receive inpatient care in Victoria.

As a VMIAC project leader, I held discussions across Victoria to give women an opportunity to identify what made them feel safe or unsafe when receiving inpatient care. Small groups were developed with the assistance of Psychiatric Disability Rehabilitation Support Services (PDRSS) in metropolitan and rural areas. Six groups were conducted in Warrnambool, Ballarat, Castlemaine, Shepparton, Mildura and Bairnsdale, and a further eight groups were held across all four regions of Melbourne. In all, 49 women participated directly, with nine women providing input through independent completion of the questions developed for the project. A brief survey was also sent to all Area Mental Health Services to establish their current women’s safety practices, together with a request for copies of their women’s safety policies.

Of the 21 Area Mental Health Services (AMHS) across Victoria, eleven metropolitan and rural services completed and returned the survey, while five metropolitan and one rural service provided copies of their women’s safety or gender-sensitivity policies. There was considerable variability in the policies we received. Of the eleven surveys returned, all indicated that the AMHS had physical and sexual assault policies in place, while only four had verbal harassment and emotional harassment policies. Ninety per cent said the possibility of previous abuse or sexual assault was discussed with women, while 100 per cent said this information was shared in a private place. Ninety per cent of the surveyed services had available single rooms with en suite facilities, 90 per cent would offer accommodation close to the nurses’ station for vulnerable women and 90 per cent would provide regular nurse checks during each shift. Sixty per cent of services surveyed displayed information about sexual assault and domestic violence support services, while 100 per cent said they supported women to access support services if a need was identified. Regrettably, our discussions with women who had been treated in inpatient units did not always support these positive percentages.

The literature reviewed demonstrated that men and women experience mental illness differently. This is a factor that has not been given sufficient attention in planning and delivering safe, gender-sensitive services. For instance, Harvard academic Mary-Jo DelVecchio Good, writing in Women and Health, contends that:

Mainstreaming a gender perspective needs to be coupled with mainstreaming mental health issues as well, because women disproportionately suffer from mental health disorders and are more frequently subject to social causes that lead to mental illness and psychosocial distress.
By 2002, the United Kingdom National Health Service had experienced aggression from male patients when placed in High Dependency Units; one woman was bashed as she slept. Many women were traumatised by the aggression from males they experienced on Victorian inpatient wards. Some had felt very isolated and vulnerable in sleeping corridors shared with men, often at a considerable distance from the nurses’ station. Some women had to share toilets and shower facilities with males using the toilet without closing the door. Other women had experienced aggression from male patients when placed in High Dependency Units; one woman was bashed as she slept.

By 2002, the United Kingdom National Health Service had as its goal ‘the elimination of mixed-sex accommodation in 95 per cent of Health Authority areas’. Victoria grappled with the task of converting mixed wards to provide for single-sex environments and ensuring newly built mental health facilities allowed provision for women-only care. Clear guidelines were developed, ensuring that ‘as a minimum requirement, male and female patients should have separate sleeping accommodation, separate toilets and separate washing facilities’.

The policy also outlines expectations of managers and staff; they ‘should be aware of all safety concerns, and alert to the possibility of assaults, not just to other residents, but also to staff’. The purpose behind redeveloping the UK mental health facilities was ‘to ensure all patients are protected from physical, psychological and sexual harm while they are being treated in facilities that make allowances, he’s very sick’. One indignant woman said, ‘I’m sick too; why doesn’t he keep away?’

As well as more appropriate accommodation, women also wanted closer contact with staff, especially nurses. Very few women who took part in our discussions had formed a close, trusting bond with their nurse. It was also clear that women were often not given an opportunity during admission to raise concerns about past abuse or assault, anxieties about how safe they would be, or worries about care of dependent family members. Several women volunteered the opinion that sharing this information would have helped them experience a better transition into hospital and a more positive stay. Many women were concerned about the difficulty in accessing nurses’ attention, saying that the nurses spent inordinate amounts of time in the nurses’ station or ‘fishbowl’.

The review of literature from Australia and overseas, plus the insights afforded to us by our group participants, resulted in a need to establish uniform policies to protect women and promote positive practice no matter where they received inpatient treatment in Victoria. V Nurses believes that service accountability, best practice and duty of care must be embedded in policies and practices that promote safety, gender-sensitivity and respect for privacy for all women. These policies must be implemented systematically across all Victorian AMHS.

Another woman said ‘the last thing you need when you’re recovering from psychosis is for a guy to hit on you. There is some sexual attraction on the ward and I don’t think it’s appropriate’.

Much of the literature surrounding women’s safety in inpatient units stresses the vulnerability of women who have experienced violence or sexual assault before coming to hospital, sometimes dating back to childhood. But what happens within the ward environment also causes women great distress and impacts on how positive their stay in hospital might be. Of the women we talked to who had recently spent time in an inpatient unit, one had been sexually assaulted, 14 per cent had been subjected to sexual harassment, 36 per cent had been subjected to physical threats and just under one third said they had experienced intimidation. Too often, when women complained about incidents of intimidation or abuse they were told to ‘just keep away from him’, or ‘you’ve got to make allowances, he’s very sick’. One indulgent woman said, ‘I’m sick too; why doesn’t he keep away?’

Keeping women safe is no longer optional. The recently enacted Victorian Charter of Human Rights and Responsibilities and the UN Convention on the rights of people with disabilities, to which Australia is a signatory, make it legally incumbent upon government and mental health services to develop policies to protect women receiving psychiatric care. But one woman who has had several admissions to different inpatient units put the case for consistent care most poignantly: ‘to know you can expect a uniform high standard of safe treatment would be nearly like Paradise’.

Our recommendations include:

• The development of uniform women’s safety policies and practice protocols by the Mental Health Branch and Office of the Chief Psychiatrist, consistent with the obligations of government and mental health services to ensure the safety of women consumers receiving inpatient psychiatric care and treatment.
• Policies and practices to be systematically implemented across all Victorian AMHS.
• All existing inpatient facilities be modified to provide, as a minimum, separate sleeping areas, separate toilet/shower facilities and separate recreation spaces for female patients.
• All newly built inpatient facilities to provide separate sleeping, toilet/shower and recreation spaces for female patients.
• Realistic consultation with women service-users and their representatives as part of proposed change.
• Funding of consumer consultant positions to allow for realistic and dedicated time on inpatient units across the state.
• Updating security provisions in line with current technology, including locks on bedroom/bathroom doors that can be overridden in an emergency.
• Realistic timelines for policy development and modifications of women-sensitive inpatient facilities to be set and adhered to.

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Department of Human Services, (1997), Mental health services: to meet the needs of women. Melbourne.

Graham, C., (1996), Certified Truths. Women who have been sexually assaulted – their Experience of psychiatric services. Southeast Centre Against Sexual Assault, Horsham Mental Centre, Melbourne.

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Getting gender on the agenda

Trish Bolton,
Policy Officer, Women’s Health Victoria

In order to achieve better mental health outcomes for women and men we need to tackle the social context of individual behaviour and empower individuals and communities to make positive change.

Growing up female plays a powerful role in shaping women’s vulnerability to mental disorders.1 While women may have freed themselves to some extent from the gendered norms of the domesticity and economic dependence of previous generations of women, they still bear the greater unpaid burden of domestic chores and have not yet achieved economic independence. Women also continue to shoulder, disproportionately, the care of children and sick or elderly relatives.

Studies show that combined risks of anxiety and depression have been found to be twice as high for women as for men.2 How else can we know, other than through gender-based research and the data it produces, that 15 per cent of women (compared to ten per cent of men), report high to very high levels of psychological distress;3 that women, while succeeding less, attempt suicide more than men, and that anxiety and depression in women is frequently accompanied by other mental health problems?4 How can we reach women and deliver mental health services responsive to women most in need and understand what may trigger mental illness in women at particular stages of life? How can we plan, provide, tailor, fund and target policy and programs to women if we do not have gendered data available to us? And, as importantly, how do we work to prevent women developing mental health problems if we do not have evidence to guide us?

If we are to be sensitive to diversity as well as gender further disaggregation of gendered data by income, education, age, ethnicity, language, sexual orientation, disability, Aboriginality and geographic location will alert us to the way gender interacts with other social factors to influence mental health. Of course, collection of this data not only helps to better tailor and target policy and programs to women, it will identify needs in male populations, too.

Gendered data

Few people working in mental health would disagree that ‘gender is a critical determinant of mental health and mental illness’.5 Yet, how many have a clear understanding of why, when we talk about mental health, we need to talk about women (and men), not just people? If we are going to meet sex-specific needs in mental health (and, indeed, in health generally), a collection of raw data is not enough; it must be disaggregated or put more simply, count men and women separately. Gendered data seems so obvious, but if you read most government reports and examine much of the research, you will find that gender is often ignored or overlooked. Yet, without gender specific data, policy and program development can only tell part of the story and address only some of the issues.

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Gender and health framework

Gendered data is a first step towards a gender and health framework; this framework can move us beyond seeing health needs and outcomes in terms of biology, to recognising the role that gender plays in mental health. A gender and health framework can help identify, understand and address mental health issues for women (and for men). The framework consists of three elements beginning with gendered data:

• Gendered data
  Gender-disaggregated statistics can be used proactively in planning and are critical in gauging the extent to which men and women benefit or are affected by policy.

• Gender impact assessment
  Monitor new and existing policies for gender impact and use knowledge to adapt existing or proposed policies to promote gender equity in both planning and implementation.

• Gender awareness raising
  Take opportunities to build capacity and understanding of how policies and programs can cause or lead to discriminatory effects.

Violence matters

The Convention for the Elimination of Discrimination against Women (CEDAW), states that ‘... gender-based violence is a critical health issue for women...’.7

There is a vast amount of literature documenting the effects of violence against women (including sexual abuse), which tells us that violence can result in post-traumatic stress disorder, depression, anxiety, low self-esteem, sexual dysfunction, self-inflicted harm and suicide.8

The Federal Government recently announced it will develop a National Men’s Health Strategy to address increasing concerns around men’s health. Such a strategy is welcome and an opportunity to develop an evidence-based approach that includes data disaggregated by sex and gender. This information will further establish men’s health needs, which can then be more appropriately targeted, and have flow-on benefits for women, children and the community.

However, when announced, the strategy did not include any reference to men’s mental health, although a glance at statistics relating to alcohol and drug abuse, suicide, crime, road fatalities and other misadventure, is reason enough for
Studies show that combined risks of anxiety and depression have been found to be twice as high for women as for men. This can, in part, be attributed to negative attitudes towards women, lack of acknowledgement of the work they do, fewer opportunities in education and employment and greater risk of domestic violence.

An ounce of prevention

We need to see from government at all levels, a commitment to building an evidence-base for mental illness prevention and to actively promote mental health and wellbeing for women by reducing inequalities in mental health.

As violence against women is strongly linked to gender inequality, early education and training that challenges masculinist norms of aggression and high-risk behaviour that imperil boys and men, girls and women, families and communities, must be part of prevention planning. Changes must also be made to social structures that perpetuate traditional gender roles. For example, men’s role in the family from childhood onwards needs to be encouraged by workplaces that put in place policies that encourage men to participate in community and family life. Men should also be supported through relationship and family breakdown, unemployment, and encouraged to connect to each other and to their wider communities.

In order to achieve better mental health outcomes for women and men we need to tackle the social context of individual behaviour and empower individuals and communities to make positive change.  

Conclusion

Too little data takes a gendered perspective of mental illness. This makes it difficult to prevent, identify and treat mental illness and promote mental health and wellbeing in women. Data, disaggregated by sex and gender and stratified to take full account of diversity, must be collected at national, state and local levels. This data can be used to:

• Build evidence on the prevalence and causes of mental health problems in women as well as on the mediating and protective factors.
• Promote the formulation and implementation of health policies that address women’s needs and concerns from childhood to old age.
• Enhance the competence of primary health care providers to recognise and treat mental health consequences of domestic violence, sexual abuse, and acute and chronic stress in women.

Traditional gender roles must be challenged through interventions that include early education of boys and girls. Men should also be freed from the demands of traditional gender roles that impose them from their families and communities, and that anticipate and often excuse anti-social behaviour that harms women, in particular. The mental health needs of women, while demanding very specific supports and interventions, cannot be addressed in isolation of social norms, values and practices that have thus far, ignored the wider context of women’s lives. The collection of gendered data, as part of a gender and health framework, will make it less likely that women’s mental health and wellbeing will be overlooked in the future.

References

10 San, C, O’Brien, P and George, A. (2007), Unequal, Unfair: Ineffective and Inefficient Gender Inequality in Health: Why it needs and how we can change it, First Report to the WHO Commission on Social Determinants of Health, Karolinska Institutet, p. 75.
Eating disorders are a group of chronic, complex mental illnesses with serious long-term effects on physical health as well as mental health and wellbeing. Eating disorders are among some of the most misunderstood and misdiagnosed mental illnesses in the world. Research has not yet been able to definitively identify the prevalence of eating disorders in Australia, and estimates vary, however the combined prevalence of eating disorders is commonly estimated at five to seven per cent of the population—and at least 90 per cent of sufferers are women. In a study of young women aged 15-24, eating disorders were the third most common disorder behind obesity and asthma.

The seriousness of the effects of eating disorders is one of the facts still most misunderstood. It still shocks many people to find out that all psychiatric disorders anorexia nervosa has the highest mortality rate, arising both from the complications resulting from the physical effects of the illness and from a high rate of intentional suicide. The overall mortality rate for anorexia is five times that of the same-aged population in general, with death from medical conditions (e.g., cardiac arrhythmia, infection etc.) being four times greater, and deaths from unnatural causes eleven times greater. The risk of successful suicide is particularly high, being 32 times more likely than the normal population. Eating disorders commonly co-exist with other mental illnesses such as anxiety, depression and obsessive-compulsive disorder.

...So why are women more affected by eating disorders than men?

Eating disorders emerge at the clinical end of a spectrum of disordered eating behaviours related closely to widespread body image dissatisfaction and dieting behaviours in developed countries. It is not coincidental that eating disorders emerge in...
countries where there is a strong media and fashion influence.

Another risk factor in adolescence which appears to be strong is the development of an eating disorder. Dieting behaviour 'trains' the body and mind to override hunger and safety signals, so that these signals become less effective. Studies also show that girls who diet tend to have greater misperceptions about their actual size.

Bulimia and binge-eating behaviour tend to be associated with emotional (comfort or guilt) eating, accompanied by loss of control of food intake, and are sometimes associated with dieting (restricting) behaviour too. Binge eating is often accompanied by the heavy pressure to be fit, attractive and successful. The role of women has been shifting over recent decades; there is now a societal expectation that women can and should do everything, all at once, e.g. have a glittering career, be a successful mother, and maintain a body that conforms to the media image of the ideal. All these social pressures affect women far more strongly than men.

The prevalence of eating disorders is directly related to dieting behaviour. We know that only a minority of young people who diet will go on to develop an eating disorder but when factors such as dieting and body image dissatisfaction combine with other risk factors for mental illness such as low self-esteem, perfectionism, anxiety, difficulties in interpersonal relationships or trauma, there is a heightened risk of the development of an eating disorder. Dieting behaviour 'trains' the body and mind to override hunger and safety signals, so that these signals become less effective. Studies also show that girls who diet tend to have greater misperceptions about their actual size.

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Bulimia and binge-eating behaviour tend to be associated with emotional (comfort or guilt) eating, accompanied by loss of control of food intake, and are sometimes associated with dieting (restricting) behaviour too. Binge eating is often followed by feelings of self-hate and guilt, which can then induce compensatory behaviours such as purging, laxative abuse and more stringent dieting behaviours. Dieting causes a further loss of hunger control, leading to further binging—this rapidly develops into a vicious circle of binge-guilt-purge / diet-depression-binge and so on.

Another risk factor in adolescence which appears to be strong in young women is peer pressure; there is a pressure to ‘fit in’ with the rest of the group, or to be able to wear the same clothing, which can lead to the development of ‘dieting clubs’ or to competitive dieting in schools. There is evidence to suggest that girls and women are more susceptible to peer pressure than men, especially relating to appearances.

Disordered or disturbed eating can also develop as a response to feeling ‘life is out of control’, particularly in adolescence. The physiological and emotional impacts of puberty, or of external pressures or stresses at home or school, can cause young people to attempt to set limits or re-establish control over their lives in areas that are still within their reach – such as eating behaviours. Whether this risk factor is higher in girls than boys has not been established.

Evidence also suggests that older women (over the age of 30) are now seeking treatment or support for eating disorders. Several reasons have been suggested for this, including a growing awareness of the issue making it easier for women to recognise symptoms and/or admit that they have struggled with eating problems for years; and a small increase in the development of eating disorders in later life due to the social/ media pressure for women to regain their ‘pre-baby’ figure in a short timeframe, and the stresses induced by careers, divorce and caring for aging parents. Whichever of the many and complex factors are involved, the fact remains that eating disorders are predominately women’s issues; and, like many such issues, ones that remain under-funded, under-researched and under-recognised. Information, support, education and advocacy are needed to tackle this problem – and that is where the Eating Disorders Foundation of Victoria (Eating Disorders Victoria) comes in.

Eating Disorders Victoria is a funded agency within the arm of PDRSS known as Mutual Support and Self-Help. We believe that with the right treatment and support, eating disorders can be beaten and recovery is possible. We are also committed to educating the Australian community so that people embrace the voices of carers and consumers with eating disorders throughout Victoria. We are the Victorian government’s prime communicator with the eating disorder consumer and carer and have a history of advocating strongly on their behalf for the evaluation, recognition of and improvement to consumer and carer experiences. Eating Disorders Victoria supports and promotes consumers’ active involvement in their own treatment and recovery.

Eating Disorders Victoria is unique in Victoria in providing a free comprehensive support and information service for the community on all aspects of eating disorders. We are also unique in our provision of non-clinical help through a blend of qualified professionals and trained volunteers with lived experience of the condition. Through our eating disorder helpline, website, support groups, individual support sessions, schools and fitness professionals programs and community education we can dispel myths, encourage positive body image, promote prevention initiatives, increase early identification and intervention, and provide support to families, carers and people experiencing an eating disorder. In this way we have a direct impact on the mental health and wellbeing of thousands of Victorians—chiefly, but by no means exclusively, women—every year.

References

Some key statistics for Eating Disorders Victoria for the 12 months ending June 2008:

| Total number of face-to-face support contacts: 227 |
| Total number of telephone contacts: 2763 |
| Total number of email contacts: 469 |
| Total number of support group meetings run (metro/rural): 151 |
| Total number of moderated Internet chat groups hosted: 118 |
| Total number of professional development / community education activities carried out: 72 |
| Total number of professional development / community education attendees: 2244 |
| Total number of website hits: 1.1 million |

FIND OUT MORE. Visit the Eating Disorders Foundation of Victoria Inc. website at www.eatingdisorders.org.au or phone the Eating Disorders helpline on 1300 550 236.
The Victorian Women and Mental Health Network: past, present and future

Heather Clarke,
Convenor, Victorian Women and Mental Health Network (VWMHN)

A group of women with an interest in mental health came together to discuss common issues and work for change in the delivery of mental health services to women. Out of this initiative grew the Victorian Women and Mental Health Network.

I became actively involved with the Victorian Women and Mental Health Network (VWMHN) in 2002, alongside a small but dedicated band of women service providers and consumers. Over the past six years, the general membership has grown as well as the number of women actively involved in the Network Planning Group. The profile of the VWMHN has also expanded primarily as a result of our project to raise awareness of the lack of safety for women in mixed-sex psychiatric wards.

In this edition of new paradigm focusing on women and mental health, I thought it would be important and interesting to briefly document some of the history of the VWMHN and the work that has been undertaken to address women’s mental health needs:

1988
A group of women with an interest in mental health came together to discuss common issues and work for change in the delivery of mental health services to women. Out of this initiative grew the Victorian Women and Mental Health Network.

1989
The VWMHN organises the ‘Women and Mental Health Conference’ in Melbourne with Kate Gilmore, then Coordinator of CASA House as one of the keynote speakers.

1990 to 1992
The VWMHN auspices several workshops and forums including one on sexual assault.

1993
The Directory of Services for Women in Mental Health is compiled by the VWMHN in response to many requests for information about women’s programs, and to address the lack of information about the availability of women-specific services.

1993 to 1994
The VWMHN and Healthsharing Women (now Women’s Health Victoria), collaborate in the development of a training and resource kit Good Practices in Women’s Mental Health with funds from the National Women’s Health Program. This kit clearly raises the issue of safety for women in psychiatric wards:

‘the presence of violent or aggressive men in hospital made women feel very unsafe… women gave examples of being harassed or even raped… responses to women’s safety concerns do not appear to be shared at an organisational level in psychiatric hospitals.’

1995 to 1996
The VWMHN forums are held on domestic violence and mental illness issues and the need for women’s-only respite.

1997
Sees the release of the Department of Human Services policy statement Tailoring Services to meet the needs of Women, and the funding of Women’s Mental Health Consultants in every region for a twelve-month period. Women’s portfolio positions are also established in some areas. At the time, the VWMHN applauded these positive steps but note:

In order to guarantee that women’s issues remain on the agenda of mental health services (and not go back to being the responsibility of individual workers), there needs to be an ongoing focus and commitment to good practices in women’s mental health… It would be unrealistic to expect that these projects could profoundly and permanently change the culture and practices of organisations within this time frame. The influence of ‘women’s portfolios’ will largely depend on the organisation’s willingness to change and its ongoing commitment to resourcing these positions.

(In 2008, only three part-time Women’s Mental Health Consultant positions continue to be funded – Northern, Eastern and Bendigo.)

1998
The VWMHN produces Speaking Out, a book of stories written by women consumers about their experience of mental health services. It identifies ‘an urgent need’ to re-think the policy on mixed-sex wards that had been introduced in the 1960s.

1999
The Directory of Women-Sensitive Mental Health Services is updated.

2000
The VWMHN organises Women-Only Day for workers, consumers and carers focusing on Women, Depression and Anxiety: Creative Approaches to Health and Recovery.

2002
New VWMHN Planning Group is formed, comprising of women from clinical mental health, PDRS, centres against sexual assault and consumers.
The main activity is the organisation of member forums focussing on women’s key mental health issues, including:

- self-harm,
- promoting recovery through community inclusion,
- issues for women consumers returning to work/study,
- mental health and sexual abuse network’s combined membership of women consumers and service providers.

This was identified as a unique strength, enabling forum discussions to explore both the service-provider perspective and the lived experience of women consumers and to promote a dialogue through which genuine change can develop.

2005

The VWMHN ‘Women on the Wards’ forum, at which consumers speak about their experience of lack of safety in psychiatric wards, creates impetus for a project to raise awareness of women’s experience of mixed-sex psychiatric wards.

2006

The VWMHN establishes quarterly liaison meetings with Mental Health Branch (MHB). Invites women consumers and service providers to complete surveys about their experiences of inpatient units (61 per cent of women consumers identified having personally experienced harassment or abuse whilst inpatients).

The postcard campaign calling on the Health Minister to address lack of safety in inpatient units takes place. Some 65 women consumers attend Listening Events and speak about their inpatient experiences. Delegation to Health Minister, Bronwyn Pike at which consumer member, Julie Dempsey shares her 25 year experience of lack of safety in inpatient units.

2007

Partly in response to the VWMHN ‘awareness-raising’ activities, MHB establishes project ‘Increasing Gender Sensitivity and Safety in Adult Acute Inpatient Units’ and the VWMHN are invited to participate in the reference group.

2008

DHS releases The gender sensitivity and safety in adult acute inpatient units project report identifying recommendations relating to the development of guidelines re-promoting sexual safety in inpatient units and the adoption of a policy of choice of single-sex treatment environment.

The VWMHN recognises the following issues also impact significantly on women’s mental health:

- the need for trauma informed care for women who have experienced past physical or sexual abuse (estimated to be 50 to 80 per cent of women mental health consumers),
- access to affordable counselling as well as gender-sensitive psychiatrists who provide therapy in relation to the needs of women consumers who are also mothers/carers,
- particular challenges faced by women consumers attempting to return to work,
- the medicalisation of women’s sadness in response to gender-based life stages/challenges, and
- women’s access to PDRS services and also to community-based alternatives to hospitalisation.

So, progress on the women’s safety issue is definitely being made and the VWMHN remains committed to continuing to work with women consumers on further advocacy in relation to this issue. However, the VWMHN is keen to hear your reflections and responses to the following questions. Or perhaps these questions spark other women’s mental health issues you wish to raise.

- Do these issues suggest the need for an overarching women’s mental health policy?
- In order to guarantee that women’s issues remain on the agenda of mental health services, does there still need to be an ongoing focus and commitment to good practices in women’s mental health?
- What role can the VWMHN and other organisations play in promoting this focus?
- Is the single-issue approach utilised in relation to the women’s safety issue the most effective strategy? If so, what issue should be the next priority the VWMHN tackles?
- Does the sector need a women-specific organisation that can work at a number of levels to address a range of issues?
- Is there an ongoing role for an organisation that enables consumers and service providers to collaborate to bring about positive changes in mental health services? If so, where does an organisation fit in relation to other service provider and consumer organisations?

We would also like to acknowledge the hard work of the many women who have participated in the VWMHN during the past 20 years.
Consumer participation: women, stereotypes and empowerment

Yvette Geljon,
Consumer Participant, South West Psychiatric Services

Stereotypes can be hard to shake off and although there have been vast improvements since the 1950s, there is still a long way to go towards empowering women to stand up, be accounted for and listened to. It is no longer acceptable for women to continue to be seen as second-class, passive individuals who are unable to contribute to their physical, mental and spiritual wellbeing.

There are many stereotypes about being a woman; add a mental illness and the challenges can appear insurmountable. This article will look at the stereotypes surrounding women, how this gender bias can affect treatment for mental health issues and how consumer participation can break down barriers and empower women.

Stereotypes and women
Growing up as a female I learnt that women don’t show their emotions (especially if angry or sad), being a woman meant being passive and submissive. I was taught not to speak unless spoken to and never to express my opinion above another’s. By way of illustration, here are some tips given to women in the 1950s from Housekeeping Monthly magazine:

- Your goal: try to make sure your home is a place of peace, order and tranquility where your husband can renew himself in body and spirit.
- Greet him with a warm smile and show sincerity in your desire to please him… never complain.
- Be a little more gay and interesting for him, this day may need a lift and one of your duties is to provide it.
- Listen to him. You may have a dozen important things to tell him, but the moment of his arrival is not the time. Let him talk first – remember his topics of conversation are more important than yours.
- A good wife knows her place!

Stereotypes can be hard to shake off and although there have been vast improvements since the 1950s, there is still a long way to go towards empowering women to stand up, be accounted for and listened to. It is no longer acceptable for women to continue to be seen as second-class, passive individuals who are unable to contribute to their physical, mental and spiritual wellbeing.

It is important to remember ‘addressing needs concerning women’s health could be the strongest means of women empowerment’.

Stereotypes and mental illness
When I was first diagnosed with borderline personality disorder (BPD), I was told by a psychologist that it would be harder for me to overcome my illness because I was a woman. The psychologist further explained that women are prone to more mental health issues because they are more emotional than men. Unfortunately, this attitude is not isolated.

‘When women dare to disclose their problems, many health workers tend to have gender biases, which lead them to either over-treat or under-treat women.’ (WHO, 1999).

However, there can be striking differences found in the patterns of mental illness:

- ‘Overall rates of psychiatric disorder are almost identical for men and women,’ (WHO, 1999).

The impact of psychosocial diversity needs to be more adequately addressed, because the gender stereotypes that talk about the proneness to emotional problems in women and alcohol problems in men:
- ‘Reinforce social stigma and constrain help seeking along stereotypical lines,’ (WHO, 1992).

These attitudes create barriers in the accurate diagnosis and treatment of women who present to psychiatric settings. In addressing and treating mental illness in women, it is important to take into account the gender-specific risk factors that are common and that disproportionately affect women. According to the World Health Organisation, these factors include gender-based violence, socioeconomic disadvantage, low income and income inequality, low and subordinate social status and rank and unremitting responsibility for the care of others.

Consumer participation
A relatively new emphasis within the mental health care service is that of consumer participation. Pleasingly, participation is now being viewed as an integral part of the approach to mental health care. Nathan & Greenfield state that consumer participation in the planning and development of health services has been adopted as an important strategy to improve health care processes and outcomes in Australia. So what is consumer participation? It can be basically defined as:

- ‘Community or individual involvement in the decision-making process’.

Such participation assists mental health care services to become more accountable and inclusive as well as being better informed about consumer needs. Principles of participation, according to Lynne include:

- trust, respect, openness, equal opportunity, advocacy and support, responsiveness, shared ownership, and dissemination and evaluation.

There are many stereotypes about being a woman; add a mental illness and the challenges can appear insurmountable. This article will look at the stereotypes surrounding women, how this gender bias can affect treatment for mental health issues and how consumer participation can break down barriers and empower women.

Stereotypes and women
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- A good wife knows her place!
In the past, consumer participation has been seen as a tedious but necessary process. However, many services have just gone through the motions of consumer participation. I agree with McLure and Kosky when they state that decisions have just gone through the motions of consumer participation. 

My experience with consumer participation

Consumers with their lived experience are in an excellent position to provide education, training, information and collaboration with health care providers. They are the experts on knowing their needs and how to get them met. As a consumer participant, I have a number of avenues to share my experiences, give my opinions and offer alternatives to treatment options. I am a member of a number of committees including the Consumer Advisory Group and Opinion Council, where the consumers form the majority and not the minority, as well as contributing to clinician training and roundtable discussions. I have been offered an opportunity to increase my confidence and feel empowered. This is a far cry from growing up around old stereotypes of being a woman.

I feel I have found my voice. I have stood up and been counted, listened to, and welcomed. My participation has not just been used as a formality. Consumers’ ideas have been utilised and accepted by clinicians as well as higher management. Clinicians have asked my opinion about my treatment and care plans. They have wanted to know what my goals for treatment are. According to Honye, it is argued that consumers and health workers need to work together to find creative ways of addressing concerns relating to power so that real power can be shared to benefit all consumers. This is where consumer participation can begin to address the power imbalance. Instead of consumers struggling to be heard, the: 

Power imbalance between health professionals who typically control the agenda and consumers, can be overcome and an equal opportunity system can be employed.

Conclusion

Women have been disempowered for far too long. It is very exciting that women with mental health issues can now address this power imbalance through consumer participation. The forum for consumer participation offers the opportunity for voices to be heard, respected and trusted and is a powerful domain where true service development and improvement can be achieved. It is through consumer participation that women can be empowered. They can:

- ‘Draw parallel lines between what they learnt in their external lives with what they learn through consumer role’.
- I hope that more and more consumers take the opportunity to participate and find new strength and power in the process.

References


I have bi-polar disorder and I am a recovering addict. This is my seventh year clean. My first admission to hospital was at the age of 19; my drug abuse began probably in my early teens but became serious by the age of 17.

Some of what I want to say is not only attached to mental illness, e.g. stuff about puberty—I was really lost at that time, I had poor self-esteem and a lot of insecurities. I started to smoke cigarettes and that had a big impact on me; it led to rebelliousness and rebellious friends that led to drinking and using drugs.

The first admission to hospital was for drug-induced psychosis; I went in there with a drug problem and I left with a mental illness. I was on strong anti-psychotic medication, which I reacted really badly to. So that journey began. I didn’t have a follow-up plan as I moved overseas and stopped the medication—I had no symptoms whatsoever—and took no drugs for quite some time. And then I really struggled with both of those issues for the next decade (addiction and mental illness) and I still did not have a correct diagnosis.

At 23 I became pregnant, with potential risks because it was unplanned. I was on medicine and using when I conceived but was really fitted and anxious to become a mum. I really thought this would be the big turn-around. I thought I can be this now, and I felt terrific throughout the pregnancy. I had a healthy, perfect son but this was followed by a huge postnatal psychosis and subsequent clinical depression and I started using drugs again on a psych ward. So I was then unable to care for my son but was able to have follow-up (post the hospital) in my area. I used services I hadn’t used before, even though I continued with difficulties (taking drugs) and with medication compliance.

During that time I was able to get an accurate diagnosis and finally able to explore dual diagnosis, the complexities of it and get help and support for both issues. During this time I did a full private rehab again and have been clean since then and I am on the right medication as well.

Through my involvement with services I was encouraged to join a committee of consumers, which was pivotal for me. What followed have been incredible opportunities to take part in various initiatives and join other committees that have been unique experiences for me. I was learning more and more and was beginning to foster a healthy self-esteem. I felt that having paid involvement in certain things made my experiences important.

I have often thought about taking on a career; that would be a HUGE effort in making up for wasted opportunities. I wanted to give something back to society... maybe change the world! I realise that I can do that by being around children, taking every opportunity to spend time with children, answering their questions and making sense of the world a bit before they take it over, and these are valuable contributions.

I am currently doing childcare and work on other advocacy initiatives and I am keen to work with children in the future, including my own son who is now with me for half the time.
Mothers: in sickness and in health

June Hopley,
Women’s Mental Health Project Worker, Bendigo Health

The guilt manifests with depression. Being involved and connected is a problem; you are in your own head a lot when you are depressed. It is difficult managing five children as a single parent.

Women’s perspectives on the pleasures of being a mother

Waking up in the morning, they keep me going; they give me the courage to do what I have to do sometimes.

I love my children they let me relive my childhood. They are my family, my blood; they give me a sense of coming home.

I wish I could have had more children but I had postnatal depression after each one and then bipolar and was put on lithium.

When the boys are not well, I don’t enjoy them being sick, but I do enjoy being there for them, not out drinking, at the pokies or with fellas. I get great pleasure in knowing I am there for them.

I like the bonding of breastfeeding. She laughs and smiles a lot and is cheeky. When the good stuff happens it makes up for the hard times. I like the responsibility of being a mother, being responsible for someone else takes time from me ruminating on myself.

As a mother, I look at my children as a gift. Their welfare is the most important part of being a mother, their welfare and happiness is a problem; you are in your own head a lot when you are depressed. It is difficult managing five children as a single parent.

...
I have been seeing a female private psychiatrist for nine years. She is very good. She said the main thing is that I am mothering my kids and I feel okay and if the house is dirty etc. it is okay just to shut the doors.

Most important is a supportive partner; someone else there on your side. You also need help with the guilt. Medication and pregnancy should be discussed. It is hard to get clear information about genetics and pharmacy.

Women who are of childbearing age and have psychosis should be given the opportunity to talk about their thoughts and feelings about pregnancy, birth and childbearing.

Be non-judgemental. Don’t be blaming and shaming women and their needs — the physical need was huge to have a child.

Services won’t help but will step in and take the kids; women need help before the crisis. They need a visit every two weeks to prevent the crisis, to encourage them, to open the curtains. Don’t leave things till they are too late.

It is nice to have the physical presence of someone when you feel like you want to die.

The right to parent should be discussed with all women of childbearing age with mental illness. If they don’t want to parent, that’s fine. In an ideal world, if the woman was well supported she could parent.

Thank you to the ten women who generously told their stories to increase awareness and understanding around the meaning of motherhood, experiences of parenting with a mental illness and accessing mental health services.

References

This qualitative study aimed to explore and understand why women who use crisis accommodation often follow patterns of moving in and out of such facilities. Their personal accounts were evaluated in order to discover what lead women to be in crisis accommodation, what stops them from achieving more secure accommodation and what they need to break this cycle. In-depth, semi-structured interviews were conducted with 14 women who were all currently residing in the Western suburbs of Melbourne. All of the participants were either current or past residents of a Supported Residential Service (SRS) or crisis accommodation facility in the Western suburbs of Melbourne. Using a phenomenological approach as described by Harrist (2006), themes were extracted from the data and arranged under each of the three research aims. The themes identified were representative of common ideas across the sample group. Quotations have been provided that exemplify these, with all names replaced with pseudonyms to ensure anonymity.

The majority of the women identified a relationship breakdown as the main antecedent to crisis accommodation, and financial difficulties as the main factor stopping them from achieving more secure accommodation. The women were able to identify the external structures they needed to break this cycle of homelessness, however, there was a significant lack of insight into the personal structures that may be hindering them.

There is a ‘changing face’ of homelessness in Australia (Robinson & Searby, 2006), and only of recent years has research emerged, which recognises that women form a significant subgroup within the homeless population; warranting a much-needed focus on the unique experiences of homeless women (Wesely & Wright, 2005).

The cycle of homelessness, which many women experience is ‘a complex trajectory of paths that may lead into, and out of, and back to, homelessness’, (Robinson & Searby, 2006, p.8).
Anecdotal evidence suggests that many people in crisis accommodation have a cycle of housing, involving supported, independent, and crisis accommodations, dispersed with bouts of homelessness and hospital stays. Empirical evidence has also revealed aspects of this cycle, showing that while some individuals experience transient episodes of homelessness in their lifetime, others remain homeless for an extended period of time or cycle in and out of homelessness (Breakey, 1997; Johnson, 2006).

In the past, the homeless population consisted of a fairly homogenous group of individuals, predominantly older, Caucasian men, many with alcohol dependency problems (Styron, Jarroff-Bulman, & Davidson, 2000). Using a combination of 2001 census data and information from the Supported Accommodation Assistance Program (SAAP), the National Data Collection Agency produced an illustration of the homeless population. It found that women made up 42 per cent of the homeless population, a substantial minority compared to 30 or 40 years ago (Chamberlain & MacKenzie, 2001).

This research involved a sample that represented women who are experiencing secondary and tertiary homelessness. Those experiencing secondary homelessness regularly move between forms of temporary shelter, including crisis accommodation facilities, refuges, boarding houses on an intermittent basis, and staying with friends or other families due to a lack of own accommodation. Crisis accommodation refers to facilities that provide short-term emergency accommodation. SRGs are accommodation facilities that provide specialist and personal care for people with complex needs (Maribyrnong City Council, 2001). However, some SRGs have developed into crisis accommodation facilities, with a high turnover of residents and homeless people (Kenny, 2003), in which case, the people staying in these facilities fall in to the category of secondary homelessness. Tertiary homelessness refers to those living in a boarding house on a medium- to long-term basis. The research aims were exploratory in nature and focused on the pattern of cycling in and out of crisis accommodation. The first research aim was to understand and educate the personal accounts of what had led women to be in crisis accommodation - what they identified as the factors that preceded their stay in crisis accommodation. The second research aim focused on what the women believed was stopping them from achieving more secure accommodation. The third research aim endeavoured to identify what the women needed to break this cycle of homelessness and to maintain more secure and permanent accommodation.

**The findings**

The women have had a variety of experiences in crisis accommodation, varying from a single occasion in such accommodation, to many years of experience in the cycle of homelessness. There were also many types of facilities involved in this cycle, including:

- foster homes
- children’s homes
- secure welfare facilities
- adolescent psychiatric wards and children’s corrections facilities as children
- women’s refuges
- caravan parks
- psychiatric wards
- SRGs
- boarding houses
- crisis accommodation
- ‘squats’ and ‘the streets’ as adults.

This supports prior research (Breakey, 1997; Johnson, 2006), which found that many individuals remain homeless for an extended period of time or cycle in and out of homelessness. Of striking significance within the findings, were the differences between what the women expressed directly and what they expressed indirectly. The women identified issues and difficulties they felt were important, however many more themes throughout these women’s lives emerged indirectly from the interviews. These themes will be outlined, followed by the findings, from the three research aims.

**Lifelong themes**

The themes shown here are by no means exhaustive of the difficulties these women experience; however they appear to be major themes within their lives. Those that arose were:

- family dysfunction
- relationship problems
- suicide and death of a loved one
- lack of adequate support
- perception of victimisation
- drug and alcohol misuse
- mental illness
- lack of education
- lack of employment
- socio-economic disadvantage
- involvement in violent or unsafe situations
- legal issues.

The majority of the women described family breakdown, in their own family and/or their family of origin:

- ‘Well, my Dad he’s a farmer in South Australia. Um, he’s been a farmer for 64 years. Um, I was actually taken away from him when I was a little girl. When I was five. My mother went in to an institution for the mentally insane, now she’s out.’ (Amelia, Transcript, p.35)
- ‘Many of the women spoke of having very few, if any friends or family to support them. Kelly described her inability to trust others: “I can’t trust anyone. I can’t even… I can’t trust anyone. You know? My bloke was murdered, by his best friend. I can’t trust anyone.” (Transcript, p.35)
- The majority of the women described the misuse of drugs and/or alcohol at some point in their lives. It was difficult to distinguish whether the drug and/or alcohol problems existed prior to being in crisis accommodation, arose through the experience of becoming homeless, or whilst living in crisis accommodation. Chloe describes her introduction to heroin, through her current partner whom she met as an inpatient of a psychiatric hospital and later whilst staying in a boarding house:
  - ‘Will came at me with a needle and said, “This is the best thing since sliced bread.” I said, “What is it?” He said, “Heroin.” He said, “Will it hurt?” He said, “It’ll hurt for a second and then you’ll feel wonderful.” And now I’m sorry I did it.” (Chloe, Transcript, p.65)
- Just over half of the women disclosed that they had been diagnosed with a mental illness. The women reported diagnoses of depression, schizophrenia, psychosis, anxiety, bi-polar, and borderline personality disorder.
When the women described their experiences and the context surrounding what led them to be in crisis accommodation, a variety of reasons and issues arose, which were as varied and unique as the women themselves. The reasons identified by the women as precedents to crisis accommodation included relationship breakdown, mental illness, alcohol issues, and housing crises.

Precedents to seeking crisis accommodation

When the women described their experiences and the context surrounding what led them to be in crisis accommodation, a variety of reasons and issues arose, which were as varied and unique as the women themselves. The reasons identified by the women as precedents to crisis accommodation included relationship breakdown, mental illness, alcohol issues, and housing crises.

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The majority of the women stated that financial difficulties were affecting their ability to achieve more secure accommodation: ‘Um, I’ve got bad credit rating. Um, young-uns … single parent… unemployeed, um, yeah that’s about it, yeah.’ (Kerry, Transcript, p.23)

Robyn described the difficulties and discrimination within the private rental market:

‘It’s hard to get a place when you just walk in there and they already don’t like you. Especially someone like me, I don’t look like the kind of person that would have a lot of money. They can just tell by the way I look, and I’m not that good at sort of talking and stuff.’ (Transcript, p.7)

Four of the women placed emphasis on ‘time’ allowing them to achieve secure accommodation:

‘Well, I’m in the top six of getting my priority housing. So, not much longer.’ (Amy, Transcript, p.12)

Robyn identified her work situation as being very closely tied in with her housing:

‘It’s more financial um, I worry about how am I going to get stuff like that.’ (Sophie, Transcript, p.15, 16)

However, there was also strong evidence of a foreshortened view of the future for some of these women, which only became more evident as ten years time was contemplated, with the overt expression that they may not be alive to see three months or ten years:

‘I could never see that for.’ (Lynn, Transcript, p.21)

‘I see myself in the streets. As an alcoholic… And just sleeping anywhere. And just deteriorating… That’s how I see my life.’ (Kelly, Transcript, p.34)

**Breaking the cycle**

Depending on what each individual woman was hoping and/or planning for in the future, they were all asked what they needed to achieve and sustain these goals. Those who were unable to see where they would be in the future, or didn’t see themselves alive, were asked what they felt they needed in order to change this. The women again appeared to have some difficulty in identifying what they needed. The majority of the women spoke about necessary external structures including:

- financial assistance
- more support
- employment
- ability to control their drug use
- education
- the need for accommodation.

Almost half of the women stated that they needed financial assistance, most of which was to be used for buying furniture and appliances:

‘Um, support to find and get furniture when I do get a transitional house…. Um… any support what I can really get, to sorta help me…. It’s more financial um, I worry about how am I going to get furniture? How am I going to get a washing machine? How am I going to get everything for the kids? When I live with the kids. Stuff like that.’ (Amelia, Transcript, p.45)

Four of the women identified needing more support to help them reach their goals:

‘I need some support. Someone that can help me, help my son.’ (Kelly, Transcript, p.36)

Some of the women stated the necessity of employment in their lives. For example, Robyn describes what she needs to do when the time comes, to achieve and sustain more secure accommodation:

‘Well, I’ve gotta find another way of earning money. Um, I’ve gotta control my addiction… Um, maybe I’ll need to sort out accommodation. I’m not sure.’ (Transcript, p.12)

Only two of the women identified working on internal structures to achieve their goals, and they spoke about having the ‘right’ attitude:

‘Persistence. Yeah, just that, I know it’s mine [the house], that I know what I’ve been through to get it, and I just want to full on keep it.’ (Amy, Transcript, p.26)

**Conclusion**

Of most interest within the findings was the discrepancy between what the women said directly and what they portrayed indirectly. When asked direct questions about what has led them to be in crisis accommodation, what may stop them from achieving more secure accommodation and what they need to break this cycle, the women were more likely to describe external structures such as education and financial management. These aspects are very important, however the interviews revealed a distinct lack of personal structures such as agency, self-confidence, self-esteem, and difficulties in relationships. This is significant because the majority of these women don’t appear to recognise the impact of these personal structures on their life situations.

Overall, the findings describe the experience of homelessness as another phase, or factor in these women’s lives. Their current accommodation didn’t stand out as the major crisis in their lives, it was one of the major crises in their lives. Furthermore, as was evident when looking into the future for these women, for some, the stress and trauma in their lives has become so chronic that they are unable to imagine how things could be any different.

**Acknowledgements**

Wesley Mission Melbourne - for their support of this research project. In particular, Sarah Pollock, for her assistance and guidance throughout this project.

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It’s my hormones, doctor, that caused my illness.’

A link between severe mental illness and changes in hormone status has been noted in many historical texts, in folklore and described intuitively by many women with mental illness. Yet little attention has been paid in a scientific manner to elucidate the facts about the noted link until the late 20th century. Beginning with a focus on women with schizophrenia, psychiatric research is finally exploring the link between gonadal hormones and mental state.

Biological research in schizophrenia prior to the 1990s largely excluded women from neuroendocrine studies, citing menstrual cycle changes as major confounding factors. Recognising the folly of excluding women from biological research, we have focused on the role of female hormones or functioning of the hypothalamic—pituitary—gonadal (HPG) axis in people with schizophrenia. One of the most compelling hypotheses needing translation to clinical practice is the ‘estrogen protection hypothesis’. The estrogen protection hypothesis essentially postulates that estrogen is an important neuroprotective agent and by its actions in the brain can protect against mental illness.

The estrogen protection hypothesis in schizophrenia

As coined by Hafner and colleagues, the estrogen protection hypothesis is described in two parts:

- In women, estrogen delays the onset of schizophrenia at an early age, thereby providing an explanation for the well validated finding that women are several years older than men at first admission for treatment of schizophrenia.
- Fading estrogen secretion at menopause in vulnerable women leads to relapse of schizophrenia symptoms or new, late onset, schizophrenia (Hafner 1991; Seeman 1990).

Hormone treatment: a new era for women’s mental health

Professor Jayashri Kulkarni,
Director, Alfred Psychiatry Research Centre

One of the most compelling hypotheses needing translation to clinical practice is the ‘estrogen protection hypothesis’. The estrogen protection hypothesis essentially postulates that estrogen is an important neuroprotective agent and by its actions in the brain can protect against mental illness.
There are three main areas of support for the estrogen hypothesis:

1. Evidence for a neuroprotective role for estrogen from animal studies

Many animal studies have demonstrated several neuroprotective effects of estrogens. The effects of estrogens are broadly classified into the slower, classical, intracellular ‘genomic’ and more rapid, direct, non-genomic actions (Mossehnan et al 1996). There are currently two recognised types of Estrogen Receptors (ER), α and β. It is suggested that ER β is more linked to cognitive and other higher brain functions, while ER α is related more to reproductive functions and less prevalent in the brain (McEwen and Alves 1999). Fink and colleagues (1998, 1999) have shown that estrogen induces a significant increase in serotonin receptors in humans that are associated with mental state, mood, cognition, memory, emotion, and neuroendocrine control. The precise mechanism of estrogen-serotonin interaction is not clear.

Dopamine and serotonin are key neurochemicals involved in the formation of the main symptoms of schizophrenia and estrogen has a protective action that appears to be mediated by central dopaminergic and serotoninergic mechanisms (Fink 1995).

2. Clinical support for a neuroprotective role for estrogen

Clinical support for the estrogen protection hypothesis comes from work done by Seeman et al (1990) showing that peri-menopausal women with schizophrenia required increased antipsychotic drug doses to maintain remission. This study strongly suggests that due to the declining estrogen levels in the peri-menopause and beyond, the ‘protective’ or ‘antipsychotic’ effect of estrogen is diminished, leading to the patient requiring a greater dose of antipsychotic medication to treat symptoms of schizophrenia. Reicher-Rossler (1994) showed that psychotic symptoms were worse in 32 women during the low estrogen phase of their menstrual cycles. This again suggests that higher circulating estradiol levels provide an ‘anti-psychotic’ effect for women with schizophrenia.

3. Epidemiological support for a neuroprotective role for estrogen

Epidemiological gender differences in schizophrenia have been reported for centuries. Knaepelin (1892) described a later age of first admission for women with schizophrenia compared with men. Angermeyer and Kuhn (1988) reviewed more than 50 studies that showed this same gender difference in the age of admission and onset of the first episode of schizophrenia. Hafer (2005) detailed his ABC study showing that in a population-based study of 232 first episode schizophrenia presentations, there was an early and steep increase in the age of schizophrenia onset in men between the ages of 15 and 25 years. In women, the rates of onset were less steep and had a broader age of onset between the ages of 15 and 30 plus a smaller, second peak in the age group of 45 to 50 years. This pattern of gender differences in the age of onset and admission for schizophrenia has been replicated worldwide in population studies such as the Danish Case Register (Loffler et al 1994).

Clinical trials of estrogen in schizophrenia

We have been conducting clinical trials using estrogen as a treatment for women with schizophrenia since 1994 and have done special dose finding plus delivery method studies. Our latest study has just been published in the Archives Of General Psychiatry (Kulkarni et al 2008). This was a ‘proof of concept’ study. In this 28-day, double-blind study, 102 women with schizophrenia were randomised to the active 100μg estradiol (a pure form of estrogen) skin patch treatment group (56 women) or an identical placebo patch group (46 women). All participants received antipsychotic drug treatment—according to a standardised protocol. Psychosis symptoms were assessed by using a well-validated and standardised scale—the PANSS rating scale—and blood hormone levels of estrogen, progesterone, prolactin, LH, and FSH were measured. A number of cognitive tests were also administered to assess and monitor higher intellectual functioning. The two groups—the estradiol 100-mcg adjunct group and placebo adjunct group were well matched in mean age, menstrual cycle phase, race, illness duration, or antipsychotic drug dose. The women who received the 100mcg estradiol adjunct made a significantly better recovery in their total, positive, negative and general symptoms of schizophrenia than the patients who received standard antipsychotic medication only. The women who received the estradiol skin patch also had better improvements in memory and other intellectual functioning when compared to the women who received placebo skin patch (Kulkarni et al 2008).

Summary of findings

From our clinical trials, we believe that adding estradiol to standard antipsychotic drug treatment is of use to improve the outcomes for women with schizophrenia. We found that in particular, women who had the onset of their illness in the postnatal period or with some other major hormone change made the best recoveries when estradiol was used. There are, of course, potential physical side effects to using estrogen treatments, such as clotting problems, breast and possibly other reproductive organ cancers that need careful monitoring if estrogen is used. We are currently testing the effectiveness of the new ‘brain estrogens’ (Selective Estrogen Receptor Modulators – SERMs) which do not have the same side effects as standard estrogens. If successful, the SERMs could be a great new, safe approach to treatment of mental illness.

Other hormone approaches to women’s mental health, deprivation and the pill

The combined oral contraceptive (COC) pill is a popular form of contraception and COCs are 99 per cent effective if taken correctly. Some 46.7 per cent of women aged 20-24 years use COC and 26.7 per cent of women aged 18-49 years use COC (Australian National Health Survey 1995).

COCs, the ‘pill’, contain both estrogen and progesterone. The usual form of estrogen is ethynylestradiol, but it is not clear which types of progesterone are markedly more depressive. To this end, we conducted a small pilot study in which we assessed depression a group of 30 women on a COC compared to 30 women not taking the COC. We found that the women who were on the COC were significantly more depressed than women not on the COC (Kulkarni, Lew 2006).

Clinically, many women describe ‘subclinical’ depression symptoms when taking the oral contraceptive pill. The main symptoms include irritability, loss of enjoyment in general, tearfulness, and change in appetite, loss of pleasure in sexual and other activities. Importantly, these symptoms are often noticed retrospectively, after the woman stops taking the pill for other reasons and then notes a lifting in mood within a few days. Typical comments made by women we have spoken with include:

‘I didn’t realise how depressed I was until I stopped taking the Pill… then I suddenly felt less irritable and angry’, and

‘On the pill, I felt a real rage… about nothing much at all’. Obviously, many women are happy while taking ‘the pill’ and do not experience depression. This fits with our observations that changes in hormone levels (estradiol and progesterone) affect some women more than others. There may be an inherited vulnerability to the response to altered hormone levels, partially explaining why some women suffer with premenstrual syndrome, or severe postnatal disorders, while other women do not.

We hope to complete a study listing the COCs in order of depressiveness so that general practitioners and women in our general community can make better informed decisions about which ‘pill’ will suit each individual woman. By gaining a better understanding of the impact of the hormone progesterone and its potential role in causing or worsening depression, can have a major effect on women’s mental health.

Depression and menopause

Until recently, mental state changes experienced by many women in the years leading up to the menopause, known as the peri-menopause, have been poorly understood and underestimated. The combination of changes in memory and depressive symptoms can greatly impact on some women’s quality of life. We now know that some women are very sensitive to changes in their hormone levels and this vulnerable group is prone to developing depression, bipolar disorder or even psychosis during times of hormone upheaval. Menopause is a time of great hormone change and can take up to ten years for the fluctuations in estrogen, progesterone and pituitary hormones to settle. Brain changes due to hormone impact can begin four to five years before the physical symptoms of menopause or cessation of menstrual periods occurs. Clearly, there are many social and psychological life changes that women experience
in the middle of their lives, but their capacity to deal with changes and enjoy life can be severely hampered by the hormone shifts that impact directly on the key brain chemicals related to depression.

It is very important to consider hormone treatments as well as standard treatments for depression in this group of women. Newer compounds that are safer than older hormone treatments with estrogen plus progesterone can improve depression for women with peri-menopausal depression.

Other areas of potential hormone treatment

Some women suffer dreadfully from depression as part of a premenstrual syndrome. This is an area where careful hormone modulation, in particular, balancing the up/down variations in estrogen and progesterone may lead to positive outcomes in mood. Postnatal depression and psychosis have not received enough attention with respect to developing hormone treatments—which seems odd, considering the stimulus to the onset of these disorders are the massive hormone shifts in the childbirth process. Hence, it would seem obvious to reverse the shifts of hormone swings that trigger postnatal mood disorders.

Eating disorders and certain personality disorders may also benefit from new thinking about their causes and treatments using a hormone shift hypothesis. Of course, hormone changes may not provide entire or even partial explanations for all mental illnesses in women. Using hormone treatments is not a global panacea, nor without side effects, but it is useful to ‘go back to the drawing board’ and reconsider new hypotheses in disorders where women and their families experience catastrophic consequences due to untreated mental illness.

Conclusion

Women experience mental illnesses differently to men for psychological, social and biological reasons. However, treatments for mental illness have largely remained ‘gender-blind’ and have disadvantaged women as a result. In considering the obvious hormone differences between the genders, we may have the key to opening up new understandings of mental illnesses in women and providing new avenues for treatment. There are also possibilities to modify and use hormone adjuncts that are successful in treating women with mental illness and use these modified hormone adjuncts in the treatment of men with psychiatric conditions. Women’s mental health is crying out for new understanding, new treatments and new services. Ironically, the pejorative comments about hormones and mental state changes that have been used against women for centuries may be turned upside down as we continue to show that estrogen modulation, in particular, balancing the up/down variations in estrogen and progesterone may lead to positive treatment of the new millennium for mental illness.

In 2006, the VWMHN invited women consumers and mental health service providers to complete brief surveys about their experiences of inpatient environments. Surveys of 75 women consumers and 42 mental health staff revealed that lack of safety and privacy were common experiences. A majority (61 per cent) of women consumers identified having personally experienced harassment or abuse during their times as inpatients…

Over the past two decades, the Victorian Women and Mental Health Network (VWMHN) has heard stories from many women mental health consumers about their experiences of being in mixed-sex psychiatric wards. The concerns these stories raise for women’s safety has prompted VWMHN to campaign for gender-sensitive facilities in psychiatric wards. This article describes this ongoing campaign and illustrates how supporting women to tell their stories and work towards positive change in the mental health system brings both challenges and rewards.

‘My name is Julie and I have been in the hospital system since 1982 with multiple admissions to a number of psychiatric inpatient units. Although the size and program of the hospital change, the issues of safety for female patients in mixed wards remains the same as it did nearly 22 years ago… Female patients often have to endure unwanted verbal aggression from male patients in the form of inappropriate sexual suggestions, insulting homophobic comments to gay women and physical/sexual threats and demands in relation to the female body and private space.’

The VWMHN was established in 1988 under the auspice of VICSERV to promote mental health policy and services that are more responsive to the needs of women. The organisation is open both to women service providers and consumers. The VWMHN first raised the issue of safety for women in psychiatric wards nearly ten years ago. In 1998, Speaking Out—a book of stories written by consumers about their experience of mental health services—was produced and identified ‘an urgent need’ to re-think the policy on mixed-sex wards that had been introduced in the 1960s. In 2005, VWMHN became convinced of the need for a project to ‘raise awareness of women’s experiences of mixed-sex psychiatric wards’.
The concerns included:
- The lack of privacy and safety for women inpatient units.
- The potential for women with past experience of abuse to be re-traumatised.
- The inappropriateness of a mixed-sex environment given that sexual discrimination is a common feature.

Julie recalls:
I first became involved with the VWMHN in September 2005 after giving a talk about my experiences in acute psychiatric inpatient units at the VWMHN’s Women on the Wards forum. Up to this point I had limited experience in public speaking; Needle to say, organising my thoughts on paper was no easy task, let alone speaking to a large group of people. However, with the encouragement of Wanda Bennett, Consumer Training Consultant, I gave it a go. This was to be the springboard for a new and more positive chapter in my life. My experience as a consumer now had a constructive value to it.

Collecting current evidence: consumer and service-provider surveys
In 2006, the VWMHN invited women consumers and mental health service providers to complete brief surveys about their experiences of inpatient environments. Surveys of 75 women consumers and 42 mental health staff revealed that lack of safety and privacy were common experiences. A majority (61 per cent) of women consumers identified having personally experienced harassment or abuse during their times as inpatients including:
- witnessing verbal/physical aggression,
- experiencing intimidation/harassment/ bullying by male patients,
- unwelcome sexual advances by male patients,
- males entering women’s bedrooms, and
- threatened and actual assault, including sexual assault.

Of the staff surveyed, 70 per cent acknowledged that harassment/abuse occurs in psychiatric wards with 30 per cent estimating this occurs ‘frequently or very frequently’. These figures are especially alarming given the high prevalence of women who have histories of past abuse. Goodman et al (2001) found that 68 per cent of women with severe mental illness had a history of sexual assault.

Postcard campaign
The VWMHN’s next step in raising awareness of these issues was a postcard campaign utilizing an image created by artist and consumer activist, Sue Armstrong. In total, 4,500 postcards—addressed to the Minister for Health and calling for more separate sleeping areas for women and men in inpatient units—were printed and distributed to psychiatric disability, women’s health and sexual assault services. The campaign created the impetus for a meeting with Bronwyn Pike, then Minister for Health, at which she agreed to fund a Mental Health Branch project to develop guidelines to ‘improve gender sensitivity and safety in adult inpatient units’. On the Advisory Committee that was established to oversee this project, both the convenor and a consumer member represented the VWMHN.

Listening to women’s stories
In 2007, drawing on a strategy utilised in the United Kingdom, the VWMHN organised Listening Events to provide women consumers with the opportunity to speak in a supportive environment about what contributed to feelings of safety or lack of safety during times they needed to be in hospital. These events were organised in collaboration with local psychiatric disability rehabilitation support services (PDRSS) and were held in areas where expansion to existing psychiatric wards is planned with a view to raising awareness of the need for more gender-sensitive designs.

Some 65 women consumers attended the five Listening Events. Key issues raised by women included:
- the impact of ward design,
- responsiveness of staff,
- safety and privacy issues including, at times, witnessing or experiencing harassment,
- high dependency and seclusion experiences, and
- the needs of women who have experienced previous physical or sexual abuse.

Women who participated in the Listening Events commented that they appreciated the chance to speak about incidents and experiences that they felt had been previously dismissed or ignored. By also focusing on what could create greater feelings of safety in the wards, the Listening Events gave women the opportunity to make suggestions for positive changes that would improve inpatient care for women. Through this process each woman’s experience and knowledge was validated with the result that women felt their opinions were valued.

Women’s narratives of their inpatient experiences illustrated by their powerful artwork have been documented in a compelling report Nowhere to be Safe which was launched at this year’s Victorian Psychiatric Services (VCSERV) conference ‘Joining the Dots… Creating Community’. The report has prompted significant media interest in the issue of lack of safety for women inpatient wards as well as interest by the Ombudsman and Office of the Public Advocate.

As Julie notes:
‘By talking to other women about my personal hospital horror stories at the beginning of our Listening Events, I think the women attending felt more able to open up about what had happened to them in hospital. A number of surprisingly positive things arose from this process of expression and empowerment such as:
- being able to meet with and bond with other women,
- sharing a refreshing and inspiring catharsis from such honest, upfront and passionate discourse,
- the courage of women to talk about issues they had not felt supported or safe to discuss up to this point, and
- working with women in their local areas to raise awareness and improve services.

In Geelong, the first step was to meet and talk together at the Listening Event. We then created postcards to express our feelings in a pictorial way. The issues women had raised were then fed back to local area management, with a further presentation to staff at hospital by the VWMHN representatives and a local consumer. Finally, the postcards were framed and will be displayed in the newly-created Family Lounge in the ward to raise awareness of the difficulties experienced by women patients and women’s suggestions for improving safety on the ward.’

Using women’s stories to make things better
The VWMHN has also used the information shared by women at other Listening Events to lobby mental health services to make conditions on wards more sensitive to the needs of women. In the Eastern region, representatives of the VWMHN and local PDRSS staff met with the Director of Mental Health Services to pass on the concerns that women had raised. As a result, an eight-bed women’s only area (with its own lounge area) has been established in the new psychiatric ward at Maroondah Hospital, which opened earlier this year, and a similar gender-specific provision is planned for second part of this facility. In the Northern region, feedback from the women’s Listening Event has also been incorporated in designs for the new ward currently being planned.

The major issues raised by women have also been taken into account in the recommendations of the DHS Mental Health Branch report. The gender sensitivity and safety in adult acute inpatient units project. Of particular significance is the inclusion of a recommendation that the Department of Human Services (DHHS) should adopt a policy of providing choice for patients to be treated in single-sex environments and that this policy should be incorporated into the acute inpatient unit design guidelines as well as creatively implemented within existing wards through developing female-only wings. The MBH and the Office of the Chief Psychologist will also be developing clinical guidelines regarding preventing sexual activity and promoting sexual safety in inpatient units.

Reflecting on her involvement with the VWMHN, Julie identifies both high and lows:
Many doors have been opened for me by being given an opportunity to talk to decision makers such as previous Minister for Health, Bronwyn Pike, Director of Mental Health Branch, as well as attending numerous other forums involved in policy making. However there have also been some ‘downlights’ in my journey through the psychiatric jungle. At certain meetings with staff there were a number of tense moments when trying to relate women’s experiences. The staff could become very defensive finding our message quite confronting. We were not trying to hang them out to dry. The testimonials from women had a truth and power about them that spoke for themselves. Yet sometimes the staff reaction was to glaze over in the eyes and steel the jaw line. I still don’t understand this—they are the ones who can dictate what happens on the wards.

At one particular forum, the audience of clinicians felt quite hostile and the small panel of pro-consumer speakers was cut short. My mental health really deteriorated after this for several months as, once again, I felt ineffectual in the face of, at times, a draconian system. The impact of how momentous a change
is needed, how far reaching and how long things have remained unchanged for gender-sensitive issues can cause feelings of great disillusionment and grief. But thanks to continued interaction with helpful staff, the opportunity to participate in the WWMHN and the ongoing courage and endurance of women patients in such a psychiatric system, my outrage becomes determination. The level of dedication of the workers who do care and want to make a difference gives hope and is an inspiration to the present dark reality faced by many women in inpatient units.

Where to from here?
The WWMHN is committed to working with women consumers and service providers to promote mental health services that are responsive to the needs of women, in particular, to advocate for improvements in inpatient environments for women. A recent grant from the Mental Health Council of Australia will enable the Network to undertake further information gathering and education in relation to the promotion of the gender-sensitivity in inpatient environments. During the next twelve months, further liaison with the Mental Health Branch of DHS and with area mental health services is planned as well as continued participation in the Victorian Mental Illness Awareness Council’s ‘Women’s Safety Project’.

Julie’s hopes for the future include:
What would now be helpful would be to have a dedicated Women’s Advocate in the mental health system. To instigate and uphold women’s rights in mental health we need our own watchdog over a system that is resilient to change and hard to hold accountable. Finally, my own mental health and confidence overall has taken a giant leap forward from being involved with the people in this process. I think the combination of worker and consumer involvement has been very effective in cross-networking, support and insight for all those involved."

OPINION PIECES

You can purchase the Nowhere to be Safe report from the VICSERV bookshop by phone 03 9519 7000 or email resourcecentre@vicserv.org.au

The gender sensitivity and safety in adult acute inpatient units project can be downloaded from this website http://www.health.vic.gov.au/mentalhealth/publications/pubs.htm

References

FIND OUT MORE. You can contact the Victorian Women and Mental Health Network (WWMHN) by visiting www.vicserv.org.au
Postnatal depression: the costs for mothers and babies

Belinda Horton, CEO, Post and Antenatal Depression Association (PANDA)

It is time for postnatal depression to be taken seriously and be afforded the attention and support that is given to other mental illnesses that dominate the mental health sector and budgets. There can be no telling which woman with postnatal depression is going to be a suicide statistic but each year five to six Australian women succeed and many more try.

Women with postnatal depression are silenced by their own and society’s expectations. Of the 77,000 women who gave birth in Victoria in 2007, approximately 11,550 women were diagnosed with postnatal depression (extrapolation using 15 per cent) and 7,700 men (extrapolation using ten per cent). Over 150 women will experience postpartum psychosis with rates of infanticide and suicide difficult to quantify. These numbers do not include the men and women who hide their depression so could be significantly higher. It is time for postnatal depression to be taken seriously and be afforded the attention and support that is given to other mental illnesses that dominate the mental health sector and budgets. There can be no telling which woman with postnatal depression is going to be a suicide statistic but each year five to six Australian women succeed and many more try.

There is huge diversity in how seriously postnatal depression is taken in mental health and broader health sectors. There are members of these sectors who respond with skill. However, many women have felt their distress and terror to be dismissed by well meaning but ignorant health professionals:

- ‘Have a break from your baby’.
- ‘Try to get some sleep’.
- ‘See how you feel over the next three weeks, came back then’.

These are commonplace responses to women’s tentative and frightened efforts to communicate the depth of their distress and depression. Too often postnatal depression is dismissed as a natural consequence of having a baby. What makes postnatal depression such a costly paradox is that women are reluctant to talk about their very dark and dangerous thoughts. Unlike other mental illnesses, postnatal depression occurs at the same time as events that also bring many societal and cultural expectations for behaviour, emotions and transition.

Pregnancy and childbirth are seen by all societies as times of joy, celebration and gratitude. A good mother does not feel sadness, grief or depression. There is little room for the anxious, angry, frightened and tormented mother who can’t put into words her terrifying life.

This article draws on the lived experiences of women and their families, captured throughout the Post and Antenatal Depression Association’s (PANDA) 25 years of support groups and helpline services in an attempt to raise the status of postnatal depression as a critical and serious mental illness. It focuses on the costs of postnatal depression if underidentified and inadequately treated and the risks for the wellbeing of the mother, baby and ultimately families.

Post and antenatal depression association

PANDA was established in the early 1980s and provided telephone support 24 hours per day and support groups around Victoria until the late 1990s when it was reviewed and restructured. Since 2000, PANDA has provided helpline and web-based services to Victoria, and increasingly nationally, with a statewide database of specialised services and practitioners and by providing referrals for ongoing interventions and support that are vital for recovery. Over 2,500 new calls for support are received each year with more than this number of calls provided for follow up. True to its early roots of sharing the lived experience of postnatal depression, the staff and volunteers have been touched personally or through family/friends by postnatal depression. Not only is this proof of recovery for callers but it is also a powerful way to reduce the stigma of postnatal depression and encourage callers to talk about it.

Postnatal depression

In current diagnostic literature the spectrum of perinatal depression is not separately identified. Postnatal depression is defined in the DSM IV (1) as major unipolar depression with the temporal specifier of the onset of symptoms within four weeks of childbirth (see Table 1). There is increasing understanding of the link between depression during pregnancy (antenatal depression) and after the birth. Antenatal depression is often harder to identify (ten per cent) as different from the normal discomforts during pregnancy. Postnatal depression is not the ‘baby blues’, which for 80 per cent of new mothers could be argued as a normal and healthy emotional catharsis: three to ten days after childbirth. Unresolved baby blues may slide into postnatal depression.

At the other end of the spectrum is postpartum psychosis, a rare (0.1 to 0.2 per cent) and medical emergency for women who experience delusions and hallucinations. Onset is often rapid within the early weeks after having the baby. Women need to be hospitalised to prevent suicide, self-harm or death of the baby or other children. Media contributes to society’s misunderstanding that postnatal depression is the cause of such tragic outcomes rather than postpartum psychosis. Because we harshly judge mothers who harm their babies, the misrepresentation of postpartum psychosis as postnatal depression further silences women.

Around 15 to 20 per cent of new mothers and ten per cent of new fathers are diagnosed with postnatal depression. It will mean different things to each person but usually includes symptoms that last for more than two weeks. They develop either suddenly or gradually, during pregnancy or within the first twelve months of the baby’s life. Diagnosis may not occur for another year or two if the woman does not seek help. Postnatal depression can make the new mother feel that she is not in control or coping with her baby and that she is not a good mother. It is normal for all mothers to feel anxious, tired or down at different times when they have a new baby, especially in the early days, but postnatal depression lasts longer and can be harder to explain. It can be very difficult for new parents to distinguish between early transition and postnatal depression.
Postnatal depression is not identified and treated. The human strength it takes to hide postnatal depression from family and friends for many months and sometimes years is very strong silencers. Depression is also a silencer – it can be because they feel they should be able to cope. The woman's own intuition and their support networks. It takes time for women – what factors have contributed to the symptoms in each area and what is required to address and support her recovery in each area. Without this holistic approach to interventions and support her recovery will be incomplete.

Biopsychosocial model of postnatal depression

There is not a single cause of postnatal depression but there are a number of things that combine to contribute to its development. Hormonal and chemical changes in the body and brain after childbirth are thought to play a part but it is not usually that simple. Other stress factors such as a demanding baby, lack of sleep and a difficult delivery may be part of it, as well as a previous mental illness, isolation, lack of support, childhood abuse and a difficult relationship with her partner or her own mother.

It is important to maintain an overview of the biological, psychological (spiritual) and social (cultural) wellbeing of the woman – what factors have contributed to the symptoms in each area and what is required to address and support her recovery in each area. Without this holistic approach to interventions and support her recovery will be incomplete.

Modern mothering

Modern mothering is at the heart of the stories of many women who experience postnatal depression and their families. Early discharge from hospital, high expectations of the ‘super mother’, lack of extended family support and exhausting isolation have broken down nature's requirement that women heal and rebuild following giving birth. There is no respite from modern life for the new mother and father – worries about finances, relationships and meeting expectations wait for them on their arrival home. Multiple and complex stresses like family, violence, drugs and alcohol, homelessness and chronic illness provide little room for the mother, father and baby to connect. Messages are subtly conveyed to women that doctors, nurses, medical systems and books are the experts that hold the answers to questions about their baby and mothering. Full-time work and limited community involvement before pregnancy are disconnecting women from each other, their own intuition and their support networks. It takes time for new parents to connect with their baby and settle into the changes in their lives but if they are not supported and they are looking outside themselves for answers this process is made more difficult.

Costs for mothers

The word ‘depression’ alludes to feelings and emotions. Unless personally experienced it is hard to imagine the incredible impact of depression on cognition – the ability to think. Regardless of which comes first, thoughts or depression, postnatal depression crowds the brains of women with circular, obsessive and paralyzing thoughts. Constant thoughts about the baby waking, sleeping, feeding, surviving, or dying, make it difficult to be responsive to the baby or to problem solve. Focus, concentration, memory and taking in new information are made very difficult by postnatal depression and yet these skills are important for women as they learn the skills of mothering and about the needs of their baby. Depression kills sensory lives – visual, tactile and auditory interactions that learning self-regulation requires. Inadequate self-regulation is the key issue in Attention Deficit and Hyperactivity Disorder (ADHD) that strengthens the link between unresolved postnatal depression and the presentation of ADHD during the primary years.

Costs for babies

Optimal parental care provides important scaffolding to support the baby and foster development. It requires the parent to be responsive and sensitive to the baby, mirroring the baby’s communication, being emotionally available, and structuring and mediating the baby’s environment. Postnatal depression can interfere in the mother and baby relationship and there are costs to the baby’s wellbeing and future development. While all women with postnatal depression want to love and do their best for their baby despite how they feel, many parents robotically and dutifully. The genuine and intimate melding of mother and baby is undermined. The reordering of the woman’s focus to pay attention to the needs of her baby is not fully achieved as she deals with her own chaos and exhaustion. If a baby is exposed to high levels of stress through their mother, man carer, or environment, it can result in suppression of the immune system and feedback to the brain that sets the baby’s reactivity and regulation of the stress system. It is important for parents to buffer the baby’s exposure and responses to stressors.

The wellbeing of the baby can be a significant cost of postnatal depression for the following reasons:

• Brain development - the development of the cortex area of the brain is hindered if a baby has less than optimal experiences during the critical periods of development.

• Self-regulation - learning to manage impulses and to regulate the self starts from birth are the cornerstones of development. A depressed parent may struggle to provide the consistency and predictability of the environment and interactions that learning self-regulation requires. Inadequate self-regulation is the key issue in Attention Deficit and Hyperactivity Disorder (ADHD) that strengthens the link between unresolved postnatal depression and the presentation of ADHD during the primary years.

• Touch interaction - a parent who is depressed may struggle to become physically involved with the baby at the level that nurtures the baby’s development. Touching her infant in the nurturing and intimate way a baby needs is also very important for a mother to develop effective maternal behaviors. If a mother is less able to touch her baby, she is less confident in her role as a parent and the development of her relationship with her baby is delayed.

Table 1: DSM IV criteria for postnatal depression

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<thead>
<tr>
<th>Symptom</th>
<th>DSM IV Criteria</th>
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<tr>
<td>Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful).</td>
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<tr>
<td>Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).</td>
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<tr>
<td>Significant weight loss when not dieting or weight gain (e.g. change of more than five per cent of body weight in a month), or decrease in increase in appetite nearly every day.</td>
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<tr>
<td>Insomnia or hypersomnia nearly every day.</td>
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<tr>
<td>Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self reproach or guilt about being sick).</td>
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<tr>
<td>Diminished ability to think or concentrate, or indecisiveness nearly every day (either by subjective account or observed by others).</td>
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<tr>
<td>Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, a suicide attempt or a specific plan for committing suicide.</td>
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The need to re-establish female-only psychiatric wards

Many female consumers expressed the concern that while they knew that they had been assaulted and their rights had been abused, the fact that they had a psychiatric disability worked against them.

Most people outside the mental health sector are horrified to learn that psychiatric wards in the public system in Victoria are mixed sex. In the mental health sector we have become used to mixed-sex wards and services. But it was not always the case. When and why did we change from female-only psychiatric wards to mixed-sex psychiatric wards?

As Valerie Gerrand explains in The Patient Majority: Mental Health Policy and Services for Women:

‘Obviously the monograph draws extensively on relevant research, available statistical data, reports on service initiatives and policy documents. It is also influenced by my experiences as a practitioner, researcher and manager in the mental health field, not all of which I remember with pride. For example, I was one of those who accepted the move to integrate wards in psychiatric hospitals in the late 1960s. This change was largely justified on the grounds that it would improve the social behaviour of the male patients, but was one which exposed the female patients to a much greater risk of sexual harassment and exploitation, let alone the usual difficulties women face in having their needs recognised in mixed-sex environments.’

Surely it begs the question: why should females be expected to be responsible for males’ behaviour and wellbeing? We have enough problems of our own to deal with when ill. Indeed, as far back as the Burdekin Report in 1993 it was acknowledged:

‘Women are the most frequent users of mental health services in Australia, yet these services and the legislation which governs them generally fail to recognise the special needs of women.’

‘The Inquiry heard disturbingly frequent allegations about sexual assault of women inpatients, who sometimes find themselves in non-segregated areas where they are particularly vulnerable.’

Women are subject to sexual harassment and abuse from male patients and staff within these [mixed] units. When they complain to staff, women are ignored, blamed, not believed or told not to worry about it. For example, a young woman who had been sexually abused in the past complained to staff when a male patient continually masturbated in front of her. She was told not to worry about it. For example, a young woman who had been sexually abused in the past complained to staff when a male patient continually masturbated in front of her. She was

References


Since 1995, there have been many calls for the re-establishment of female-only psychiatric wards to ensure the safety of women. Psychiatric facilities need to adopt better measures to address the specific needs of female patients, particularly those with psychiatric disabilities. In addition to allegations concerning misdiagnosis and maltreatment of women inpatient, the Inquiry heard evidence of violence and sexual abuse and the development of affective disorders such as depression and posttraumatic stress disorder. Many female consumers expressed the concern that while they knew that they had been assaulted and their rights had been abused, the fact that they had a psychiatric disability worked against them:

‘I thought that if I complained they’d just say I was mad anyway and they wouldn’t believe me’.

In addition to allegations concerning misdiagnosis and maltreatment of women inpatients, the Inquiry heard evidence of violence and sexual abuse and the development of affective disorders such as depression and posttraumatic stress disorder. In 1995 the Inquiry was reconvened and the following recommendation was made:

‘Major psychiatric facilities should establish women-only wards for vulnerable female patients in hospital. Psychiatric facilities should adopt better measures to ensure the safety of women in mixed-sex wards, including effective complaint mechanisms, staff training and, where appropriate, referral to police.’

Since 1995, there have been many calls for the re-establishment of female-only wards so that females can have a choice of female-only or mixed-sex psychiatric wards. For example, in 1997, the Victorian Mental Health Branch produced Tailoring Services to Meet the Needs of Women. The document explored the issues impacting on women using public mental health services and promoted ideas, strategies and examples of good practice to assist in improving service responses. In particular, the document highlighted the importance of raising the awareness of all staff and pursuing training and service development opportunities to ensure the service system, as a whole, provides better services to women.

Of significant interest, the report noted: ‘It is also critical to acknowledge that a woman’s ethnic and cultural background will impact not only on her mental health, but also on her experience of the mental health service system. Services need to respond in a manner sensitive to cultural norms and understandings. For example, in some cultures it will be considered inappropriate for a woman to reside in a mixed-gender ward or to be seen at home by male staff. Services should be aware of these different cultural beliefs and ensure that their practice does not inadvertently exclude women from particular backgrounds from using services.’

Incidentally, Tailoring Services to Meet the Needs of Women is still current policy. It might seem that such a reference is out of date. But unfortunately, in Victoria, we keep reinventing the wheel when it comes to female mental health issues. That said, two current initiatives bode well for the future:

- The gender sensitivity and safety in adult acute inpatient units project
  The Mental Health Branch of the Victorian Government Department of Human Services has undertaken a specific project to consider gender sensitivity and safety in adult acute mental health inpatient units. The project is scheduled to run over a twelve-month period. The gender sensitivity and safety in adult acute mental health inpatient units project was completed in December 2007.

- Building partnerships between mental health services, family violence and sexual assault services
  This 2006 project established levels of collaboration between those sectors across Victoria. It provides recommendations for the three sectors to work towards greater levels of collaborations between service sectors, and to ultimately improve the quality of service for those clients with a mental illness who have experienced family violence and/or sexual abuse no matter which sector they make contact with.

For up-to-date accounts from females about their experiences in acute psychiatric wards, I recommend the 2007 Victorian Women and Mental Health Network project report NextWear to be safe: Women’s experiences of mixed-sex psychiatric wards.
Dear Editor,

Recently, we, Valerie Gerrand and Janice Chesters, have both written about Prevention and Recovery Care Services (PARCS) in *new paradigm*, including responding to each other’s observations about this new type of service in Victoria. Then we met up at the May VICSERV conference—Joining the Dots… Creating Community—and realised our views of PARCS overlapped as well as differed. So this time around, we are providing a joint letter.

In this letter, we focus on particular points in order to further debate the development of PARCS. We use our initials to identify where our views differ. We both agree that a particular facility in itself cannot guarantee good outcomes for all those who use it. So PARCS are not a solution for everyone.

Arguably however, there are certain elements, which if in place, mean that PARCS are more likely to provide a positive experience for most consumers needing such a service.

First of all, for a PARC service to be effective, adequate funding, design and fit-out are necessary pre-conditions. We will say more on design shortly. Other ingredients are less tangible but equally critical, as they directly influence consumer experiences. A recovery-oriented model of care must be embedded in how and what is provided, with staff whose experience, skills and attitudes fit them for this type of work. Furthermore, provision of regular in-service training and support is essential. Consumer involvement in the development and operation of PARCS is another key element. Staff and consumer accounts in the Summer 2007/2008 edition of *new paradigm* attest to the importance of these ingredients. However, the extent to which they are part of PARCS already established, as well as those being developed, remains a matter for investigation.

Both of us share a commitment to PARCS being available across the state, rather than only in some geographical areas. For someone experiencing early stages of an acute episode, a PARCS can provide an alternative to either hospital admission or staying in current living arrangements. Additionally, it can offer a period of transition following hospitalisation. These ‘step-up’ and ‘step-down’ functions are particularly important for people who lack daily support through living alone or for other reasons. Anecdotal accounts indicate, however, that PARCS are largely being used as step-down facilities for patients discharged from acute inpatient units, which limits their contribution to averting unnecessary admission. The recently released Victorian *Because Mental Health Matters* consultation paper proposes that the step-up function of PARCS be enhanced, indicating this imbalance has been noted (p75).

Now we turn to points of difference. Even though a facility in itself cannot ensure good outcomes, VG contends that particular design features are more conducive to positive consumer experiences than others, even though the hard evidence may be lacking. Size is one such feature. Commonsense suggests that if a residential facility has more than about ten people, it becomes harder for staff to recognise and appreciate individual differences, let alone respond to individual needs. So the relatively small size of PARCS is important.

Facility design should enable at least a modicum of privacy. Single bedrooms and en suite bathrooms are two examples of how privacy can be enhanced. Conversely, shared living spaces can foster a sense of communal living both between the residents, and also between staff and residents. A ‘homelike’ environment can help in maintaining everyday living skills. Consumers also frequently refer to the importance of ready access to outdoor areas for general relaxation and most,
if not all, the PARCS already established have a garden. 
Lastly, PARCS that are deliberately located in ordinary 
suburban streets rather than on a hospital campus, at least 
in theory, promotes rather than hinders social inclusion. 
Again, the extent to which PARCS meet these features 
and their impact warrants examination.

JC partly agrees but has some concerns with the concept 
of ‘homelike’. There are significant cultural and sub-cultural 
differences in what constitutes the emotion of feeling ‘at 
home’. For example, JC’s understanding about how clean, 
quiet and warm the ‘home’ should be, or even what food 
should be eaten there may make others feel decidedly 
uncomfortable. Also, she might have strong ideas of an 
appropriate division of labor that others—such as traditional 
males—from a number of cultural groups, may disagree with. 
These men may be very uncomfortable in a middle class Anglo 
Celtic service that encourages everyone to undertake ‘home’ 
duties and contribute to cooking and cleaning work. Small 
units that have strict rules about the ‘way we do things here’ 
can produce anxiety, resistance and anger in clients who have 
different world views, but nowhere to avoid the service’s 
and their impact warrants examination.

To conclude, both of us would welcome a comprehensive 
evaluation of PARCS and their effectiveness, including which 
consumers benefit most and why. Such an evaluation should 
compass elements already identified in this letter. In 
addition, not all AMHS have a PARCS, so a comparison of acute inpatient use across AMHS 
with and without a PARCS would be instructive. The Summer 
2007/2008 edition of newparadigm, with staff reports on 
how their PARCS have been developed, and accounts by 
individual consumers of their experience, provides a rich 
source of material to inform such an evaluation.

Associate Professor Janice Chesters is an academic with a 
research interest in mental health services. She also chairs the 
Board of a PDRSS. Dr. Chesters’ opinions that are expressed 
in this letter are not intended to represent the opinions of 
her PARCS have been developed, and accounts by 
individual consumers of their experience, provides a rich 
source of material to inform such an evaluation.

Dr. Valerie Gerrand is an independent consultant with a 
background in mental health policy, service management and 
development, professional education and social work practice 
in community mental health and institutional settings.

Hanover is committed to the continuation of a gender-
specific approach to homelessness and the differing 
needs of single women without children in their care. 
It is important that women are viewed as individuals 
within the context of their experience of homelessness.

**Member Profile: Hanover East St Kilda – Women’s Service (HES)**

**Tracey O’Donnell, Coordinator**
**Eloise Tregonnig, Assistant Manager**
Hanover East St Kilda – Women’s Service (HES)

Hanover is committed to the continuation of a gender-
specific approach to homelessness and the differing 
needs of single women without children in their care. 
It is important that women are viewed as individuals 
within the context of their experience of homelessness.

Why does HES exist and who do you mainly work 
with and assist?

Established in 1995, HES evolved in recognition that women 
experiencing homelessness are often vulnerable in mixed-
gender accommodation settings and that there are limited 
housing services—both accommodation and support 
services—for adult women without children in their care. 
HES is one of only two services in Victoria of its kind.

HES engages women in a number of ways:

- we support women living in transitional 
  housing and manipulate of mixed- 
  gender accommodation settings and that there are limited 
  housing services—both accommodation and support 
  services—for adult women without children in their care. 
  HES is one of only two services in Victoria of its kind.

HES has a fifteen-bed, women’s only crisis accommodation 
service, and women need to be 18 years of age or over, 
without children in their care, to access this service. HES 
also supports women over the age of 25 who are living in 
the community in transitional, medium-term and long-term 
housing. HES supports women to access long-term safe, 
appropriate and affordable housing and to explore and address 
issues contributing to women experiencing homelessness.

What are some of the services or programs HES offers?

- women living in transitional housing in the community.
  The nature of the support HES provides is reflective of the 
  needs of women we are working with in terms of length and 
  frequency of support and referrals made. In order to address 
  the issue of homelessness, HES works holistically by looking at 
  the intersection of different experiences and issues in women’s 
  lives and how these intersect with their experience of 
  homelessness, trauma, family and domestic violence, sexual 
  assault, drug and alcohol use, mental and physical health.
Can you highlight changes and developments in the way HES operates as an organisation?

Hanover is structured into client-specific portfolios; HES is within the Women, Youth, Families and Children portfolio. This structure recognises that there are significant issues pertaining to women’s experience of homelessness. The portfolio structure allows for more of an emphasis on a gender-specific perspective of homelessness.

HES has recently shifted its crisis accommodation from a three-month to a six-week crisis stay. Our practice and service continues to evolve in response to the needs of the women accessing the service. Over recent years, there has been a significant increase in working with women asylum seekers and refugees and this is an example of how practice has needed to evolve in order to meet the needs of particular client groups.

What are some of the new initiatives or highlights of HES?

We are in the process of establishing wellbeing and relationship groups with the women living in a local women’s only rooming house. These groups are co-facilitated in partnership with Good Shepherd and will involve creating a sense of community within the rooming house. HES is also a partner in the Women’s Housing and Complex Needs Project, which resulted in the establishment of an Intensive Case Manager to work across different organisations in Melbourne’s Inner South to support women presenting with complex needs.

Does HES have any future directions?

Hanover is committed to the continuation of a gender-specific approach to homelessness and the differing needs of single women without children in their care. It is important that women are viewed as individuals within the context of their experience of homelessness. For women who have children, but for whatever reason their children are currently temporarily out of their care, Hanover’s portfolio approach allows for ease in the transition back to forming a family again.

Future responses entail a view to further explore women’s engagement into community participation beyond their experience of homelessness, with a focus on how they can engage as members of their community in meaningful ways.

Lisa Appignanesi is a biographer, cultural theorist and writer of fiction who grew up in Europe and Canada and is now based in London. This book, published in 2008 by Virago Press, ‘is the story of madness, badness and sadness and the ways in which we have understood them over the last two hundred years’. Appignanesi is concerned with two things: firstly ‘how the dividing lines between [these states] have been conceived and patrolled’; and secondly, how ‘these states of mind and being’ have been experienced by women.

Appignanesi is critical of current understandings of madness, that have ‘medicalised unhappiness’ to such an extent that ‘many aspects of our lives... have ended up within the terrain of the mind doctors when they might more aptly belong in a social or political sphere either of action or of interpretation’. She proposes a historical consideration of understandings of madness as a corrective for this view.

The work is identified by its author as being of a ‘blurred genre’ that draws on sources from various disciplines but is itself none of these. Its aim is to use the study of specific cases to ‘tease out the intersections and interactions of culture, psychiatric practice and illness in a given historical moment’. The body of the book consists of case studies of particular women who have been identified and treated as mad, juxtaposed with accounts of the development of the theories and treatments employed by the ‘mind doctors’ who treated them.

The book is presented over three sections: the first considers the 1800s, the second covers the first half of the 20th century, and the third looks at the period from 1960 to the present. Within these sections the narrative is shaped around themes such as asylums, nerves, hysteria, sleep, sex, love, body and abuse. Whereas early chapters focus on events in England and Europe, later chapters consider the evolution of psychiatry as a profession in the United States, the development and successive iterations of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as
a taxonomy for diagnosis, and the advent and proliferation of drug therapies (and to a lesser extent, of cognitive behavioural therapy) as treatments of choice.

In declining to locate the work within the boundaries of a particular discipline, Appignanesi expresses her confidence in the advantages that come with ‘the outsider’s view’. For the most part, this confidence is well founded. Appignanesi’s approach works well: her writing style is assured and engaging, the cases are vivid, and the book is easy reading.

Themes that recur throughout the book include changing views about where the boundaries of mad, bad and sad should be located; whether madness is best understood in biological and medical terms or in terms of a person’s life history; whether it is best treated through medical means or by talking therapies; and what are the prospects for improvement and recovery? Appignanesi’s historical account shows repeatedly that questions hotly contested in contemporary debates are far from new.

The case studies represent the experience and understanding of illness as achieved in collaboration between doctor and patient. Diagnosis may provide a ‘script for the performance of illness’. Appignanesi notes also that symptoms mirror the times in which they appear: anorexia is identified as an illness in times of plenty, not of famine; and depression is seen in times of peace and prosperity, not times of war.

Considering the effectiveness of various forms of treatment, Appignanesi observes that ‘few people are mad, bad or sad continually or forever’. She notes that in her case studies, improvement is associated more consistently with ‘humane care, attentiveness and occupation’ than with the recommended treatment of the day. In each case Appignanesi describes, improvement is supported by an enduring, trusting relationship with another person. Where the therapeutic relationship is with a spouse or family member, its contribution is seen by the ‘mind doctors’ as secondary to the effects of treatment; where it is with a professional, the relationship itself may be seen as therapy.

Although she makes no explicit statement of her theoretical orientation, Appignanesi’s approach implies firstly an interactionist framework, in considering the making of meaning in interaction between people who are situated in place, time and culture; and secondly a concern with power, in considering the implications of these understandings for the women who were affected by them. I feel that this theoretical perspective is used more effectively in the earlier part of the book, than in the latter.

Two examples illustrate this. In her discussion of Freud, Appignanesi attributes misogynistic views and practices arising from Freud’s theories to ‘the psychoanalytic profession’ rather to the theories themselves, and is curiously uncritical of Freud’s methods and ethics as a researcher and a therapist. Similarly, in the case studies of women diagnosed with schizophrenia, Appignanesi writes at times as if the diagnosis refers to a material ‘thing’, rather than to a category elaborated in the DSM. Her analysis slips, in these instances, from being a critical account of how meaning is created, to a bland narrative that accepts certain meanings (such as the Oedipus complex as a map of psychic territory, or schizophrenia as a discrete and proven entity) as fact.

While in my view the book would be stronger if its analysis was more persistent, it remains a substantial and provocative body of work. In our time, behaviour that is identified as mad is understood by some people as being primarily biological in origin, and by others as having its origin in life experiences. Appignanesi’s book does not provide an answer as to which of these views is more correct. What it does show is that the ways in which madness is understood are shaped by the situations in which they are created. At its best, this is a critical study that shows how understandings of madness are created in interactions between people who are situated in place and time, and are shaped by the interests of the people who create them. Its case studies demonstrate how understandings adopted by the ‘mind doctors’ have real and material effects on the lives of the women they treat.

Some of the questions raised by Appignanesi are topical and urgent. Her account shows that where in the 1800s the boundary most hotly disputed was that between mad and bad, in our time boundary wars concern the increasing medicalisation of normal responses to life events. As Appignanesi observes: ‘no amount of serotonin will bring Mr Darcy to the door, [or] bring peace to warring neighbours or end global warming’. This is an important and useful book. A recommended read.

Reviewed by Dr Meg Carter, Research Fellow, Institute for Social Research, Swinburne University of Technology.
Psychiatric Disability Services of Victoria (VICSERV) is the peak body for Psychiatric Disability Rehabilitation and Support Services in Victoria. These services include housing support, home-based outreach, psychosocial and pre-vocational day programs, residential rehabilitation, mutual support and self help, respite care and advocacy.

Our Vision
A world of opportunity for people with a psychiatric disability.

Our Mission
VICSERV is dedicated to the achievement of the best outcomes for people with a psychiatric disability, their families and their communities.

We do this through:
• promoting the principles and practices of psychosocial rehabilitation
• building and disseminating knowledge
• providing leadership
• building partnerships
• undertaking workforce training and development
• promoting quality in service delivery
• undertaking advocacy and community education.

The mission statement is underpinned by the following values:
• respect, dignity and responsibility
• equity
• perseverance
• interdependence/inter-connectedness
• flexibility and responsiveness
• honesty and integrity
• participation and consultation, and
• camaraderie.

We are committed to honoring consumer and carer experience, embracing diversity, promoting a sense of belonging and inclusiveness, and encouraging innovation.

Call for Contributions
We have identified ‘diverse communities’ and ‘rights’ as two up-coming focuses for newparadigm. We very much welcome input in the form of an Opinion Piece, a letter or a formal submission piece on these subjects or anything that interests you on psychosocial rehabilitation and mental health. We encourage people to pick up on our previous themes, including social inclusion, consumer leadership and women and mental health.

Diverse Communities
We are keen to present a range of interesting analyses and commentary on the issue of diverse communities and mental health. We are intentionally keeping the focus broad to allow for the widest range of submissions as possible. We may develop a more specific theme or sub-theme closer to the publication date.

Launched three years ago, the Victorian Government’s A Fairer Victoria outlines commitment to developing culturally inclusive public policies. This landmark action plan focuses on reducing disadvantage and supporting inclusion and mental health services that—as recognised in the Cultural diversity plan for Victoria’s specialist mental health services 2006-2010—need assistance in developing culturally competent workforces and service-delivery approaches. We are keen to explore a range of issues and our areas of interest include the following:
• mental health and ageing in culturally and linguistically diverse communities (CALD),
• mental health and ageing in culturally and linguistically diverse communities (CALD),
• historical perspectives on the mental health system and CALD,
• analysis or opinion on services for CALD and mental health,
• coping with stigma and trauma, and
• the experience of people from culturally and linguistically diverse backgrounds.

Rights and Mental Health
We want to present a stimulating and thought-provoking edition on rights and mental health. This issue was briefly covered in the March 2007 edition of newparadigm, with a piece by former Human Rights Commissioner Sev Ozdowski and Consumer Academic Cath Roper. Cath’s piece posed the question: Human Rights Charter Victoria. Does it mean anything for people who are subject to mental health legislation? We want to pick up on some of these threads and add to the discussion by also looking at:
• an examination of rights in relation to people with mental illness (projects, reports, quality practice, legislation),
• commentary on empowerment in a psychosocial rehabilitation setting,
• how reporting of abuse has been managed and dealt with,
• discrimination, stigma, community stereotypes in relation to rights,
• services and/or programs encouraging and reinforcing rights, and
• education initiatives that affect people with mental health issues.

We are looking for and very much encourage contributions on these issues. Please note that the deadline for submissions for either of these editions is still to be confirmed. If you are interested in contributing and for our Contributor Guidelines, please contact: Kristie Lennon, newparadigm@vicserv.org.au or 03 9519 7000.
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☐ Ordinary (full) ☐ Associate ☐ Individual

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☐ Mutual Support and/or Self help ☐ Residential Rehabilitation ☐ Statewide (describe)

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The funding level of your organisation (for billing and statistical purposes) ________________________________

The above named organisation (or individual) hereby applies for membership of Psychiatric Disability Services of Victoria (VICSERV) Inc. and nominates the above-named person as the contact person for all correspondence.

Upon acceptance of this application, Psychiatric Disability Services of Victoria (VICSERV) Inc. is authorised to insert the name of this organisation (or individual) in the register of members of the incorporated association.

We hereby agree to abide by the Rules of Psychiatric Disability Services of Victoria (VICSERV) Inc.

Signed Official Representative ____________________________________________

Name ____________________________________________

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