Victoria's Mental Health Service

Tailoring Services To Meet the Needs of Women

April 1997

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Many individuals and groups assisted in the development of this document. Staff and management of many clinical and disability support services shared ideas and experiences and contributed innovative practice examples.

The members of the Women's Advisory Group were a particularly important source of ideas and information. Membership of the Women's Advisory Group included:

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Foreword

Women experience mental ill-health differently to men and have particular needs which should be taken into account in the way mental health services are delivered.

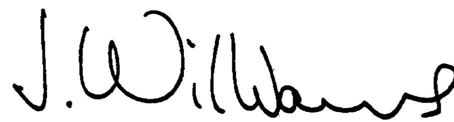
Victoria's Mental Health Service: The Framework for Service Delivery, Better Outcomes Through Area Mental Health Services (1996) provided the policy direction for the continuing reform of public mental health service delivery in Victoria.

The considerable growth in community-based services, the redevelopment of inpatient and community residential services, and the mainstreaming of direct management and delivery of services are particular markers of the changed service system.

It is now important to continue to give attention to the task of ensuring the new service system is responsive to the needs of all service users. Women with mental illness are a key group of service users who will benefit from policy directions that require mental health services to continue to adapt current practice to more appropriately and adequately meet the needs of consumers.

Tailoring Services to Meet the Needs of Women explores the issues impacting on women using public mental health services and promotes ideas, strategies and examples of good practice that may assist in improving service response. In particular, the document highlights the importance of raising the awareness of all staff and pursuing training and service development opportunities to ensure that the service system as a whole provides better services to women.

I am confident that this document will provide a clear statement to consumers and service providers about the commitment and expectations of the Mental Health Branch for the provision of high quality, accessible services able to respond effectively to the needs of women experiencing mental illness.



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At a Glance

Women's life roles and experiences can significantly impact on their mental health and generate additional service needs.

The aim of this policy and strategy statement is to raise awareness within mental health services of women's particular needs and to promote a basis for improved service response. The document:

- Identifies six priority areas for change.
- Discusses women's needs in relation to these priority areas.
- Proposes principles for service delivery.
- Offers examples of good practice.
- Provides potential strategies for change.
- Establishes standards and key areas of responsibility.

The document includes sections focusing on each of the six key priority areas:

Providing Services Responsive to the Needs of Women with Mental Illness Who Are Parents

Services are prompted to consider the needs of women with a mental illness who are parents and the relationship between parenting and mental illness. Principles for service delivery focus on the identification of a woman's family responsibilities, recognition of the implications of these responsibilities and ensuring that practices do not exclude women who have children from using services.

Delivering Services Responsive to the Needs of Women with Experience of Sexual Assault

A significant number of women using mental health services will have previously experienced some form of sexual abuse. Staff are prompted to consider the physical and emotional legacy of these experiences. Principles for service delivery stress recognition of the importance of these experiences and the provision of a safe, non-threatening environment.

Developing Inpatient and Residential Services that Provide Women with Adequate Safety and Privacy

Consumer feedback frequently reports that women feel vulnerable in terms of safety and privacy in acute inpatient and residential services. The importance of ensuring that women feel safe and have adequate access to private space in such settings is highlighted. Guidelines for the physical design of facilities are presented, and strategies to ensure that practices safeguard against breaches of a woman's safety or privacy are suggested.

Delivering Services Responsive to the Needs of Older Women

In recognition of the fact that almost one-quarter of women using public mental health services in Victoria are over 65 years of age, the particular needs of older women are highlighted. The importance of links with generic aged services and between adult and aged persons' mental health services are noted. Principles stress the need to consider a range of options in the treatment of older women and to look broadly at the factors that will impact on the mental health of older women.

Providing Services that are Responsive to the Needs of Women Who Are Carers of People with Mental Illness

The majority of people caring for someone with a serious mental illness are women. This role can have a significant impact on the life of the carer. Services are prompted to consider the needs and experiences of women carers alongside those of the presenting client. The need for support, information and training for carers is also highlighted.

Increasing Participation of Women in Psychiatric Disability Support Services

Despite women making up almost 50 per cent of registered clients of clinical mental health services, they are notably under-represented in their use of psychiatric disability support services. A number of possible explanations for this under-representation are suggested and principles for a responsive service that may redress this imbalance are proposed. These principles include issues of access for women—particularly those who may have dependent children—the provision of a safe and non-threatening environment and the opportunity for women to participate in women-only activities.

The Context for Change

Key Characteristics of Women Using Mental Health Services

Numbers

The client information system for public mental health services in Victoria identifies 93,000 women registered with public mental health services. This represents about 47 per cent of the total population of registered clients, and about four per cent of all women in Victoria.

Of these women, 17,000 made use of one or more components of the public mental health system during the period July 1994 to June 1995.

Estimates suggest that as many as 455,000 women in Victoria will at some time in their lives experience a form of mental ill-health (this figure is based on a lifetime prevalence rate of mental ill-health among women of 20 per cent). Most of these women will, with treatment and support from their family doctor or services in the private sector, be able to continue their everyday lives with minimal disruption. Others whose symptoms are more disabling will require assistance from one or more of the public mental health services.

Characteristics of the Target Group

Age

Women of all age groups used public mental health services between July 1994 and June 1995 (table 1).

Table 1: Age Group of Women Clients Receiving Services in 1994–95

Age Group	Number of Women	Percentage
0–14	748	4.4
15–19	821	4.8
20–29	2,560	15.1
30–39	3,231	19.1
40–49	2,750	16.2
50–59	1,904	11.2
60–64	789	4.7
65+	4,127	24.4
Total	16,930	100

Source: Client Information System Victorian Public Mental Health Services (PRISM)

Diagnosis

The most common diagnoses among women using public mental health services in Victoria between July 1994 and June 1995 were schizophrenic disorders, major affective disorders, other affective and somatoform disorders, and acute stress reactions. A smaller number of women received a range of other diagnoses (table 2).

This pattern of diagnosis is somewhat different to that for male clients using services during the same period. A significantly higher proportion of male clients received a diagnosis of schizophrenic disorders (31.3 per cent) and fewer were diagnosed as having major affective disorders (9.8 per cent) or other affective and somatoform disorders (4.9 per cent).

It should be noted that the diagnosis information available refers to the most recent primary diagnosis a person has been given. It is likely that many women will have received more than one diagnosis during their use of mental health services and may at any one time have multiple diagnoses. It should also be noted that the data are constrained by the significant number of women for whom a diagnosis was not recorded.

Table 2: Diagnosis of Women Clients Receiving Services in 1994–95

Diagnosis	Number of Women	Percentage
Schizophrenic Disorders	3,821	22.6
Major Affective Disorders	2,560	15.1
Other Affective and Somatoform Disorders (Other Than Major Affective Disorders)	1,382	8.2
Acute Stress Reactions	1,260	7.4
Dementia and Disturbances of Cerebral Function	914	5.4
Personality Disorders	600	3.5
Paranoid and Acute Psychotic Disorders	512	3.0
Anxiety Disorders	362	2.1
Alcohol and Drug-Related Disorders	308	1.8
Mental Disorders Originating in Childhood or Adolescence	177	1.1
Eating and Obsessive Compulsive Disorders	147	0.9
Conduct Disorders	118	0.7
Other Disorders of the Nervous System	85	0.5
Sexual Disorders	4	–
No Diagnosis Recorded	4,680	27.7
Total	16,930	100

Source: Client Information System Victorian Public Mental Health Services (PRISM)

The diagnosis data included refer only to women who are registered consumers of public mental health services in Victoria. Many other women will receive mental health care services from private practitioners or in general hospitals. It is likely that a far greater proportion of women receiving services in these settings will have eating disorders, postnatal disorders, anxiety, affective and somatoform disorders. The primary focus of this document is, however, women using the public mental health care system.

Living Environment

The majority of women who used public mental health services between July 1994 and June 1995 were living in private flats or houses (75 per cent). Smaller numbers of women lived in a range of other accommodation settings (table 3).

This pattern of accommodation use is similar to that for male public mental health service users. However, men are less likely than women to live in private flats or houses (71 per cent), and are more likely to reside in boarding houses (2.8 per cent).

Table 3: Accommodation Type of Women Clients Receiving Service in 1994–95

Accommodation Type	Number of Women	Percentage
Private Flat/House	12,731	75.2
Special Accommodation House	589	3.5
Special Residential Support Services	518	3.0
Nursing Home	514	3.0
Hostel	473	2.8
Boarding/Rooming House	167	1.0
Caravan	106	0.6
Homeless Persons' Shelter	26	0.2
None	18	0.1
Other	316	1.9
Unknown/Data Unavailable	1,472	8.7
Total	16,930	100

Source: Client Information System Victorian Public Mental Health Services (PRISM)

Participation in Psychiatric Disability Support Programs

Information from the Psychiatric Disability Support Sector minimum data set indicates that a total of 1,629 women used disability support day programs, home-based outreach or residential rehabilitation services in the period October to December 1995 (table 4). Women represented 38 per cent of people using these services in this period.

Table 4: Women's Participation in Psychiatric Disability Support Sector Programs October–December 1995

Disability Support Sector Program	Number of Women	Women as Percentage of all Service Users (%)
Day Program	1,089	36.7
Home-Based Outreach	481	39.2
Residential Rehabilitation	59	45.4

Source: Psychiatric Disability Support Minimum Data Set

Women appear to be represented in greater numbers among attendees at self-help and mutual support programs, however, the data set for these programs is limited and more specific information about attendance and the gender breakdown of service users is not available.

Parental Responsibilities

At present within Victoria there is no reliable information that identifies the number of women suffering from mental illness who are parents of dependent children. Estimates obtained from the available data suggest approximately 22 per cent of women using public mental health services in 1994–95 resided with their dependent children. These figures are significantly higher than the dependent comparable figures for male clients (eight per cent).

It should be noted, however, that these data have significant limitations. The estimated number of clients living with children is likely to include those clients living with children over the age of sixteen years, and there is a significant proportion of registered women clients for whom there is no information recorded about living arrangements. Further, there is no means of identifying the number of women who are mothers of children who are dependent on them but, for whatever reason, reside elsewhere.

Data collected through other means suggest that the number of women using services who are parents may be significantly higher than that suggested above. In December 1993 the Early Psychosis Research Centre conducted a one-day census of Victorian psychiatric centres. Of the 766 questionnaires returned, 206 of the respondents said that they had children, that is 27 per cent of the sample. Approximately one-third of these respondents indicated that they had been treated for psychotic illness before the child was born.

A significant number of women may experience some form of postnatal mental illness. Postnatal depression affects as many as one in seven women in Victoria. Many of these women will find appropriate care and support outside the public mental health system. However, for a smaller number with more severe postnatal psychiatric disorders, a specialist service response from either the private or public sector may be required.

Incidence of Physical or Sexual Assault

Research has shown that a notably high proportion of women using mental health services are likely to have had some experience of physical and/or sexual abuse as a child and/or as an adult.

While a history of abuse does not necessarily lead to individuals seeking specialist mental health care, it is thought that a significant number of people using mental health services, whether public or private, are survivors of abuse. Some studies have suggested that 50 per cent or more of women using mental health services will have experienced some form of sexual assault or abuse (Cox, 1994).

The experience of sexual assault, in particular childhood sexual abuse, has been linked with a number of psychiatric disorders. Childhood sexual abuse has been found to be associated with higher rates of anxiety disorders (panic disorder, phobias and post-traumatic stress disorder), major depression, psychotic and suicidal symptoms, borderline personality disorder and dissociative disorders.

The Service Context

The identification of women's specific needs from mental health services and the development of this document occur concurrently with other major changes in the mental health sector. Victoria is at the midway point of a five-year period of reform to redevelop services for people with serious mental illness. A particular focus of these reforms is to develop services that are responsive to clients' needs.

Significant steps have been taken since 1992 to bring the overall management of mental health services into the same framework as the rest of the general health system. Inpatient services are being co-located with general hospitals and are managed along with community-based services as part of an integrated area-based mental health service.

Concurrently, there has been an emphasis on providing an increased level of community and home-based care options. At the general adult service level, the range of community-based services organised within Area Mental Health Services include 24-hour mobile Crisis Assessment and Treatment (CAT) Services; Mobile Support and Treatment (MST) Services; Continuing Care, Clinical and Consultancy Services; Non-Residential Rehabilitation Services and Community Care Units (CCU).

The Aged Persons Mental Health Services system includes community-based Psychogeriatric Assessment and Treatment (PGAT) Services and Acute and Extended Care Inpatient Services.

Services for younger people are provided by Child and Adolescent Mental Health Services (CAMHS) providing a range of community-based services, outpatient programs, day programs and inpatient services.

In order to ensure continuity of care for consumers using these community-based service systems, comprehensive case management has been introduced for clients of public mental health services.

In addition to these clinical services, a range of services are also offered in the Psychiatric Disability Support sector. These include statewide specialist mutual support and self-help programs; non-residential disability support services, including psychosocial rehabilitation day programs, and home-based outreach support; and residential psychiatric disability support programs including residential rehabilitation services and planned respite services.

In recent years there has been an increased recognition by service providers and policy makers of the important contribution of family members and other carers of people with serious mental illness. This has been accompanied by a growing awareness of the needs of carers and the importance of allowing for collaboration and information sharing between consumers, mental health services, and families and other carers wherever possible.

The policy document *Victoria's Mental Health Service: The Framework for Service Delivery* (1994) highlighted the need for service planning and development to ensure an improved service response for women requiring specialist mental health services. The document highlighted the need to address particular issues faced by women with mental illness including risk of sexual assault and abuse, and responsibility for infants, children and older family members.

This identification of women's needs was reiterated in *Victoria's Mental Health Service: The Framework for Service Delivery, Better Outcomes Through Area Mental Health Services* (1996). This document stated that:

> [T]he room for improvement remains significant, ranging from specific issues such as postnatal serious mental illness or the aftermath of child sexual abuse to ensuring the safety and privacy needs of women in bed-based settings and responding to the needs of women with mental illness who are caring for children.

This response to women's needs is also in line with the National Mental Health Strategy (1992), which similarly stressed the need for recognition of the specific needs of particular client groups in the planning and delivery of services.

The Priorities

Background

In June 1995 the Mental Health Branch established a Women's Advisory Group to provide advice on program and policy development priorities for women using publicly funded mental health services. The group comprised consumers, carers, service providers, researchers and educators.

The Women's Advisory Group addressed a broad range of issues in relation to the provision of mental health services for women, and discussed priorities for change in order to create a service system more responsive to the needs of women. Where possible, practical and immediate strategies for improving service provision were identified, and are presented within this document.

It was recognised that the needs of all women will not be the same. A woman's individual background and social context will influence her experience of mental health service use. A woman's current circumstances—her level of financial security, her age, her physical status, her housing situation, her role within her family, and the presence of any children will also impact on her service needs. The importance of services being aware of and responding to this diversity was stressed. A number of important principles which should enable effective service responses were identified and are explored in this document.

It is important that a service response to women is not based on gender stereotypes. For example, the experience of many women using mental health services has been that, although they have had access to living and social skills programs, access to vocational training and employment support has been more limited.

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. Guidelines developed to improve services to people from a non-English speaking background are now available through the document *Victoria's Mental Health Service: Improving Services for People from a Non-English Speaking Background* (1996).

Similarly, a woman's place in her family and other social institutions will impact on her experience of the mental health system. Women make up the vast majority of carers—both of children and other dependents, and of mentally-ill family members. The impact of this caring role must be recognised in the provision of services, and treatments provided in a manner which is cognisant of a woman's other responsibilities.

Individual women will have differing levels of personal support available to them. Women in rural regions and older women in particular may be isolated and have fewer service and support options available. The availability of personal supports and generic support services will impact on a woman's service needs.

Among the many needs identified by the Women's Advisory Group, a number of priorities were highlighted and strategies for the improvement of services were proposed. These are addressed in detail within this document. The particular priorities include:

- Providing services responsive both to the needs of women with mental illness who are parents, and to the needs of their children.
- Delivering services responsive to the needs of women with experience of sexual assault.
- Developing inpatient and residential services that provide women with adequate safety and privacy.
- Delivering services that are responsive to the needs of older women.

- Providing services that are responsive to the needs of women who are carers of people with mental illness.
- Increasing participation of women in Psychiatric Disability Support Services.

Women with a Mental Illness Who Are Parents

The continued shift to a community-based service delivery system has afforded people with serious mental illness greater opportunity to have and care for children.

The relationship between mental illness and parenting is a complex one. Not only does serious mental illness have implications for parenting, but parenting also has significant ramifications for the person suffering mental illness and may have an impact on the course of the illness. Parenting may cause additional stress and exacerbate a pre-existing illness leading to relapse and hospitalisation, or trigger an incidence of mental illness.

Staff need to be aware of the impact of the parenting role on women's lives in order to provide support and assistance to allow women to maintain and fulfil this role. It is also important to understand the effect of a woman's illness on her children and other family members, and to assist women in ensuring that the needs of dependants are met.

In particular, the needs of infants should be given careful consideration. Infants are more vulnerable to neglect and maltreatment than other children and young people due to the fragility of their bodies, limited capacity to communicate and total reliance on adult caregivers to attend to their needs.

Occasionally, risk to children presents a crisis and immediate safety issues need to be addressed. This adds to and does not replace the ongoing support and monitoring required as staff of mental health services work with women who are parents in the context of the family unit as a whole.

Women with children may avoid using mental health services because of fears as to how this may affect their children, fear that children may be removed, and at times, simply because there is no-one else to care for their children while they attend appointments. These women are often single parents and frequently have low incomes and limited access to appropriate housing.

Research suggests that there is a high incidence of unplanned pregnancy among women who have a mental illness (Mowbray et al. 1995). These factors can tend to compound the stresses associated with motherhood.

Often a woman with a serious mental illness who is a parent may be involved with a large number of service agencies. In addition to mental health services, she may use parenting support services, specialist children's services, respite and foster care services, and may be the subject of a Protective Services intervention. The involvement of such a large number of services can add additional stress for women attempting to negotiate service provision and inadvertently result in increased disruption for the family. At times there can be confusion over role boundaries and responsibility and struggles for authority in relation to case planning.

The response is commonly fragmented and can involve a perceived conflict between the interests of the child, who may be at risk of serious harm, and those of the mother whose wellbeing is likely to be severely affected by statutory intervention and removal of the child. These tensions can be exacerbated when those advocating from the perspective of the rights of the child have a limited understanding of mental illness and its implications, and those, who are advocating on the part of the parent with a mental illness are uninformed about child protection concerns and legislative requirements.

The involvement of Protective Services for mothers with a mental illness can be distressing. Consumer feedback consistently reports that such involvement is threatening

because of women's anticipation or experience of losing custody of their children. Many women report being unsure of their rights in relation to child custody and the processes involved in Protective Service intervention.

Medication can have particular implications for women in a parenting role. For example, medication may be excreted during breast feeding, or may affect a woman's capacity to perform the parenting role by inducing lethargy or disturbing muscular functioning. Service providers need to consider and inform women about these possibilities, and to assist them in making decisions about medication and developing means of coping with such side effects.

A number of specialist inpatient mother/baby services are available for the assessment and treatment of women suffering from postnatal or other psychiatric disorders and their infants. Within the Psychiatric Disability Support Services sector, the Mother Support Program provided by Prahran Mission offers a specialist supported housing and outreach service to work specifically with women with a mental illness who are caring for dependent children in the inner and central south of Melbourne. Early Parenting Centres can also provide an important service response. The majority of women with a mental illness who are parents will, however, use Adult Mental Health Services. It is important that these services are sensitive and responsive to the needs of mothers, and that they are aware of, and actively liaise with, other services working with this client group.

The experience of having a parent with mental health problems can be disturbing for a child. Children may be faced with inappropriate caring demands, and without adequate support and information, children can become confused and fearful (Pietsch and Cuff, 1995). It is important that in addition to ensuring that dependent children are adequately cared for, services offer support and education to children of service users and where necessary assist them to identify and access other services that may be of assistance. Consultation and collaboration with other specialist services is an important step in providing appropriate support to these children.

Principles for Responsive Service Delivery

Public mental health services responsive to the needs of women with a serious mental illness who are parents and to the needs of their children:

- Consider the needs of the family unit as a whole rather than treat the mother's illness in isolation of the parenting role.
- Identify any children, their ages, and current family responsibilities at the point of intake and assessment. Care arrangements for children should be clarified as a priority if there is a need for inpatient admission. Where possible, supports such as partners, grandparents, other relatives or friends should be sought to provide short-term care for children.
- Clarify with women if and how children should be informed about their mother's admission to an inpatient setting.
- Ensure they are easily accessible by women who are parents. This can include consideration of child care needs and outreach visits rather than centre-based services.
- Welcome children by providing a child-friendly environment.
- Include an assessment of the need for development and support in undertaking parenting responsibilities in treatment planning, rehabilitation and/or hospital discharge planning. Women should be supported in accessing appropriate services where a need for parenting support is identified.
- Take into account the impact of a woman's illness on her children in treatment planning and implementation and the need for these children to be given information and education about the illness and treatment.
- Provide support and assistance to women to help them develop plans for the care of children in the event of a crisis.

- Identify the support system available to a woman with a mental illness and consider the needs and responsibilities of this support system and their role in keeping the family functioning.
- Provide training for staff to identify and assist with parenting issues for women with mental illnesses. This may include seeking additional assistance from family support agencies.
- Maintain awareness of issues relating to medication for mothers with mental illness. This includes developing an understanding of the impact of medication on the parenting role.
- Ensure that staff have an understanding of the legal and protective issues for women with a mental illness who are parents, and are aware of the implications of these issues for the woman.
- Develop effective working relationships with Protective Services, and relevant child and family services.

Waverley Community Mental Health Service

Waverley CMHS (part of the Central East area service) has had a philosophy of aiming to respond to the needs of women since it was established in 1990. As a part of this philosophy, access to the service is made as easy and comfortable as possible for women who are parents.

Women are offered the choice of receiving service in their own homes or at the house from which Waverley CMHS operates. Transport is also possible if required, as two baby seats have been purchased for use in the service's vehicles.

Toys, activities, children's books and snacks appropriate for children are available at the centre for those women who wish to bring their children with them. Staff hope that these items make women feel more comfortable in bringing their children, and make visits to the centre enjoyable for their children.

Strategies to Consider

- The development of an outreach capacity that would enable women with children to be seen within their own homes. This could be particularly useful for women with very young children for whom clinic attendance could be difficult. This approach would also allow staff members to develop an understanding of the woman in her role as a mother as well as client and to see the impact of the illness and treatment on her parenting role.
- The nomination of a particular member of the multidisciplinary team to have responsibility for a portfolio area—'parents with a mental illness'. As part of this portfolio they could:
  - Liaise with local Protective Services and foster care agencies.
  - Research the availability of generic parenting support agencies within the local area and make this information freely available for women using the service.
  - Work with relevant local agencies to ensure availability of parenting groups where parents could support one another and discuss issues related to the parenting role.
  - Act as a contact point for specialist mother-baby services.
- The review or audit of registration and intake forms to ensure that the details of any dependent children are being recorded.
- The arrangement of appropriate child care so that a woman may have a one-to-one session with her case manager if required. This may include using previously identified supports.
- A review of treatment plans to ensure that strategies are being developed to care for children in the event of a crisis.
- Consultation with specialist mother-baby services when developing a service response for a woman with a serious mental illness who is a parent of a young infant.
- The development of links with support groups for children of parents with a mental illness. Such groups could take an educative role and provide information to children about mental illness and its treatment.

Working Together Project

The Working Together project was undertaken collaboratively by the Broadmeadows and Craigieburn Community Health Service (BCCHS) and the Mental Health Research Institute. It is an action research project that has attempted to address the difficulties and build on the strengths encountered in inter-agency collaboration in health and welfare agencies. The project was designed specifically to tackle these issues and to develop solutions in the context of working with families in which a parent has a mental illness.

A series of forums were held to identify relevant issues from both agency and consumer perspectives, and to explore potential solutions in terms of individual, agency and systems change.

The project was steered by an action research group involving representatives from adult and child psychiatric services, welfare services and child protection services.

A report titled *WORKING TOGETHER: Families in which a Parent has a Mental Illness: Developing "Best Practice" for Service Provision and Inter Agency Collaboration* has been developed and distributed widely. It is anticipated that this report will assist agencies in the local area to be better equipped to work with this client group.

Antenatal Care

Women with serious mental illness who are pregnant may be at risk of both obstetric and psychiatric complications of pregnancy with a likely need of increased care at this time.

The introduction of new management arrangements for mental health services in mainstream general health settings places service providers in a much better position to meet the needs of women who are pregnant or post-partum.

Increasingly there is an opportunity for some services to combine obstetric and psychiatric care with a focus on:

- Medication management during pregnancy.
- Targeted psycho-education and illness management.
- Parenting skills development—early intervention.
- Specialist consultation and collaborative work with other health, community or welfare services.
- Development and maintenance of appropriate support systems.

Women Who Have Experienced Sexual Assault

Policies and practices throughout mental health services should reflect the fact that many women using psychiatric services may have previously experienced some form of sexual assault involving physical, sexual and/or emotional abuse.

Experience of abuse may cause women to perceive a greater threat to their safety and to experience difficulty in forming trusting relationships. Staff should be aware of the physical and emotional legacy of these experiences and work with all consumers in a manner that will be as non-threatening as possible.

A woman may not disclose an experience of abuse until many years or even decades after the event, due to feelings of confusion, shame or guilt, and fears of retribution or of not being believed. A history of sexual abuse may not be disclosed throughout the course of psychiatric treatment. It is therefore important that services are conscious that women may have a history of abuse even if this has not been stated, be aware of likely indications, and attempt to provide services to all clients in a manner which is sensitive to this possibility.

Responses involving disbelief or little support may lead to greater distress and harm for the woman. This is irrespective of the staff members' judgement of the validity or seriousness of the reported incident. What is vitally important is the woman's reporting of the matter and the impact on her life. When a woman does choose to disclose it is usually a considered decision. While it is important for staff to be aware of other services that may provide specialist support and assistance, it is also important that staff working in public mental health services are able to respond appropriately to disclosure. After what may be years of silence, the opportunity, time and space for a woman to talk about her experiences and how these have affected her may be very important. An effective response may include feedback that indicates belief, validation and understanding of that woman's experience.

Waverley Community Mental Health Service

Staff at the Waverley CMHS are aware of the high incidence of experience of sexual abuse among their clients. A recent file audit indicated that a high proportion of women using the service had experienced some form of abuse.

Staff recognise the importance of identifying a woman's experience of abuse and the impact this experience has had on her. Staff do not pressure women for a disclosure; however, the possibility is highlighted on the intake form in order to raise staff members' awareness of the possibility that this may be an issue for some clients.

In addition to monitoring their own practice, the Waverley CMHS has liaised with staff of inpatient facilities if hospitalisation becomes necessary for women clients who are known to have a history of abuse. Staff raise this issue with hospital staff to ensure that they also provide service in a manner which is sensitive to this aspect of a woman's experience.

Principles for Responsive Service

Public mental health services responsive to the needs of women who have experienced sexual assault:

- Recognise the importance of ensuring a safe and non-threatening service environment.
- Recognise the importance of responding appropriately to a woman's disclosure of abuse. This may necessitate the provision of specialist training and supervision for staff.
- Are prepared to respond quickly and appropriately to a woman's disclosure of ongoing physical, sexual and/or emotional abuse.
- Ensure that adequate information, including information about legal and medical options, is available to women who report or disclose abuse.
- Take into account in assessment and treatment planning any information that is revealed during the course of the intake process regarding past or current experience of physical, sexual and/or emotional abuse.
- Ensure that female staff are available to provide or participate in an outreach or home-based service if a woman is receiving that service. This will be particularly important for women who are living alone.
- Ensure that if it is necessary for a woman in an inpatient setting to be secluded or mechanically restrained, the legislative requirements regarding seclusion and mechanical restraint are met, and that the clinical guidelines for the management of persons in seclusion and mechanical restraint issued by the Chief Psychiatrist are adhered to. Particular attention should be paid to ensuring that adequate clothing is available to women if they are secluded and ensuring that any restraint is employed in a way that is minimally traumatising.

Boomerang Club—'Speaking Out' Group for Survivors of Sexual Assault

The Boomerang Club is a Psychiatric Disability Support Service. As part of its day program activities, the Boomerang Club piloted a ten week 'Speaking Out' program for women with mental illness who are survivors of sexual assault.

The Speaking Out group was co-facilitated by workers from the Boomerang Club and the Domestic Violence and Incest Resources Centre. The group aimed to create a safe place for women to discuss their experiences and to explore how their experiences have affected their mental health, and conversely how mental illness has affected their capacity to deal with the abuse. A pamphlet *Women, Childhood Sexual Assault and Mental Health* was also developed, exploring similar issues and providing contacts for relevant support services.

South-West Area Mental Health Service and West Centre Against Sexual Assault

The South-West AMHS has begun working closely with the West CASA service to identify ways to improve each agency's response to individuals with a mental illness with a history of sexual assault.

The agencies have each provided training and information sessions for the other about the services they provide and the way in which they work with clients. This exchange of information has led to an increased number of referrals from the mental health service to the CASA. Ongoing liaison about individual clients has been an important part of ensuring that these referrals result in positive outcomes for the women who use these services.

More recently, the South-West AMHS and the West CASA have commenced work to establish a group for women with a mental illness who have a history of sexual assault. This group is to be co-facilitated by staff from the two agencies, and will involve structured activities to allow women the space to discuss their experience of mental illness and of sexual assault and the links between these experiences. Staff believe that the collaborative relationship that has been developed through earlier joint activities will be an important factor in the success of this group.

Strategies to Consider

- Nomination of a liaison person on physical, sexual and/or emotional abuse to consult and share information with relevant specialist services in the local area.
- Provision of access to and promotion of training opportunities for staff about issues relating to responding to the needs of women who have experienced abuse.
- Exploration of opportunities for service development and information exchange with specialist sexual assault services at a local area level.

Safety and Privacy in Inpatient and Residential Facilities

Clinical Services

Admission to acute psychiatric inpatient units or placement in extended care facilities are situations where women receive treatment in unfamiliar environments, sometimes on an involuntary basis, and in a mixed gender setting. Consumer feedback consistently reports that in such a treatment context, women feel vulnerable in terms of safety and privacy.

Where women have had previous experience of sexual assault or abuse, vulnerability is heightened and the perceived risk accentuated. Infringement of privacy and feelings of personal security in this context can have

significant implications for engagement in appropriate treatment and the potential for optimum recovery.

It is important that the risk of sexual assault, harassment or intimidation is minimised at a time when:

- Judgement may be impaired due to illness and/or medication.
- A woman's ability to protect herself may be compromised by the system/environment in which she is temporarily placed, or in which she lives.
- The environment is part of a treatment approach that aims to maximise therapeutic outcomes.

In a similar way, staff should be attuned to the safety and privacy needs of women residing in extended care inpatient facilities or CCUs.

Guidelines for Facility Design—Inpatient Services

While environmental design alone cannot ensure safe and appropriate treatment facilities for women, it is an important component along with the local development of congruent policies and practices. Facility design should include attention to basic security and privacy needs as a priority. These guidelines for the design of facilities have been developed to assist gender-sensitive practice when men and women are treated in the same environment.

Core Features

Sleeping Quarters

- It is preferable for bedrooms to be separated into male and female areas to aid staff observation, minimise the risk of harassment and aid privacy. Facility design must, however, be sufficiently flexible to allow services to respond to the demand for beds as they arise. The design of sleeping quarters should ensure that close supervision and support from staff is readily available to some bedroom areas in the case of particular concerns about safety and security.
- Bedroom areas should be designed so that they are not exposed to people walking through the facility.

Bathroom Facilities

- Bathroom facilities should be included as ensuites to bedrooms. In facilities where ensuites are not available, bathrooms should be designated as male or female and located within separate bedroom areas.
- Where ensuites are shared between bedrooms in an inpatient unit, there should be one entrance to the shared bathroom, accessed from the hallway, corridor or common area but set back from the same to ensure privacy. Ensuites should only be shared between patients of the same gender.
- Bathroom facilities associated with recreational areas should be designated as male and female.

Recreational Areas

- There should be a mix of recreational areas including large and some small areas, which increase the capacity for individuals to make choices about the degree of privacy and to avoid intrusive behaviour.

Visiting Areas

- Within inpatient units, areas identified for patients to spend time with visitors should include an area which can be made private for children to visit a parent who is an inpatient.

High Dependency (Locked) Areas

- The design of sleeping areas and bathroom facilities should emphasise privacy while ensuring ease of supervision by staff for the purposes of safety and security.

Physical design can go some way towards ensuring a safe and comfortable environment but in itself cannot completely ensure safety and privacy. It is equally important that the service and its staff follow practices that minimise the risk to women and provide a safe environment that fosters trust and feelings of security.

Where it is clear from the medical history, or where a woman discloses that she has past experience of sexual assault or abuse, staff should be particularly alert to her need for privacy and a sense of personal security.

It is also crucial that services have in place a clear process or mechanism for registering and responding to complaints about threats to or abuse of personal safety and privacy. Such a mechanism should be clearly communicated and exist in addition to general complaints processes.

Dandenong Hospital Department of Psychiatry

The policies and procedures of Dandenong Hospital Department of Psychiatry stress that staff must be sensitive to gender issues of clients. This is considered particularly important during the use of intrusive or invasive procedures.

Whenever a procedure of an intrusive nature needs to be carried out, for example, administration of depot medication, the policy recommends that a staff member of the same gender as the client is made available to carry out the procedure.

If it is necessary for a woman to be secluded, wherever possible a woman staff member is involved. In the case of open seclusion, there is a minimum requirement of two staff. If a woman client is in open seclusion this staff team will always comprise at least one woman staff member.

Residential Disability Support Services —Psychiatric Disability Support Sector

Residential disability support services provided within the Psychiatric Disability Support Service Sector have a psycho-social rehabilitation focus and work towards clients moving to more independent accommodation.

A number of residential disability support services cater for people with high dependency and high support needs and have staff available 24 hours per day. Others rely on an on-call system. The services vary in their degree of structure, depending on the particular needs and age of the residents.

Service activities include provision of support for the individual resident to plan and work towards self-determined goals within a safe and reliable environment.

Almost all residential disability support services are mixed gender and require similar considerations as those guiding clinical services to ensure that needs for safety and privacy are met.

As services aim to provide a stable home-like environment, staff work towards ensuring individual safety and privacy. This is achieved through establishing a culture that is respectful of individual space and needs and which makes use of a peer support approach to assist residents to learn together, deal with conflict and cooperate with others.

As with clinical services, it will be important for staff of residential disability support services to be aware of any concerns or anxieties that residents have about safety in a new or different environment, and to be particularly attuned to the needs of women who may have disclosed an experience of sexual assault or abuse in the past.

Orientation of residents to the service should include information about:

- Expectations regarding behaviour in relation to others' privacy and security.
- Overnight contact points in case of emergency.
- Complaints mechanisms.

Where possible, service management should consider strategies to achieve and maintain a reasonable ratio of male to female residents to ensure some balance in the mixed gender environment.

Victoria Lodge—Richmond Fellowship

Victoria Lodge, located in Brunswick, is a residential disability support program. The program caters for 28 residents with significant psychiatric disability in a mixed gender setting.

Staff within the program have recognised and worked with gender specific issues. Support and education around these issues is offered in an ongoing way through gender-specific groups and individual sessions between residents and their key workers.

More recently, staff have become particularly concerned about the vulnerability of female residents to sexual harassment and assault in the busy, inner urban community in which the service is located.

Staff decided to address these concerns by employing a facilitator from Healthsharing Women to run a six-day workshop with the women's group, which worked on safety, security and assertiveness. Two female staff members were also involved as participants. The group were given experiential exercises to practise as homework with the support of their key workers. Following participation in the workshop series it was observed that some women were notably more expressive and assertive.

Older Women

Almost one-quarter of women using public mental health services in Victoria are over 65 years of age.

The ageing of the population generally means that the proportion of people over 65 years of age using mental health services will continue to increase. The increased longevity of women's lives in particular is likely to mean that the issues for older people using mental health services will be especially important for women.

The need to ensure that services meet the specific needs of older women who have mental health problems was raised in the 1996 policy document *Victoria's Mental Health Services: The Framework for Aged Persons Mental Health Services*. This document outlines in detail the service system established to meet the needs of people with a serious mental illness and/or chronic disabling condition who are over 65 years of age.

As with Adult Mental Health Services, the focus of Aged Persons Mental Health Services is community based. Psycho Geriatric Assessment and Treatment (PGAT) services provide initial specialist assessment and treatment for elderly persons in a community setting. Acute and Extended Care Inpatient Services are also available as part of the range of services for each area. Close ties to generic aged care services are an important feature and where possible these services are utilised to provide additional support and other specialist services to older people with a mental illness.

Older women with a mental illness will confront many of the challenges of older women generally. They frequently face social, economic and psychological difficulties. Poverty, widowhood, the loss of family members, friends and confidants are all common among older women. Ageing brings physical changes and sometimes physical health problems. In addition, older women are also likely to play a significant role in caring for other family members. They may have cared for family members with

illness or disability over many years or have some responsibility for care of grandchildren.

Each of these challenges can impact upon a woman's mental health. For example, social isolation and loneliness are major contributing factors to depression, and it is well recognised that depression is a particularly pressing problem affecting older women's health.

Similarly, an existing psychiatric condition can be exacerbated or re-triggered following traumatic life events such as the death of a spouse. This can be particularly severe in cases where the death leaves a woman isolated.

Assumptions that ageing will bring with it a loss of intellectual and emotional competence have negative consequences for the diagnosis and treatment of all women with serious mental illness. Such assumptions can also often disguise the fact that the majority of older women with a mental illness have not developed their illness as a part of the ageing process, but rather have grown old with a pre-existing mental health problem. It is important that this is recognised so that the impact of a lifetime of mental health problems and treatments can be assessed.

For older women today who have experienced long-term mental health problems, the experience of treatment and service use will have changed dramatically. Many women in these circumstances will have received treatment in a very different mental health system, based on institutionalised care and with a more limited choice of treatments available. It is likely that these experiences will also impact on a woman's needs for services in later life.

The experience of growing old and of using mental health services will not be identical for all older women. For example, women from non-English speaking backgrounds will face particular challenges. The experience of relocation, of having limited language skills, of leaving behind an extended social network can prove particularly distressing for some women as they age.

It is also important to recognise that older women of different ages will be from different generations and therefore will have had very different experiences and expectations of growing old and of mental health treatment.

Treatment planning for older women should be based on an individual assessment and should not be constrained by assumptions about mental health and the elderly. For example, assessment of medication needs and presence of side effects may need particular attention. Assessment and treatment planning should take place in a collaborative way with the service network responding to a woman's needs. Collaboration with general practitioners (GPs) working with older women with mental health problems is particularly important. In many cases, identification and treatment of mental health problems will commence with GPs, and mental health services can be an important point of consultation around diagnosis and treatment planning.

Principles for Responsive Service Delivery

Mental health services responsive to the needs of older women:

- Consider the impact of social, economic and personal factors on the mental health of older women using the service.
- Take into account in treatment planning the level of social and economic support available to older women.
- Ensure that a full range of treatment options are considered for older women.
- Recognise the individual differences between older women that can result from different ethnic backgrounds and from different age groups.
- Work with the wider service network to ensure that the physical health needs of older women receive attention.

Strategies to Consider

- The provision of targeted information to older women about their rights when using mental health services and the features of mental health services of today.
- Review of registration and intake forms to ensure that the details of support networks and responsibilities of older women are identified.
- Facilitation of social activities for older women using the service who have limited support networks.
- Development of forums for education and information exchange with GPs about the needs of older women with mental illness, with a particular focus on the prescription of psychiatric medications for this group.

Women Who Are Carers of People With a Mental Illness

Caring for a person with a serious mental illness or severely disabling condition can represent a significant burden for the carer, and the great majority of such carers are women. There is frequently a social expectation that women will take on a caring role for ill family members. In particular, women who are parents often feel particularly obliged to provide ongoing care for children and this can take a significant psychological, physiological and economic toll on women's lives.

Schizophrenia Fellowship of Victoria—Case Scenario

Joseph was diagnosed with a serious mental illness five years ago. He is in his mid-20s and lives at home with his family. He experiences persistent psychotic symptoms, is very withdrawn and rarely leaves the house.

Joseph's mother Maria provides the bulk of the care and support for Joseph as well as caring for two teenage children. She struggles to keep up with her part-time job and has lost touch with many of her friends.

The case manager working with Joseph at the community mental health service has identified, through meetings with the family, that Maria carries most of the burden of care and is stressed and becoming increasingly isolated herself. After contacting the Schizophrenia Fellowship and discussing the situation he encouraged Maria to call them.

After initial contact with a trained volunteer, Maria saw a staff member for individual appointments and participated in a training course aimed at understanding and coping with mental illness. She has also become involved in workshops and support groups.

Over time Maria has begun to feel less isolated in her caring role and feels that she has more resources to draw on for her own support.

This strain can be exacerbated when carers have dependent children or other family members to care for, or if adequate supports are not available to them.

The demands of caring for a person with a serious mental illness can pose risks to carers' emotional and mental wellbeing, and in rare circumstances, to their physical safety at times of psychiatric crisis.

It is now well-recognised that families and carers play a critical role in supporting and caring for people with a mental illness. Research and carer feedback is also revealing more about the demands of this caring role and the way in which services can consider and respond to carers' needs.

The stress and strain of the caring role can be lessened by providing carers with adequate time to talk about their experiences, the opportunity to interact with others in a similar situation, and the existence of a strong support network both for the carer and for the person with the illness. Support and involvement of carers in the delivery of mental health services and access to quick and

effective assistance in the event of a crisis have been highlighted as particularly necessary.

Carers typically receive no preparation or training in providing support for a person with a serious mental illness and the type of information that they can obtain about their family member's condition and treatment and the type of services available to them becomes critical.

Carers also need to have their knowledge and experience in relation to the person's illness recognised and respected by staff of mental health services. Often carers may be well-placed to provide information on the history of their family member's illness, the recurrences and early warning signs and response to medications.

Particular issues may confront women of non-English speaking backgrounds. Expectations within some cultures for women caring for a family member who is ill or has a disability may be very demanding. Access to information and support groups may be limited due to language barriers.

Carers who are elderly women may have particular age-related needs such as increasing physical frailty and/or the presence of chronic illness, increased isolation, or financial constraints that may impact on their ability to care for a seriously mentally ill person.

Principles for Responsive Service

Mental health services responsive to the needs of women who are carers:

- Provide information and/or training for carers which is tailored to the needs of the individual family.
- Take carer's views and opinions into account in service planning.
- Assess the needs of carers alongside those of the client.
- Avoid making assumptions or expectations that a woman should be able/willing to act as a carer.
- Ensure that a plan is established in advance to respond to a crisis, and that the needs of carers as well as the consumer are taken into account in the plan, including safety issues.
- Ensure that carers of non-English speaking backgrounds have access to appropriate support, information and educational opportunities.

Strategies to Consider

- The nomination of a member of the clinical staff to provide a point of contact for carers. As part of this portfolio responsibility this staff member could:
  - Collect and make accessible information for carers about mental illness, care and treatment options and additional services which may be of use.
  - Facilitate regular carer support meetings.
  - Develop and run educational sessions for carers on ways to manage their caring role and/or provide information on agencies which provide such programs.
- Initiation of a support and information sharing forum for carers, or formal contribution to such forums where they already exist in the local area.
- Implementation of a means to ensure that carer feedback and opinion form part of the local service evaluation/quality assurance strategy.

When considering the needs of carers, it is important to acknowledge that many women with mental health problems will themselves be caring for children, older relatives, disabled family members or for another person with a serious mental illness. Women in this situation will have similar needs to other women carers, and many of the principles outlined above will be relevant.

Participation of Women in Psychiatric Disability Support Services

Psychiatric Disability Support Services (PDSS) play an important role in providing community support for people with a serious psychiatric disability and assisting them to participate in everyday community life. Psycho-social

rehabilitation principles inform much of the work of this sector, and in particular, the need for collaborative work with participants to enhance their social and daily living skills. A variety of service types are available on a residential and non-residential basis as well as state-wide mutual support and self-help services.

A diverse group of individuals participate in Psychiatric Disability Support Services. However, while women make up almost 50 per cent of registered clients of clinical mental health services, they are notably under-represented in their use of these specialist disability support services. For example, in the period October to December 1995, women made up just 36.7 per cent of people attending disability support day programs.

Services that have attempted to increase women's representation in the disability support sector have identified a number of potential barriers to women's participation.

Women have reported feeling alienated or threatened by the predominantly male environment that they sometimes perceive as being prevalent in many psychosocial rehabilitation day program settings. This can be particularly confronting when it is part of a woman's initial experience of such a service. Similar concerns and anxieties will sometimes exist in the minds of families whose assistance is often required to support or facilitate participation in these services.

Other life roles and responsibilities of women may also act as a barrier to their participation in psychiatric disability support services. Attendance at day programs, or participation in residential services can be difficult for women who have children or other family responsibilities to attend to. Services can decrease such barriers by considering the timing of particular programs, exploring with participants appropriate child care arrangements or considering ways in which the service can ensure there is some time or space for women to bring their children along in a child-friendly environment.

Residential services could explore ways to support residents who are not full-time parents and, due to their current living environment, find access visits with their children difficult to manage. Possibilities may include providing appropriate space for such a visit or assisting women to arrange or coordinate visits with their children.

In addition, women with children may be encouraged to make use of disability support services if they can see that programs have relevance for them. Identifying parenting as a life role that should be addressed as part of rehabilitation and skill development or support programs will assist this.

For women from some cultural backgrounds, participation in mixed gender activities can be difficult and confronting for them and their families. Services should be attuned to the differing needs of such women for support or supervision. Supported and gradual orientation to programs, including residential services, will assist women to make informed decisions about their participation in disability support services. Opportunities for services to work in partnership with ethnic specific groups or agencies in the local community may assist in providing a relevant service response to this group of women.

Participation in Psychiatric Disability Support Services will often follow referral from a clinical mental health service. It is important that these clinical services recognise the potential benefits for women of disability support programs and play a role in introducing and facilitating the participation of women in these programs.

Many Psychiatric Disability Support Services have put creative and flexible responses to the needs of women service users in place, and there is much scope for the exchange of ideas and experiences.

Service Improvement Initiative

The 1997–98 Funding and Service Agreements for Psychosocial Rehabilitation Day Programs, Home-Based Outreach Support services, and Residential Disability Support Programs include a Service Improvement target—that women make up at least 40 per cent of participants over the period of a year.

Principles for Responsive Service Delivery

To be responsive to the needs of women, and ensure their participation in services, Psychiatric Disability Support Services:

- Ensure that activities that are undertaken in the service do not inadvertently exclude women.
- Ensure easy access to women who are parents. This could include consideration of child care needs or providing an environment that is child friendly.
- Recognise that many women who could potentially benefit from these services may be initially uncomfortable in mixed gender settings, or undertaking mixed gender activities.
- Ensure that women have access to the full range of activities including vocational or work skills programs.
- Consider a woman's cultural and family context when trying to engage her in the service.
- Ensure that there are clear codes of behaviour in place to support a safe environment.

Examining Access and Participation Issues At Terra Firma

Terra Firma is a psychosocial rehabilitation service run by the Inner East Mental Health Service. After identifying low participation rates for women, the service commissioned a research project to review the relevance and responsiveness of the service to women with a psychiatric disability. The resulting report *Developing Women Sensitive Service at Terra Firma* (1995) examines the issues impacting on women's access and participation in the service and formulates strategic recommendations for an improved service response.

Catch 23

Catch 23 is a North Eastern Alliance for the Mentally Ill (NEAMI) day program service for people with seriously disabling mental illnesses. In recognition of the small number of women using the service a women's only time was established.

The women's only time involves both structured and unstructured activities which are planned in consultation with participants. Activities have included guest speakers on women's issues, outings, and skill-based activities. The group has become involved in planning for International Women's Day 1996.

Since the women's only time was established the number of women attending the centre has increased markedly, and many women have also gained the confidence to participate more fully in mixed gender activities.

The Hestia Program, Amaroo

The Hestia Program is a women's only program offered two days each week at Amaroo, a Richmond Fellowship of Victoria day program centre.

The Hestia program was established in 1993 in response to the small number of women attending the centre, and feedback that the behaviour of men at the centre could be threatening for some women.

The women's only program comprises a drop in time in addition to more structured activities and information sessions.

Staff are committed to retaining contact with participants and encouraging women to attend not just the Hestia program but also other programs offered at Amaroo. A bus is available for outreach purposes which can be used to transport women to and from the centre. When women have young children, the service hires a baby capsule so that they can also be transported. Women are encouraged to bring their children to the centre if this makes it easier for them to attend.

The number of women attending the centre has grown markedly, and staff believe there has been a notable increase in the women's self esteem and confidence since the Hestia program began. The Women themselves take a considerable amount of pride in the Hestia program and its achievements.

Strategies to Consider

- Consult with women service users to identify activities that they would find useful or interesting and program times that are most suitable.
- Liaise with staff of the relevant Area Mental Health Service to discuss needs and opportunities for women service users and to facilitate referrals.
- Arrange for staff to visit other Psychiatric Disability Support Services introducing initiatives targeted to women service users; consider negotiating a short-term exchange of staff to facilitate development of staff skills and awareness.

Practice Guidelines for Clinical Services

Women using public mental health services have a number of specific service needs. The experiences of women and their role within the family will affect both women's mental health and how they use services. Sensitivity to issues of safety and privacy, cultural norms, and women's family responsibilities are important in ensuring that services are effective in meeting the needs of women. Public mental health services should also ensure that the basic physical health needs of women are addressed and that support is provided for women where necessary to participate as fully as possible in all aspects of life.

Identifying components of service planning and delivery which can be shaped in a way that acknowledges and is sensitive to the particular needs of women is central to good mental health service provision.

Indicators for Practice Responsive to the Needs of Women

The development of these indicators has been informed by the experience of women in accessing and using mental health services. They identify a number of practices that should be adhered to at various stages of service delivery. The indicators have application across the continuum of service delivery, and the principles involved should inform practice across the range of mental health services, both community-based and inpatient.

Intake and Assessment—Community Mental Health Services

- Intake and assessment procedures should include details of any dependants, such as children or elderly relatives, identification of current family responsibilities, and clarification of alternative care arrangements for dependants.
- If, in the course of the intake process, information regarding past or current experience of sexual, physical and/or emotional abuse is revealed, this should be taken into account in assessment and treatment planning.

Service Planning and Implementation

- Treatment plans and their implementation should take into account the impact of the woman's illness on family members, and the need for the latter to be given information and education about the illness and treatment.
- Attention should be given to ensure that basic physical health needs (for example, pap smears, breast examinations) are addressed in collaboration with women consumers.
- Treatment plans should identify the needs of dependants, and develop plans to meet these needs, including additional assistance from family support agencies if appropriate.
- Treatment plans for women admitted to residential rehabilitation or secure extended care inpatient services should address the need for women's health screening, information and education.

Medication

- The administration of medication should include consideration of the possibility of a woman being pregnant, and the provision of information to women about the possible impacts of medication on pregnancy.
- Decisions in regard to the dosage of medications administered to women should take into account both the physical effects of the medication on women, and the impact of medication on life roles, such as parenting.

Crisis Intervention

- A female worker, wherever possible, should form part of the CAT service (or PGAT service in the case

of women using Aged Persons Mental Health Services) response to a woman in crisis, particularly if that woman is living alone, is a single parent or alone in care of other dependants.

- Women with a mental illness who have children or other dependants should be given support and assistance to develop plans, in conjunction with mental health staff, as to how these dependants are to be cared for in the event of a crisis.
- The demands being placed on carers should be identified as part of the initial intervention or assessment, and taken into account in treatment planning, including possible use of emergency respite arrangements.

Outreach and Home-Based Services

- Female staff should be available wherever possible to provide outreach and home-based services to women, particularly women who are living alone, are single parents or are alone in care of other dependants.

Rehabilitation Services

- Rehabilitation should include:
  – An assessment of the need for development and support in undertaking parenting responsibilities.
  – An assessment of the need for pre-vocational training and/or employment support, and assistance in accessing appropriate services.

Hospital Admission Procedures

- Intake and assessment procedures should include details of any dependants such as children or elderly relatives, identification of current family responsibilities, and clarification of alternative care arrangements for dependants.
- Staff should clarify with women the people who should and should not be informed of their admission.
- Staff should consult with women about how these people are to be notified of their admission. This is particularly important in the case of children or other dependants.

Use of Intrusive or Invasive Procedures, for example, Seclusion, Restraint and Involuntary Sedation

- Service providers should ensure that in all cases the least restrictive practice possible is employed. Seclusion and restraint, in line with best practice, should be avoided whenever possible. Guidelines issued by the Chief Psychiatrist should be followed at all times.
- If it is necessary for a woman to be secluded, restrained or involuntarily sedated, the team that performs this procedure should be made up of a majority of female staff. The staff member communicating with the woman during this procedure should also be a woman.
- If it is necessary for a woman to be secluded, staff should ensure that she is adequately clothed.

Hospital Discharge Planning

- Discharge planning should contribute to ongoing treatment planning through identification of needs for:
  – Education and information about sexuality and contraception.
  – Basic health monitoring and care.
  – Assistance with parenting responsibilities.

Training

Customising services for women may require some changes in the culture and orientation of agencies as well as equipping staff with the skills to respond effectively to particular needs of women service users. While many staff already draw on a wide range of skills to work with women in a way that is sensitive to their needs, others may look to further support and resources that can be gained through training. It is important that training does not occur solely through interested staff self selecting for courses but rather is promoted and made available to all staff.

Training and skill development can take place in a variety of ways, including:

- A specific course developed by The Mental Health Training Service—Working with Women. This two-day course is aimed at improving service effectiveness for women clients and has been designed to enable participants to then train their colleagues in this approach.
- Purchase of specific training for staff according to needs.
- Identifying a staff member to undertake specific training and follow up with other staff through a 'train the trainer' approach.
- In-service and education exchange with other specialist services; for example, sexual assault services, carer support services.
- Opportunities for staff exchange; for example, negotiation of a time-limited exchange between a staff member of a general Adult Mental Health Service and a staff member from a specialist mother-baby unit.

Key Responsibilities—Service Managers

Service managers have a key role to play in creating services that are responsive to the particular and varying needs of women.

Ensuring that services are responsive to the needs of women will require particular attention to training needs, quality assurance strategies, consumer participation mechanisms, and service development initiatives that focus on monitoring and promoting good practice.

It is important that the responsibility for implementing changes to ensure that services are responsive to the needs of women is not left only to those staff with an interest in the area who may self select for the task. Responsibility should be taken by all staff in senior positions to see that such changes are implemented throughout the service, and should involve all staff.

Individual services may identify areas, in addition to the priority areas outlined in this document, that warrant particular attention within that service. For example, the needs of women who are homeless or live in rural or remote areas may be of particular importance in some services. Other particular needs to be addressed may include those of women who have a dual diagnosis, dual disability or forensic issues.

Key responsibilities include:

- Identify and monitor training needs of staff in relation to gender issues.
- Consider strategies to monitor and evaluate service response to the needs of women.
- Ensure avenues and mechanisms for consumer participation and feedback are available and accessible to women consumers.
- Pursue opportunities for relevant service development initiatives with other services in the local area.
- Identify opportunities for collaboration around women's health and mental health needs within the wider service network.

Appendix

Reading Guide

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