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THE PATIENT MAJORITY

MENTAL HEALTH POLICY AND SERVICES FOR WOMEN

Valerie Gerrand

CENTRE FOR APPLIED SOCIAL RESEARCH, DEAKIN UNIVERSITY

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PREFACE

When I first began to make known my interest in women's mental health policy, I was often asked why I was focusing on women rather than men. I was told for instance, that it was men not women who needed attention, and that it was men not women who were disadvantaged because of their difficulties in acknowledging emotional problems, let alone taking their problems to a psychiatrist. Initially I would become defensive in response to this type of question, quoting statistics on women's greater propensity to mental ill-health, their higher use of mental health services, their subjection to psychotropic drugs, and so forth.

Having now spent several years exploring what happens to women with mental health problems, I no longer feel the same need to defend and justify my interest. At times, the mental health field has seemed like one of the last bastions in the human services in terms of its neglect of the special needs of women. The difficulties women face when they have psychiatric problems, and the insensitivity they often encounter when they use mental health services have been marginalised for too long. Most women have a wealth of knowledge about these experiences from their own lives or those of other women, from autobiographies, novels and even women's magazines. However, these experiences have tended to remain part of women's domain, and encapsulated from the largely male-dominated worlds of policy formation and service planning. As a consequence, although women do use mental health services more than men and policy therefore affects them directly as consumers, policy and service development in the mental health field could proceed as though women were already well-served.

This monograph therefore comes without apology but with a commitment to ensuring that women's needs are taken seriously in mental health policy-making and service planning in Australia. It aims to specify the issues to be taken into account in developing policy and services responsive to women. The introductory chapter provides an overview of the extent to which women's issues have been included to date in mental health policy in Australia. This is followed by a chapter which identifies and develops a framework of issues to guide the analysis which follows. This framework draws on the results of community consultations as well as research. The ensuing three chapters discuss in detail the issues facing women with mental health problems, and appropriate policy responses. These chapters explore in turn women's experience of psychiatric diagnosis and treatment; their use of mental health services such as treatment, housing and rehabilitation services; and women with special needs, namely women from non-English speaking backgrounds, women with dependent children, ageing women, severely disabled women and women as carers. The final chapter presents a set of general strategies for improving the responsiveness of mental health policy and services to women's needs.

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.

The monograph had its origins in a dissertation submitted in 1987 for the Diploma of Public Policy at the University of Melbourne. Redrafting took time, and occurred over a period of intense and active development of mental health policy and services at both a national and state level, some of which is still in a state of fruition. The monograph thus reflects a situation in flux, but one which holds much promise for greater responsiveness to the needs of women.

I have also been encouraged and stimulated by my professional and personal contacts with psychiatrically disabled women, women carers, and workers keen to improve women's lot in the mental health field. By sharing experiences and ideas, recounting horror stories and passing on articles and books, they fuelled my commitment to finalise the project. In particular, I would like to thank those women who were founding members of the Victorian Women and Mental Health Network, including Ann Ball, Thea Bates, Merrilee Cox, Jenny Gee, Marg Goding, Kerry Short, Sally Stephens, Kim Robinson, Sandy Weinberg, Barb Wigley and Ann Woods. I greatly appreciated the untiring support of Professor John Power, who was always ready to believe another draft was on the way, and the helpful editorial advice of Michael Muetzelfeldt. Finally, Peter, Sasha and Felix Gerrand had first-hand experience of what was involved in producing this monograph. Peter's active encouragement and practical assistance proved invaluable for completing the document, and our sons Sasha and Felix were commendably tolerant of a distracted parent.

The views put forward in this monograph are mine and not necessarily those of any organisation with which I am or have been associated.

Valerie Gerrand
May 1993

1. Intoduction– Women's Growing Visibility in Mental Health Policy in Australia

'The female is not the special but the *normal* form of the psychiatric patient'.[1]

The resurgence of the women's movement in the 1970s undoubtedly sharpened interest in what had been known for many years - that women use mental health services more than men. The higher numbers of women identified as having mental health problems had attracted little concern from the psychiatric profession: 'the understanding that women suffer more mental morbidity than men is so well established and so congruent with stereotypical views about women generally - as unstable, irrational and changeable - that its statistical confirmation evokes little surprise or reflection'.[2] For the women's movement, however, such social 'facts' had a special meaning and raised particular questions.

One of the first to publicise the concerns of the women's movement was the American psychologist Phyllis Chesler in her book *Women and Madness*.[3] She provided a feminist analysis of the high involvement of women in the mental health system. In essence Chesler's thesis can be summarised as follows: more women are users of mental health services than men because they are more oppressed than men, hence more distressed and unhappy; are more likely to seek help for their problems; are exposed to masculinist standards of mental health when they do seek help; and will be perceived as sick whether they display behaviour at odds or in keeping with a stereotypical female role.[4] This analysis has dominated much of the later writing on women and mental health.[5]

Both before, but largely since Chesler's book, a number of studies have sought to refine understanding of women's greater use of mental health services, and to provide explanations.[6] It remains debatable whether Chesler's thesis is applicable to all women with psychiatric problems. However evidence to date provides good grounds for arguing that the mental health problems and experiences of women as users of services are sufficiently different to warrant special attention in policy terms. For instance, psychiatric disorders diagnosed in women show a particular pattern such as high rates of clinical depression and late onset of schizophrenic disorders; women are more likely than men to be treated as out-patients and to be prescribed psychotropic medication; and women are less likely than men to be involved in rehabilitation programs.

Although evidence of the distinctive characteristics of women's experience of mental ill-health is abundant and long-standing, mental health policy in Australia made little reference to women until very recently, despite an unprecedented burst of policy development in the 1980s. The publication of the New South Wales Richmond Report in 1982 marked the beginning of a period of active policy-making in the mental health field which is still continuing, especially in the more populous states of New South Wales and Victoria. The Richmond Report was the first example of a comprehensive policy statement on future directions for state mental health services. It gave rise to further more detailed policy documents relevant to the New South Wales situation. At the same time, policy statements on directions for mental health services began to emanate from other Australian states, for

example, 1985 in South Australia, 1986 in Victoria. In Victoria the 1986 consultation paper *New Directions for Psychiatric Services in Victoria* was in turn followed by publication of several policy and program statements on particular client populations or types of services, such as older people (1988), forensic services (1988) and rehabilitation services (1990).

At a national level, work towards formation of a national policy for mental health services began in the late 1980s. A key consultation paper by Eisen and Wolfenden[7] culminated in a report presented in 1989 to the Australian Health Ministers' Advisory Council (AHMAC).[8] A strategy statement on policy goals and action proposals was submitted to AHMAC the following year,[9] and consultations regarding this statement resulted in a further policy document which was the subject of a further consultative process in late 1991.[10] The national mental health policy was launched in April 1992.[11] In early 1991, AHMAC had also published a document entitled *Mental Health Statement of Rights and Responsibilities*, covering service users, service providers and carers.

What is striking about the early policy statements up to the late 1980s is that they were largely gender-blind. By 'gender-blind', I mean that women and men were not differentiated in terms of policy or service development. For instance, no reference was made to gender in the 1982 Richmond Report, the 1985 Policies for Mental Health Services in New South Wales, the 1985 Mental Health Services in South Australia Discussion and Policy Paper, or the 1986 consultation paper New Directions for Psychiatric Services in Victoria. The latter document made reference to the special service needs of two groups, the elderly,[12] and people from non-English speaking backgrounds (NESB).[13] Similarly, a key paper outlining the principles and directions of the new developments in Victoria referred to special needs groups as being the elderly, children and adolescents, NESB people, aboriginals and mentally-ill offenders.[14]

The problem with gender-blind policy is that it ignores differences in the service needs of women and men. The use of gender-neutral language is equally problematic as it can disguise known gender differences.[15] For instance, the 1988 Policy and Program Statement on Psychiatric Services for Older People in Victoria uses the terms 'older people' and 'the elderly' throughout the document. It predicts that 'the number of dementia sufferers is expected to increase by about 50 percent by the end of the century'.[16] By using gender-neutral terminology, the document masks what is already well-documented: that women are both more likely to receive a diagosis of dementia as they tend to live longer than men; and women are also more likely to be hospitalised for this condition either because they are widowed by the time they develop the condition, or because their ageing spouses are unable or unwilling to nurse them.[17]

It would be interesting to examine why women were overlooked as a group with special needs at this stage of policy development. It could be that the magnitude of the changes needing to be tackled worked against detailed consideration of groups requiring particular attention. Women's frequent use of services could also have encouraged the assumption that their needs were already being met. Case study methodology would be a valuable way of examining the validity of these hypotheses and exploring the processes at work in the different states. This type of investigation is, however, not the purpose here. At this point, the aim is to identify the extent to which women's issues have been included in mental health policy, rather than to analyse retrospectively why women have been ignored.

In contrast with the gender-blindness of the early policy statements of the different states, the initial national mental health policy document acknowledged gender was relevant to service development.[18] The document identifies the principle 'that Governments ensure

provision of and access to mental health which is sensitive to gender issues',[19] and specifically refers the particular mental health problems faced by women.[20] Clearly this raised the possibility of women's needs being given attention. Unfortunately detail was not given on what gender-responsive services might look like, nor have later drafts of the national policy provided any elaboration. The danger is of course that this principle will remain rhetorical unless more specific direction is given.

In its global references to gender, the 1991 *Mental Health Statement of Rights and Responsibilities* (MHSRR) runs the same risk of tokenism. This statement does go further at one point, and specifically mentions the right of consumers to be protected from the threat of sexual harassment and abuse when using mental health services.[21] However, by referring to 'he and she', the statement is open to one of the criticisms of gender-blindness already mentioned, as this even-handedness denies that it is women rather than men who are most vulnerable to sexual harassment and abuse. In relation to carers, the document is more explicit, and acknowledges that 'in the majority of cases the caring role is assumed by women'.[22]

Ironically, concurrent with the gender-blindness of mental health policy statements in the 1980s, increasing attention was being paid to issues for women in the development of health policy. For instance, in late 1985 the Victorian Health Department began a process of consultation on women's health. This process resulted in the publication in August 1987 of a report with specific recommendations for improving health services to women in Victoria, including the development of psychiatric services and therapies more relevant to women.[23] The report does not specify what the development would entail, leaving this to the state Office of Psychiatric Services.

At a national level, women's health gained prominence in the late 1980s, with formation of a National Women's Health Policy in 1989 and the allocation of funds for an initial five year period to a National Women's Health Program. Women's emotional and mental health was one of the seven priority issues identified in the National Women's Health Policy.[24] The five areas then targeted for action do not include a coherent plan for responding to women's mental health problems. Rather, specific strategies in relation to mental health issues are interspersed amongst others relating to different aspects of women's health.[25] Consequently, little guidance is offered for mental health policy development in regard to women, either nationally or by the states.

Clearly, because of years of neglect, the national policy objective of improving women's health has proved daunting in size and complexity. The seven priority issues identified include those affecting the majority such as reproductive health and sexuality, as well as others relevant to particular groups such as ageing women. Inevitably, some issues are also more amenable than others to policy development and strategies for change. Violence against women is an example. It is generally socially abhorred, relatively easy to define, directly experienced by only some women but recognised as a threat by all, and the types of services needed by victims are clearly identifiable. Women's mental health is less easily recognised as a serious policy issue. Use of the term 'women's emotional and mental health' in itself is problematic. It invites sidelining in terms of policy formation and action for change, as the wording is too vague to be easily translated into identifiable and achievable goals.

Being couched as a self-evident good, 'women's emotional and mental health' also masks the spectrum of problems needing attention. The types of problems which could potentially be included is vast, ranging from the mildly debilitating to the seriously disabling.

This vagueness and over-inclusiveness mean the relevance of the national priority issue of women's emotional and mental health is particularly elusive for policy-makers at the state level, where the focus is largely on the seriously mentally ill. Despite the momentum created by the National Women's Health Policy and the associated National Women's Health Program, women's mental health is therefore still in danger of being marginalised as a policy issue.

In identifying mental health issues for women, it is obviously tempting to keep the agenda broad to encompass the full range of problems faced by women. An example of this approach is *Women and Mental Health*, a report published in 1990 by the Australian National Health and Medical Research Council (NHMRC). The report outlines physiological, social, cultural and psychological factors affecting the emotional and mental health of women. However the range of solutions proposed is as wide as the range of problems identified, and a specific blueprint for change is lacking.

Another limitation of the broad approach exemplified by the NHMRC report is that all types of emotional and mental health problems encountered by women end up being given the same status in terms of impact. Whilst admirable in its intent to cover concerns for the majority, the consequence is that issues for women with the most disabling conditions are not given particular attention. It can be argued however that these women need to be a prime focus for policy and service development. For instance, women with serious mental health problems, along with their male counterparts, are demonstrably one of the most disadvantaged groups in our society. This group of women are also those most likely to use specialist mental health services and therefore to be most affected if policy and services are unresponsive to their needs. Furthermore, as has already been outlined, policy in relation to specialist mental health services is undergoing rapid change, and it is critical that women's mental health issues not be overlooked as part of this change.

This discussion shows developments in health policy for women have not provided clear directions for the way women's issues could be included within mental health policy either at the national or state level. Given the difficulties outlined, there is a need to move away from an all-inclusive agenda and to define the policy issues more sharply. A promising development in this regard is found in the document *Policy and Strategic Directions for Public Psychiatric Services in Victoria*, published in January 1992. Women are identified in the document as one of the groups whose needs require special attention if equitable outcomes are to be achieved, and a number of priorities are specified for service development.[26] For the first time in Australia, a statement on mental health policy began to provide detail on what is needed for the service system to be responsive to the majority of its users.

Whilst the Victorian policy document is a landmark, women's issues still remain overlooked or marginalised in mental health policy development in the other states and nationally. This highlights the importance of clarifying what issues should be included and why, and how they could be tackled. The central aim of this monograph will be to delineate the issues which need to be taken into account in ensuring that mental health policy is sensitive to the special needs of women. The intent is to provide a blueprint for women's mental health policy which will be useful across Australia. However, particular reference will be made to Victoria, as a state at the forefront of policy and service development in the mental health field.

Footnotes

1 Allen,1986,p.85
2 Allen,1986,p.86
3 Chesler, 1972
4 *Ibid.* 1972,p.118
5 Smith & David,1975; Penfold & Walker,1983
6 Carman *et al*,1981; Kessler *et al*,1981; Russo & Sobel, 1981
7 Eisen & Wolfenden, 1988
8 Mental Health Discussion Paper,1989
9 National Mental Health Strategy Statement,1990
10 Report of the Mental Health Task Force,1991
11 National Mental Health Policy, 1992
12 New Directions for Psychiatric Services in Victoria, 1986, p.4
13 *Ibid.*, 1986, p.5
14 Rimmer *et al*,1988,p.12-13
15 Weeks,1986,p.13-14
16 Office of Psychiatric Services, 1988a,p.3
17 Allen,1986,p.109-110
18 Mental Health Discussion Paper, 1989,p.34
19 *Ibid.*
20 *Ibid.*, p.33-34
21 Mental Health Statement of Rights and Responsibilities, 1991,p.7
22 *Ibid.*, p.17
23 Why Women's Health,1987,p.71
24 National Women's Health Policy, 1989,p.5
25 *Ibid.*,1989,p.88-106
26 Office of Psychiatric Services, 1992, p.20-21

2. Framing The Issues

In identifying mental health issues important for women, my analysis will be influenced by feminist thinking and research. In succinct terms, a feminist approach is 'about keeping women on the stage rather than relegating them to the wings'.[1] Use will be made of the relatively recent feminist approaches to mental health policy[2] emanating largely from the United States, as well as the body of literature applying this framework to public policy more generally.[3]

A feminist approach to the field of mental health not only highlights issues faced by women with mental health problems, but in turn acknowledges that these issues often reflect women's general status and position in society. This perspective 'recognises that we live in a sexist society - where many attitudes, beliefs, practices, policies and laws discriminate against women on the basis of gender'.[4] Indeed women psychiatric patients are doubly disadvantaged, as they carry two inferior social statuses. The most poignant illustration of the effect of this double disadvantage is the woman who is sexually abused by a male therapist whilst she is psychiatrically disturbed. The double jeopardy faced by women psychiatric patients emphasises the importance of appropriate policy responses.

Some of the issues raised such as access to suitable housing will have relevance to men as well as women. These issues will however be explored for their particular meaning for women - for instance, why women-only housing should be an option. Other issues such as sexual harassment and exploitation are predominantly a concern for women.

The analysis which follows makes extensive use of relevant research, and this warrants discussion. It would be naive to believe that research alone could bring about a change in policy. Indeed, existing policy in mental health or any other area of public policy does not necessarily reflect the present state of knowledge in that field. The critical influence of political processes on policy development is now sufficiently well-documented that gaps and lack of fit between research and policy are no surprise in contemporary policy analysis.[5] Furthermore the questions a researcher is seeking to answer may not have direct bearing on relevant policy issues. In turn, policy makers may be concerned with policy questions which hold little interest for researchers. However research can have a particularly useful role in making visible that which has been outside public consciousness, because it is seen as too controversial, or trivialised as unduly subjective, or ignored as irrelevant. Examples relevant to women's mental health include the number of male therapists who have sexual relations with their female psychiatric patients,[6] the relationship between clinical depression in women and their life circumstances,[7] and the inadequate attention given to the physical health needs of long-term women psychiatric patients.[8] Whether we call the process 'naming'[9] or 'legitimation',[10] research offers the systematic documentation often needed for such issues to become an acceptable part of public discourse, and hence it illuminates the policy-making arena.

For women, this documentation has particular value. It can give visibility and coherence to insights based on direct or shared experience, which otherwise remain privatised and fragmented. It is also important to note that what is made visible through research depends on what questions are seen as important. For instance, it is only since the 1980s that U.S.A. journals began to record a concern for the implications for women of the deinstitutionalisation programmes begun in that country in the 1960s, especially women with long-term psychiatric problems.[11]

At times it would appear that women's experiences have remained invisible because of androcentricism, that is, assuming that the male experience is universal or the norm.[12] The scarcity of research on women's experience of psychiatric hospitalisation is an example. Attention has been paid to what happens to patients in psychiatric institutions, but little consideration has been given to the 'distinctive experiences women have of institutionalisation'.[13] The main source of awareness here has had to be women's personal accounts published in the form of autobiographies, novels or poems.[14]

Another reason for the invisibility of women's experience seems to lie in a lack of interest in the relevance of particular structural variables to the experiences of women or men. For example, until very recently research on the situation of aged people with psychiatric disorders has been minimal, and in the Australian context little attention has been given to the experiences of mental ill-health of people from non-English speaking backgrounds, of aborigines, and of people from rural as opposed to urban areas. It would also appear that the lack of research on certain experiences of women can be similarly linked to their apparent irrelevance to prevailing forms of theorising or analysis. Examples are the relative paucity of studies of women diagnosed as having a schizophrenic disorder, or on the use of electroconvulsive therapy (ECT) or psychosurgery for women. The lack of attention to these areas can be contrasted with the active interest in depressed women and in the use of psychotropic medication.

So a research-based analysis will inevitably be a selective account, and many questions relevant to women's mental health still remain unasked and unanswered. A further difficulty in the Australian context is the lack of relevant local research. This gap was noted in the 1989 Report on a *National Women's Health Policy* ,[15] and little has changed since then. Consequently my analysis will rely largely on the findings of studies undertaken in countries such as U.S.A., Canada and the United Kingdom.

Where research has been instrumental in legitimising particular issues, it can also provide the impetus for action. This directly concerns the strategic potential of research in relation to the political processes now regarded as integral to policy-making. The United States is an instructive example in this regard.

In the U.S.A., the particular needs of women in relation to mental health policy were first addressed formally through the 1977 President's Commission on Mental Health, which had a Subpanel on the Mental Health of Women.[16] Other key developments have included the formation of a women's mental health agenda as the outcome of a national conference in 1984, establishment of a national coalition for women's mental health as another outcome of the conference, and the setting up of a working group at the National Institute of Mental Health to develop a women's mental health research agenda.[17] In addition, the Women's Task Force of the Department of Mental Health in the State of Michigan has been active in developing and publishing material and recommendations on changes to mental health policies and services for women.[18]

In a review of the influences leading to these important policy developments, Russo acknowledges the key role played by established women's groups, particularly those already active in the policy-making arena.[19] She also accords research a central place, in particular research informed by a feminist framework. She notes 'the emergence of a new feminist scholarship on women to criticise traditional approaches and to document the destructive effect of women's social roles and disadvantaged status was a critical foundation for these efforts'.[20]

To Russo, insights from this research provided both the momentum and the tools for activist groups to get women's mental health on the US policy agenda.

The U.S.A. example usefully illustrates the strategic contribution of research to policy development, but also shows that its impact depended on how it was used by lobby groups. This sounds a warning about the limitations of the analysis presented in this monograph. Put simply, the analysis will be insufficient in itself to ensure the development of mental health policy sensitive to women's needs. What it can do is show what such policy should look like, and suggest how and why certain issues might be more easily addressed than others. However getting these issues on the policy agenda relies on political processes beyond the scope of this analysis.

In part the issues considered here are those already identified by researchers as being of concern for women with mental ill-health. Obviously research does not arise in a vacuum, but is influenced by researchers' values, experiences and theoretical interests. Similarly, the selection of issues for my analysis is informed by a particular perspective, which is feminist in orientation. The focus will therefore be on the special concerns of women with mental health problems because of their gender. Much of the research drawn on derives from feminist perspectives, although it cannot be assumed that just because a study focuses on women it has a feminist orientation.

Feminist approaches stress the importance of women themselves having a voice in identifying their concerns, largely because women's accounts of their experience have been ignored in the past, with the male version being assumed to be common to both sexes. Ideally then, the selection of issues for the current analysis would be derived from a combination of what women with mental health problems said were their concerns and related research. This was the approach followed by the Women's Task Force of the Michigan Department of Mental Health, which used both public consultation as well as research in developing recommendations for change to the mental health system in that state, and more broadly within the U.S.A.[21] Whilst the results of the Michigan process have value for sensitisation purposes, the outcomes of consultation undertaken in the U.S.A. cannot necessarily be generalised to the Australian context.

Mental Health Issues Raised by Women

Taking the state of Victoria as a local example, so far no formal consultation with women specifically focused on mental health. Despite this gap, within the last seven years there have been two local opportunities for women to contribute their views about mental health issues that concerned them. The first was a government-initiated consultation process undertaken in 1986 regarding women's health, and the second was the Victorian Women and Mental Health Conference held in November 1989. In addition, nationwide consultations were carried out in 1987 and 1988 to fulfil the federal government's commitment to the establishment of a national women's health policy.[22] Each of these will be discussed in terms of their contribution to identifying mental health issues of concern for women.

From the mid-80s, as already mentioned, the Victorian government had shown a particular interest in the health needs of women. This interest was demonstrated in the formation in late 1985 of a Women's Health Policy Working Party in the Victorian Health Department 'to investigate women's health issues and to recommend measures to improve health services for women in Victoria'.[23] The Working Party undertook an extensive process

of consultation with Victorian women users of health services, publishing the report of its findings and recommendations in August 1987.[24] The visible outcomes of the report's recommendations included the setting up of a women's health service in the western suburbs of Melbourne, an area of marked social and economic disadvantage, and the establishment of a women's health policy and program unit within the Health Department.

Unfortunately, the approach followed by the Working Party had marginal value in identifying and drawing attention to issues for women users of mental health services. This group was only one of many categories of users covered by the consultation, which was geared to the articulate and well-organised. In contrast, women users of mental health services in Victoria, especially those with serious psychiatric disturbance or marked disabilities, were not organised around their disability or their status as consumers. Presumably, also as individuals, they were less likely to voice their concerns than those whose health issues did not carry a social stigma. As a consequence, issues for women users of psychiatric services had minimal visibility, occupying barely five of 162 pages in what has been described as a 'user-driven' report.[25]

The authors of the report were mindful of these limitations, and their comments are worth repeating in full: 'many of the issues raised by the consultations and submissions in reference to psychiatric services are distressing and warrant further investigation. Unfortunately, it was not within the Terms of Reference of the Working Party to fully investigate all these concerns'.[26] The authors went on to recommend 'that the Office of Psychiatric Services take up these issues and develop services and therapies more relevant to women in consultation with the Office of Women's Health', specifically through the secondment of an Office of Psychiatric Services senior policy officer to the proposed Office of Women's Health 'to develop and coordinate new service models for women in psychiatric care'.[27] This recommendation was not implemented, so the current analysis relies on the issues reported from the original consultation.

Despite these problems, it is still important to note the issues raised by women users of mental health services who participated in the consultation. These included the following :

- lack of information on the nature and side effects of psychotropic drugs;
- the insensitivity of general practitioners to women's concerns;
- lack of alternatives to psychiatric hospital admission when problems became overwhelming for women with dependent children, with the result that children had to be placed in care;
- the risk of sexual harassment for hospitalised women from other patients and staff;
- the limited accommodation options for women following psychiatric hospitalisation, and the risk of coercion and abuse associated with some types of accommodation.[28]

As already mentioned, in 1987-8 the Australian federal government sponsored nationwide consultations on women's health issues. The process used in the national consultations demonstrated similar problems to the Victorian example in capturing the concerns of women with mental health problems. Those managing the consultation process faced enormous logistical obstacles, and inevitably those women able to use the opportunities offered were again the articulate and well-organised. The account given in the report made this clear. 'The meetings attracted many individual women who had a strong interest in women's health issues,

as well as representatives of community and consumer groups and health care and social welfare professionals'.[29] Those unable to attend meetings 'were able to make their views known to representatives of women's organisations at local meetings and workshops',[30] and individuals and groups also made written submissions.

The point here is not that the findings of this consultation were necessarily invalid, rather that the way the process was structured would tend to exclude women with mental health problems, particularly the more disabled. The ensuing report, in identifying specific health issues, devoted only three pages to women's emotional and mental health, although these were identified as major concerns for women, and 'were mentioned in most of the submissions received'.[31] Furthermore, findings given in relation to women's emotional and mental health are largely based on Australian and overseas research, with the rider that 'in common with other areas of women's health, there is little information on women's emotional and mental health relevant to policy decision making'.[32]

The research discussed covered issues of prevention as well as those relating to women who had already experienced mental ill-health.[33] Sifting is needed however, to identify issues raised by actual users of services, and the only ones directly reported were criticisms of treatment. These involved 'treatment of symptoms rather than the underlying social and economic influences, lack of counselling, and overreliance on tranquillisers'.[34] The authors of the report did not indicate in which state(s) the comments were made so there is no way of knowing the extent to which women from different states were involved.

In summary, the recent Victorian and nationwide consultations on women's health issues had limited value in giving women with mental health problems a chance to voice their concerns. Thus it cannot be assumed that the issues raised form a comprehensive account, nor that they would be common to most or all women with mental ill-health.

The 1989 Victorian Women and Mental Health conference had the promise of a forum where local women could focus specifically on their mental health issues. For example, two of the conference aims were to 'unite women around mental health issues and build a common agenda for change', and to 'identify and raise awareness of issues specific to women and mental health'.[35] The conference attempted to attract attendance by consumers, largely through a concession rate for those on low incomes, although pre-conference workshops were also offered to consumers. Childcare, local billets, and assistance with languages other than English were made available to reduce known barriers to attendance. Around two hundred women attended, with a mix of workers and service users: staff from government psychiatric services were minimally represented, and workers outnumbered consumers.

As could be expected at a landmark conference with a diverse group of participants, issues raised were not only numerous but also wide-ranging, and it is difficult to identify common themes. The conference was not designed as a formal consultation process with responses being sought to predetermined areas, such as the particular concerns of women who have been hospitalised for their psychiatric condition. Inevitably some issues also arose out of the conference process itself, such as whether the concerns of women who identified themselves as lesbians were adequately addressed. The conference was however, the first in Victoria for many years with a specific focus on women's mental health, so the issues raised warrant consideration. What follows is not an exhaustive list, but a summary of the main themes of the conference in relation to women users or potential users of mental health services, based on a detailed record of recommendations from the action groups formed over the two days.

A strong theme arising from the conference was the importance of consumers having a say in what services they were offered, and how these services were provided. Consumers considered women service users often lacked information, the needs and rights of consumers were ignored, and the label of mental illness was stigmatising and disempowering. Workers were seen to be generally poorly informed about the particular needs and experiences of women with mental health problems. Furthermore, women from non-English speaking backgrounds (NESB) were seen to have particular difficulties in using existing services, because of the lack of bilingual workers, particularly bilingual women workers. Consequently NESB women had to seek assistance from workers with whom they could not communicate directly, and who often had little understanding of cultural differences in concepts of mental health and ill-health.

Another area of major concern was housing. Issues raised included the limited range of accommodation options for women leaving hospital or as an alternative to hospital admission, and the lack of women-only housing and accommodation for women with children. The situation of women with mental health problems who had dependent children was seen as particularly difficult. Not only was suitable accommodation often hard to find, but hospitalisation also typically necessitated placement of children. Furthermore, conference participants pointed out that community-based services lacked child care facilities which could be used for young children whilst their mothers attended programs. If a child was considered to be at risk because of the mother's mental ill-health, then often other government departments became involved, such as protective service workers. In this situation women at times felt exposed to conflicting expectations.

Community support services that were seen as important included women-only self-help and consumer advocacy groups, validation and support for women carers, 24-hour long term outreach support as well as crisis intervention, and women-specific services generally. Affirmative action was held to be necessary for women to be referred to psychosocial rehabilitation programs. Finally, conference participants stressed the importance of more research on women's mental health problems, and of mental health policy which took account of women's needs. Other issues raised by conference participants-such as the problem of burnout faced by women workers in mental health services, community education about mental health, and ways to raise women's self—esteem more generally—are not included as they fall outside my current focus.

A Framework of Women's Mental Health Issues

The themes of the Victorian and national consultations and the Victorian Women and Mental Health Conference will now be summarised, and a framework of issues developed for further examination in terms of relevant research and appropriate policy responses. In doing so, it is important to note the limitations involved in each forum, and not assume that the concerns of all women with mental health problems were necessarily represented. Instead developing an issues framework will involve an interplay between research and the issues raised in the three forums. For instance some concerns will be included which have already been the subject of much research interest, along with others which barely have been touched by research. Conversely some issues not mentioned in the forums will become part of the framework because studies have demonstrated their significance for women. Research performs a particularly valuable role here as researchers have at times deliberately captured experiences which would otherwise be neglected. A good example are the studies of chronically mentally

ill women recently published in a book edited by Bachrach and Nadelson.[36]

At this point the focus will be on outlining the framework of women's issues to be taken into acount in mental health policy. More detailed discussion on each issue will be provided in later chapters, particularly in terms of relevant research and appropriate policy responses.

A recurrent theme in the forums and in research is how women's mental health problems are diagnosed and treated. As already noted, a constant concern raised by women is the way these key aspects of psychiatric practice leave them feeling misunderstood and disempowered, *let a*lone over-medicated. It appears the individualistic focus favoured in clinical practice in which problems and solutions are located in the individual is out of kilter with women's experience.[37] In pointing to the impact of a psychiatric diagnosis on women, Busfield makes a pertinent general comment that this

> helps to ensure that little is done to focus on the situational aspects of their problems. This is not something that is specific to women; however, since many more women than men now receive treatment for psychiatric complaints it is of especial importance to them.[38]

Women's concerns about the diagnostic and treatment process, and the centrality of this process therefore accords this issue a primary place in the framework of issues. A second and related issue is how and where diagnosis and treatment is provided to women. Research indicates different patterns in the use of in and out-patient services by women and men which warrant exploration.[39] It is also possible that socio-economic factors are influential here. For example, women who have private health insurance have more choices about which services to use than those without. Finally, this brings to our attention women's concern with the lack of alternatives to psychiatric hospitalisation, especially when placement of children is involved, and this deserves attention.

Another major concern raised by women is the limited range of housing options for women with mental health problems. Undoubtedly the importance of safe and secure accommodation has been magnified with community placement of those previously occupying long-term psychiatric beds.[40] However, given that at least in Victoria the major reduction in the long-term psychiatric population occurred from the late 1960s to early 1980s,[41] it seems likely that shorter hospital admissions is the major reason for housing now being seen as a significant issue.[42] Recent Victorian studies of the extent of psychiatric disturbance amongst people who are homeless,[43] and of the problems faced by homeless women in particular,[44] have also sharpened attention to this issue. For women with mental health problems, housing issues include not only the need for choice between living alone or with others, but also having access to a safe environment free from the risk of sexual harassment. The option of women-only housing seems particularly important.

Whilst housing is an issue for women living in the community, access to rehabilitation programs spans both hospital and community settings. Opportunities for involvement in rehabilitation was not a major issue raised in the three forums already discussed, receiving only passing comment at the Women and Mental Health conference. Consequently, it is the work of others which provides the basis for claiming this issue is important for women with mental health problems.

The key concerns have been firstly, that women are less likely than men to be referred

for rehabilitation, apparently on the grounds that women are best fitted for domestic roles whereas rehabilitation is concerned with paid employment.[45] Obviously this raises problems of isolation, social and economic dependence, and lowered performance expectations. Secondly, it has been noted that rehabilitation programs pay little if any attention to improving skills in domestic roles, such as household management and child-rearing, thereby negating an important area of development for women.[46] Even if referred for vocational rehabilitation, women are likely to be limited to training based on sexist stereotypes of women's employment.[47] Finally, women-only programs are held to be important in attracting women, who are often deterred by the behaviour of men in mixed sex programs.[48]

Overall then, access to appropriate rehabilitation opportunities is a critical issue for women, particularly those with ongoing psychiatric disabilities. Lack of referral, or referral to programs which pay little attention to their needs, can deny women with mental health problems the chance to increase their self-confidence, improve their daily living skills and develop new activities and networks.

Another issue, that of sexual harassment and abuse, was raised solely in the Victorian consultation and couched in terms of the risk of sexual harassment in hospital settings and mixed sex accommodation. In contrast, the vulnerability of women to sexual abuse and exploitation has been a strong concern in the U.S.A.[49] In various American states, impatience with ineffectual action by professional associations is leading to enactment of various types of legislation, including in four states criminalisation of sexual relations between patient and therapist.[50]

In Australia, the sexual exploitation of women psychiatric patients has only recently been aired as a public issue, through a case successfully prosecuted in New South Wales in May 1990. In August 1990, the ANZ College of Psychiatrists released its first formal ethics statement on sexual relationships with patients. Women with mental ill health are at risk of sexual harassment and abuse in a number of situations, from staff as well as others, and there is now considerable evidence of the damaging effects when women are exploited in this way.[51]

The next issue is broader in scope. It concerns those women with mental health problems who are seen as having special needs. Two of these groups were identified by women themselves in the Victorian consultation and conference discussed earlier in this chapter - women with children, and women from non-English speaking backgrounds. The particular difficulties faced by these particular have already been outlined and will be explored further in Chapter 5.

Inclusion of two other special needs groups is based primarily on research. The first is ageing women with mental ill health, and the second is women with marked psychiatric disabilities. In relation to the first group, there is evidence to indicate that psychiatric problems are often overlooked in the elderly, and that women are particularly vulnerable in this regard because of longer life spans and societal attitudes to age and gender.[52] In Australia aged women referred to private psychiatrists are more likely to receive shorter consultations than younger women, and were the most likely to receive electro-convulsive therapy (ECT) of all age groups of either sex.[53] In the United States they are also more likely to be prescribed psychotropic medication than elderly men.[54]

The last special needs group is often called 'chronically mentally ill women' in the United States.[55] The women in this group have serious ongoing disabilities, often from a combination of experiencing a major psychiatric disorder such as schizophrenia and having

spent considerable time in hospital. Many of their needs are common to other women with mental health problems, such as housing and access to rehabilitation. Women with marked psychiatric disabilities warrant special attention not only because their needs are often overlooked, but also because they face particular difficulties due to the continuing nature of their disabilities. For example, there is evidence that their physical care is neglected.[56]

A separate group altogether comprises women as carers of people with mental ill-health. Whilst typically not in themselves users of mental health services, their caring role is primarily related to gender as it is women in Western societies who are expected to care for other family members who are disabled. Changes to mental health policy have had a direct bearing on women as carers. For example, the increasingly restricted use of hospitalisation has meant more people with mental health problems spend more time living in the community, and 'the relatives of people with mental illness bear by far the greatest burden in management, care and support'.[57] Research in both the U.S.A.[58] and the U.K.[59] has noted that this burden is largely borne by women, and there is no reason to believe the situation is different in Victoria. Participants in the Victorian Women and Mental Health conference saw women carers as needing support and validation through recognition of their skills and strengths.

A theme relevant to most of the issues already discussed is the limited data available on women's use of mental health services and related research. I have already recorded the comment made in the Report on a National Women's Health Policy which refers to the lack of information relevant to policy decision making.[60] The Report notes that 'data are needed on such things as mental hospital admissions, utilisation of mental health care systems and use of psychoactive drugs'.[61] In Victoria a report from the Office of Psychiatric Services on patterns of psychiatric service use comments that

> the lack of a reliable and comprehensive data base by which to view the whole system of care is a major obstacle to informed policy analysis and is itself an important issue in the planning for change process.[62]

For example, the report notes that in relation to out-patient services, information was lacking on the public hospital and private sectors.[63] Needless to say, these unavailable data also include detail on use of such services by women. To date, the Office of Psychiatric Services has been unable to provide statistics on the comparable proportions of women and men using its own out-patient services.

In summary then, the framework of issues includes the following :

- how women with mental health problems are diagnosed and treated
- women's use and experience of treatment services
- housing options for women with mental health problems
- women's access to rehabilitation
- the risk of sexual harassment and abuse
- women with mental health problems with additional needs, including women with children, women from non-English speaking backgrounds, ageing women, and women with marked psychiatric disabilities
- women as carers
- the inadequacy of research on women with mental health problems

A Definition of Terms

Several essential terms in the following analysis are open to more than one interpretation. These include mental health problems or mental ill health, mental health policy and mental health services. Given each can have several meanings, it is important to make clear how these terms will be used in this analysis.

The terms 'women with mental health problems' or 'women with mental ill health' are broad and can encompass a range of conditions which may be more or less disabling for the woman concerned. For instance the experience of mild depression may have little effect on a woman's involvement in everyday activities, and she may not seek professional help unless her depression becomes disabling. In the interests of avoiding over-inclusion, the focus here will be on women whose mental health problems or mental ill health are sufficiently disruptive or distressing for the women concerned to be at least potential users of specialist psychiatric services. The term 'psychiatric problems' will also be used, but mainly when referring to situations where it is clear a psychiatric diagnosis has formally been made. Finally, the term 'psychiatric disability' will be employed to indicate disabilities associated with the experience of a diagnosable psychiatric disorder, acknowledging that particular disabilities can also be exacerbated if not created by institutional practices.

The term 'mental health policy' also warrants attention. It has been pointed out that 'any public policy that touches women's lives (eg. housing, energy, criminal justice, health) has an effect on women's mental health'.[64] To maintain focus and depth, a narrow definition will be employed. 'Mental health policy' will be taken to include those policies which affect women as users or potential users of mental health services.

The focus on policy related to mental health services raises other conceptual issues as the term 'mental health services' is open to a number of interpretations. The term 'mental health' is usually a misnomer when applied to services, as it is typically taken to refer to those services which aim at restoring or achieving mental health for those experiencing mental *ill* health. Again, in the interests of maintaining clear boundaries, this interpretation will be retained. It is beyond the scope of this analysis to include policy concerning services aimed at prevention or at the promotion of mental health. Even retaining the conventional interpretation, however, does not remove the difficulties in delineating the scope of 'mental health services'.

One way of refining this concept is to focus on a particular auspice, such as the government department with prime responsibility for mental health services. In Victoria for instance, this would mean a focus on those services under the auspice of the state Department of Health and Community Services. However, even in relation to short-term psychiatric in-patient care, this Department has for some years been a minority service-provider if one combines use of similar facilities provided by private and general hospitals. In 1985-6, 39.9 percent of acute psychiatric admissions were to state facilities (9,480 episodes), and 60.1 percent to private or general hospitals (14,290 episodes).[65] The consequent distortion involved in using auspice as a basis for defining mental health services is compounded when it becomes known that women constituted 70.7 percent of admissions (4,314 episodes) to Victorian private psychiatric hospitals in 1985-86, compared to 51 percent of admissions (4,834 episodes) to state acute psychiatric units over the same period.[66] Furthermore, women comprised 59.6 percent of admissions to public hospitals (4,931 episodes) for acute psychiatric disorders in 1984-5.[67]

Another way of defining mental health services is to focus on the professional discipline

of service providers. For example, it could be argued that mental health services are those services provided by psychiatrists, as it is this profession which our society formally acknowledges as the experts in diagnosing and treating psychiatric problems. However, there are also difficulties with this type of definition, particularly in regard to women. Overseas studies show that women are, for instance, more frequent users than men of general practitioners, and are more likely to receive a psychiatric diagnosis and be prescribed psychotropic medication from such practitioners.[68] Conversely, but of no less concern, I have observed that women have lower participation rates in community-based rehabilitation programmes, programmes which are typically staffed by non-psychiatrists. Using the qualifications of service providers to define mental health services would thus rule out services which raise pertinent issues for women.

A third basis for defining mental health services builds on Talbott's reconceptualisation of the public mental health system.[69] Talbott argues convincingly that those mental health services funded with public dollars should legitimately be considered part of the public system, even if they are run for profit or by non-profit making organisations.[70] In the Victorian situation, such a definition would include services provided by the private psychiatric sector, which are heavily subsidised by the public purse through Medicare, and by voluntary organisations, which may receive funding from both state and federal governments. Such a definition could also be extended to include the type of for-profit supervised accommodation provided by Special Accommodation Houses (now known as Supported Residential Services) in Victoria. It has been estimated that around 4000 psychiatrically disabled people, or 20 percent of residents, live in such accommodation in Victoria.[71]

To sum up, mental health services will be taken to mean services for those experiencing mental ill health which are funded totally or in part by public dollars. Indeed, it is difficult to identify any services used by women with mental health problems which do not fall into this category. This way of conceptualising mental health services avoids the limitations of the other definitions already outlined. It also has the advantage of revealing the extent to which private for-profit services are actually supported by public funds. Although traditionally mental health services have been seen as a responsibility of state governments in Australia, this definition of mental health services will encompass services provided by other levels of government, as well as the private sector.

The example of Victoria will again be used to illustrate the range of government instrumentalities, voluntary organisations and private agencies involved in mental health service provision. In Victoria the state Department of Health and Community Services has been a key direct and indirect provider of mental health services. The Department funds and directly manages state psychiatric hospitals, and a growing number and range of community-based services throughout the state.[72] Psychiatric beds in public hospitals are expanding through targeted funding, with the management of these services being the responsibility of independent boards. Finally, the Department provides funding for community support services in the mental health field, run by voluntary organisations. Limited departmental control is exercised over services provided by the private for-profit sector, such as through the licensing of private psychiatric hospitals, and the registration and monitoring of Supported Residential Services and nursing homes.

Apart from the Victorian Department of Health and Community Services, other state government instrumentalities in Victoria also provide services used by people with mental

health problems. An important example is the state housing authority. This authority for instance has not only made flats available for use as transitional supported accommodation, but also provides funding for the purchase of houses to be used as group homes by people with psychiatric disabilities. To date, voluntary organisations have applied and provided the operational management for group homes bought by the state housing authority, with off-site support for residents often coming from local community mental health clinics. There is also potential for targeted allocation of public housing to psychiatrically disabled people on low incomes, with specialist mental health services providing backup support as necessary. In the recent past, the state Department of Labour had some involvement in services for people with psychiatric disabilities, for example through funding a community employment support project; and the state Department of Sport and Recreation has been involved through funding outreach recreational support.

Two other Victorian organisations warrant noting because of their advocacy role in the mental health field. One is the Mental Health Legal Centre, which provides guidance to individuals seeking advice on legal issues related to their psychiatric condition. For instance, the Centre offers legal representation to psychiatric patients seeking to have their case heard by the Mental Health Review Board set up under the 1986 Mental Health Act. The Centre has received funding both from the Victorian Health and Community Services Department, and the state Attorney General's Department.

The second is the Office of the Public Advocate (OPA), established as a quasi-autonomous government organisation. As well as responding to issues affecting the rights of individuals with disabilities, OPA also oversees the system of community visitors, who have a statutory brief under the 1987 Mental Health Act to visit and report on conditions in state psychiatric services. In 1991, a new scheme of psychiatric advocates for users of public psychiatric services was established under OPA's auspice.

On a federal level, the category of psychiatric disability was included in the 1986 Disability Services Act.[73] In principle, this meant community organisations providing rehabilitation services to the psychiatrically disabled were eligible for funding of capital works and equipment.[74] Until recently the federal Department of Health, Housing and Community Services saw these services as largely a state responsibility, and focused its funding efforts on other types of disability. Following initiatives announced in the 1990 August Federal Budget, including special funding for rehabilitation for people with psychiatric disabilities, the Department's Commonwealth Rehabilitation Service has now set up training programs for this client group. These programs have taken different forms in different states, with Victoria piloting specialist support to existing CRS units and the other states establishing specialist programs for people with psychiatric disabilities.

In the area of housing, the Department has funded transitional housing for homeless people, many of whom are psychiatrically disabled, under the Supported Accommodation Assistance Program (SAAP). SAAP is administered locally by state government departments, such as Health and Community Services in Victoria, who are therefore influential in which projects obtain funding.

Another important new development is the establishment of Disability Service Agreements between the Commonwealth and the states. These agreements are designed to rationalise responsibility of the different levels of government for different types of support services for disabled people. The Commonwealth, for instance, will assume responsibility for employment

and vocational programs, and the states for housing, rehabilitation and other community support services.

Also on the federal level, the Department of Health, Housing and Community Services is indirectly involved in the provision of private sector mental health services. From 1983 under Medicare, the national health insurance scheme, patients could seek reimbursement for visits to private psychiatrists. If the psychiatrist bulk-billed, in effect the patient need make no direct payment at all. Previously patients had to carry private health insurance to receive reimbursement, and were then only partially reimbursed for the service. The introduction of Medicare predictably not only increased use of private psychiatrists, but also led to more psychiatrists moving into private practice, as payment for services was ensured.[75] In Victoria the number of private psychiatric consultations grew from around 320,000 in 1982-3 to 360,000 in 1985-6, only three years later.[76]

Finally, local government has been marginally and unevenly involved in mental health services. For example in Victoria, a state with a well-developed system of local government community services, home help services and meals on wheels are in principle available to those with psychiatric disabilities living at home, and at least one municipal council (Essendon) initiated establishment of a community-based psychosocial activity program. Particular councils have also provided local leisure and recreation programs for people with disabilities, including those with psychiatric disabilities. There has been scope for more consistent involvement by local government in the provision of community support services to people with psychiatric disabilities, particularly under the Home and Community Care scheme (HACC).

This necessarily brief outline indicates different ways in which government, semi-government, voluntary and private sectors are involved in providing services for people with mental health problems. By intention or default, policy is important in determining what services are delivered, how and to whom. In ensuing chapters I will consider the extent to which issues for women as users or potential users of these services have been addressed.

Footnotes

1 Pascall,1986,p.1
2 Walker,1984; Mowbray *et al*, 1984; Howell & Bayes,1981
3 Baldock & Cass,1983; Dale & Foster, 1986;Goodnow & Pateman,1985; Pascall,1986
4 Weeks,1980,p.27
5 Nelson,1977,p.15
6 Appelbaum,1990
7 Brown & Harris,1978; Belle,1982
8 Handel,1985
9 Du Bois,1983, p.108
10 Bachrach,1988b,p.81
11 Test & Berlin,1981; Bachrach,1984,1985 &1988
12 Du Bois,1983,p.107
13 Davis *et al*,1985,p.72
14 Frame,1961; Geller,1985; Showalter,1987,p.210-213
15 National Women's Health Policy, 1989, p.45
16 Russo,1984,p.22ff
17 Russo, 1987,p.35
18 Mowbray *et al*,1984
19 Russo, 1987,p.34-5
20 Russo,1987,p.35
21 Mowbray *et al*, 1984
22 National Women's Health Policy,1989,p.1-3
23 Why Women's Health?,1987,p.iv
24 *Ibid*
25 *Ibid*,p.67-71
26 *Ibid*,p.71
27 *Ibid*,p.71
28 *Ibid*,p.69-70
29 National Women's Health Policy,1989,p.2
30 *Ibid*,p.3
31 *Ibid*, p.43
32 *Ibid*,p.45
33 *Ibid*,p.43-45
34 *Ibid*,p.45
35 Conference brochure
36 Bachrach & Nadelson, 1989
37 Penfold & Walker,1983,p.49; Johnstone,1989,p.120
38 Busfield,1988,p.535
39 Berah,1983,p.268; Office of Psychiatric Services,1987,p.38
40 Office of Psychiatric Services,1987,p.8
41 *Ibid*
42 *Ibid*,p.10
43 Herrman *et al*,1988

[44] Council to Homeless Persons,1986
[45] Mowbray *et al*,1984,p.113
[46] Parry,1983,p.243
[47] Mowbray *et al*,1984,p.113
[48] Council to Homeless Persons,1986
[49] Bouhoutsos,1984,p.207-216
[50] Appelbaum,1990
[51] Bouhoutsos,1984,p.212
[52] Rodeheaver & Datan,1988,p.652
[53] Jorm & Henderson,1989,p.265
[54] Rodeheaver & Datan,1988,p.651
[55] Bachrach & Nadelson,1988
[56] Handel,1985
[57] Office of Psychiatric Services,1987,p.6
[58] Thurer,1983; Ascher-Svanum & Sobel,1989
[59] Busfield,1986
[60] National Women's Health Policy,1989,p.45
[61] *Ibid*.
[62] Office of Psychiatric Services,1987,p.1
[63] *Ibid*,p.34
[64] Stringer & Welton,1984,p.43
[65] Office of Psychiatric Services,1987,p.21
[66] *Ibid*,p.38
[67] *Ibid*,p.38
[68] Berah,1983,p.268
[69] Talbott,1985,p.49
[70] *Ibid*.
[71] Ministerial Review of Special Accommodation Houses[MRSAH],1986,p.53&55. Residents of Special Accommodation Houses and, in turn, the maintenance of this type of accommodation, are typically reliant on social security benefits, such that the Department of Social Security had developed the practice of block payments of residents' benefits made out as a cheque to the proprietor.(MRSAH,1986,p.38)
[72] In the near future it is proposed that management will be assumed by public hospitals through the policy of mainstreaming of psychiatric services with the general health system.
[73] Disability Services Act, 1986,p.5
[74] Psychiatrically disabled people had been omitted from the proposed legislation, and were only included after an intensive lobbying campaign by voluntary organisations.
[75] Rimmer *et al*,1988,p.2
[76] Office of Psychiatric Services,1987

3. Women Psychiatric Clients - Victims Of Socialisation Or Misunderstood?

The first issue to be considered in detail is the way women with mental ill-health are diagnosed and treated. In the Victorian and national consultations and the Victorian Women and Mental Health conference, women identified a number of concerns about the response of clinicians to their mental health problems. The concerns included being given insufficient information, feeling misunderstood and disempowered, and their social and economic circumstances being ignored. Over-prescription of tranquilisers was another major concern.

This chapter begins by exploring what has been documented about these concerns. It concludes by discussing possible policy responses.

Women and Clinicians in Interaction

Turning to the literature, what is striking is the dearth of formal research on women's experience of being diagnosed and treated for mental health problems, compared to the richness and diversity of autobiographical and fictional accounts. For over a hundred years, women have written about what happened when they encountered clinicians, using autobiographies, novels and poetry.[1] Contemporary personal accounts have been included in a number of publications.[2]

The themes that emerge strongly from this form of documentation confirm the concerns already noted. That is, whilst women may initiate contact with professionals for assistance with mental health problems, they often find these problems are then defined in ways that do not fit their experience, they are not included as active partners in the diagnostic and treatment process, and the treatment given may not be explained and may bring other problems, such as medication side-effects.

It could be argued that women who write about their experiences in this way are atypical in that dissatisfaction with the response of clinicians provides stronger motivation for writing than satisfaction. Unfortunately it would appear no general surveys of women users of treatment services have been undertaken which would test this claim. For instance, a recent summary of studies on consumer satisfaction with hospital and community-based care refers to only one which focused on women.[3] In addition the summary itself did not identify gender as a variable warranting special attention.

Obviously, even if the women who do recount their experiences are an atypical group, this does not invalidate their particular experiences. Nor does it mean that we have necessarily heard from other women whose diagnosis and treatment may have been inappropriate to their needs. For instance, Johnstone comments from her observations as a clinical psychologist on women who have accepted the traditional female roles of mothers and homemakers and who become depressed:

> .. such women tend to be pushed to one side in the hospital as they are in life. They are viewed as cured if they manage to force themselves to take up their old roles as wives and homemakers, at whatever cost to themselves. Not believing that they deserve any better treatment, they pass through the psychiatric system without

protesting or attracting the kind of attention that has been paid to less common but more dramatic conditions like schizophrenia.[4]

The process of diagnosing and treating mental health problems is an interactive one, and it is important to consider issues for clinicians as well as those of women seeking their services. There is some evidence, for instance, that medical practitioners find women more difficult to understand than men. Roberts reports on British research that showed general practitioners identified women as the most troublesome patients, particularly those with vague complaints, and also refers to a Canadian study where it was found that physicians were more frustrated and anxious with women patients.[5] Johnstone makes a relevant comment in relation to depressed women in traditional roles: 'psychiatrists, particularly male ones, often find these women as bemusing and frustrating as the husbands who suddenly find themselves with a weepy, despairing woman on their hands, and the tone of their letters often betrays this'.[6]

Medical practitioners are not the only clinicians women approach for assistance with mental health problems. For instance, most Victorian state community mental health services have an intake system staffed by the full range of disciplines represented in the service, including community psychiatric nurses, psychologists, social workers and occupational therapists, as well as medical officers and psychiatrists. The lack of research on how non-medical practitioners respond to women with mental health problems is a major gap. However, considerable evidence now exists that women typically first approach their general practitioner for help for apparent mental ill-health,[7] so the way these clinicians respond is of particular interest.

The research that suggests medical practitioners find women more puzzling than men goes some way in explaining why women patients experience difficulty in having their problems understood. Medical training also does not prepare its practitioners well for its largely female patient population. Not only is attention to new knowledge on women's lives or on gender-sensitive practice still ignored, but medical practitioners are also trained in a model which screens out the context of women's lives. 'Diagnoses are attached to individuals - there is no such thing as a medical diagnosis that includes a husband, children, parents, or wider society as an equal part of the problem'.[8]

This is not to say that women themselves necessarily always see a broader context to their mental health problems. Female socialisation accords women the role of caring for the emotional needs of others and of ensuring family harmony, with a concomitant tendency to hold themselves responsible when things go wrong. It is therefore not surprising that women have been found more ready than men to label themselves as psychiatrically ill, to enter treatment voluntarily, and to accept a patient role.[9] Notions of self-blame can collude with the individualistic approach of medical practice: 'the woman's belief that it is all her fault, which is preventing her from seeing possible changes and solutions, is reinforced'.[10]

Self-labelling and self-blame do not always go hand in hand. For instance, a study of in-patient records in an American psychiatric hospital showed whilst women patients were more likely than their male counterparts to admit problems existed, they talked about their problems in terms of the structure of their lives, whereas their families and the staff concurred in defining their problems in terms of a mental or nervous condition.[11]

This evidence supports concerns about the way women's mental health problems are interpreted by clinicians. Formal research is lacking on the extent to which concerns can be

generalised to all women with mental health problems, and to different types of clinicians. There is some evidence to suggest that medical practitioners in particular find women's problems perplexing and frustrating. Adherence to an individualistic approach leaves little room or justification for seeking to understand the relevance of a woman's life circumstances to the problems she presents. Even when women's own definition of the nature and source of their mental ill-health meshes with that of their clinician, there is reason for caution because of women's tendency to self-blame. When definitions differ, the clinician's version is most likely to prevail, leaving open the potential for the woman concerned to feel misunderstood and the contribution of key contextual factors ignored or underrated.

The way in which women's mental health problems are diagnosed obviously has a powerful influence on how they are treated for these problems. Before looking at women's concerns about treatment and related research, two other aspects of psychiatric diagnosis warrant attention. The first relates to the diagnoses typically received by women, and the extent to which these reflect gender bias. If the application of psychiatric diagnoses is not gender-neutral, then we need to consider the implications for women.

The second aspect is the relationship between particular psychiatric disorders experienced by women and their life circumstances. If the conditions of women's lives demonstrably have a bearing on the type of mental health problems they experience and bring to clinicians, then the latters' tendency to take these problems out of context has the potential danger for problems to be improperly understood, and treated inappropriately.

The Pattern of Psychiatric Diagnoses Received by Women

In examining first the psychiatric diagnoses characteristic for women, there is a remarkably similar pattern of sex differences in diagnoses across studies in North America, Britain and Australia. An analysis across different psychiatric treatment facilities in the United States from 1969 to 1973 showed that women were more likely than men to receive diagnoses of depression, men were more likely than women to be diagnosed as having an alcohol or drug disorder, or a personality disorder, and each sex was more or less equally likely to be given a diagnosis of schizophrenia.[12]

Victoria also shows this general pattern. From 1961 to 1979, the main causes for women's admissions to Victorian state psychiatric facilities were in order: schizophrenia, depressive neuroses and personality disorders; and for men: alcoholism, schizophrenia and personality disorders.[13] Berah reports that her study of Victorian data showed that

> in all data sources men were more likely than women to be diagnosed as alcoholic or personality disordered, while women were more likely than men to be diagnosed as having a depressive or other neurosis. With the exception of general hospital data, sex differences in the diagnosis of psychotic illness were negligible.[14]

My own analysis of Victorian general hospital data on psychiatric diagnoses received by in-patients for 1984-5 shows comparable trends, although interestingly in that year more women than men received the diagnosis of personality disorder, mainly due to the high percentage of women compared to men who were categorised as having either an hysterical (82 percent) or a dependent personality disorder (73 percent). What remain elusive in Victoria are any data on sex differences in the types of diagnoses given to patients in the private sector,

whether as in or out-patients.

Particular writers question the nature of diagnostic classification systems in themselves, arguing that these are constructed such that sex differences in diagnoses are predetermined. Russo and Sobel for instance claim that 'for disorders that are congruent with idealised sex role stereotypes, such as depression, females show higher rates of service utilisation than do males'.[15] Presumably a similar sort of claim could be made for those diagnoses predominantly given to males. At one level it could be said that these findings do no more than reveal how psychiatric diagnoses capture the way women and men are socialised to express distress and stress in Western societies. At face value this seems unproblematic. However, Busfield notes that by behaving in ways considered acceptable to their gender, women are more likely to become phobic, depressed, or anxious.[16]

A different type of problem associated with sex-stereotyping is that those who do not conform to gender-appropriate ways of expressing distress and stress may therefore be seen as more disturbed. For example one study found that 'persons who acted in a manner incongruent with their sex role were seen as more maladjusted than those who acted in a sex role congruent manner'.[17] Another study reported that 'for disorders in which females predominate (neuroses and depression), males were significantly more likely to be hospitalised than females. For disorders in which males predominate (personality disorders and substance abuse), females were more likely than males to be hospitalised'.[18]

In line with these findings, a study of users of Victorian state psychiatric facilities from 1961 to 1978 showed that for personality disorders, drug addiction and alcoholism, 'females were more likely (than males) to be admitted initially to a hospital, to be treated on an in-patient basis only, and to spend more time in residential care'.[19] In the light of Russo's interpretation, the explanation given by Krupinski *et al* for this finding is somewhat ingenuous: 'although these disorders occur more often in males, their severity is usually much greater in females'.[20] Males also had marginally longer periods of hospitalisation for depressive psychosis than females.[21]

This suggests that sex stereotyping can lead to mental health problems being considered as more serious if sex stereotypes are contravened, with implications for the medical response to the experiences and situations of those whose problems conform to sex stereotypes. Anecdotal accounts support the view that medical practitioners are inclined to attribute women's physical symptoms to psychological causes, and that this tendency is not confined to male practitioners.[22] In terms of physical examinations of presenting patients, it has been found that if a person's behaviour fits a psychiatric diagnosis, the practitioner will usually not pursue physical factors,[23] and that in relation to women, men were given a more extensive physical examination than women presenting with the same complaint.[24]

It would seem therefore that if women present with complaints which fit a typically female psychiatric diagnosis, they would be less likely to be checked out for physical factors which might be causing or contributing to such behaviour. Women could be said to be in a particularly vulnerable situation here, as the predominant diagnosis for men, alcoholism, requires some degree of physical examination because of the physiological effects of prolonged alcohol consumption, whereas depression, the diagnosis which is more common for women, does not similarly have physical concomitants.

Kaplan makes a more substantive criticism of psychiatric diagnostic categories, focusing on the third edition of the Diagnostic and Statistical Manual (DSMIII) which is the standard

reference work for psychiatric diagnoses.[25] She claims that 'masculine biased assumptions about what behaviours are healthy and what behaviours are crazy are now codified in DSMIII', and most explicitly in the diagnostic criteria for personality disorders.[26] The two types of personality disorder she focuses on are the 'histrionic' and 'dependent' personality disorders.

In regard to dependent personality disorders, Kaplan argues that

> the DSMIII singles out for scrutiny and therefore diagnosis the ways in which women express dependency, but not the ways in which men express dependency in short, men's dependency, like women's dependency, exists and is supported and sanctioned by society; but men's dependency is not labeled as such, and men's dependency is not considered sick, whereas women's dependency is.[27]

To drive home her point, Kaplan creates two fictitious diagnostic categories of 'independent personality disorder' and 'restricted personality disorder', both of which are based on stereotypical male behaviour but neither of which would attract a diagnosis of psychiatric disturbance.[28]

Whilst Kaplan does not extend her argument to cover all the diagnostic categories in the DSMIII, her thesis is an important one. To receive a psychiatric diagnosis is not a neutral event. As we have seen, it typically takes the person's problematic experiences and behaviour out of their social context and locates the problem in that individual, thus limiting the definition by individualising both the source and solution of potentially socially created and maintained problems.[29] If, as Kaplan argues, at least some diagnoses 'reflect the male centered culture in which they are created and used',[30] and as a consequence, some women end up being labelled as sick for behaviour which conforms to the female sexual stereotype, then this is a serious matter. It is important to note too, that Kaplan is not talking about sexually stereotyped ways of expressing stress or distress as were Russo and Sobel[31] or Busfield,[32] but stereotypes about how women should behave ordinarily.

Some attempt has been made to counter Kaplan's critique, but on weak grounds.[33] Williams and Spitzer for instance, defend the DSMIII against the charge of sex-stereotyping primarily on the basis of women being included as members of the working groups who developed this classificatory system, the constant use of 'he or she' throughout the DSMIII Manual, and the inclusion of 'homemaking' as an example of occupation.[34]

A stronger counter to Kaplan's thesis would focus on why someone would be seeing a psychiatrist in the first place, and therefore liable to receive a psychiatric diagnosis of, say, dependent personality disorder. People characteristically come to psychiatrists because their experiences are troubling to themselves or others or both. Kaplan's counter to this would presumably be that this cannot justify diagnosing someone as psychiatrically disturbed who is merely displaying sex stereotypical behaviour. Unfortunately, psychiatrists are not noted for diagnosing people as normal. They are trained in the medical orientation which holds that it is worse to pronounce a sick person healthy than a healthy person sick (which contrasts with the legal orientation that it is worse to find an innocent person guilty than a guilty person innocent).

Kaplan's thesis is a warning about the part played by values in the psychiatric diagnostic process, and certainly in the application of particular diagnoses, and the extent to which such values may be primarily male values about which behaviours are disturbed and which normal.

What is clear from this examination is that psychiatric diagnoses are not necessarily gender-neutral, nor is their application. Women are more vulnerable to particular psychiatric disorders if they behave in ways considered gender-appropriate, are likely to be seen as more disturbed if the problems they present transgress those norms, and can receive particular diagnoses even if their behaviour conforms to sex-stereotypes.

Women's Life Circumstances and Psychiatric Disorders

Women and Depression

The next question to be considered is what relationship if any has been found between women's life circumstances and particular psychiatric disorders. The first group of studies to be discussed are those which have looked at women and depression, with the major research continuing to be that undertaken by Brown and Harris in London from 1969-71 and 1974-75.[35]

Brown and Harris included in their study women already receiving treatment from general practitioners or specialist psychiatric services for depression, as well as random samples of women living in the same locality (fifteen percent of whom were found to be exhibiting symptoms of clinical depression).[36] The researchers hypothesised that 'clinical depression is an understandable response to adversity we could imagine practically anyone developing depression given a certain set of circumstances'.[37] The model used to inform the research design is succinctly summarised as follows : 'Provoking agents influence when the depression occurs, vulnerability factors whether these agents will have an effect, and symptom formation factors the severity and form of the depressive disorder itself'.[38]

The most striking finding of the study was that working class women with children were four times more likely than middle class women to become depressed.[39] The researchers found that whilst 'working class women experience more severe life events and major difficulties, especially when they had children, most of the class difference in depression is due to the greater likelihood of a working class woman having one or more of the four vulnerability factors and not to their greater risk of experiencing a provoking agent.[40]

These four vulnerability factors were as follows : loss of the woman's mother before the age of eleven; three or more children under 14 years at home; absence of a confiding relationship, especially with her husband; and lack of full or part-time paid employment.[41]

For the women in the study who were clinically depressed, apart from what affected their vulnerability to becoming depressed, other sets of factors were found to trigger the current depression, and influencing its severity. Examples are inadequate housing or a poor marriage,[42] loss of a member of the woman's immediate family either as a child or adult, a previous depressive episode, and severe life events happening after the onset of depressive symptoms.[43] In Brown and Harris's explanatory model of women's depression, they proposed that a woman's level of self-esteem affects how these different factors influence if, when and how she becomes depressed.[44]

These researchers were open about the problems of generalising their results, due to its focus on inner-urban residents, and the move of the more skilled workers out of London which meant those left there may have been a more disadvantaged group.[45] Other writers have not heeded their cautionary note, and use Brown and Harris's research as the definitive work on women and depression.[46] Certainly it is tempting to do so, as there have been no other recent studies of comparable magnitude. A more modest study undertaken in the United States

deserves noting as it produced similar results to the findings of Brown and Harris.[47]

Belle and her co-researchers reported that those most at risk of depression were the women 'with particularly low or unreliable incomes, those unable to secure the kind of paid employment they seek, those without confidantes and child care help, and those with a history of change and loss in childhood'.[48] The researchers also found that chronically difficult living conditions were more important than the experience of stressful life events in the women becoming clinically depressed.[49] The more depressed mothers also had markedly worse relationships with their children than those who were less depressed or free of depression, although it is not clear which came first: the poor mother-child relationship or the mother's depression.[50]

The research discussed to date highlights the relationship between depression in women and their socio-economic circumstances, especially the combination of caring for dependent children, lack of emotional support, low income, and inadequate housing. Others have reviewed research on the range of variables presumed to create or influence depression in women. The most oft-quoted survey of this type is that by Weissman and Klerman.[51] These authors reviewed depression research from a wide range of countries from the late 1960s to the mid-1970s, including both studies of incidence and those of prevalence.[52]

Weissman and Klerman's survey is relevant here as they sought to clarify whether the higher rates of depression found in women reflect the different way women 'perceive, acknowledge, report and seek help for stress and symptoms' compared to men.[53] In other words, they wanted to examine the hypothesis that women's greater propensity to depression than men's was more artifical than real, and due to the particular way women responded to stress and emotional problems. The way they test the validity of this 'artifact hypothesis' both warrants critical scrutiny, and also sheds light on the relationship between women's life circumstances and their experience of depression. For these reasons, Weissman and Klerman's examination will be considered in some detail.

In seeking to test the artifact hypothesis, Weissman and Klerman first consider whether women experience more stress-inducing life events than men.[54] Here they looked at studies based on scales of stressful life events which sought to measure whether females and males differed in the number of such events experienced. There are however, two problems with such scales. First, stress scales typically measure only 'discrete life events and acute changes in life conditions',[55] and do not take into account difficult and chronic living conditions such as inadequate income or housing. We have already seen however, that the latter may be as important, if not more important, than life events in the development of women's depression.[56]

A second problem is that scales of stressful life events are constructed in such a way to misrepresent events likely to be stressful to women.[57] Makosky provides a careful argument to this end, which I will only touch on here. For instance, she points out that stress scales contain a number of questions about paid work (eg. promotion, changes to work hours, being sacked etc.,) all of which would apply to more men than women, but at the same time do not ask about the effect of such events on a spouse or partner's life which would be more relevant to women.[58] Consequently, such scales are likely to systematically under-report the events which are stressful for women. Furthermore, stressful events most likely to be experienced by women, such as 'abortion, rape, physical assault, changes in childcare arrangements, and incidents of sex discrimination' are not included at all.[59] It is therefore hard to take seriously the claim made by Weissman and Klerman that 'the available evidence is that women do not experience or

report more stressful life events' and or their statement that 'men and women do not appear to evaluate the standard lists of life events as having different impacts on their lives'.[60]

Weissman and Klerman next explore whether women's higher rates of depression could be a reflection of their greater likelihood 'to respond to stress with affective distress because they feel freer to acknowledge symptoms'.[61] This hypothesis is dismissed on the grounds that one study showed no significant sex differences in the role of social disapproval in affecting the reporting of symptoms.[62] Dismissal seems unduly premature, as there are other studies which have found gender differences in both the acknowledgement and response to psychiatric symptoms, including those of depression.

A relevant study is that by Horwitz of differences in the ways women and men seek psychiatric help.[63] Horwitz's respondents were 120 patients of a state community mental health centre in Connecticut. He found that the women were more than twice as likely than the men to have self-labelled their problem as psychiatric, were more likely to have spoken to more of their friends about the problem and to professionals other than medical practitioners prior to seeking medical or psychiatric help, and were twice as likely as men to say that they had wanted to enter psychiatric treatment.[64] Whilst Horwitz was not focusing solely on those patients diagnosed as being depressed, his findings do highlight quite different patterns of acknowledgement of psychiatric problems between men and women. I have already noted the claim that depressive symptoms are a socially acceptable way for women to express stress and distress in Western societies.[65] Furthermore, other research has found that 'men were less likely than women to interpret symptoms associated with depression and low general well-being as signs of emotional problems'.[66] Contrary to Weissman and Klerman's conclusion then, it appears there is good evidence for arguing that women are more likely than men both to respond affectively to stress and to take their emotional problems, including depression, to medical practitioners.

Weissman and Klerman then proceed to examine whether women's known higher rates of usage of health services in general could explain their higher rates of diagnosed depression.[67] They discount the explanatory value of this behaviour by pointing out that whilst community surveys show women to be more depressed, the majority of those assessed as depressed in such surveys have not received psychiatric treatment, and consequently would not appear in official statistics from psychiatric facilities.[68] An alternative interpretation is that if more women are found to have depressive symptoms in community surveys, this supports the hypothesis that women tend to express stress and distress in ways that fit a depressive diagnosis.

The final explanation tested by Weissman and Klerman is that men's high rates of alcoholism could be equivalent to women's high rates of depression.[69] After reviewing relevant studies, they conclude that whether as cause or effect, it is possible that 'a substantial portion of depressed men appear under the diagnostic rubric of alcoholism'.[70] It would seem this conclusion has some validity, although as yet supporting evidence is slim.

An important study which suggests that alcohol abuse may at least mask men's rate of depression, is that of Egeland and Hostetter.[71] These researchers measured the extent of affective disorders amongst the Amish over the period 1976 to 1980.[72] The Amish are highly conservative, strict Protestants, who live in a tightly bounded and socially isolated community in the United States.[73] According to Egeland and Hostetter, who have been studying this community for many years, alcohol is culturally prohibited in the Amish and 'the cultural constraints are powerful enough to preclude pathological use'.[74] Of those diagnosed with an

affective disorder, 53 percent were men and 47 percent women, with a higher percentage of men than women receiving a diagnosis of bipolar depression (58 percent), and more women with a unipolar depressive diagnosis (51 percent).[75]

Unfortunately, the researchers do not express these findings in terms of rates per number of women and men in the Amish community, nor do they comment on the social acceptability of Amish men showing behaviour characteristic of depression. However, they do comment on 'the high tolerance of the Amish people for peculiar behaviour and minor ailments as long as the person continues to function in daily activities'.[76]

In summary, this critical evaluation of Weissman and Klerman's testing of the artifact hypothesis casts serious doubt on their conclusion, which is that 'the female preponderance is not an artifact' and 'we must regard the sex differences as real findings'.[77] Even the ways in which they seek to test the artifact hypothesis in themselves are questionable. For example, to ask whether more women than men may be depressed because they experience more stressful events is to ask a question about the conditions of life experienced by women. Indeed it could be argued that the artifact hypothesis in itself is the problem. If 'women perceive, acknowledge, report, and seek help for stress and symptoms differently than men',[78] then this is as important for understanding why women show different rates of depression as findings which show that 'some portion of the sex differences in depression, probably during the child-rearing years, may be explained endocrinologically'.[79] Each is necessary for explaining sex differences in depression, and neither is more 'real' or alternatively 'artificial' than the other.

We have noted that in seeking to dismiss the artifact hypothesis, Weissman and Klerman underrated characteristics of women's behaviour and life circumstances which could contribute to their higher rates of depression. In concluding that sex differences in depression are 'real', the authors also identify factors which influence women becoming depressed. These include the following: the experience of giving birth; restriction to the full-time role of married homemaker, particularly if the woman has several children and limited financial resources (based on the results of Brown and Harris's study); a poor marital relationship; and the frustration of expectations raised during a period of social change.[80] They are aware of the extent to which these explanations represent a smorgasbord: 'it is highly unlikely that any one of the explanations already described will be the sole factor accounting for the phenomena, or that all types of depressions will be associated with the same risk factors'.[81] Their plea is for more interdisciplinary studies so that interaction between different types of factors can be explored.[82]

An explanation for women's higher rates of depression which is mentioned briefly by Weissman and Klerman,[83] but which has received more attention from other writers, focuses on what is seen as women's 'learned helplessness'.[84] This hypothesis essentially involves extrapolation from research on animals, where it was found that when dogs were subjected to repeated electrical shocks in a laboratory situation where they could not predict when the shocks would occur or take action to stop them, the dogs developed 'symptoms' analogous to human depression.[85] Women's depression is supposed to be the result of their 'training in helplessness' whereby faced with adversity, they retreat into a depressed state. Gove attacks the simplicity of this hypothesis, citing for example, evidence that girls outperform boys academically.[86] Whilst the argument used by Gove is not strong (for example, girls and boys typically study different subject areas), the 'learned helplessness' hypothesis does seem to involve questionable logic, drawing as it does on the anthropomorphology of animal experi-

menters to construct a *post hoc* explanation of how women become depressed.

The more sophisticated versions of the 'learned helplessness' hypothesis examine in more detail women's socialisation, pointing out how women are not rewarded and may in fact be punished for competent instrumental behaviour, leading to reduced rates of problem-solving;[87] that women are taught to be submissive and at the service of others, to avoid aggression and refrain from displaying anger or hostility, and to discount their successes but to take responsibility for their failures or those of significant others.[88] The assumption is that such socialisation, when combined with the difficult social and economic circumstances encountered by many women, is sufficient to account for the higher rates of depression in women.

Whilst this explanation is clearly plausible, it is not yet supported by research of the complexity of that of Brown and Harris. Furthermore, in itself it does not explain why some women do not become depressed even when presumably as well-socialised as their sisters and confronting particularly harsh socio-economic conditions, or, alternatively, why some do become depressed when their socio-economic conditions are relatively favourable. It is important to retain sensitivity to the links between disadvantage, how that disadvantage is perceived and experienced, and women's depression. However more attention is needed to how this relationship is played out for particular groups of women, otherwise this explanation is in danger of being relegated to the irrelevant because of its attempt to speak for all depressed women.

Women and Schizophrenia

Much of the research and writing on women's mental health problems has focused on depression, as women are far more likely than men to become clinically depressed. What has received less attention is that in relation to schizophrenia, women and men are equally likely to be affected. In their lifetime, women are as likely as men to be diagnosed as having this disorder.[89] Despite similar rates of schizophrenia for women and men, some differences have also been noted. Firstly, whilst findings are not unanimous, there seems overall agreement amongst researchers that diagnosis and hospitalisation for this disorder occur at a later age for women than men.[90] Secondly, researchers also concur that women appear less severely affected than men.[91] Explanations advanced for these differences are still tentative.

Taking age differences first, the peak period for a diagnosis of schizophrenia for men seems to occur between late adolescence and the mid-twenties, and for women between the mid-twenties and early thirties.[92] Lewine notes that 'the difference may be as little as 1 year or as great as 10 years. In general, we may say that the risk for schizophrenia in men is concentrated below 25 years of age, whereas for women it is above 25 years of age'.[93] This difference has been explained largely in terms of the age patterning of social role expectations for women and men. It is argued for instance, that in late adolescence and early adulthood, men are under intense career and work-related pressures.[94] Men are also held to be exposed at an earlier age than women to demands for autonomy.[95] Exacting role demands for women are seen to come later in the form of resolving conflictual family relationships, managing child-birth and child-rearing, and re-entering the paid work force,[96] to which could be added the stress of the double workday for women in paid jobs who have families. It would appear then that the life tasks associated with the development of a schizophrenic disorder differ for women and men. Gaining independence in terms of work, finance, accommodation and relationships

have significance for men, and resolving conflictual family relationships and managing childbirth and childrearing are more important for women.[97]

An alternative though related explanation is as follows: because of the societal expectation that young men secure paid work, any psychological disturbance that prevents this expectation being met will attract more attention and be taken more seriously than comparable disturbance shown by young women.[98] The apparent lower visibility or higher tolerance for particular forms of psychological disturbance in young women may mean they could have experienced the dysfunctional impact of schizophrenia for some time before psychiatric help is sought and treatment provided. Associated disabilities, particularly in terms of lowered performance of everyday skills could therefore be more entrenched by the time rehabilitation becomes a possibility. On the positive side, that the diagnosis of schizophrenia in women often occurs after they have left the parental home appears to lessen parents' sense of guilt. The self-blame and mutual recrimination characteristic of the parents of sons with schizophrenia may therefore be absent.[99]

The adult careers of women are clearly different to those of men, and the role demands and expectations for women change throughout their life, whether they have partners and children, or are single, childless and living at home with ageing parents. Specific research is lacking, however, on the particular psychosocial demands experienced as stressful by the women (and men) who are diagnosed with a schizophrenic disorder. As we have seen, the response of family members is also important. For instance, what may be tolerated and tolerable behaviour for women in their late teens and early twenties may not be so in their thirties and forties. As caregivers grow older and problems remain unresolved, families may re-define what is wrong and what should be done about it.

Seeman notes that female physiology may also be relevant, although her argument that elevated oestrogen levels in puberty may delay the onset of schizophrenia in young women does not explain why it may then emerge when they are in their late twenties.[100] Lewine postulates a similar explanation based on different rates of physiological maturation, although allows for a trigger as well as a suppressor hypothesis.[101] He acknowledges however that adequate research is lacking. At this stage it is therefore difficult to do more than speculate on reasons for the age of diagnosis and hospitalisation for schizophrenia being different for women and men. What is interesting is that most of the explanations are couched in terms of psychosocial factors.

Attempts to explain the apparently more benign course of schizophrenia for women compared to men are as tentative as those for the different ages of diagnosis and hospitalisation. The outcome for women tends to be assessed in terms of length of hospitalisation, and recurrence as measured by rates of re-hospitalisation.[102] These studies typically ignore quality of life indicators.[103] One study found for instance that long-term women psychiatric patients were discharged earlier than their male counterparts. This was due to relatively dependent domestic roles being seen by staff as acceptable for women.[104] In contrast, staff considered men should be in paid employment following discharge.[105] If conventional measures are used, the women in this study could be considered to have better outcomes than the men. However lower expectations were applied to the women, and success was measured in terms of locus of care,[106] rather than quality of life indices such as opportunities for socialising and meaningful daily activity. Others have pointed out how low expectations can act as a self-fulfilling prophecy in not allowing women to develop their potential.[107]

The need for studies which advance the understanding of how women come to be diagnosed with a schizophrenic disorder is much overdue. Chesler claimed that this diagnosis is given to women who act out against sex role prescriptions.[108] Since Chesler's book was published, it appears no researcher has sought to test her claim. Indeed, the dearth of research on schizophrenia in women is striking. Studies have been largely androcentric or focused on men with schizophrenic disorders. Furthermore, schizophrenia can lead to chronic disability but as Nadelson notes: 'since male subjects predominate in studies of chronic mental illness, many of the gender differences that may emerge if we reverse dependent and independent variables in our studies are obscured'.[109] Similarly, Bachrach comments that 'although the population of chronically mentally ill individuals consists of both women and men, relatively few contributions to the literature acknowledge, let alone discuss adequately, gender differences in patient careers or service requirements'.[110] For example, a major recent publication on the political economy of schizophrenia has barely five pages on gender differences.[111]

Even if schizophrenia can best be explained according to an illness model, there is already evidence that stressful events precede the onset of symptoms,[112] and that the nature and degree of 'expressed emotion' in the person's social environment will affect rates of relapse.[113] What is absent is research on the events women find stressful and which may precipitate schizophrenic symptoms, and the type and level of expressed emotion women find problematic.

Women and Other Psychiatric Disorders

Sex differences in other diagnostic categories such as anxiety disorders, personality disorders and substance abuse (alcoholism and drug dependence), have not attracted the attention paid to women's higher rates of depression. The lack of research specifically focused on women and anxiety disorders suggests, for instance, that women's predominance amongst those diagnosed with this type of disorder is seen as predictable given social expectations. That is, it is socially more acceptable for women to exhibit anxiety than men, and therefore that women are more likely to be diagnosed with anxiety disorders attracts little curiousity.

In relation to personality disorders, I have already noted Kaplan's critique of the way particular types of personality disorder in the DSMIII represent stereotypical descriptions of female behaviour.[114] A study undertaken by Kass *et al* of sex differences in the diagnosis of personality disorder showed that women were more likely to receive a diagnosis of histrionic or dependent personality disorder, the two diagnoses on which Kaplan focused her critique.[115] The typically higher rate for the diagnosis of antisocial personality disorder in men seems to be taken as unremarkable in the light of greater societal permission given men in terms of aggression and acting out behaviour.

Men's prominence amongst those diagnosed with alcoholism again tends to be interpreted in psychosocial terms. For example Berah, in explaining the higher rates for men's alcoholism in her analysis of Victorian data, argues that 'it would seem possible that for many men, alcohol may provide a socially conditioned and sanctioned means of repressing the distressing emotions which are proscribed by the traditional masculine sex role'.[116] Others have noted that because alcohol abuse in women contradicts societal expectations, alcohol problems in women are more likely both to go unrecognised or misdiagnosed, and also seen as more serious when they *are* recognised.[117] Services specifically aimed at women with alcohol problems have also been slow to develop.[118]

Overview of Women's Life Circumstances and Psychiatric Disorders

In summary, this analysis of research on the relationship between the psychiatric diagnoses received by women and their life circumstances reveals particular themes. The mental health problems experienced by women are likely to be linked to the conditions of their lives. This involves both the type of socialisation they have experienced as women, including social expectations about appropriate role behaviour, as well as the nature of their current life circumstances. Whilst the causal nature of this relationship is not clear, research does suggest that a woman's life circumstances may well influence the type of mental health problems experienced, when problems emerge, and their magnitude.

Exploring the potential relevance of women's life circumstances for the problems they present would therefore seem to be an important and necessary component of psychiatric diagnosis and treatment. The earlier examination of what happens when women take their mental health problems to clinicians suggests however that this approach is not always followed. This of course has major implications for women with mental ill health. If a woman's life circumstances are ignored, then the opportunity for an accurate and comprehensive understanding of her problems is thereby diminished and, presumably, development of an appropriate range of responses curtailed.

Psychiatric Treatment Received by Women

In terms of psychiatric treatment, the most striking difference between women and men is prescriptions for psychotropic (mood-modifying) drugs. These drugs include major and minor tranquilisers, sedatives and hypnotics, stimulants and anti-depressants.[119] Berah reports that a review of Australian research on the use of such drugs showed that 'at least twice as many women than (sic) men took these drugs regularly'.[120] North American studies have demonstrated that women receive over two-thirds of all prescriptions for psychotropic drugs,[121] and in Australia in 1984-5, 70 percent of the 6 million prescriptions for the benzodiazepine group of drugs (eg. Valium, Serepax, Mogadon) were for women.[122] The 1980 Australia Health Survey found that twice as many women as men were taking prescribed sleeping pills and tranquilisers.[123]

Other research provides more detail on differences in prescription patterns. Data from the United States in 1978 showed that whilst women made 58 percent of all visits to doctors, they received 78 percent of prescriptions for psychotropic medication.[124] A study of prescribing patterns in general practice in the U.K. showed that twice as many women as men were prescribed psychotropic drugs.[125] Women in a full-time homemaker role have been identified as the largest single group of tranquiliser users in the U.S.A.[126] A review of studies in different countries undertaken for the *Report of the NSW Women and Prescribed Drugs Working Party* found that 'women most likely to receive prescriptions (for benzodiazepines) are the poor, uneducated, urban dwelling, housewives, unemployed, those living alone, the middle aged, elderly or migrant women'.[127] *The Why Women's Health?* discussion paper circulated by the Victorian Women's Health Policy Working Party in November 1985, also identified a 'high rate of tranquiliser prescriptions for non-English speaking women'.[128]

As with sex differences in depression, much effort has gone into explaining differences in the higher rates of psychotropic drugs prescribed for women. An immediate and obvious explanation is that not only do women visit doctors more frequently than men, but they are also more expressive of feelings, and consistently report more symptoms of physical and emotional

discomfort than men.[129] As I have already noted, women have been found to be more ready than men to label themselves as psychiatrically ill, to enter treatment voluntarily, and to accept a patient role.[130] They are also more accepting of having drugs prescribed, and more compliant about taking medication.[131] The high rate of prescription of psychotropic drugs for women could thus be a reflection of the types of symptoms women present to doctors, and the latters' perception that women will follow the treatment prescribed.

Several studies have however indicated that doctors are generally more inclined to prescribe psychotropic drugs to women than men, and to particular groups of women more than others. For example, a study of doctors' prescribing patterns in a family practice clinic in the United States found that when women and men attended with similar presenting problems of (i) unhappiness, crying, depression, (ii) nervousness, or (iii) tension, restlessness and worrying, 'women received significantly more minor tranquilizers than men, while men received slightly more laboratory tests and physical therapies. Six months later the prescribing differential had increased; women were receiving even more minor tranquilizers'.[132] The *Report of the NSW Women and Prescribed Drugs Working Party* notes that a study carried out for the Royal Australian College of General Practitioners found 'doctors overestimated emotional and social problems in middle aged and elderly women and underestimated these problems in young and middle aged men'.[133]

Another study adds weight to the inference that it can be as much the sex of the patient as actual symptomatology that leads to women receiving more psychotropic drugs. 'Samples of male and female patients found to be equally distressed on the basis of self-report were compared with regard to treatment length and prescription of medications. Female neurotic depressives were seen for more therapy sessions and were more often given medications, especially the more potent types, than were male neurotic depressives'.[134]

In the United States, male psychiatrists have been found to prescribe drugs proportionately more often than do female psychiatrists (33 percent of office sessions with male psychiatrists involved prescriptions, compared to only 17 percent of those with female psychiatrists), and this tendency of male psychiatrists to prescribe drugs was more pronounced with women than men patients.[135] This study did not unfortunately control for presenting symptoms, and focuses on only those doctors specialising in psychiatry. Much of the prescribing of psychotropic medication occurs in general practice.

A 1977 study in the United States suggests that higher rates of psychotropic drug prescriptions for particular groups of women may be linked to stereotyped views of women's roles: '87 percent of physicians judged the daily use of minor tranquilizers as legitimate for housewives, whereas only 53 percent considered even occasional use as legitimate for students'.[136] Presumably legitimacy here referred to the effect of the drugs on the person's role performance. It can be argued of course, that the work of 'housewives' who have children is a good deal more demanding than that of students, as they are typically 'on call' 24 hours a day.

Given the limited experience that male doctors in particular have of the roles of full-time homemakers and parents, it is equally likely that the problems presented by women in this role may be seen as trivial or difficult to understand, especially if they are couched in terms of vague complaints such as 'fatigue, headache, sleeplessness and unhappiness'.[137] In such situations it has been found that 'a prescription is given for a medication that is likely to be as non-specific as the complaint (a tranquilizer)'.[138] A pithy quote from a woman consumer sums up the issue: 'I feel that, essentially, when a doctor prescribes a pill for me, it's to put him out of my misery'.[139]

The higher rate of prescriptions for psychotropic drugs for women in particular occupations could be explained in terms of self-selection rather than the devaluing of some occupations in comparison to others. For example, a North American study in 1976 found a statistically significant correlation for women between the amount of time spent in paid work outside the home and psychotropic drug use, with the use of drugs increasing with a decreasing amount of time in the paid labour force.[140] This finding could be interpreted as showing that those in paid work were mentally healthier and without symptoms needing treatment with psychotropic drugs. The problem here is that a self-selection hypothesis assumes choice, yet a woman's lack of a job may be as much due to her not having marketable job skills or access to adequate child care as to her state of mental health. It also seems that the effect of psychotropic drugs on women's ability to cope with homemaking and mothering roles has been undervalued by the clinicians doing the prescribing.

Psychotropic drugs have side-effects, including 'drowsiness, lassitude, lightheadedness and impaired psychological functioning'.[141] However, if women's work at home is seen as unimportant or undemanding, then the impact of these side-effects may be perceived as irrelevant or of little importance by the prescribing doctor. Physical dependence on psychotropic drugs seems to have been of only relatively recent concern of doctors, and information on the addictive potential of benzodiazepines, which are commonly prescribed in general practice to women, has been slow to reach the public. According to the *Report of the NSW Women and Prescribed Drugs Working Party*, 'if benzodiazepines are prescribed, the aim should be to tide the patient over a crisis until alternative measures can be used. The drug should be prescribed over a short period to avoid the risk of dependence', with the recommended period being only five days.[142] However, of the 538 people who responded to a phone-in run by the Working Party, 69.2 percent had been taking benzodiazepines for more than one year.[143]

In Australia physical dependence gained exposure in 1986 through the out-of-court settlement of almost $20,000 made to a Perth woman who sued her psychiatrist for damages for the effects of addiction to a minor tranquiliser he had prescribed.[144] Interestingly, the reported response of local psychiatrists was to shift blame on to patients. For example, a Melbourne psychiatrist was quoted as saying: 'There is a group of people that potentially could become dependent to benzodiazepines by increasing their dosage level themselves. This is a problem of non-compliance', and furthermore, 'he said minor tranquilisers were probably overprescribed in Australia, but this was due mainly to patient request'.[145] Ironically, at roughly the same time, the NSW Women and Prescribed Drugs Working Party was initiating its public campaign to educate women in particular, about the dangers of the use of benzodiazepines.

Whilst also open to the charge of 'blaming the victim', the NSW campaign sought to provide women with information about the addictive properties of these drugs so that they could make more informed choices about accepting prescriptions. Referrals were offered to health workers who had been specially trained to assist women with withdrawal as part of the campaign.[146] Since the campaign started, at least 25 support groups for women concerned with benzodiazepine use have been set up in New South Wales, apart from the counselling provided to individual women.[147]

Not only are some side-effects of psychotropic drugs arguably more distressing to women than men, such as 'weight gain, changes in skin coloration or texture and hair loss', but research on gender-specific effects of psychotropic drugs has been limited.[148] For instance, Mogul comments that 'less is known about drug effects on female than on male sexual

functioning'.[149] What is known about sex differences in response to psychotropic drugs is not reassuring. For instance, Seeman reports that 'subacute effects, the akathisia, akinesia and parkinsonism that occur in the first three months of treatment, are more frequent in women' and that 'several recent studies have shown women to be at greater risk for late side-effects, ie. tardive dyskinesia'.[150] Bachrach reports on a study that found 'women tend to experience a higher prevalence of more severe forms of tardive dyskinesia than men'.[151]

What seems yet to be undertaken is research on the effects of psychotropic drugs on the role performance of women responsible for the full-time care of children, especially children under five. Another significant gap is research comparing the cost of psychotropic drugs, which are subsidised by the Australian federal government, with that of drug-free support services for women aimed at alleviation of the stresses leading to the type of symptoms treated with psychotropic drugs.

Sexist advertising of psychotropic drugs in medical and psychiatric journals, and the influence on doctors of such advertising, has also been held responsible for the high prescribing of such drugs for women. 'Drug advertising, by portraying women in stereotypic roles and emotional situations, can reinforce sex biases and encourage the administration of drugs to women'.[152] A 1975 study of drug advertisements in professional medical journals in the United States showed that women were commonly portrayed as the patient for advertisements for psychoactive drugs, and men in advertisements for non-psychoactive drugs.[153]

Another study showed that women were pictured fifteen times as often as men in advertisements for psychotropic drugs.[154] Furthermore, 'drugs are often presented as the solution for women's problems, to help them cope with their traditional role', so pictures of women in drug advertisements will typically show them carrying out household chores.[155] Conversely, pictures of men will typically portray them in job situations.[156] Drug advertisements in Australian medical journals were found to show that men's illnesses were 'painful interruptions of normal life and work, whereas women's ills were often shown as inconveniencing others'.[157]

'Before and after' pictures may also be part of advertisements, with drugs appearing to have instant curative effects. This sort of message is one with particularly adverse effects for women if it is taken seriously by doctors (and the high prescription rates for women suggests that it is). 'In so far as the social and emotional problems which women face are dealt with wholly or in part by drug therapy, the situations which oppress them are maintained by default, and frequently are actually legitimised'.[158] Australian doctors' inadequate training on the use of benzodiazepines, and the absence of information from official sources, mean that 'the promotional material of pharmaceutical companies becomes a major source of information for doctors'.[159]

Studies that actually attempt to measure the effect of drug advertising on doctors seem lacking. Instead the impact has been estimated by those critical of sexist advertising. It could also be argued that drug companies have a vested interest in ensuring that their advertising works. The use of self-regulation of advertising by the pharmaceutical industry seems ineffective. A 1986 Australian study found that 'one in three of all the advertisements in their sample of 138 could be considered "misleading or containing unjustifiable claims"'.[160]

The extent to which sex differences might exist in the use of other physical methods used in psychiatric treatment does not seem to have attracted much research attention. Psychosurgery has been reportedly used on three times as many women as men in the United States but these

data came from a 1974 study.[161] There appear to be few aggregate data on its use in Australia, *let al*one on sex differences amongst those subjected to this procedure, although anecdotal evidence indicates it is now rarely used.

The lack of recent research on the use of electroconvulsive therapy (ECT) is more puzzling as ECT is still regarded as particularly helpful for the treatment of severe depression, particularly psychotic or endogenous depression,[162] and, as has already been shown, women have higher rates of depression than men. Pippard and Ellam found that women were more frequently given ECT than men in their 1980 research on the use of ECT in Britain.[163] An average female:male ratio of 2.27:1 was reported for psychiatrists who recorded patients given ECT over a 3 month period, and a female:male ratio of 2.78:1 was reported by general practitioners giving details on patients in their practice who had received ECT in the previous two years.[164] Ironically, given these ratios, the questionnaire sent to the general practitioners used 'he' and 'his' throughout when seeking information about patients.[165] The findings regarding sex differences attracted no comment from Pippard and Ellam, presumably because such findings were unsurprising given known higher rates of depression amongst women.

Overseas data indicate that ECT is far more frequently used in private for-profit hospitals than in public sector hospitals. For instance, a study carried out in Massachusetts in 1973-4 found that use of ECT in the private sector was twenty times that in the public sector.[166] A 1979 study in New York State discovered that 'although treating a small proportion of the total psychiatric patients in the state, private hospitals accounted for 86 percent of the total ECT treatments'.[167] It has been suggested by local professionals that private psychiatric hospitals in Victoria make more frequent use of ECT than state or general hospital psychiatric facilities, and as women comprise 70.7 percent of admissions to private hospitals,[168] it is possible that they also receive a higher proportion of ECT than men.

An Australian study by Jorm and Henderson is relevant here.[169] Drawing on Medicare data for the 1985-86 financial year, they examined the age and sex distribution of use of private psychiatric services over a twelve month period. In relation to administration of ECT, their analysis shows this procedure was applied around three to four times more often to women than to men.[170] Whilst receipt of ECT increased with age for both sexes, 'this trend was particularly strong for women'.[171] Unfortunately there is a lack of data on the use of ECT in the public sector which would enable assessment of the comparable rates in each sector.

If more ECT was given in the private psychiatric hospitals this would be worthy of attention, given that this sector is not able to admit involuntary patients, who are presumably the most disturbed. It could be argued of course that involuntary patients are those whose behaviour is most socially disruptive, and that those with schizophrenic disorders are more likely to fall into this category than those with the disorders seen as most suitable for ECT, namely depression. However in itself a higher use of ECT for female patients raises similar questions to those already outlined for psychotropic medication, for example what is the effect of ECT on the lives of women, and to what extent does its use preclude other approaches that might address the conditions of women's lives and their contribution to any disturbance.

The use of physical treatments such as psychotropic drugs and ECT focus on changing the individual concerned. They thus imply that individuals are both the cause and the solution of their mental health problems. Yet this individualistic approach may not only misrepresent how women themselves define their difficulties: it may also discount or minimise the extent to which women's life circumstances contribute to their mental health problems.

Psychiatric Diagnosis and Treatment Issues for Women: Policy Responses

It could be claimed that current changes to government policy are largely driven by financial considerations, and women's concerns about how their mental health problems are assessed and treated therefore have little relevance. However, psychiatric services in Australia are largely government-funded, whether indirectly or directly. It has been estimated for instance, that most specialist psychiatric services are provided by the private sector and subsidised by government through Medicare.[172] In turn, women form the majority of users of specialist psychiatric services, whether in the public or private sector: Jorm and Henderson's analysis of Medicare data from 1985-6 showed that women used private psychiatric services 1.73 times more than men.[173]

Public sector psychiatric services are also used more often by women than men, particularly as in-patients of general hospitals[174] and, it would appear, as out-patients of state services (figures still unavailable). Furthermore general practitioners are another source of treatment of mental health problems, especially those of women, and the cost of government reimbursement of these services needs to be added to that of specialist psychiatric services. Finally, the prescription of psychotropic drugs is primarily funded by government, and the main users of these drugs are women.

Although specific costings are not available, this brief examination shows governments have a financial interest in assessment and treatment practices. The cost to government of existing clinical approaches is most evident in the prescription of psychotropic drugs for women. Less expensive alternatives to the present clinical reliance on psychotropic medication would clearly interest policy-makers. I have also noted that women themselves are seeking changes to the current emphasis on medication. Finding ways to alter this tendency is not easy, as will be discussed shortly. What would be harder to measure financially, l*et al*one change, is the impact of other practices that are detrimental to women, such as reliance on sexist stereotypes, or ignoring the context of women's mental ill-health. The cost savings involved in alternative gender-sensitive approaches would be equally difficult to demonstrate.

Apart from economic arguments not being readily available for policy change to current clinical practice, a further obstacle arises from professional territoriality. The conduct of clinical practice has traditionally been seen as the province of practitioners themselves and their professional peers. Governments have generally supported this territorial approach, preferring to influence practice through indirect measures such as setting particular rebate levels for certain procedures, rather than to invite professional hostility and to assume unwelcome levels of accountability through direct intervention.

Changing how women's mental health problems are diagnosed and treated therefore needs to take account of professional sensitivities. One source of influence which has been largely untapped is women themselves. For example the New South Wales campaign against the abuse of benzodiazepines sought to inform and educate women consumers about the appropriate use of these drugs. A more modest campaign has also recently been active in Victoria. In addition Healthsharing Women, a Victorian women's organisation with a primary interest in promoting interest and education on women's health issues, has prepared material informing women about where to go for mental health problems and what to expect from service providers.

There are also signs that the rights of users of mental health services are increasingly being acknowledged. For instance the national *Mental Health Statement of Rights and*

Responsibilities identifies particular rights for service users, such as 'the right to have age, gender and culturally appropriate mental health services provided in an environment which is conducive to his or her continued participation in community life'.[175] The challenge for the consumer movement is to ensure that women users of mental health services, especially those women not used to questioning professional expertise, are able to articulate their concerns and ensure their right to gender-appropriate services is met.

In terms of clinical practice the two potential sources of influence on existing practice are education and training, and quality assurance. Education and training includes both pre-service and in-service areas. The obvious topics to be covered include the following: new material on women's developmental psychology;[176] information on the changing roles of women and men; training in gender-sensitive practice in relation to women with mental health problems;[177] research data on the relationship between women's life circumstances and their mental ill-health; and training in interventions that minimise the use of psychotropic drugs and improve the conditions of women's lives.

Influencing practice through introducing new content into pre-service curricula is a major challenge. A long lead-time is involved both in convincing accrediting bodies and university departments of the need for new input, and in the actual effect on clinical practice. In-service training is a more immediate source of influence, but cannot be guaranteed to reach all practitioners. In an article on the future of Australian psychiatry, Andrews points out that 'at present practising psychiatrists are likely to spend 40 years in practice yet are not required to participate in any continuing education that would keep them abreast of new developments'.[178] Even in the public sector, attendance at staff in-service training sessions is largely voluntary. However, as with most change processes, the initial involvement of even a small group can provide the impetus for wider change. Opportunities for clinicians to be exposed to new ways of working with women thus need to be fostered. The Victorian Women and Mental Health Network, an offshoot of the 1989 Women and Mental Health Conference, has already been active in identifying topics for staff training in women-sensitive practice, and a more detailed program is ripe for development.

Like consumer rights, quality assurance is gaining greater prominence in the mental health field. Quality assurance includes measures taken by a service to ensure the quality of care provided to the consumer, and includes both clinical review as well as evaluation of the cost-effectiveness of the service. Quality assurance entails the development of appropriate criteria against which the service can be evaluated, and an obvious criterion of relevance to women consumers is the extent to which the service is responsive to their needs. The first Discussion Paper on the Australian National Mental Health Services Policy provided direction in this regard by recommending 'that Governments ensure provision of and access to mental health care which is sensitive to gender issues'.[179]

Women-sensitive practice in the areas of diagnosis and treatment would include: practitioners taking account of a woman's life situation in assessing factors relevant to her mental ill health; regarding physical symptoms seriously rather than automatically assuming they have psychogenic causes; and considering drug-free options as part of a treatment plan. Ideally, women consumers or their representatives would be also be involved in the process of identifying the features which constitute care sensitive to women's needs. Consumer groups again have a key role in ensuring this involvement.

To this point the focus has been on how current clinical practice can be changed to

respond more appropriately to women's mental health problems. It should also be acknowledged that there are gaps in our existing knowledge which need attention. A recurrent theme has been the extent to which research on women's experience of mental ill-health is lacking. Clearly this situation requires attention so that practice and practitioners can be better informed. A minimal requirement would be that any psychiatric research consider the needs and experiences of women separately from those of men, so that women are considered in their own right rather than as non-men. This would avoid the type of androcentricism that I have already noted in the research on stress. A more important step would be to pursue research specifically focused on women, such as: the predisposing factors and service needs of women diagnosed with schizophrenia; the efficacy of different treatment approaches (including drug-free alternatives) to mental health problems characteristically experienced by women, for example, depression; and the relationship between women's mental ill-health and their life circumstances.

In summary, formal acknowledgement by policy-makers that women with mental health problems have special needs would provide legitimacy for changes aimed at making services more responsive to women. In a policy environment driven by economic factors, priorities will go to changes that are demonstrably cost-neutral or involve a reduction in costs. However, it may be difficult to show that new ways of responding at a clinical level to women's mental ill-health will have financial advantages. Opposition by clinicians to perceived intrusion into the clinical domain could further limit the feasibility of explicit policy change being pursued in this area. On the other hand, rapid and major developments occurring in mental health services, such as in Victoria, offer new opportunities for attention to the quality of service delivery. The directions being set for mental health policy at a national level also favour this emphasis. The challenge is for consumer groups and those committed to improved clinical responses to women's mental health problems to take advantage of this climate.

Footnotes

1 Frame,1961; Geller,1985; Showalter,1987
2 Smith & David,1975; McColl & Hough,1979; and Burston & Weitz,1988,p.37-95
3 Corrigan,1990
4 Johnstone,1989,p.103
5 Roberts,1985,p.30-31
6 Johnstone,1989,p.103
7 Berah,1983,p.268
8 Johnstone,1989,p.120
9 Horwitz,1977
10 Johnstone,1989,p.120
11 Thompson, 1984,p.51
12 Belle & Goldman,1980
13 Unpublished analysis undertaken by Office of Psychiatric Services in 1987 on data from MHRI Statistical Bulletins,1961-80
14 Berah, 1983,p.269
15 Russo & Sobel, 1981,p.11

16 Busfield,1988,p.533-534
17 Russo,1984,p.35
18 *Ibid*
19 Krupinski *et al*,1982,p.53
20 *Ibid*
21 *Ibid*
22 Brozovic,1989
23 Handel,1985
24 Roberts,1985
25 Kaplan,1983
26 *Ibid*., p.788
27 *Ibid*.,p.789-790
28 *Ibid*.,p.790
29 Penfold & Walker,1983,p.25
30 Kaplan, 1983,p.803
31 Russo & Sobel, 1981
32 Busfield, 1988
33 Williams & Spitzer,1983; Kass *et al*,1983
34 Williams & Spitzer, 1983
35 Brown & Harris, 1978
36 *Ibid*.,p.49-50
37 *Ibid*.,p.46
38 *Ibid*.,p.270
39 *Ibid*.,p.278
40 *Ibid*.,p.279
41 *Ibid*.,p.235-236
42 *Ibid*.,p.275-6
43 *Ibid*.,p.284-5
44 *Ibid*.,p.286
45 *Ibid*.,p.289-290
46 Mowbray *et al*,1984
47 Belle,1982
48 *Ibid*.,p.241
49 *Ibid*.,p.236-7
50 *Ibid*.,p.239
51 Weissman & Klerman,1981
52 *Ibid*.,p.189-195
53 *Ibid*.,p170
54 *Ibid*.,p.170
55 *Ibid*.,p.171
56 Brown & Harris,1978; Belle,1982
57 Makovsky,1980
58 *Ibid*.,p.117
59 *Ibid*.,p.117-118
60 Weissman & Klerman,1981,p.171

61 *Ibid.*,p.171-2
62 *Ibid.*,p.171
63 Horwitz,1977
64 *Ibid.*,p.171-175
65 Russo & Sobel,1981,p11; Busfield, 1988,p.533-534
66 Kessler *et al*,1981,p.60
67 Weissman & Klerman,1981,p.172
68 *Ibid.*,p.172
69 *Ibid.*,p.172-4
70 *Ibid.*,p.174
71 Egeland & Hostetter,1983
72 *Ibid.*
73 *Ibid.*,p.57
74 *Ibid.*
75 *Ibid.*,p.60
76 *Ibid.*,p.60
77 Weissman & Klerman, 1981,p.174-5
78 *Ibid.*,p.171
79 *Ibid.*,p.181
80 *Ibid.*,p.181 & 186-8
81 *Ibid.*,p.188
82 *Ibid.*,p.188
83 *Ibid.*,p.182
84 Mowbray *et al*,1984,p.10
85 Gove,1980,p.356
86 *Ibid.*
87 Radloff,1980,p.107-8
88 Smith,1975, p.109-110; Mowbray *et al*,1984, p.9-10; Radloff,1980, p.107-8
89 Warner,1985,p.231; Berah,1983,p.267 & 269
90 Warner,1985,p.231-3; Angermeyer & Kuhn,1988; Mueser *et al*,1990,p.138
91 Warner,1985,p.143; Mueser *et al*,1990,p.138
92 Warner,1985,p.232
93 Lewine,1981,p.436
94 Warner, 1985,p.231-2
95 Lewine,1981,p.441
96 Lewine,1981,p.441; Warner,1985,p.231-2
97 Lewine, 1981, p.441
98 Mueser *et al*,1990, p.138)
99 Seeman,1983,p.143
100 Seeman,1988,p.22-3
101 Lewine,1981,p.440
102 Warner,1985,p.143-4
103 Bachrach,1984, p.1172
104 Keskiner *et al*,1983
105 *Ibid.*

106 Bachrach, 1984,p.1172
107 Test & Berlin,1981,p.138
108 Chesler, 1972,p.49-57
109 Nadelson,1988,p.182
110 Bachrach,1988a,p.3
111 Warner,1985
112 Brown,G.W. & Birley,1968
113 Brown,G.W. *et al*,1972
114 Kaplan,1983
115 Kass *et al*,1983
116 Berah,1983,p.272
117 Russo & Sobel,1981,p.11
118 Mowbray *et al*,1984,p.13-14
119 Fidell,1980,p.322
120 Berah,1983,p.271
121 Carman *et al*,1981,p.1325; Mowbray *et al*,1984,p.121
122 Report of NSW Women & Prescribed Drugs Working Party,1986,p.4
123 Australia Health Survey,1980,p.80
124 Mowbray *et al*,1984,p.121
125 Roberts,1985,p.70
126 Carman *et al*,1981,p.1325
127 Report of NSW Women & Prescribed Drugs Working Party,1986,p.8
128 Why Women's Health?,1987,p.16
129 Penfold & Walker,1983,p.190
130 Horwitz,1977
131 Mowbray *et al*, 1984,p.123;Penfold & Walker,1983,p.123
132 Penfold & Walker,1983,p.197
133 Report of NSW Women & Prescribed Drugs Working Party,1986,p.9
134 Davidson & Abramowitz,1980,p.383-4
135 Carman *et al*,1981,p.1325
136 Mowbray *et al*,1983,p.123
137 Penfold & Walker,1983,p.191; Roberts,1985,p.30-1
138 Penfold & Walker,1983,p.191
139 Penfold & Walker,1983,p.191
140 Howell & Bayes,1981,p.135
141 Report of NSW Women & Prescribed Drugs Working Party [NSW Report},1986,p.7
142 *Ibid*.,p.7-8
143 *Ibid*.,p.46
144 *The Age*, 13/5/86
145 *The Age*, 15/5/86
146 Report of NSW Women & Prescribed Drugs Working Party,1986,p.50
147 *Ibid*.
148 Mogul,1985,p.1085
149 *Ibid*.
150 Seeman,1983,p.145

151 1985,p.1067; it is not clear from her report whether this difference was due to different reactions to similar dosages or to different dosages
152 Mowbray *et al*,1984,p.126
153 Hoppe,1984,p.131
154 Roberts,1985,p.73
155 Penfold & Walker,1984,p.198-9
156 Roberts,1985,p.73-4
157 Report of NSW Women & Prescribed Drugs Working Party,1986,p.10
158 Roberts,1985,p.75
159 Report of NSW Women & Prescribed Drugs Working Party,1986,p.9
160 *Ibid.*,p.11
161 Dale & Foster,1986,p.93
162 Palmer,1981,p.21 & 31; Pippard & Ellam,1981,p.106
163 Pippard & Ellam,1981,p.83&97
164 *Ibid.*
165 *Ibid.*,p.97
166 Breggin,1979,p.3-4
167 *Ibid.*,p.5
168 Office of Psychiatric Services,1987,p.38
169 Jorm & Henderson,1989
170 *Ibid.*,p.466
171 *Ibid.*,p.465
172 *Ibid.*,p.461-2
173 *Ibid.*,p.462
174 Office of Psychiatric Services,1987,p.38
175 Mental Health Statement of Rights and Responsibilities,1991,p.7
176 Kaplan & Surrey,1984
177 Weeks,1980
178 Andrews, 1990,p.373
179 Mental Health Discussion Paper,1989,p.34

4. Women's Use Of Mental Health Services

This chapter will consider different types of mental health services and their use by women. A key question will be the extent to which services respond to the particular needs of women with mental health problems. The three types of mental health services which will be examined are treatment services, housing or accommodation services and rehabilitation services.

Treatment Services: The Catch 22

In considering treatment services, the focus will be on those explicitly aimed at minimising or removing problems seen as indicative of psychiatric disorder. This category covers both the treatment offered by generalist services such as general practitioners as well as by specialist psychiatric services. The latter include government psychiatric hospitals and community mental health clinics, private psychiatrists and private psychiatric hospitals, and psychiatric units in public hospitals. Treatment services thus span both the public and private sectors, and include those provided on an in-patient or out-patient basis.

In the consultative forums described in Chapter 2, the concerns raised by women in relation to treatment services largely focused on the lack of alternatives to hospital admission for women experiencing a psychiatric crisis. A key issue was the impact of hospitalisation on women with dependent children, as alternative care for children then became necessary. Another concern was the threat of sexual harassment and abuse faced by women in-patients. As well as taking these concerns into account, this section will also pay attention to the accessibility of different treatment services to women.

A relevant initial question is how women come to use different treatment services. Personal accounts reveal a process often marked by confusion and frustration on the part of the woman involved, with reasons given for referral often experienced as sketchy and options not explained.[1] In contrast there is a lack of formal research that examines this process longitudinally, either prospectively or retrospectively. Consequently it is unclear what factors influence how women come to use particular treatment services, and the sequence followed. Unfortunately, even when relevant research is undertaken, it does not always differentiate between women and men. An example is a recent British study by Morgan on the reasons why general practitioners refer patients to psychiatrists.[2] Morgan found that such referrals were as much due to the pressures of general practice or requests by the patient or relatives as to the practitioners' judgement of the severity of symptoms. However as the impact of the gender of patients (*let a*lone practitioners) was not explored in this research, it is not possible to determine whether these factors operated differently for women compared to men.

Given the scarcity of research on referral processes, the current focus will be on available data on women's use of treatment services. This exploration will raise questions about the implications for women of using particular treatment services, questions which deserve further attention in policy and research terms.

A consistent trend shown in both overseas and local studies is that women and men use treatment services differently. An analysis of 1975 United States data found that higher proportions of women were in-patients of private psychiatric hospitals and psychiatric units in general hospitals, and out-patients of community mental health centres and general hospital psychiatric out-patient facilities.[3] Men were more numerous as in-patients of state and county

mental hospitals. Busfield reports on 1981 English figures which show that 'women have higher levels of admission to psychiatric beds, constitute a higher proportion of residents, make more use of psychiatric outpatient clinics, and have far more contact with general practitioners for conditions medically defined as mental illnesses'.[4] She also notes that more men were long stay residents in mental hospitals.

It can be difficult making valid comparisons between treatment services in different countries, as detail is needed about the range of services available, and the types of disability involved. For example psychiatric hospital populations vary across countries in terms of whether they include older people with dementia, people with alcohol or substance abuse disorders, or the intellectually disabled. Overseas studies concur however in showing women to be higher users than men of out-patient treatment services, less likely to be in extended care psychiatric beds, but to predominate as in-patients of psychiatric facilities outside the government sector.

In Australia a comprehensive picture is impossible due to gaps in available data. For instance, it is not known how many women attend general practitioners for mental health problems. This is a major limitation as women are known to seek help initially from general practitioners, and may continue to receive treatment from this source rather than from specialist psychiatric services.[5] Routine data are also lacking on women's use of private psychiatrists, although a study of Medicare data from 1985-6 provides relevant information on the national population for that year. This analysis showed that women used private psychiatric services 1.73 times more than men, with women aged 35 to 44 years being the most frequent users (peak prevalence of 2.51 percent).[6]

Using Victoria as a state example, data on gender differences in the use of acute psychiatric in-patient services have been reported for all sectors for 1985-6.[7] In contrast, information is not available of the proportions of women and men using psychiatric out-patient services, provided either by government community mental health services or public hospital out-patient clinics. The Victorian data on acute psychiatric admissions show some predictable patterns. Firstly, women and men had similar rates for overall admission episodes to government psychiatric in-patient facilities but were differentiated according to whether admission was for acute or extended care. Women and men had comparable rates for acute admission episodes in 1985-86 (51 percent female : 49 percent male), but 'men outnumber women on greater than a two to one basis in entry to mental hospitals'.[8] This pattern is similar to that found overseas. There were only marginal gender differences in terms of whether Victorian admissions were voluntary or involuntary.

The reasons given for psychiatric admission, especially involuntary admission, has yet to be explored in detail. For earlier historical periods, a study of committal records in New South Wales from 1880-1940 suggests particular factors were influential in the admission of women.[9] On the basis of recording in patients' files, women's hospitalisation was related to their social and material circumstances, and prevailing ideas on appropriate female behaviour. It could be expected that an examination of contemporary records would be similarly revealing of the living situations and demands experienced by women in our own time, and the nature of sex-role expectations.

In terms of the Victorian data on private psychiatric hospitalisation, the gender differences in admission episodes are comparable to overseas trends. In 1985-6, the percentage of women admitted to Victorian private psychiatric facilities was much higher than of men (70.7

percent compared to 29.3 percent).[10] In relation to use of out-patient services, I have already noted that overseas data consistently show higher rates for women than men.[11] Krupinski *et al* in their analysis of Victorian government out-patient services from 1961 to 1978 report that 'the average number of out-patient attendances was higher for females in all diagnostic categories'.[12] Unfortunately, since 1978, figures have not been available on the use by women and men of government out-patient treatment services, although there is no reason to doubt the continuation of patterns already identified.

The trend noted in both overseas and Victorian data for higher admissions of men to extended care facilities and women to private psychiatric hospitals calls for explanation. However, it is the former rather than the latter which has received attention, and only in overseas studies. For Tudor *et al*, higher rates of extended care admissions for men and their higher rates of residency per first admission reflect a more restricted range of acceptable societal roles for men, and higher expectations by staff for the performance of men in these roles.[13] Consequently, to be discharged from extended care, men may have to be perceived as less disabled than women, or in other words more able to meet the demands of social roles seen by staff as appropriate for men.

The study by Tudor *et al* was undertaken more than ten years ago, and recent relevant research is lacking, especially in the Australian situation. I have previously referred to the earlier study by Keskiner *et al* which provided some support for the hypothesis that sex role expectations play an important role in men's higher occupancy of extended care beds.[14] This study examined gender differences in the post-hospital placements of long-term psychiatric patients in 'foster' communities. The researchers found that staff, community members and patients themselves put more emphasis on males being employable, whereas it was 'more acceptable for female patients to assume relatively dependent social roles in the foster community, providing they will maintain an acceptable level of self-care, housekeeping and social contacts'.[15]

On the basis of the findings of Keskiner *et al*, albeit from a different societal context and time period, it could be said that successful post-hospital placement for men was limited by the range of available options as well as the perceptions of staff and patients themselves. It could also be argued in relation to the women patients that the type of post-discharge options seen as acceptable limited women's opportunities for further development. This will be explored further when considering women's use of rehabilitation services.

The study by Keskiner *et al* focused on discharge criteria, hence it is most directly relevant to explaining why more men than women may continue to occupy extended care beds. Unfortunately a relevant Victorian study did not consistently examine gender as a differentiating variable. The study concerned was undertaken in 1983, and aimed to estimate the feasibility of discharge for all patients resident in government psychiatric hospitals during a particular week, using assessments by hospital staff.[16] Patients included in the research were those whose current admission was longer than three months or who had two or more previous admissions. Of the total sample of 2795 patients, there were more men than women (57.5 percent to 42.5 percent) but the researchers did not differentiate between women and men in reporting estimates of discharge potential.[17] As with other 'gender blind' research, it is therefore impossible to gauge the relevance of the sex of the patient.

The question of why women have higher rates of admission to private psychiatric hospitals does not seem to have attracted research interest either in Australia or overseas. The

explanation given for Victorian data showing higher proportions of women admitted to public hospitals and private psychiatric facilities is couched in terms of 'differences in the psychiatric disorders treated in each sector'.[18] 'For example, the greater proportion of neurotic depressive disorders treated in public hospitals entails a higher number of females, due to the greater presentation of this disorder among women. A similar phenomenon may be operative in the private sector'.[19]

Other influences on women's high use of private psychiatric hospitals in Victoria apart from the type of disorder are likely to include class, the source of referral, and availability of facilities. Hollingshead and Redlich's classic 1958 study showed that it was primarily the middle and upper classes who use private sector psychiatric services in the United States.[20] With the advent of different reimbursement arrangements, this situation has now changed in the United States as it did in Australia with the introduction of Medicare, so that use of out-patient services is less differentiated along class lines.[21] In Australia, private out-patient treatment services can now be used by a wider section of the population, especially when psychiatrists are prepared to bulk-bill. There is still the need for private health insurance to cover the extra costs of a private psychiatric hospital bed, which consequently puts this form of treatment service out of reach for those on low incomes. It could also be argued that government psychiatric hospitals are seen as the most stigmatising, hence those with the resources to do so seek private hospital care.

Apart from socio-economic factors, it could be anticipated that the majority of patients in Victorian private psychiatric hospitals were admitted by private psychiatrists, following referral by general practitioners. Women are both more likely than men to visit general practitioners, and also more likely to be diagnosed by GPs as psychiatrically disturbed.[22] Furthermore, given their own involvement in private practice, general practitioners may well favour private over state psychiatrists for their patients, particularly those who are middle or upper class. Finally, private psychiatric facilities burgeoned in Victoria in the 1980s and consequently more private psychiatric hospital beds are available: 'the inpatient capacity of the private system grew by 18 percent during the past seven years'.[23] It would seem that these factors in combination could explain the higher rates of women as in-patients in the private sector, although this explanation has yet to be tested.

Women's greater use of private psychiatric treatment services, whether as out-patients or in-patients raises a number of issues from a feminist perspective. It could be argued for instance, that in private psychiatric practice, women's problems are most likely to be personalised and the relevance of social circumstances ignored. The autonomy of the psychiatrist in terms of assessment and treatment is most pronounced in private psychiatry, and the tendency of psychiatrists as well as other medical practitioners to individualise rather than contextualise women's problems has already been noted. Furthermore, private psychiatric services do not have the same level of public accountability as government or public hospital services. Consequently they remain largely removed and insulated from debate and public policy decisions about mental health issues, particularly those related to women as service users.

Finally, the mental health consumer movement is underdeveloped in Australia, and does not include groups concerned about issues for users of existing private psychiatric services. Groups in Victoria representing consumer interests have focused on advocating for the interests of users of government psychiatric services (Psychiatric Clients' Union, Victorian

Mental Illness Awareness Council), providing mutual support groups (GROW) or arousing public concern and support for those diagnosed with a particular condition (Schizophrenia Fellowship, ARAFEMI). Former patients of a private psychiatric hospital have got together to lodge complaints about the treatment they received, but the hospital with which they are concerned closed some years ago.

If minimisation of stigma is a primary reason for use of private psychiatric services, then probably those using services in this sector are unlikely to engage in the public airing of experience necessary for setting up a consumer group. In turn, this makes less likely the emergence of consumer groups aimed at enforcing greater accountability on the part of treatment services in the private sector.

As already noted, overseas data have shown a higher use by women of out-patient psychiatric treatment services, a pattern also found in Australian data on the use of private psychiatrists from 1985-86[24] and Victorian figures on government out-patient services from 1961-78.[25] This has been interpreted in a number of ways. Women have been found to have a greater propensity to define their problems as psychiatric and to seek psychiatric help,[26] to request psychiatric help at lower levels of distress and symptomatology than men,[27] and to be more amenable and compliant in taking medication.[28] Taken together, these patterns of behaviour provide an explanation of women's predominance as users of out-patient services. That is, women are likely to be treated on an out-patient basis for mental health problems because they tend to seek medical help when symptoms are first experienced, and take care to follow medication directions.

There is another way of interpreting the high use by women of out-patient treatment services, which remains speculative because of lack of relevant research. Based on a feminist analysis, this interpretation highlights the implications of societal ambivalence towards 'women's work' of homemaking and childcare. Women's work is not seen as demanding nor is it highly valued, yet maintenance of this work is important for ensuring the care of other family members, especially men and dependent children. Consequently, women responsible for care of a family will be more likely to be given the nominal and only partial sick role of the out-patient. As Tudor *et al* say in relation to men: 'greater access to a sick role and subsequent treatment of illness is a perquisite of power even if it is a perquisite which is more difficult for the powerful to avoid'.[29]

Hospitalisation of women who are fully responsible for care of a family is typically more socially disruptive to the family than that of their male partners. It may therefore be seen as justified only in cases of marked disturbance involving abandonment of domestic tasks. However 'just as dropping into the role of psychiatric patient has its costs for women, so does the alternative. Coping, with help from medication, does not release the individual from the range of personal and family role'.[30] It is significant too that out-patient treatment typically involves visiting the practitioner concerned, with the associated difficulties of managing transport if childcare is unavailable for dependent children. That domiciliary visits are rare, especially by private psychiatrists, also means the practitioner lacks first-hand knowledge of the woman's living situation.

In this context, it is worth noting that the alternative to out-patient treatment, psychiatric hospitalisation, has been construed by labelling theorists as the ultimate step in labelling someone as 'mad', with associated changes in self-definition.[31] Those who receive treatment on an out-patient basis could therefore presumably minimise this change to their self-

perception and how others see them. Alternatively, for women with mental ill health who have full responsibility for the care of a family, hospitalisation has the potential to provide needed respite as well as specialised care. The potential advantages could include a physical rest, people to talk to, protection and security, a lessening of everyday demands and an opportunity to re-assess their situation away from those demands.

Labelling theorists have been primarily concerned with the effect of admission to a psychiatric hospital. It could be argued though that admission to other facilities such as a private psychiatric hospital or a psychiatric unit in a public hospital does not carry the same social stigma and labelling potential as hospitalisation in a government psychiatric facility. These former options are still largely dependent however on accessibility and the woman's financial resources. In Victoria for instance, not all public hospitals have psychiatric units, and private hospitals cost money. Furthermore, until recently, psychiatric beds in public hospitals have not been gazetted for involuntary admissions, and this change has yet to be fully implemented across the public hospital system. For women responsible for the care of dependent children, hospitalisation in any of the three options also requires arranging alternative care. Partial hospitalisation when other forms of childcare may be possible, such as at weekends or during the day, is rarely available. If care cannot be provided by relatives, and financial resources are unavailable for paid child care in the home, then foster care will be necessary, often involving unwelcome attention from state child welfare authorities.

Women would thus seem to be faced with an invidious situation in relation to use of treatment services, a Catch 22 which is more pronounced for those of low socio-economic status and responsible for the care of young children. Unless the woman has the resources to afford private hospital care, or her problems are significantly affecting her ability to meet domestic role expectations, she most probably will only be offered treatment on an out-patient basis. Currently, hospitalisation which is free of charge is largely only available for those seen as markedly disturbed, unable to carry out their usual responsibilities and/or posing a risk of harm to themselves or others. Whilst hospitalisation can offer a degree of respite, the present way in-patient care is provided also requires alternative child care arrangements if the woman concerned has young children. Out-patient treatment has different implications for women. The need for alternative child care is avoided, but out-patient treatment is unlikely to involve changes to a woman's domestic responsibilities, even though it may well be the demands of these responsibilities which are contributing to her mental ill-health.

I have already discussed research which suggests women from the lower socio-economic strata at home full-time with several dependent children are the most vulnerable to depression, the psychiatric disorder most commonly experienced by women. Unfortunately, it is these women who are likely to be most disadvantaged by the way treatment services are currently provided. In Victoria an important exception to this general situation is Clara House, a women's accommodation service set up in Melbourne by a non-government organisation with funding from the Department of Health and Community Services. Clara House provides housing for women with psychiatric problems and their children for up to three months. It is intended to support women through crises which otherwise might have led to hosplitalisation and the placement of children. Only four families can be accommodated at any one time so the service is necessarily limited in its cover. In addition, being in a particular Melbourne municipality, use of Clara House by women from other municipalities or from the country involves disruption to their local networks. It would appear there is no plan to replicate this service elsewhere in Victoria.

Exposure to Sexual Harassment and Abuse

Another concern raised by women in the consultations in relation to treatment services is the risk faced by women in-patients of sexual harassment and abuse from male patients and staff. Local anecdotal evidence suggests that more than risk can be involved in that some women have been actually sexually assaulted whilst in-patients. The seriousness of this issue is magnified by the apparent prevalence of a history of sexual abuse amongst women hospitalised for psychiatric problems. It seems highly probable that the integration of wards in government psychiatric hospitals, seen as a progressive step in the late 1960s and early 1970s, has exacerbated the risk of sexual harassment and abuse for women patients. In the conversion of wards from single to mixed sex occupancy, protection for women patients is likely to be overly reliant on staff vigilance, and privacy in using bathrooms and toilets may be minimal.

The vulnerability of women to unwanted sexual advances, especially when psychiatrically disturbed, has received little formal attention within Australia, either from government authorities, professional publications or women's groups. In many ways the silence symbolises the extent to which the particular needs of women with mental health problems have been ignored or overlooked in this country. Psychiatric treatment services whether public or private have not provided information to patients for the reporting of sexual harassment or abuse. In Victoria, procedural guidelines for responding to complaints of sexual harassment or assault by psychiatric patients using government services were first issued in 1991, and are written for staff use. Finally, it was not until August 1990 that the Australian and New Zealand College of Psychiatrists, the relevant professional body, issued a statement on the ethics of sexual relationships with patients. It seems no coincidence that the statement appeared a few days before the hearing of an appeal against a well-publicised and successful prosecution of a psychiatrist for professional misconduct in New South Wales. The irony of this case is that the psychiatrist concerned was a woman, whereas both overseas formal research and local anecdotal evidence overwhelmingly point to the perpetrators being predominantly male.

In the United States, the potential or actual sexual exploitation of women psychiatric patients has been a concern for feminists for almost two decades, with Chesler apparently the first to broach the topic in print.[32] Since then, it has been the subject of considerable research, and is now being pursued through legislation following frustration with inaction by professional bodies.[33] Whether sexual exploitation refers to actual intercourse or the more broadly defined erotic contact, the most likely victim has been found to be a woman client with a male professional.[34]

Several methods have been used to investigate sexual exploitation in psychiatric practice. One is to ask psychiatric professionals themselves whether they have been sexually involved with their patients, or whether they know of others who have been so involved; another is to ask women who have been in psychiatric treatment about their own involvement or approaches by their therapist, and a different approach again is to ask therapists about patients who reported sexual intimacy with a previous therapist.[35] Studies to date in the United States have focused on psychiatrists and psychologists in private practice, which unfortunately suggests the experiences of hospitalised women are being overlooked, especially the more disabled.

In studies based on therapist self-report, from 16 to 19 percent of males have admitted to erotic contact with female patients, a percentage seen as likely to reflect an under-reporting of such behaviour.[36] The professionals tended to be aged 40 years or over, with a mean age of

43.5 years being reported in one study, and their female clients around 12 to 16 years younger.[37] Fifty percent of psychiatrists in another study admitted to knowing of the sexual involvement of colleagues.[38]

There are two major reasons for concern about this behaviour. One is that it represents an abuse of power, and male power in particular. 'In most instances they (the women) abdicated their right of choice and submitted to the therapist because of his status, authority and the aura of the profession; frequently depressed, dependent, delusional, and even frankly psychotic, they were vulnerable to exploitation'.[39] The second and more serious concern relates to the effect on the women involved. Studies of women who reported sexual involvement with their therapists, or of second-hand reports from psychologists who were treating women with such involvement with a previous therapist, indicate that considerable psychological damage was experienced by the women concerned. Common client reactions which have been documented include guilt, shame and self-blame, grief, anger and rage, depression and the loss of self-esteem, ambivalence and confusion, fear, and massive distruct of male therapists (at times being generalised to distrust of all men).[40]

One of the features of sexual exploitation of women by psychiatric professionals is that complaints are rarely made by the women concerned, and there is a lack of follow through when formal complaints are made. An American study carried out in 1983 found that 'action is taken in about 4 per cent of the cases where sexual intimacy occurs between patients and therapists, and only half of these are carried to completion'.[41] Amongst the reasons given for the lack of complaints about sexual exploitation are the woman's sense of powerlessness, feelings of shame and guilt, fear of not being believed due to disturbance, fear of the consequences of disclosure, and statutes of limitations.[42] Inadequate reaction on the part of official bodies, whether law enforcement agencies or professional bodies is put down to: resistance; discounting of the seriousness of the complaint; cases being seen as 'poor risks' because it is one person's word against another of higher social status and power; concern for due process; and the focus by professional associations on rehabilitating rather than punishing the offender.[43] Bouhoutsos notes that in the United States in recent times, 'growing public sensitivity to the problem has led to a greater willingness to seek redress on the one hand, and limitation or punishment of the sexually acting out therapist on the other'.[44] Appelbaum also reports that several states are now instituting 'statutory remedies', including mandatory reporting, civil or criminal statutes.[45]

Without comparable research or formal reporting procedures in Australia, it is difficult to know how much of this material can be generalised. Where official bodies established to respond to complaints follow a conciliatory model, as in Victoria, there is the associated danger that women's complaints of sexual abuse by a health practitioner will receive a response comparable to a concern about overcharging. That is, the complaint will be handled as though it can be resolved through a meeting between the complainant and the alleged perpetrator. If the woman concerned rejects this approach as inappropriate, then no formal complaint will be lodged, and no record kept that could serve to indicate the extent of the problem.

Issues for Women Using Treatment Services: Policy Responses

From this examination of women's use of treatment services, several issues stand out as requiring attention. One is the uneven accessibility of existing treatment services and the extent to which different options may be equally difficult for women with family responsibilities.

Another is the lack of accountability of the private sector. A third is the problem of sexual harassment or abuse encountered by women when using treatment services. Finally, there is the recurring issue of lack of pertinent data on women's use of treatment services.

As already noted, women's ability to make use of current types of treatment services will vary according to where they live and their income, as much as their clinical condition. For instance, a woman of affluent means with dependent children who is moderately depressed can opt for treatment through private psychiatric hospitalisation, or can make use of private or government services on an out-patient basis. A woman with dependent children and a similar level of depression, but whose income is a supporting parent benefit, will probably only have the option of out-patient treatment from her GP or a local community mental health service, either of which could well involve visits by public transport with children in tow.

For this situation to become more equitable, the answer is not vouchers to enable the less well-off to use private psychiatric hospitals. That the latter do not necessarily follow progressive approaches to women's mental ill-health has already been noted. What does seem desirable is that treatment services become more responsive to women users. Some Australian states such as New South Wales and Victoria are already pursing a policy of establishing more locally accessible services, whether this be in the form of acute psychiatric units in public hospitals or new community mental health services. This can only benefit women. Other changes should also be considered to make government-funded services easier for women to use, such as increased provision of domiciliary visits, and the availability of intensive treatment in the community. Short-term crisis accommodation that provides time out and respite is another important option for women.

The establishment of model mental health services for women would be a more ambitious step, but could act as a stimulus to further policy and service development. The National Women's Health Policy proposed a dual strategy for improving health services for women, an approach also adopted by the Victorian Women's Health Services Program. The dual strategy includes both 'the provision of more special women's health services and complementary improvements to existing general health services'.[46] Special women's health services were justified on the grounds that they would enable the examination of new issues and development of new models of service, and would influence general health services. 'Such services are often more responsive to women's health needs due to the greater participation of women in all aspects of service delivery'.[47]

To date, the focus of this dual strategy has been on improving health services for women without specifically including mental health services, although the dual approach was to include the seven priority health issues identified within the National Women's Health Policy, one of which was women's emotional and mental health. No attempt has been made to establish a special women's mental health service, although in at least one instance a worker was appointed to a Victorian women's health service with a brief to work with women with mental health problems. The arguments put forward to justify establishment of women-specific health services are however equally applicable to mental health services focusing on women. The analysis presented in the preceding chapters, for example, indicates the need to try out new models of service for women with mental ill health, and to provide a source of innovation and influence for mainstream mental health services.

The National Women's Health Program is close to the end of the initial five year funding period, so it is unlikely that a special women's mental health service would be considered for

funding at this stage under this Program. However, mainstreaming of psychiatric services with general health services is a policy objective of both the national mental health policy and of the states, so there may be another way of providing such a specialist service. Hospitals specialising in the treatment of women's health problems are well-established in most Australian states, and some already provide psychiatric treatment services, especially for women with post-natal disorders. These hospitals could extend their services to meet the needs of women with major psychiatric disorders, including involuntary patients. Whilst only a proportion of women with the most disabling conditions would be covered, this type of service could explore new ways of responding to their needs, especially as in-patients. There is also a possibility of employing women staff to provide the service, in order to test the claim by Dr Margaret Cleaves that 'insanity in women would be better understood if insane women were placed in charge of physicians of their own sex'.[48]

Even if special women's mental health services were established, this would not eliminate the impact of hospitalisation on women with dependent children. The particular difficulties faced by women with low incomes have already been identified. The development of new ways of addressing their needs seems imperative and will be discussed in more detail in Chapter 5.

Another issue is the extent to which women are aware of the type of treatment services available and are involved in the decision of which is most appropriate at the point of referral. Anecdotal accounts indicate that practitioners do not always explain the reason for referral to a particular service, nor are they necessarily well-informed about the implications for the woman concerned. Policy directions being developed at a national level give new emphasis to the right of consumers to be informed about available treatment and service options.[49] Education of practitioners will also be necessary, both in how to include consumers in decision-making, and also about the impact on women's lives of different ways of providing services. Similarly, mental health consumer groups and women's health organisations such as Victoria's Healthsharing Women should also be ensuring that information is accessible to women on existing service options.

Although women have high usage rates of private psychiatric services, whether on an in or out-patient basis, there are few mechanisms for accountability in how these services are provided. Governments are generally loathe to be seen to intervene in how private psychiatrists conduct their business, even when abuses are clearly suspected as exemplified by the Chelmsford Hospital case in New South Wales. Two sources of changing the practice of private psychiatrists are firstly, through professional bodies endorsing new approaches, and secondly, through consumers themselves becoming more aware of alternatives and forming lobby groups to bring about change. Unfortunately, the promise of either source becoming active is minimal at this stage.

Tackling the threat and actual experience by women of sexual harassment and abuse when using treatment services should be a high priority, and an imperative under equal opportunity legislation. Government departments with responsibility for public psychiatric services should be taking a lead role in such developments, especially given that their women clients include the most disabled and hence the most vulnerable to sexual exploitation. Creating hospital environments which are safe for women in-patients may mean physical re-arrangements in integrated wards. Policy which proscribes sexual harassment and abuse needs to be explicitly endorsed and well-publicised within each facility, and accompanied by reporting

procedures which take account of women's difficulties in making such complaints. The current Burdekin Inquiry into the Rights of the Mentally Ill could well provide the impetus for changes, with submissions being made on the way women's rights to protection from sexual harassment and assault are abrogated in psychiatric institutions.

Overseas research and local anecdotal reports indicate that women are also at risk of sexual exploitation when they use out-patient treatment services. The capacity of existing health complaints bodies to respond appropriately to complaints of sexual exploitation by health practitioners will be limited by the extent to which they rely on a conciliation model, which does not fit the nature of these complaints. For individual complainants, it would seem that consulting an informed legal practitioner may be a more effective way of seeking redress.

At another level, a community education campaign along the lines of the protective behaviours program for children is also desirable so that women are better informed about the appropriate behaviour to expect from clinicians providing psychiatric treatment or therapy services. In Victoria, Healthsharing Women could provide a base for such a campaign. Lastly, in order to influence the attitudes and approaches of practitioners themselves, it may be necessary for bodies concerned with consumer rights such as the Victorian Office of the Public Advocate (OPA) and mental health consumer groups to lobby professional organisations. It would appear, for instance, that OPA is becoming increasingly aware of sexual abuse experienced by people with different types of disabilities, including the psychiatrically disabled. This body should be well-placed to campaign on a number of fronts to curtail such abuse.

Lastly, our understanding of which treatment services women use and why is again limited by the inadequacy of available data and the lack of relevant research. Apart from the importance of filling known data gaps, there are also important questions to answer through research about patterns of service use. For example, the more specialised services are the most expensive, and women are the highest users of specialist psychiatric services, yet we do not know whether referrals are always appropriate or necessary.

Morgan claimed that the findings of his UK study of referrals to psychiatrists by general practitioners showed the availability of specialist consultation and support would enable more patients with psychiatric problems to be managed in general practice, which is also a cheaper way of delivering services.[50] In addition, it is important to note that women and men may have comparable rates of re-admission to psychiatric hospitals, for instance, in 1988/89 re-admission rates for women and men to Victorian psychiatric hospitals were almost identical (30.5 percent for women and 30.6 percent for men, OPS figures), and government psychiatric hospitals provide the most expensive form of psychiatric care. The factors leading to re-admission for women and for men, and whether different service responses are required to minimise the need for re-hospitalisation, warrants exploration.

A Safe Place to Live: Housing for Women with Psychiatric Disabilities

Suitable accommodation has long been accepted as a basic need for people with psychiatric problems. In the past decade, concern has sharpened in Australia about the inadequacy of housing options for people with psychiatric disabilities. With the average length of hospitalisation becoming shorter, and an increasing number of patients being discharged from extended care, more people with psychiatric problems and disabilities are spending more time living in the community.[51] Problems with available accommodation for people with significant

psychiatric disabilities have also been highlighted by government reports on the commercial accommodation sector,[52] and research on the extent of psychiatric disorder amongst the homeless.[53] Provision of an adequate range of community residential services has been identified as a program priority for several years by the Victorian Health Department.[54]

A concern for the housing options for psychiatrically disabled women, especially those discharged from hospital, has been slower to surface. The 1989 Victorian Women and Mental Health Conference identified as a major concern the limited range of accommodation options for women leaving hospital or as an alternative to hospital admission. The lack of women-only housing, and of accommodation for women with children, were seen as two significant gaps.

There seem to be several reasons for the particular accommodation needs of women receiving little attention. It has been argued, for example, that women are more likely than men to continue living with their families, even if the circumstances are less than satisfactory, because of their greater tendency to experience 'low self-esteem and problems of dependence, lack of assertiveness, and a need for emotional support'.[55] Research also suggests that parents are more accepting of a daughter who experiences a major psychiatric disorder such as schizophrenia.[56] It would also appear that if families are still involved, a return home becomes an unquestioning part of staff's discharge plans for hospitalised women, whether or not the environment is conducive to the women's wellbeing. Although sex role stereotyping could be a major influence here, staff could also be aware of the limited alternative housing options available for women.

Low incomes are one reason for women having few housing options open to them. Women with psychiatric disabilities in need of suitable accommodation are typically dependent on social security benefits, and cannot afford private market rents for their own flat or house. It has been acknowledged that the number of psychiatrically disabled women needing alternatives to living with their families is on the increase.[57] However, the range of affordable options for someone on social security remains more restricted for women than men. In Victoria for example, it has been said that 'good special accommodation houses don't take women with psychiatric disabilities',[58] though it should also be noted that for those living in special accommodation houses, the lack of privacy, independence, stimulation, and disposable income are problems for women and men alike.[59]

The alternative of boarding or rooming houses poses particular difficulties for women with psychiatric disabilities because of their susceptibility to emotional and sexual exploitation: 'loneliness, difficulties in judgement and in interpersonal relationships increase their psychological vulnerability'.[60] Shared housing either through government-auspiced programs or private rental presents additional problems in that women residents in mixed sex houses may be relegated to the homemaker role,[61] as well as being vulnerable to sexual exploitation. Women also often dislike the lack of privacy in mixed sex group homes.[62] For instance, staff of voluntary organisations in Victoria which sponsor shared housing report difficulty in attracting women to move into this sort of accommodation. It is worth noting however, that only one, the Association of Relatives and Friends of the Emotionally or Mentally Ill (ARAFEMI) has to date established a women-only house. Supported accommodation that takes account of the particular vulnerabilities and needs of women is the type of accommodation seen as most appropriate to psychiatrically disabled women.[63]

The lack or inappropriateness of crisis or emergency accommodation for psychiatrically disabled women is a further problem, prompting Bachrach to ask in the United States context:

'are there fewer shelters and more restrictive admission policies for women because women are expected to be responsible for their own domestic arrangements?'[64] The availability of crisis or emergency accommodation for women with children is an even more acute problem. In Victoria for example, several women's refuges have refused to accept women with psychiatric histories as residents. This meant there were few if any alternatives in Victoria before Clara House was established to provide short-term accommodation for women with psychiatric disabilities and their children. However, as noted already, the service offered by Clara House is necessarily limited by size and geography.

Overseas, particularly in North America, homelessness amongst women with psychiatric disabilities has been identified as a serious problem requiring innovative program responses.[65] The programs which have been established provide a range of services on an outreach basis to women either living on the streets or referred from shelters or crisis services.[66] The emphasis is on flexible and responsive approaches to meeting the women's basic needs, and respecting their autonomy and preferred lifestyle, such as moving between residential services.[67]

It is difficult to estimate the extent to which women with psychiatric disability are homeless in Victoria, or conversely the proportion of homeless women who are psychiatrically disabled. The way in which homelessness is defined will influence how many are included. For example, a study in 1988 by the Victorian Council to Homeless Persons defined homelessness largely in terms of disaffiliation, including residents of special accommodation houses as well as emergency shelters and rooming houses in its sample population, but not those living on the streets.[68] Even in terms of lack of shelter however, homelessness is also likely to be less visible amongst women, as it could be argued that women will share a bed in preference to the risk of violence or assault associated with 'sleeping rough'.

Furthermore, assessing psychiatric disability amongst those regarded as homeless requires more than a casual encounter or passing observation. The Council to Homeless Persons' study for example, relied on a face-to-face interview with a trained interviewer using a modified diagnostic schedule, and focused on diagnosable symptoms rather than associated disabilities.[69] Of the 382 people interviewed as part of this study, only 69 or 18 percent were women.[70] However, although the number of women in the study was relatively small compared to men, a far higher proportion of women compared to men was found to have symptoms of a major psychiatric disorder. Of those interviewed, 35 percent of the women and 15 percent of the men were assessed as currently showing symptoms of a psychotic disorder, with 40 percent of the women and 18 percent of the men having had such a disorder at some stage in their lifetime.[71] Unfortunately the analysis of results did not indicate how many of the psychiatrically disabled women were residents in crisis accommodation as opposed to rooming houses or special accommodation houses.

On the basis of their findings, the authors of the Council to Homeless Persons' study argue that 'the data presented here indicate the need for more services, probably various in type and with improved deployment and improved access'.[72] This report lacks any acknowledgement that the service needs of women and men might differ, and require different program responses.

In Victoria, there have been recent developments which suggest that the importance of adequate housing for women with psychiatric disabilities is receiving more attention. One is the funding by the then Ministry of Housing and Construction of a resource book on housing

and support options for women with mental health needs.[73] Another is funding by the Victorian Health Department of a project in the western Melbourne metropolitan region, aimed at examining current accommodation options for women with psychiatric disabilities as a basis for recommending necessary future developments. Finally, there are now two women-only rooming houses set up with funding support from the state housing body, which accept psychiatrically disabled women.

Housing Issues for Women with Psychiatric Disabilities: Policy Responses

As noted, women with psychiatric disabilities are likely to be on low incomes, such as social security benefits, which makes rental or ownership on the private market almost impossible for an individual. A major requirement for women and for men is therefore access to affordable housing with security of tenure. For women, safety is another key requirement, especially avoidance of sexual exploitation and the threat of sexual harassment or abuse. The availability of women-only accommodation is one way of ensuring housing options meet women's particular needs. Housing for psychiatrically disabled women with children is another important component of an adequate range of options.

State public housing bodies obviously have a key role in the provision of housing for people on low incomes. For instance the Victorian government housing authority recently took a major step in increasing access to public housing for people with psychiatric disabilities by removing the requirement that applicants be able to demonstrate adequate independent living skills. The long waiting lists for public housing continue to present a significant barrier however. A related issue is the capacity of community mental health services to ensure appropriate support to their clients when the latter obtain tenancy of public housing accommodation. This is already provided in Victoria to residents of shared housing managed by non-government community mental health organisations, and could well be extended to public housing tenants with psychiatric disabilities.

These developments show recognition at a policy level of the need for adequate housing and support for psychiatrically disabled people. What could be more difficult to achieve, especially in a climate of dwindling resources, is acknowledgement that women may require special arrangements, such as allocation of public housing in neighbourhoods known to be safe, and the availability of women-only accommodation. In addition, awareness of women's particular housing requirements needs to become part of hospital discharge planning, as well as incorporated into case management at the community mental health service level. This is likely to require attention at the level of staff development and in-service training.

The non-government or community-managed sector is a promising source of initiatives in regard to the special housing needs of psychiatrically disabled women. Clara House for example, was the initiative of a non-government organisation, though supported by government funds. Other non-government organisations in Victoria such as ARAFEMI and the Richmond Fellowship manage a number of group homes, some rented on the private market with rent shared between residents, others allocated through the government shared housing program. ARAFEMI already has one shared house for women. Another non-government body in Victoria, the Mental Health Auxiliaries, runs a hostel for psychiatrically disabled women.

The potential exists for non-government organisations to make a proportion of their group homes available only to women, which would encourage tenancy from women who see mixed sex households as unacceptable. This form of affirmative action seems overdue given

that women and men are equally likely to be diagnosed with the most disabling psychiatric disorder, schizophrenia, and that men outnumber women in occupancy of group homes.

Recovering Lost Opportunities: Rehabilitation for Women with Psychiatric Disabilities

Rehabilitation is aimed at assisting people with disabilities achieve their maximum potential. There are both intrapersonal and interpersonal disabilities associated with psychiatric disorder and hospitalisation, and these extend to problems in the everyday use of resources and facilities that most members of the community take for granted. Rehabilitation may mean re-acquiring abilities lost through periods of institutional care, or new learning which fills in gaps due to the disruption of schooling and of social and emotional development. Goals typically include not only the learning of skills, but also the improvement of self-esteem and self-confidence, the expansion of social networks, and an increase in economic and personal independence.

The area of rehabilitation was not identified as an issue of concern for women in the consultative forums discussed in Chapter 2. However there is evidence from overseas studies, albeit limited in number, and from local observation, that rehabilitation services have neglected the needs of women with psychiatric disabilities. It would seem that the opportunity for many of these women to regain lost skills and learn new ones has been ignored, and their potential underdeveloped.

The experience of a major psychiatric disorder such as schizophrenia can result in ongoing disabilities even if acute symptoms have been overcome. It is therefore not surprising that people disabled by schizophrenia form the majority of participants in psychosocial rehabilitation programs, and that such programs are mainly targetted at this group. Research data also show that women are as likely as men to be diagnosed with schizophrenia during their lifetime. Consequently it would be reasonable to expect that women would be equally represented amongst participants of rehabilitation programs. Instead men tend to outnumber women. This difference seems more pronounced in community-based programs, where the ratio of men to women may be as high as four to one (author's observations).

Obviously it is important to ask why women have low participation rates in rehabilitation programs. It is not easy to answer this because of the lack of research in this area. Rehabilitation research is often as 'gender-blind' as the programs studied. That is, it does not differentiate between women and men, presumably on the assumption that the needs and experiences of the two sexes are so similar that distinctions are unnecessary. Research on psychiatrically disabled women mainly comes from the United States and to a lesser extent the United Kingdom. Even in those countries there are few relevant studies.[74] It would appear no comparable research has been undertaken in Australia.

One possible explanation of women's low participation rate in rehabilitation is that they are less disabled than men by the experience of a psychiatric disorder, even a major disorder such as schizophrenia. For instance studies have consistently shown that women diagnosed with a schizophrenic disorder have fewer rehospitalisations and shorter stays than men with the same diagnosis.[75] Unfortunately these measures are not necessarily adequate indicators of the extent of disability. Ideally research should assess the level of disability across a range of living skills and also take into account quality of life indices such as personal satisfaction, meaningful daily activity, extent of social networks and financial independence. Such comprehensive research has yet to be undertaken in Australia.

To date, work undertaken overseas indicates that women with long-term psychiatric disabilities are more likely than men to be living with their families, whether partners, parents or offspring.[76] Yet in comparison with single people, women living with a spouse were found to have a lower level of personal independence and fewer social contacts outside the home.[77] Another follow-up study showed that both women and men experienced increased economic dependence after a period of psychiatric hospitalisation.[78] It has been suggested that women diagnosed with schizophrenic disorders have better outcomes than men due to a higher level of social skills.[79] However a study which found women with this diagnosis were more socially competent than similarly diagnosed men, also discovered that this was unrelated to level of symptomatology or length of hospitalisation.[80]

It would seem therefore that research to date does not indicate that women are less disabled than men following the experience of a major psychiatric disorder and hospitalisation. Whilst further research may identify differences, other issues are relevant to the low participation of women in rehabilitation programs. One is the rate of rehabilitation referrals for women, especially following hospitalisation. Although formal documentation is only available through overseas studies,[81] local observation supports their finding that fewer women than men are referred for rehabilitation.

For many women leaving hospital, though probably most commonly those who are married, a return to a full-time homemaker role seems to be accepted without question by all concerned, including staff, families and the patient herself.[82] Often the only aftercare provided is individual out-patient appointments. Even when single, women are less likely than men to be referred to rehabilitation programs, and especially those involving vocational training.[83] Referral for work preparation may also involve limited types of training that follow sex stereotyped notions of female occupations.[84] Finally, local rehabilitation workers report that when referred, women often drop out after attending programs once or twice.

Each of these issues merits separate discussion. The low rate of referrals of women for rehabilitation, for instance, is arguably based more on sex stereotypes than the needs of the women concerned. The prevailing assumption seems to be that men need daily occupation away from where they live, and their potential for paid employment should be developed. In contrast, in itself the home is clearly often taken to be an appropriate and adequate post-hospital placement for women. Referral or non-referral for rehabilitation may therefore be based on conventional notions of what is right and proper for a person of that sex, rather than level of disability and rehabilitation needs.

A return to full-time domesticity raises a number of concerns however. Full-time domestic roles may not only limit women's potential, but also be particularly problematic for psychosocially disabled women. Test and Berlin point to the advantages of the traditional full-time homemaker role, such as flexibility and low public visibility.[85] They also note the disadvantages, such as social isolation, lack of structure, inadequate economic benefits and additional stresses if child-rearing is involved.[86] Another disadvantage is dependence on the family, especially the woman's partner, for emotional and financial support. Acceptance of a return to full-time homemaking seems also to be based on the assumption that domestic roles are 'natural' for women. As a consequence, assessment of the impact of disabilities on performance of these roles, with opportunities for training or re-training, is often ignored.

From her experience in the United Kingdom, Parry argues strongly that rehabilitation is conceptualised 'in a way which disregards the family as an arena of social performance', and

comments that 'within the field of mental health, aetiology is generally associated with the private, domestic sphere and rehabilitation with the public, employment worlds'.[87] Child care and home management are two areas neglected in rehabilitation, yet both may be significant components of women's post-hospital domestic responsibilities.

The finding that single women are also less likely than men to be referred for rehabilitation seems further confirmation of the prevalence of sex stereotyping, and associated lower expectations of women's performance. For single women the obvious disadvantages are lessened opportunities for meaningful daily activity, skill development and social contact. Sex stereotyping probably also explains the low referral rate of women to vocationally-oriented programs. This practice lowers women's employability and potential earnings, and leaves them vulnerable to continued economic dependence on others and the state.[88]

In local community-based rehabilitation programs, it has also been noted that when women are referred, their drop-out rate is high (local reports). A number of factors seem involved. The majority of participants in community-based programs are men, a male-oriented culture predominates, and young women in particular are likely to be subjected to harassment ranging from sexist comments to unsolicited physical contact. A study of homeless women carried out in Melbourne in 1986 commented in terms of day programs that 'women with psychiatric disabilities are seeking (and not being able to find) programs without men'.[89] Women sought women-only services due to 'fear of harassment by men and discomfort experienced because of men'.[90]

Using Victoria as an example, there are no non-residential rehabilitation programs run specifically for psychiatrically disabled women. In addition, few programs run women-only activities, *let a*lone activities that focus on issues of relevance to women such as dealing with sexual harassment, managing family relationships, establishing and maintaining social relationships, handling contraception and improving self-image. The problem is thus circular. Women who attend a program for the first time may find that they are in the minority, are subjected to unwelcome attention from male participants and are not offered activities which encourage them to stay. When these women do not return, this not only limits their opportunities for further development but also reduces the likelihood of other women attending.

When women do participate in rehabilitation programs, research indicates that their needs may be inadequately met. A recent study of service usage by women and men of rehabilitation and continuing care services in South London showed that the women had had longer contact with the services, had received less intensive input, and that there had been less variation in service response to women than to men.[91] Even where women and men were assessed as functioning at a similar level, the women were more likely than the men to be engaged in activities designed for the more disabled.[92] This trend was particularly pronounced for women over 45 years old. Overall, the findings of this research showed an institutionalised response by the service to the rehabilitation needs of women participants, which was in contrast with a responsiveness to the men's level of functioning and changes in that functioning. Unfortunately, comparable research has not been undertaken in Australia.

In summary, rehabilitation services have yet to respond adequately to women with psychiatric disabilities. It would appear that women's rehabilitation needs are being overlooked at the point of assessment and referral, and that available programs are not necessarily attuned to meeting those needs. As Perkins and Rowland point out, 'it cannot be assumed that the same service will be equally appropriate for men and women and more detailed investigation of the service needs of chronically mentally ill women is required'.[93]

Rehabilitation Issues for Women with Psychiatric Disabilities: Policy Responses

The majority of rehabilitation services for people with psychiatric disabilities are either directly provided or funded by government departments in Australia. In Victoria, the Office of Psychiatric Services' Policy and Program Statement on Rehabilitation Services acknowledged that rehabilitation services have been limited in availability or accessibility to women as well as other groups.[94] Individual program planning is identified in the document as a necessary component of the provision of rehabilitation services, with this planning to take into account specific needs relevant to the client's gender as well as other variables such as age and cultural background.[95] It would seem however, that more specific direction and strategies are called for if rehabilitation services are to become more responsive to women. Policy development would need to include hospital and community-based services, and both the government and community-managed or non-government sector.

In terms of policy development, there is a risk that a low priority will be given to ensuring rehabilitation services are responsive to women, because of the major issues facing public psychiatric services in Australia. However as already noted, the extent and pace of the changes taking place in public psychiatric services are also providing opportunities for other developments. What is important therefore is the identification of strategies which could lead to changes in how rehabilitation services respond to women's needs.

A starting point would be to ensure that the involvement of women in rehabilitation becomes the norm rather than the exception, especially at the point of discharge from hospital. In terms of service provision, this change in itself would require a recognition that many women with psychiatric disabilities are currently being excluded from access to post-hospital rehabilitation opportunities. It is therefore important to highlight the implications of excluding women, such as disabilities becoming chronic and the likelihood of rehospitalisation being increased. For the women themselves, their potential is likely to be underdeveloped and their quality of life impoverished.

In itself however this strategy would be insufficient without other developments. For instance, if sex stereotyping prevails at the point of assessment and referral, this can lead to low performance expectations for women and limit what rehabilitation opportunities are offered. Staff are key gatekeepers in this regard, and the extent to which they may be relying on outdated assumptions is an area for immediate attention, with staff development and training the key strategy. Programs developed should aim at increasing knowledge and understanding of the impact on women of psychiatric disabilities, their rehabilitation needs and how these could be better met.

Another essential step is developing rehabilitation assessment which captures how psychiatric disabilities affect women's lives, rather than assuming the adequacy of generic assessment. Research has shown, for instance, that through being structured in terms of life events common to men, conventional life stress scales ignore events experienced solely or largely by women, such as childbirth, incest and rape, or more prosaically, the impact of changes to their partner's lives such as a job move.[96] Similarly, rehabilitation assessment must be sensitive to expectations characteristically experienced by women in terms of both their age and also their social roles as daughters, wives or mothers. These expectations are typically different to those for men. For instance, hospital staff report that frequently a woman in-patient goes home for weekend leave and finds her family's washing waiting for her. Families may also change their expectations following hospitalisation, such as parents becoming more protective

of a daughter and inappropriately restricting her movements. For women in these situations, learning how to identify and negotiate levels of activity which minimise stress may be a key component of their rehabilitation.

Assessment is typically limited by what can be offered as a result. It has previously been reported that existing rehabilitation programs may lack appeal or relevance to many psychiatrically disabled women. A further strategy is therefore program review and development, an area which again calls for attention to staff training, and exposure to alternative ways of working. Program activities for women may need to include improving competence in the domestic sphere as much as providing opportunities to develop marketable job skills. Program methods as well as content require attention. Given the known importance of teaching skills in the environment in which they will be used, rehabilitation in the woman's own environment may be most appropriate for the learning of domestic skills. Similarly, women's well-trained tendency to defer to men in mixed sex groups highlights the importance of offering women-only program activities.

A further aspect of program review and development is the creation of program environments in which women feel safe and valued as people in their own right. Although times of economic constraint are not conducive to setting up new types of programs, and women-only programs may be seen as a luxury, there is potential for innovative ways of deploying existing resources. For example, even within the same program it is possible to have regular women-only use of a facility, with separate off-site activities being provided for male participants. No-one would miss out, but the need of the women for their own physical and emotional space could be recognised for the first time.

Apart from this type of development, clear policy and procedures should also be established to ensure women program participants are not subjected to sexual harassment or exploitation by male participants or staff. This should include mechanisms for dealing with complaints. In addition, education of women clients in sexuality, protective behaviours, contraception and safe sex practices should be an essential component of rehabilitation programs. Being psychiatrically disabled does not preclude a woman engaging in sexual relationships, and may heighten her wish to be like her age peers. This may include not only involvement in sexual relationships, but also becoming pregnant and caring for the child.[97] The ability of staff to respond appropriately to this wish to be normal may require specific staff and program development.[98]

As with other areas of service provision, quality assurance mechanisms are becoming an accepted part of the evaluation of rehabilitation services. One way to ensure that the strategies already discussed become an integral part of the development of rehabilitation services is to include relevant indicators in regular quality assurance programs. Making assessment of the responsiveness of rehabilitation services to women part of quality assurance brings this aspect of service delivery into the mainstream, rather than marginalised as an 'extra'. It would not be difficult to develop a set of indicators to be used to assess how rehabilitation services respond to women, drawing on the strategies already discussed.

Apart from ensuring current rehabilitation services are more responsive to women, relevant local research should be encouraged. Given the lack of work in this area, it is essential to promote research which focuses specifically on rehabilitation for women. Studies which seek to chart the experiences and use of services by women with significant psychiatric disabilities would be an appropriate starting point. Service planning would also benefit from

systematic documentation of the pattern of women's present involvement in rehabilitation, and evaluation of which programs work for whom and in what way. At the very least, committees which currently evaluate and approve research proposals involving clients of psychiatric services should ensure that proposals do not involve unwarranted assumptions about the similarity of women and men. This is one way to avoid the continuation of gender blind research. Similarly, it should be a requirement that data collected on the use of rehabilitation services record the sex of the client, to enable greater understanding of how these services are used by women and men.

Footnotes

1 McColl & Hough,1979
2 Morgan,1989
3 Russo & Sobel,1981,p.7
4 Busfield,1986,p.139
5 Berah,1983,p.268
6 Jorm & Henderson,1989,p.462-4
7 Office of Psychiatric Services,1987,p.38
8 *Ibid.*
9 Garton,1988,p.136-154
10 Office of Psychiatric Services, 1987,p.38
11 Gift & Zastowny, 1990,p.11
12 Krupinski *et al*,1982,p.53
13 Tudor *et al*,1977
14 Keskiner *et al*,1973
15 *Ibid.*,p.692
16 Krupinksi *et al*,1983,p.365
17 *Ibid.*,p.368-371
18 Office of Psychiatric Services,1987,p.39
19 *Ibid.*,p.39
20 Hollingshead & Redlich,1958
21 Brown,1985,p.111
22 Berah,1983,p.268
23 Office of Psychiatric Services,1987,p.14
24 Jorm & Henderson, 1989, p.462-464
25 Krupinski *et al* , 1982, p.53 & 61; more recent data are unavailable.
26 Horwitz, 1977
27 Smead *et al*, 1982: Kessler *et al*, 1979
28 Penfold & Walker, 1983, p.197
29 Tudor *et al*, 1977, p.109
30 Davis *et al*, 1985, p.74
31 Scheff, 1966
32 Chesler, 1972, p.124-132
33 Appelbaum, 1990
34 Mowbray *et al*, 1984, p.43

[35] Mowbray *et al*, 1984, p.43; Schoener *et al*, 1984, p.63; Bouhoutsos, 1984, p.212
[36] Mowbray *et al*, 1984, p.43; Schoener *et al*, 1984, p.63-4
[37] Bouhoutos, 1984, p.210-1
[38] Schoener, *et al*, 1984, p.64
[39] Bouhoutsos, 1984, p.210
[40] Schoener *et al*, 1984, p.64-6; Bouhoutsos, 1984, p.212
[41] Bouhoutsos, 1984, p.213
[42] *Ibid*., p.214
[43] *Ibid*., p.215-224
[44] *Ibid*., p.215-6
[45] Appelbaum, 1990, p.15
[46] National Women's Health Policy, 1989, p.82
[47] *Ibid*., p.82
[48] Quoted in Mogul, 1985, p.1056
[49] Mental Health Statement of Rights and Responsibilities, 1991
[50] Morgan, 1989, p.752-3
[51] Office of Psychiatric Services, 1987, p.vi
[52] Victorian Ministerial Review of Special Accommodation Houses, 1986
[53] Herrman *et al*, 1988
[54] Rimmer *et al*, 1988, p.11
[55] Council to Homeless Persons, 1986, p.43 &45
[56] Seeman, 1983, p.143; Golstein & Kreisman, 1988
[57] Council to Homeless Persons, 1986, p.43
[58] *Ibid*., p.42
[59] Victorian Ministerial Review of Special Accommodation Houses, 1986, Sections 3 & 5
[60] Test & Berlin, 1981, p.142
[61] Davis *et al*, 1985
[62] Council to Homeless Persons, 1986, p.44
[63] *Ibid*.
[64] Bachrach, 1985, p.1065
[65] Martin, 1988; Harris & Bachrach, 1990; Goering *et al*, 1990
[66] Martin, 1988; Harris & Bachrach, 1990; Goering *et al*, 1990
[67] Martin, 1988, Harris & Bachrach, 1990
[68] Herrman *et al*, 1988, p13
[69] *Ibid*., p.20
[70] *Ibid*., p.27
[71] *Ibid*., p.29
[72] *Ibid*., p.38
[73] Women's Housing and Support Guide, 1990
[74] Bachrach, 1984; Test & Berlin, 1981; Parry, 1983; Mowbray *et al*, 1984; Perkins & Rowland, 1991
[75] Goldstein, 1988
[76] Wattie & Kedward, 1985; Conning & Rowland, 1991
[77] Wattie & Kedward, 1985, p.208
[78] Kinard & Klerman, 1980

[79] Mueser *et al*, 1990, p.145
[80] *Ibid.*, p.143
[81] Parry, 1983; Mowbray *et al*, 1984, p.113
[82] Parry, 1983; Test & Berlin, 1981
[83] Mowbray *et al*, 1984, p.113
[84] *Ibid.*
[85] Test & Berlin,1981, p.140
[86] *Ibid.*
[87] Parry,1983, p.241
[88] Mowbray *et al*, 1984, p.113
[89] Council to Homeless Persons, Victoria, 1986, p.47-8
[90] *Ibid.*
[91] Perkins & Rowland, 1991, p.76-78
[92] *Ibid.*, p.78
[93] *Ibid.*, p.79
[94] Office of Psychiatric Services, 1990, p.5
[95] *Ibid.*, p.6
[96] Makovsky, 1980, p.117-118
[97] Apfel & Handel, 1992, p.1-5
[98] Apfel & Handel, 1992, provide a wealth of information and case examples on working with women with long term mental illness around issues of sexuality, pregnancy and motherhood.

5. Women With Special Needs

The preceding chapters have focused on the distinctive features of women's mental ill health and service use which warrant attention in terms of policy and service development. It may therefore seem incongruous to devote a chapter to women with special needs. There are, however, particular groups of women whose circumstances are such that extra attention is warranted to ensure their needs are not overlooked. These groups include both women with mental health problems as well as those who are carers of psychiatrically disabled family members. The former category includes women from non-English speaking backgrounds, women with dependent children, older women and women with long-standing significant psychiatric disabilities. A beginning consideration is the situation of women in Australia whose first language is not English.

Women from Non-English Speaking Backgrounds

The risk to mental health posed by migration is not a new discovery, nor is the particular vulnerability of migrants from non-English speaking backgrounds to mental health problems. Amongst women migrants in Australia, researchers have been able to pinpoint those most likely to be referred for specialist psychiatric care. Women of Southern European origin are the group identified to date as being most at risk.[1] It has been found that 'the peak incidence of psychiatric disorders in Southern European women occurs after 7-15 years' residence in Australia where the mother has remained as the only non-English speaking person in the family, where her role as mother and wife has significantly diminished'.[2]

In the 1991 National Non-English Speaking Background Women's Health Strategy, data from the 1983 Australian Health Survey are reported which show the highest proportion of women reporting 'mental disorders' ('nerves, tension, depression') were from Southern Europe.[3] Women from non-English speaking backgrounds (NESB) generally demonstrated 'a higher rate of poor mental and emotional health conditions' than those born in Australia or in English-speaking countries.[4] A 1984 survey of patients with schizophrenic disorders in the Western region of Melbourne found women migrants from non-English speaking backgrounds had the highest rates of this disorder.[5]

The 1988 Australian Survey of Disability and Handicap found psychiatric and emotional conditions accounted for a higher proportion of the disabilities of NESB women than for the disabilities of women from other countries of origin.[6] A 1991 study indicates that the levels of psychiatric disability amongst NESB women who are refugees may be considerably higher.[7] 'According to the study, it is likely that two-thirds of all refugee women in Australia suffer ongoing forms of serious mental and emotional disability, that arise from their pre-immigration experience but which persist for many years after arrival, largely as a result of settlement problems'.[8]

The emotional and mental health problems experienced by NESB women in Australia have been attributed to a complex interplay of factors. These include the following: unemployment and hazardous working conditions; the burden of caring for other family members; isolation, loneliness and lack of supportive social networks; inadequate command of English; domestic violence; and poor access to social resources such as childcare, housing and transport.[9] Not surprisingly, in the state consultations undertaken as part of development of the

National Non-English Speaking Women's Health Strategy, improving mental health was one of the two 'substantive areas of health care most frequently given priority'.[10] The strategy most commonly identified by the states to change this situation was the development of mental health services which were culturally appropriate and therefore more accessible to NESB women.[11]

Since the early 1980s, mental health policy statements in Australia at both a national and state level have acknowledged the importance of services being responsive to the ethnicity of consumers. The 1990 National Mental Health Strategy Statement is the most explicit, with one of its principles being that 'the ethnic background and communication problems of consumers, together with the cultural aspects relevant to mental health and mental disorder and their management, need to be taken into account in policy development and the provision of all mental health promotion, prevention, treatment and rehabilitation services'.[12] In this document women are largely disguised through use of the generic term 'gender', so predictably no specific attention is paid to the responsiveness of services to NESB women with mental health problems.

The National Non-English Speaking Women's Health Strategy attempts to remedy this situation by making a number of recommendations about improving mental health services for NESB women. One is that not only should health interpreters 'be made available as a right for NESB women with low English proficiency, or on request', but also that NESB women should have the right of access to a female interpreter.[13] A further recommendation is Commonwealth funding of 'community-based ethnic access officers' in each state 'to work with mental health services to better address the needs of older, isolated NESB women with low English proficiency'.[14] Other recommendations focus on NESB women who are refugees, and include service development for torture and trauma victims, increasing the availability of bilingual female counsellors and doctors, and developing support services for refugee women who have recently given birth, and/or been victims of sexual assault or domestic violence.[15] Finally, expansion of followup services under the Supported Accommodation Assistance Program (SAAP) is recommended for NESB women who have experienced domestic violence.

This set of recommendations is laudable in intent, and clearly aimed at addressing specific problems uncovered during the development of the National Non-English Speaking Women's Health Strategy. Unfortunately, in relation to mental health services, the Strategy is hampered by this area being only one of those needing to be covered, and is over-reliant on existing research, little of which focuses specifically on issues for NESB women in the use of current mental health services. As a result, the recommendations lack the breadth needed to bring about significant changes to the majority of mental health services presently used by NESB women.

Clearly there is a need to develop greater understanding of how mental health services could be more responsive to NESB women. Anecdotal accounts indicate for instance that the mixed sex environments of psychiatric in-patient wards pose particular difficulties for NESB women, especially those from cultures which set limits to contact between men and women. Whilst ideally women-only services should be an option, it may also be possible through physical design and program planning to place limitations on the interaction between men and women patients in hospital wards.

Similarly, my observations indicate that community-based mental health services, including those providing rehabilitation programs, appear to have problems engaging partici-

pation by NESB women. This in part seems due to the lack of bilingual staff, but is also possibly related to the unwittingly ethnocentric nature of service delivery and the mixed sex nature of programs. The overall scarcity of bilingual mental health workers means the employment of such staff tends to be fortuitous rather than planned, suggesting that alternative models may need to be explored. For instance it would appear that following discharge from psychiatric hospitalisation, a number of NESB women seek after care from bilingual general practitioners, who in turn may lack familiarity with current methods of psychiatric treatment. It may be more productive for community mental health staff to provide specialist consultation for such practitioners, than to attempt to obtain the bilingual resources to cover all the non-English speaking groups in the catchment area of a service.

It is beyond the scope of this analysis to detail a comprehensive plan for how mental health services could be more responsive to NESB women. However the Victorian Transcultural Psychiatry Unit offers a model which could be followed by other states. In addition to providing a direct service to patients from different ethnic backgrounds, the Unit is also involved in training mainstream practitioners in cultural issues and undertakes research into the psychiatric needs of NESB groups. This Unit is therefore well placed to promote service responsiveness to the needs of NESB women, and to provide expert advice on relevant quality assurance indicators.

With regard to the next two groups, women with dependent children and older women, the lack of relevant research and service development places considerable limitations on both understanding their needs and identifying appropriate policy responses. The aim will therefore be to suggest possible future directions rather than to provide a definitive brief.

Women with Mental Ill Health and Dependent Children

Women with dependent children were noted as having special needs in relation to mental health services by both the consultation for the Victorian Why Women's Health Report and the Victorian Women and Mental Health Conference. In the consultation, a major concern was the lack of alternatives to psychiatric hospital admission for women who had serious mental health problems such as depression and were also responsible for the care of young children.[16] 'The only solution offered by health or welfare services was to admit and/or certify the women for depression and to take the children away from their mothers'.[17]

Participants in the Victorian Women and Mental Health Conference identified additional issues, including the inadequate state of research into the specific needs of women with mental health problems who have children, the need for parenting support and assistance, and for facilities in hospitals so children could remain with their mothers, and improved coordination between government services involved with women with mental health problems and dependent children. Where the care of children was being supervised by protective service workers, women reported at times feeling caught between the expectations of these workers and those of psychiatric staff.

One immediate difficulty in exploring issues for women with mental health problems who have dependent children is the absence of available data on the number of women in this category. The marital status of women who are users of mental health services is more likely to be recorded than whether or not women have children, let alone the number and ages of the children in their care. There are some studies on the parental involvement of women with mental ill health. Research on clinical depression in women, such as that of Brown and Harris

in the UK or Belle in the USA, included the number and age of children of women in the research population. Indeed, as has already been noted, Brown and Harris found that responsibility for the care of three or more dependent children was one of the factors increasing women's vulnerability to depression.[18]

In contrast, there appears to have been little research interest in the relationship between schizophrenic disorders in women and the size and age of their family. This gap is curious given that it is estimated the marriage rates of women diagnosed with schizophrenic disorders are only slightly below normal,[19] and the peak period of onset of this disorder in women is between 24 and 29 years of age.[20] As Hafner comments: 'For married women, the years between 24 and 29 generally coincide with maximum sex-role conflict and marital strain: children are young and demanding; husbands are committed to work rather than domestic matters; and there are many other conflicts and problems that even the best adjusted couples have difficulty in acknowledging and resolving'.[21]

Unravelling the relationship between the mental health problems experienced by women and their family responsibilities is important on at least two levels. One is in terms of assessment and treatment, the other relates to the type of services provided. For instance, if the demands of caring for young children is associated with the type of psychiatric disorder experienced by women, it is particularly important to take this into account in assessment and treatment. Even if a significant association is not demonstrated, responsibility for childcare cannot be excluded as a source of stress. For women with dependent children, the types of services provided and how they are delivered have the potential to exacerbate or diminish this stress. For example, if a woman's condition is such that hospitalisation is seen as necessary, she will typically be admitted without her children, necessitating alternative childcare. Mother and baby accommodation is available in some acute psychiatric units, but is typically in high demand. The problem with alternative care for children is firstly, not all women have access to informal backup arrangements from relatives or friends, and foster care may be necessary. Secondly, alternative care involves a break in the mother/child relationship and resuming that relationship is characteristically stressful for both parties.

Obviously there are inherent difficulties in providing a woman with the type of intensive treatment assumed by psychiatric hospitalisation and at the same time enabling her to continue her child care responsibilities. It is unlikely that in-patient units will have the flexibility to offer accommodation for mobile young children, and the desirability of exposing young children to the environment of an acute psychiatric unit is questionable. It may well be however, that alternatives to 24 hour admission are possible which do not entail women being separated for extended periods from dependent children.

Clara House in Victoria is an example of a short-term residential program for women with acute psychiatric problems and their children. Innovative use of extensive treatment in the community may be another alternative, and may not involve re-locating families. It would seem possible, for instance, for women with young children to be involved in acute treatment programs during the day when childcare facilities are open, or at weekends when partners, relatives or friends could provide childcare. On the other hand, 24 hour hospitalisation could be be a source of respite and renewal for women who find family responsibilities burdensome and stressful.

Following discharge from hospital, or if psychiatric care can be provided in the community without the need for hospitalisation, additional support may be appropriate.

However rehabilitation programs typically pay little attention to the needs of women, especially in relation to their domestic responsibilities. In reversing this situation, support on an outreach basis may be more valuable than expecting attendance at centre-based programs. A local service of relevance here is the family aide program offered by Careforce, a non-government family agency operating in four areas of metropolitan Melbourne. The state Department of Health and Community Services funds Careforce for family support workers to provide practical support and guidance in their own home to psychiatrically disabled mothers. Careforce also runs groups on parenting skills and actively seeks the participation of women with mental health problems. In North America, there are also examples of mental health services which offer groups for women with psychiatric disabilities on childcare and parenting skills, although these programs are centre rather than home-based.[22]

From this brief account, it can be seen that too little is known about the particular needs of women with mental health problems who have dependent children. In policy terms, what is important is that this group is identified as having distinctive requirements in terms of service development. A promising start is provided by Apfel and Handel's recent U.S. publication *Madness and Loss of Motherhood*. The authors highlight how the reality of sexuality, reproduction and motherhood amongst women with long-term mental illness has been largely ignored or denied by clinicians.[23] Whilst focusing primarily on clinical practice issues, Apfel and Handel also make recommendations about service developments, including provision of supported housing options for couples and one or two parent families; specialist inpatient programs for pregnant psychotic women, particularly those with drug addictions; and ongoing parent support programs.[24]

Older Women with Mental Health Problems

Given the aging of the general population, and women's greater longevity, the service needs of older women with mental health problems warrant particular attention, especially as the current state of knowledge about this group is limited. The National Women's Health Policy identified the health of older women as one of its seven priority issues for policy and service development, and mental ill health as one of the areas of concern.[25]

As could be expected from trends already identified, older women are more likely to use mental health services than older men. For example, in the UK in 1981, women comprised 1737 or 57 percent of the 3066 psychiatric hospital admissions of people aged 65 years and over.[26] There is also some evidence that older women receive a different response from mental health services than either men or younger women. Jorm and Henderson's study of Australian Medicare data from 1985-86 for instance, showed that in private psychiatric practice, 'the main recipients of shorter consultations were older women'.[27] Older women were also more likely than younger women or men of all ages to be given ECT.

Jorm and Henderson are cautious in their interpretation of these findings, but suggest that the high number of short consultations show 'the elderly are more likely to have received somatic treatments and less likely to have received psychological ones'.[28] They also refer to American research which found that 'American psychiatrists regarded older patients as less ideal than younger patients, even with identical symptoms. They saw elderly cases as having a poorer prognosis and as being less suitable for psychotherapy'.[29] Surprisingly, Jorm and Henderson do not comment on the higher use of ECT amongst older women. It could be argued for instance, that the pattern of psychiatric morbidity amongst older women is insufficiently

different from that of younger women to explain the different use of ECT on clinical grounds alone. In addition, the side-effects of ECT include memory loss and confusion, which would suggest caution in its use for the elderly. On the basis of these observations, it is at least plausible to link the higher use of ECT for older women to the devaluing of this group of patients already noted amongst American psychiatrists.

Rodeheaver and Datan claim that in the American context, 'growing old and needing mental health services may be risky business for women'.[30] They argue that older women are particularly vulnerable to mental ill health due to poverty, widowhood and caregiving responsibilities,[31] and are likely to receive inadequate or inappropriate treatment of their mental health problems due to ageist and sexist attitudes on the part of medical practitioners.[32] Rodeheaver and Datan argue that medical practitioners are prone both to overlook the psychological problems of older women, assuming symptoms are a normal part of ageing, and also to attribute physical problems to psychogenic causes. They see the 'wastebasket status' of Alzheimer's disease as contributing to the overlooking of psychological problems: 'real and treatable problems (may) present the same symptoms of Alzheimer's, most notably alcohol and drug misues and depression'.[33] The tendency to psychologise symptoms on the other hand, coupled with the already noted undervaluing of psychotherapeutic treatments for the elderly, could well be responsible for the high rates of psychotropic medication prescribed for elderly women. In turn, this practice carries additional risks for older women because of the frequency of acute drug reactions from the misuse of tranquilisers and sedatives amongst the elderly.[34] Rodeheaver and Datan also refer to the way side effects of drug misuse 'mimic the early symptoms of Alzheimer's disease' and report that 'misdiagnosis is quite common'.[35]

In terms of policy responses, clear direction is not yet possible in relation to the service priorities for older women with mental ill health. However the foregoing discussion indicates this group is one deserving particular attention in terms of research and service development. A more sophisticated understanding of their needs is certainly warranted given the aging of the population.

Women with Substantial Psychiatric Disabilities

Women with long-term, significant psychiatric disabilities may be either extended care patients in psychiatric hospitals, or living in the community often following lengthy periods in hospital. In the United States, this group of women is frequently referred to as the 'chronically mentally ill', defined by Test and Berlin as 'those individuals who by reason of severe and persistent mental disorder experience serious limitations in their functioning relative to primary aspects of daily living such as personal relations, living arrangements and employment'.[36]

In passing, it is worth noting that both the term 'chronically mentally ill' and the definition used by Test and Berlin present some difficulties. Firstly, 'chronically mentally ill' implies that the presence of marked disabilities is necessarily linked to continuation of psychiatric disturbance. It could be argued of course that many of the disabilities shown by those who have spent long periods in psychiatric institutions are due to the effects of adapting to institutional life rather than their psychiatric condition *per se*. Secondly, the definition rules out those who do not have continued 'severe and persistent mental disorder', yet who experience the limitations included in the definition because of disabilities associated with previous psychiatric disturbance and institutionalisation. The term 'chronically mentally ill'

may therefore have been chosen as much to capture the attention of policy-makers and service planners rather than as an accurate description of the population of concern. In the following discussion, it is important to bear in mind that some women in this group will have persistent and marked psychiatric disabilities without active symptoms.

Concerns in North America about lack of attention to the needs of women with long-term and significant psychiatric disabilities culminated in the recent publication *Treating Chronically Mentally Ill Women*.[37] The major theme in this book is that because women with long-standing psychiatric disabilities have tended to be seen as 'genderless' by practitioners and policy-makers, they 'are often the victims of insensitive planning and inadequate services'.[38] As Bachrach notes: 'In short, gender-determined considerations appear to be superimposed on more general problems associated with service delivery for chronic mental patients'.[39]

In relation to women who are extended care patients, particular concerns are inadequate attention to general health care and sexuality issues, and insufficient consideration to gender differences in program design.

There are two grounds for concern about the quality of medical care of chronically mentally ill women. One is that the physical examination given on admission or during hospitalisation has been found to be often the only maintenance health care these women receive, and the other is that evidence suggests a comprehensive examination is not always undertaken.[40] Handel's study at the Newton-Wellesley Hospital in Boston found 'a pattern of deferred pelvic examinations that were often not completed before the patient's discharge. Our study concluded that female psychiatric patients were not receiving the kind of generally acceptable physical examination that basic good medical care requires'.[41] Handel comments further that in the hospital concerned 'the standard adopted for physical examinations among chronic mental patients responded to the needs of the male patients, who constituted a numerical minority'.[42] Whilst this research was undertaken in the United States, there is little reason to doubt its applicability to the local situation. Clearly there is a need to ensure routine gynaecological examinations for women who are extended care psychiatric patients, and to establish this type of examination as an acceptable part of assessment on admission.

The sexual behaviour of psychiatric patients is a complex and controversial area. Sexual needs are not necessarily suppressed during a period of psychiatric disturbance, and for some patients, their disturbance may actually be associated with loss of inhibition and sexual acting out as well as with impaired judgement. Long periods of hospitalisation may also lead to poor self-esteem in women patients, the use of sexual relationships to gain money or affection, the risk of sexual exploitation and abuse, unplanned pregnancies, and vulnerability to sexually transmitted diseases and HIV infection. Mixed sex ward environments, the 'open door' policy of most contemporary psychiatric hospitals, and the encouragement of weekend leave allow more possibilities for engaging in sexual relationships. The experience of being a psychiatric patient may intensify a woman's wish to be normal in other respects such as sexual expression and having a child.[43]

Developing responsible policy and practice in regard to the sexuality of patients is not easy as staff have to confront personal, practical and legal issues, such as their own values and attitudes, the extent to which they can or should supervise patients, and what constitutes informed consent. It is important for women patients that they are given opportunities for education about sexual issues, including sexual behaviour, contraception, protective behaviours and safe sex practices. This education needs to have as its goal women learning to 'own,

value and protect their own bodies'.[44] Hospital policy also needs to be established regarding sexual harassment or abuse, and mechanisms for reporting incidents should be easily understood and accessible to patients.

I have already noted that rehabilitation programs tend to ignore the needs of women. Extended care wards are now usually mixed, with women and men sharing the same daily living space, which means particular attention is necessary in designing programs to meet the needs of each sex. One study, albeit undertaken in 1976 and therefore somewhat dated, noted different behaviours by women and men patients with long-standing psychiatric disabilities and made suggestions about how programs could respond to these differences.[45] For instance, the researchers recommended program activities for women patients focusing on structured interactions between staff and patients, emphasising self expression, self-validation and listening to others, and for men, programs which promoted control over physical impulses and encouraged a sense of independence and autonomy.[46] The researchers also paid attention to the physical design of mixed sex wards, suggesting 'spaces that permit and encourage private, quiet conversation might be appropriate for many female patients', with these areas being separated from those for physical activities and watching television.[47]

Women with long-standing and significant psychiatric disabilities but who are living in the community also warrant particular attention. Test and Berlin comment sharply on the neglect of this group of women: 'chronically mentally ill women are often poor, unemployed, battered, abused, old, lonely, unskilled and unwell. The severity of their disorder subdues research or clinical interest in their experiences'.[48]

Most of the priorities already identified for women extended care patients are also relevant for women with marked psychiatric disabilities living in the community, such as provision of good health care, education about sexuality and reproduction, and rehabilitation programs which cater for their needs. A major difference is that once discharged, women are no longer relatively captive hospital patients. More effort and ingenuity are therefore needed on the part of community mental health services to engage these women and provide appropriate care and support.

A separate issue is adequate and safe housing. Concern about the lack of appropriate accommodation options for psychiatrically disabled women has been previously discussed. Bachrach reports that in the American context, the proportion of homeless women who are chronically mentally ill 'is both marked and rapidly increasing', and that 'severe psychopathology is more widespread and more intense among homeless women than homeless men'.[49] This is supported by the survey of severe mental disorders amongst homeless people in Melbourne.[50] As already noted, the survey found 35 percent of the women interviewed showed symptoms of a psychotic disorder compared to 15 percent of the men, and 40 percent of the women compared to 18% of the men had a past history of this type of disorder.[51] The dearth of women-only shelters and outreach programs working with psychiatrically disabled women makes this problem more serious in the Australian context.

In summary, women with long-standing and marked psychiatric disabilities clearly warrant particular attention in terms of policy and service development. Mental health policy for public psychiatric services increasingly gives priority to responding to the most disabled.[52] However unless their gender-specific needs are acknowledged, women with substantial psychiatric disabilities will continue to be disadvantaged by being seen as genderless or relegated to the status of pseudo males. As Bachrach notes, 'such concerns must be addressed

in any system of care that purports to be responsive to the needs of chronically mentally ill individuals'.[53]

Women Carers of People with Psychiatric Disabilities

Following a careful analysis of the history of community care for the psychiatrically disabled in the United Kingdom, Busfield makes the telling point that this type of care is now largely provided in the home by women, rather than by publicly funded community services.[54] She notes that the concept of community care is open to being reinterpreted as meaning private rather than public care, and the former is attractive to governments in an era of cutbacks to public expenditure. 'And in as far as this private care can be presented, as it often is, as care within the family then it can be made to seem therapeutically advantageous as well as desirable, and standard institutional critiques can be used to support it, just as they can the provision of public community services. A privatised model of care replaces that of public community services. And as a result financial constraints hasten rather than delay the move to community care'.[55]

In the United States, it has been estimated that the majority of 'deinstitutionalised' psychiatric patients have been discharged to their families.[56] Reflecting Busfield's observations on the British situation, it has been found in the US that due to inadequate community services, the family has become 'the primary and often exclusive resource for many mental patients', and that in most of these families, women are the primary care givers.[57] A more recent study notes that women also play a key role as caregivers while a relative is hospitalised for psychiatric treatment.[58] This research indicated that 'women are three times as likely as men to be the primary caregivers for their non-married adult mentally ill relatives during hospitalisation regardless of the patient's diagnosis, age, gender, number of previous hospitalisations, or years since first treatment for psychiatric problems'.[59]

Thurer argues that women have the 'least cultural ammunition for disclaiming the role of caretaker', due to the way women internalise expectations about being nurturant.[60] He notes that the consequences can be damaging, including 'feelings of entrapment and chronic overload, of role strain due to having to neglect their responsibility to other family members, and of futility, confusion, isolation and exhaustion'.[61] Women at home in the caretaker role may well have to provide the sort of care to their ex-patient child or partner formerly administered by trained hospital staff. Furthermore, such women receive no special training or support for this role, do not have structured time off, and are not paid for their services.

As a result of changes in the philosophy of psychiatric care, which includes a more sparing use of hospitalisation, women may also face the continued care at home of those who previously would have been hospitalised. The implication is 'an extension of women's culturally prescribed nurturant role beyond the child-rearing years. They are expected to manage and care for their mentally ill offspring and relatives, possibly a lifelong career'.[62] Ascher-Svanum and Sobel also note that as most parents of psychiatrically disabled people are in their late fifties and sixties, and as women live longer than men and are unlikely to remarry after their husbands die, 'one would expect a high rate of widowed caregiving mothers by the end of this century'.[63]

Whilst comparable local research is as yet unavailable, there is little reason to doubt the applicability of these findings to the Australian situation. Local studies suggest that women of non-English speaking origins are more involved in caring for disabled family members at home

than their Australian-born and English-speaking counterparts. Research shows that NESB people make up a smaller proportion of those cared for in institutions (3.8 percent) than would be expected from their representation in the community at large (11 percent).[64] The inference is that this difference is met by people with disabilities being cared for at home, largely by wives, daughters and daughters-in-law.[65] This research does not separate out types of disability, but anecdotal reports indicate that when living in the community, NESB people with psychiatric disabilities are likely to spend more time at home than people with similar disabilities from other ethnic backgrounds, largely because of the cultural inappropriateness of community-based rehabilitation programs.[66] NESB women caregivers, especially those who are older, may well lack access to carer support groups due to language difficulties.

In a critical review of research on the experience of caring for mentally ill family members, Maurin and Boyd note that 'research findings should be interpreted with some caution because of various methodological problems or inconsistencies among studies'.[67] They identify several factors which appear to lessen the sense of burden felt by caregivers, noting that women typically fulfill this role.[68] These include the following: a sense of competence in handling the situation; the absence of other children; the disabled person not living with the caregiver; the carer having her own small supportive network, including her spouse spending a significant amount of time with the disabled person; the disabled person having her/his own support system; and a high degree of support and information from community-based services including provision of comprehensive care and 24 hour availability of staff.[69]

Interestingly, no mention is made in this review article of the impact on caregivers of involvement in a support group for family members, or of the availability of respite care. Maurin and Boyd comment on surveys of membership of support groups in California, and report that members of these groups were not necessarily representative of all families of the mentally ill, being typically middle class, married middle-aged mothers of sons with severe disabilities, and more supportive of their disabled child than most parents whose offspring are mentally ill.[70] It is not clear whether the characteristics of members reflected those who could make best use of such a group or whether this type of membership excluded others who could benefit from sharing their experience with families in a similar situation.

Anne Deveson, an Australian journalist, has recently published a book detailing her experiences with her son, who was diagnosed in his late teens with a schizophrenic disorder and continued to be markedly disabled until his death aged 24.[71] Her account adds a personal dimension to the research findings already mentioned. Deveson's experiences were marked by lack of information and inadequate understanding from mental health services about her dilemmas as a caregiver, and continued problems in obtaining admission or a reasonable period of hospitalisation for her son when she saw him as needing hospital care. These difficulties were compounded by her son's fluctuating mental state, his refusal to accept conventional treatment, inadequate discharge planning by hospital staff and limited options in the community for ongoing care and support, particularly on a residential basis. Deveson's account would lend itself well to a feminist analysis, particularly as she was a lone parent over the seven or so years of her son's illness, and she is clearly mindful of how her status as a woman affected her responses as well as those of others. As most carers are women, her description of the difficulties she faced are invaluable for expanding our awareness of what it is like to be in this role.

The Mental Health Statement of Rights and Responsibilities acknowledges that the majority of carers of psychiatrically disabled people are women.[72] This explicit recognition of what is often an invisible contribution is an important beginning.

This analysis suggests a number of ways in which women's involvement as carers can be made easier. Examples are an adequate range of community-based services to meet the needs of the psychiatrically disabled family member, including alternative accommodation; carer involvement in planning for the care of the disabled person; the availability of respite care to enable a break from the caring role; and education of carers about psychiatric disability and methods of treatment. Ascher-Svanum and Sobel also suggest there is a need 'to lighten women's load by involving other family members of both genders in the patient's support system',[73] which to achieve would involve sensitive negotiation with the families concerned.

A substantial change to women's role as caregivers may be difficult as it would challenge expectations that are both internalised and socially reinforced. Most women have had years of implicit and explicit training to be caring and nurturant, so the role both comes easily and seems a natural part of being a woman. Their readiness to act as carers not only meets their needs but is also socially convenient, whether for other family members, mental health services or the community more generally. Changing this pattern may therefore be met with resistance by some women and, more importantly, by others around them.

Sadly, the impetus for a significant change may come as the result of a crisis, before alternative caring arrangements are in place. After such a situation, Anne Deveson was told to use 'tough love' with her son, and not allow him to return home. Knowing alternative support was not available, she observes caustically: 'Listen you guys (it was mostly guys), if you'd been prepared to take him into hospital and keep him there until his mind was clear enough to face his illness, all this wouldn't be happening. How about *your* being tough. Okay, I know he kept running away, but that's par for the course. If you couldn't deal with the difficult ones, then how the hell did you expect me to?'[74]

If women are to avoid constantly being the fallback for service deficiencies and effectively being punished if their efforts to fill the breach are quite reasonably insufficient, then policy-makers and service providers must not only refrain from assuming women should take on this role, but also ensure the appropriate services are provided to prevent it being necessary. Women themselves can assist this process by making clear what expectations are unacceptable, and what is needed to take their place. To paraphrase the views of a local mother: 'in the past we were scapegoats, then we were victims, but now it's time we became activists'. Carer groups have a particular contribution as they enable experience to be normalised and provide a basis for advocacy through shared commitment, even if it is the middle class and articulate who lead the way.

Footnotes

1 Krupinski, 1984
2 Krupinksi 1984, quoted in National Women's Health Policy, 1989, p.45
3 Alcorso & Schofield, 1991, p.45
4 *Ibid.*
5 Wijesinghe & Clancy, 1991
6 Quoted in Alcorso & Schofield, 1991, p.51
7 Alcorso & Schofield, 1991, p.51
8 *Ibid.*, p.52
9 *Ibid.*, p.58-69
10 *Ibid.*, p.16
11 *Ibid.*, p.12-15
12 National Mental Health Strategy Statement,1990, p.5
13 Alcorso & Schofield, 1991, p.107
14 *Ibid.*, p.130
15 *Ibid.*
16 Why Women's Health, 1987, p.69-70
17 *Ibid.*, p.70
18 Brown & Harris, 1978, p.235-6
19 Hafner, 1986, p.184
20 *Ibid.*, p.194
21 *Ibid.*
22 Seeman, 1983, p.144; Bachrach in Bachrach & Nadelson, 1988, p.84-85; Apfel & Handel, 1992, p.163-165
23 Apfel & Handel, 1992, p.xxiii-xxvii
24 *Ibid.*, p.169
25 National Women's Health Policy, 1989, p.39-42
26 Busfield, 1986, p.58; rates per 100,000 of population
27 Jorm & Henderson,1989, p.465
28 *Ibid.*, p.467
29 *Ibid.*
30 Rodeheaver & Datan, 1988,p.652
31 *Ibid.*,p.649
32 *Ibid.*,p.650
33 *Ibid.*,p.651
34 *Ibid.*
35 *Ibid.*
36 Test & Berlin, 1981, p.137
37 Bachrach & Nadelson, 1988
38 *Ibid.*, p.6
39 Bachrach,1988a, p.4
40 Handel, 1988, p.116
41 *Ibid.*

[42] *Ibid.*, p.119. This suggests that rather than tending to be seen as almost genderless, women are treated as pseudomales.
[43] Apfel & Handel, 1992, p.1-8
[44] Test & Berlin, 1981, p.141-142
[45] Bennett *et al*, 1988
[46] *Ibid.*, p.41
[47] *Ibid.*
[48] Test & Berlin,1981, p.143
[49] Bachrach, 1988b, p.82
[50] Herrman *et al*, 1988
[51] *Ibid.*, p.29
[52] Office of Psychiatric Services, 1992, p.3-4
[53] Bachrach, 1988a, p.5
[54] Busfield, 1986, Ch.10 & p.366
[55] *Ibid.*, p.350
[56] Thurer, 1983, p.1162
[57] *Ibid.*
[58] Ascher-Svanum & Sobel, 1989
[59] *Ibid.*, p.844
[60] Thurer,1983, p.1162
[61] *Ibid.*
[62] Ascher-Svanum & Sobel, 1989, p.844
[63] *Ibid.*, p.845
[64] Alcorso & Schofield, 1991, p.59
[65] *Ibid.*, p.60
[66] A. Papakotsias, personal communication
[67] Maurin & Boyd, 1990, p.100
[68] *Ibid.*
[69] *Ibid.*, p.100-102
[70] *Ibid.*, p.104
[71] Deveson, 1991
[72] Mental Health Statement of Rights and Responsibilities, 1991, p.17
[73] Ascher-Svanum & Sobel, 1989, p.845
[74] Deveson, 1991, p.182

6. Conclusion - Developing The Responsiveness Of Mental Health Policy And Services To Women

Mental health policy in Australia looks very different now than it did at the time of the first upsurge in policy development in the early 1980s. A national policy for mental health services is in place, with the promise of consistency across the states in terms of policy objectives, standards and consumer rights. The new policy directions are already being implemented by states such as Victoria, and are likely to change the shape of public psychiatric services in most states over the next five to ten years. Examples are mainstreaming of psychiatric services with the general health system, developing more locally accessible services, increasing the integration of hospital and community-based services, and improving the range of service responses to the most psychiatrically disabled.[1]

As already discussed, over recent years there have also been changes in how issues for women have been addressed. Mental health policy at the state level was gender-blind until the late 1980s. Beginning with the first discussion paper on a national mental health services policy in 1988, the need for mental health services to be responsive to gender has now become an integral part of formal policy statements, leading to the identification of service priorities for women in the Victorian policy and strategic directions document in early 1992.

Explicit attention in mental health policy to women as a group with specific needs is an important development. However there is little room for complacency. In the current era of economic constraint, policy development at both national and state levels is inevitably influenced by financial considerations. A major preoccupation for governments is how to limit expenditure, whether this occurs indirectly through subsidising private services or directly through financing public services, with the most visibly and directly funded being a prime target. A second and related focus is how to ensure the targetting of both private and public services so that dwindling resources are used more effectively, the most disadvantaged are not ignored, and the cost of discretionary service use is born by the individual consumer. Within a climate of major and urgent policy change driven largely by economic concerns, there is the danger that improving service responsiveness to women's mental health problems could be downplayed or even ignored as a policy objective either nationally or by the states.

Another threat comes from a different source. As we have seen, whilst national policy statements acknowledge the importance of services being responsive to gender, little if any detail is given on what this might mean. In addition, there is no identification of women as a group of consumers with particular needs, nor what these needs might be and how they might be met. This is a critical omission given that service providers are not necessarily well-informed about issues for women. The even-handedness implied by use of the generic term 'gender' provides no guarantee that issues for women will be recognised let alone addressed in policy and service development.

Relying on the term 'gender' and making constant reference to both women and men in policy documents also implies that not being even-handed could be taken as transgressing the rules of equal opportunity. This is most evident in the Mental Health Statement of Rights and Responsibilities, which as already pointed out, by using 'he and she' in relation to protection

from the threat of sexual harassment and abuse overlooks the fact that this threat as well as actual harassment and abuse are overwhelmingly experienced by women. The gender neutrality of 'he and she' may therefore be gender-blindness when it masks or disguises ways in which women or men are currently disadvantaged. Superficially, the fact that men use mental health services less often than women could be taken to mean they are those discriminated against in service provision. As previously noted however, women's greater use of mental health services does not entail their needs and interests will be taken into account, either in what services are available or how they are delivered. To ensure gender-responsiveness does not remain an empty principle and is not misinterpreted by the uninformed, it is important that specific objectives are documented in mental health policy at both national and state levels.

Although the potential for further development may seem bleak, there are also opportunities in the current climate which favour mental health policy and services becoming more responsive to women. Apart from gender at least being acknowledged at a national level, and service priorities for women being specifically targetted in Victoria, an increased concern about standards of care and respect for consumer rights is evident. Since the late 1980s, there have been a number of inquiries into the quality of care provided in psychiatric hospitals in Australia. Examples include the New South Wales 1987 Review of Standards of Patient Care in Fifth Schedule Hospitals, the Queensland Royal Commission into Ward 10B at Townsville General Hospital, the Victorian Inquiries into Lakeside and Aradale Hospitals in 1991, and the Audit of Standards of Treatment and Care in Psychiatric Hospitals in the State of Victoria, released in 1992. Each of these inquiries has documented instances of poor standards of care, and has been explicit in recommending changes to the quality of care received by patients.

The ongoing Burdekin National Inquiry into the Rights of the Mentally Ill spans both issues of quality of care and the rights of consumers. The theme of consumer rights is central to the 1991 Mental Health Statement of Rights and Responsibilities. This document spells out in some detail what consumers have a right to expect when they experience mental ill health and use mental health services. Its adoption by all Australian Health Ministers publicly demonstrates a new commitment to consumer rights across all states, a commitment reinforced in the national policy documents. Finally, the mainstreaming of psychiatric services with general health services begins the process of opening up the beliefs and practices of what has been a relatively closed service system.

None of these developments focuses specifically on women, but they do signal the introduction of a new set of priorities which should benefit women. The challenge is to make maximum use of the opportunities now available. The analysis of issues for women with mental ill health presented in the foregoing chapters provides the detail needed to flesh out policy and service development objectives. However there is an inherent problem in assuming this analysis is sufficient. As already observed, our understanding of the impact of mental ill health on women, especially the more disabled, and the best way of responding to their needs is limited by what research has been undertaken, the extent to which psychiatrically disabled women have been involved in community consultations, and the types of services and programs already in place. The lack of attention to these areas in Australia is a major difficulty, and we remain over-reliant on work undertaken overseas.

In seeking to provide a blueprint for further policy and service development, we therefore need to be mindful that the blueprint will be incomplete due to the limitations already outlined. Consequently it is essential that strategies for change are chosen for their developmental

potential as well as the extent to which they will bring about improvements. Ideally strategies should have the capacity both to improve responsiveness to women and also to stimulate new insights and provide new directions.

In the preceding chapters, a number of specific action proposals were put forward in response to the particular issues under discussion. Rather than repeating these proposals here, a set of general strategies will be identified which flow from the more specifically targetted proposals, and also meet the criteria outlined above. The five general strategies are as follows:

- Include indicators of responsiveness to women in quality assurance guidelines for specialist psychiatric services;
- Provide staff education and training in women-sensitive practice;
- Give priority in service development to women with special needs as identified in Chapter 5;
- Establish routine recording and reporting of women's use of mental health services;
- Promote research on women's mental ill health and appropriate service responses, focusing especially on women with major psychiatric disorders and substantial psychiatric disabilities.

Whilst these strategies are interrelated, each deserves separate elaboration.

At the service level, quality assurance has become an accepted way of monitoring the quality of care received by users of a service. As already mentioned, improving the quality of care for people with psychiatric problems is a priority under the proposed national mental health policy. The emphasis is on establishing service standards and outcome measures applicable to all the states. The quality assurance indicators developed for measuring quality of care obviously differ according to the type of service: for instance, hospital or bed-based services will draw on different indicators to those used by community-based services.

Including *service responsiveness to women in quality assurance programs for specialist psychiatric services* would have value on several levels. Apart from giving meaning to the nationally endorsed service principle of responsiveness to gender, it would be a way of ensuring women's needs were not marginalised, and would give a concrete message to service providers that attention to women's special requirements should be built into service delivery. Quality assurance indicators themselves are subject to review, and so have the potential to respond to changing needs and reflect new models of practice.

Staff training and development is another priority in the proposed national mental health policy. *Staff education and training in women-sensitive practice* is a key strategy if service providers are to be more responsive to women with mental health problems. It has already been noted that the pre-service training of most disciplines in the mental health field provides little or no preparation for meeting the special needs of women with mental ill health. Indeed, women may not even be considered as a separate group in teaching on human development, and the concept of non-sexist or gender-sensitive practice may not be covered. In addition, the specialist psychiatric training of many professionals working in the mental health field occurs on the job, whether through practical placements or in-service educational programs such as workshops or seminars. Programs on women-sensitive practice have to date been infrequent and typically 'one-off' in nature. However new emphasis both nationally and at a state level on responsiveness to gender issues provides new impetus for this type of program becoming

a regular component of staff education and training.

The *special needs of the groups* identified in Chapter 5 warrant particular attention in policy and service planning. The specific action proposed already in relation to these groups draws to some extent on the general strategies discussed in the preceding paragraphs, such as quality assurance and staff education and training. Other proposals discussed in Chapter 5 involve more targetted service development. Examples are providing specialist psychiatric consultation for bilingual general pracitioners who provide aftercare to NESB women following psychiatric hospitalisation; ensuring attention to the general health care needs of women who are extended care patients in psychiatric hospitals; and providing respite care services for women carers of psychiatrically disabled family members living in the community. These types of service development deserve immediate priority.

An essential component of the infrastructure for policy and service development responsive to women is *routine recording and reporting of women's use of specialist psychiatric services*, whether hospital or community-based. This would establish a data base which could be used for research purposes as well as service planning and development. It would also enable the monitoring of changes over time, which at present is virtually impossible.

Although gender is a critical differentiating variable, others are also important for understanding more about women who use specialist psychiatric services. The most obvious additional variables are diagnosis, age, ethnicity, marital status, family size and the number and age of children. Others which would help in understanding women's life circumstances would be current occupation, current or previous place of residence, and partner's occupation. The availability of a case register would also permit identification of the socio-demographic characteristics of those who are frequently re-hospitalised, which would obviously be invaluable for understanding more about possible gender differences in the so-called 'revolving door syndrome'.

Regular recording of women's use of specialist psychiatric services is most relevant at the state level. A report from the Australian Institute of Health on Women's Health Data Requirements also recommended that the 1989/90 Australian Health Survey include measures of women's emotional well-being and stress related to employment and housework, as well as information on health service utilisation such as psychiatrists and psychologists.[2]

The preceding chapters have noted the inadequate state of *research on women's mental health problems*, and in particular, the lack of studies on women with substantial psychiatric disabilities. In Australia, the scarcity of relevant research is even more striking. Apart from the lack of specific research on women with mental ill health, a further problem is that women and men are often not differentiated in psychiatric research. Obviously there is a need to encourage research on mental health issues relevant to women, such as reasons for the low rate of referrals of women to psychiatric rehabilitation programs. It is also necessary to ensure that the methodology of studies using mixed sex research populations enable the needs and experiences of women and men to be distinguished, allowing for instance for identification of possible gender differences in factors leading to re-admission.

In conclusion, the themes pursued in this monograph are that women experience mental ill-health differently to men, and the differences in terms of diagnoses received, treatment given and services used are sufficient to warrant the further development of mental health policy and of services responsive to women. It can no longer be assumed that gender-blind or even supposedly gender-neutral policy will address the needs of women. It is also possible that

such policy will be based on androcentric assumptions which ignore or distort women's experiences.

Mental health policy for women has to have two broad aims. One is to set overall standards and directions in relation to women as service users, which will serve to legitimise the status of women's issues on policy agendas and guide service planning and development. The second is to identify and implement priorities in the development of services and programmes responsive to the more pressing issues for women as mental health service users.

Women as the majority of mental health service users have a particular claim on the development of policy and services responsive to their needs. The aim of this monograph has been to make that claim more tangible and specific, in order to rectify a situation in which women have been the patient majority for too long.

Footnotes

1 Report of the Mental Health Taskforce to AHMAC, 1991, p.7-8
2 Lee, 1988, p.39

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About the Author

Valerie Gerrand lives and works in Melbourne. She has tertiary qualifications in social work, sociology and public policy. Her experience in the mental health field includes service management, policy development, teaching, research and clinical practice.

About this Volume

Mental health policy and services in Australia have largely ignored women's predominance as users of mental health services. As a result, their particular needs are often overlooked and devalued. For instance, both hospital and community-based services characteristically run mixed sex programs, yet little attention has been paid to how this affects women.

This volume analyses the way prevailing practices in the mental health field pose constraints for women. It exposes the gender-blindness of current policy and services, and identifies changes required for a more effective response to women's special needs.

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Alfred Deakin was a minister in several governments in the colony of Victoria and was responsible for many notable achievements, including the adoption of water law and the establishment of the irrigation industry. He left the cabinet in 1890 to concentrate his efforts on the formation of an Australian federation. He was later to become the second Prime Minister of the government of the Commonwealth he had helped create.

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