The Royal Australian & New Zealand College of Psychiatrists

Submission to the Department of Health and Ageing: **National Women's Health Policy**

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working with the community

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Executive Summary

Approximately 1 in 5 Australian adults will experience a mental illness in any given year and about 1 in 7 children and adolescents will experience behavioural or emotional problems over a 6 month period (Department of Health and Ageing, 2007). However, it is women who experience higher rates of 12-month mental disorders than men (22% compared to 18%). The National Survey of Health and Wellbeing showed that Young women (16-24 years of age) had nearly twice the prevalence of 12-month affective disorders compared with men in the same age group (8.4% and 4.3% respectively)(Australian Bureau of Statistics, 2007).

Whilst the Royal Australian and New Zealand College of Psychiatrists (RANZCP) were pleased to note that women's mental health has been at the forefront of the Department of Health and Ageing's development of a National Women's Health Policy, the RANZCP believes there is significantly more to be done in terms of services and training for the massive breadth of mental health issues that women face from the mild to the severe, from infants to old age.

With regards to services, only 38% of adults and approximately 25% of children and adolescents experiencing a mental disorder seek assistance from a health service (Department of Health and Ageing, 2007). Whilst the Better Access to Psychiatrists and General Practitioners through the Medicare Benefits Schedule (MBS) program has made mental health services more widely available, there is still a gap in services for women with more severe forms of mental illness. Of people who seek help for a mental disorder, 77% consult their general practitioner (Department of Health and Ageing, 2007). The quality of service provided by general practitioners can be variable and the broader mental health services required by women are often not appropriately demographically located.

Mental disorders are responsible for an estimated 11% of disease burden worldwide (thought to increase to 15% by 2020) (Department of Health and Ageing, 2007). The Australian Institute of Health and Welfare reported mental disorders to be the third leading cause of overall disease burden accounting for 27% of total years lost due to disability (Department of Health and Ageing, 2007). It has also been found that 24% of Australians with a moderate or severe disability also have a mental disorder (Department of Health and Ageing, 2007).

It is vital that appropriate and effective services are provided to all women in Australia who have or are at risk of developing a mental illness. There is currently a lack of any designated service or specific framework for promoting women's mental health and preventing mental disorder. This is necessary across all spectrums and ages of disorder.

The RANZCP has formed a women's mental health expert advisory group which has developed this submission, and will continue to develop and promote women's mental health strategies. The key priorities for women's health are the focus of the submission, particularly as they relate to mental illness, and the mental health and wellbeing of women in general. The RANZCP sees this as only the start of the process in developing the Women's Health Policy and looks forward to contributing further.

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1. About the RANZCP

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand and has responsibility for the training, examining and awarding the qualification of Fellowship to medical practitioners. There are approximately 3000 Fellows of the RANZCP who account for approximately eighty-five per cent of all practicing psychiatrists in Australia and over fifty per cent of psychiatrists in New Zealand. There are branches of the RANZCP in each state of Australia, the ACT and New Zealand.

Through its various structures, the RANZCP accredits training programs and administers the examination process for qualification as a consultant psychiatrist; supports continuing medical education activities at a regional level; holds an annual scientific congress and various sectional conferences throughout the year; publishes a range of journals, statements and other policy documents; and liaises with government, allied professionals and community groups in the interests of psychiatrists, patients and the general community.

The RANZCP is a leader amongst Australasian medical colleges in developing partnerships with consumers and family and other carers in respect to excellence of service provision. The Board of Practice and Partnerships includes consumer and carer representatives from a variety of backgrounds who contribute extensively to the development and management of RANZCP programs and activities, and works together with the community to promote mental health, reduce the impact of mental illness on families, improve care options and supports, and ensures that the rights of people with mental health concerns are heard by mental health professionals.

2. About Women's Health and Mental Health

The RANZCP was pleased to note that The Department of Health and Ageing had referred to mental health as a key focus of the new Women's Health Policy in the New National Women's Health Policy Consultation Discussion Paper 2009 (Consultation Discussion Paper).

It is fundamental that any women's health policy includes mental health. Projections suggest that the mental health related disease burden will grow markedly as a proportion of overall disease burden (Begg, Vos, Barker, Stanley, & Lopez, 2008). This issue places significant pressure on crisis services which are not adequately resourced to deal with disorders at the more severe end of the spectrum.

There are a number of psychosocial and community risk factors affecting women and women's health including motherhood, domestic violence, workplace and family stress, social violence on young women, stereotypes portrayed by the media, eating disorders, sexualisation of young girls and child abuse. There are also a number of high risk groups including the Australian indigenous population, female immigrants. Further, women often undertake the burden of being carers.

Although literature demonstrates that there is no significant gender difference in the prevalence of mental health disorders, the pattern of presentation and onset does vary between males and females and there is a marked difference in accessing mental health services depending upon age and social factors (NHMRC, 1995).

It is also important to recognise that depression, although important, is not the only mental health concern experienced by women, and funding needs to also be invested in acute psychiatric services, specialist children's services and integrated community mental health support services for women.

The Australian Government's investment over the last few years has provided a significant boost to the mental health system, however the RANZCP believes that the overall investment in the mental health service system remains inadequate and does not reflect the burden of disease in the community. A significant increase in funding to the mental health sector is required so that available resources are proportionate to the increasing number of people with mental illness.

3. Priorities

3.1 Prevention and Early Intervention

The leading specific cause of health loss in women is anxiety and depression (Begg et al., 2008). Whilst there have been significant inroads into screening for women and children at potential risk of developing a mental disorder, there are massive improvements still to be made.

Further investment must be made in the prevention, identification and appropriate treatment of mental illness in women and children. In particular, attention should be focused on early and single parenting as well as childbirth and associated issues.

3.1.1 Pregnancy and parenting

Pregnancy signals a time of vulnerability to the onset or relapse of mental disorders (Judd, Armstrong, & Kulkarni, 2009). It has been found that women with a serious mental illness are less likely to seek and receive adequate antenatal care, have higher rates of smoking and are more likely to continue substance use during pregnancy than other women – leading to a potential increased risk of prematurity, intrauterine growth retardation and low birth weight babies (Judd et al., 2009). The post natal period can pose a risk of onset of new psychotic illness or the relapse in women with depressive disorders (Abel & Kulkarni, 2006) whilst the symptoms of those women suffering antenatal depression will often go unrecognised, explained away as part of being pregnant and that such symptoms will disappear following birth (Buist, 2002). Whilst antenatal clinics and hospitals screen for physical disorders that are often less common than depression few routinely ask about the woman's mental health (Buist, 2002). In particular women at high risk of mental disorder should be targeted, including women with a history of trauma or attachment issues, women who have had children previously removed from their care, or women for whom protective services have previously been involved. The needs of pregnant women who require psychiatric inpatient care is also an important consideration and this is addressed under section 4.3 of this submission.

Although women with a serious mental illness are more likely to have unwanted or unplanned pregnancies than the general population, accessible support should be available to all women who have unwanted or unplanned pregnancies. This should include, as appropriate, access to termination of pregnancy. There remain significant barriers to accessing such services, especially in relation to late termination of pregnancy which, unfortunately, particularly affects women with mental illness as they often present late.

With regards to the impact of environment on infants, it has been found that experiences in the early years lay the foundations of the neuronal pathways in the brain (Macdonald et al., 2005). For example, "infants exposed to repeated distress in infancy, without the support of a responsive parent, have been found to later display impaired functioning" in the part of the brain associated with the experience of positive emotions (Macdonald et al., 2005). Whilst services for parents and infants have been developed over recent years, there are still limitations, for example many do not adequately address both the needs of the parents and their infants (Macdonald et al., 2005). Mothers and infants are often treated separately where mothers suffer substance abuse or other mental heath issues exacerbated by the fact that physical health and mental health are also treated separately (Macdonald et al., 2005). It has been

found that services focusing on antenatal or neonatal problems do not then address problems that arose later on (Macdonald et al., 2005). There should be an increased focus on parent-infant interactions including mental health checks. Whilst there is already a focus on baby checks, this should be enhanced to include mother mental health checks. There is currently a gap in services and programs for children aged between 12 months and 5 years. There is a need to integrate perinatal, infant and child mental health services with parenting support being given in a coordinated way from 0-5 years, particularly for at-risk groups.

Recommendation 1:

That parenting support for women with children from 0-5 years be provided in an ongoing coordinated manner, particularly for women with, or at risk of, developing severe mental disorders. This support should focus on early intervention of ongoing disorders in the mother and prevention of mental health problems in the infant/child.

3.1.3 Sexual health checks

A significant area of concern is the sexual and reproductive health of women with a serious mental illness. People with a serious mental illness report poor support regarding sexual health, with a high number not receiving regular health checks such as pap smears and breast screening. A survey of 424 people with mental illness undertaken by SANE Australia conducted between September and December 2008 found that 46 percent of women who took part were not receiving regular pap smear tests or breast screening. 32 percent had never been tested for sexually-transmitted diseases (SANE Australia, 2009). These figures reflect the often poor physical healthcare provided to people with mental illness.

Recommendation 2:

Provision of incentives for General Practitioners and health services to provide regular health checks for people with a mental illness including pap smears, breast screening, and tests for sexually-transmitted diseases.

3.1.4 Eating disorders and body image

There is a need to have greater focus on treatment for eating disorders, improving coordination amongst services and ensuring consistency in quality of care. This is imperative in the adolescent mental health area. Research has shown that girls as young as four are exhibiting symptoms that may lead to eating disorders. Further research is required into prevention and early intervention with regards to eating disorders, including further research into the area of body disturbances and the impact of the media and advertising on self-esteem and child development.

Recommendation 3:

Increased funding for research into eating disorders and, in particular, early intervention and prevention.

3.2 Disadvantaged and other at-risk populations

There are a number of disadvantaged and at-risk populations of women for whom prevention and early intervention, adequate access to services, and an appropriately trained workforce are fundamentally important to their mental health. The RANZCP has identified the following priority groups, based on the high incidence of mental disorder within these populations. This list is by no means intended to be exhaustive and the RANZCP is fully appreciative that there are other important populations which will need to be considered as part of the development of a Women's Health Policy.

3.2.1 Gender-based violence

Despite some change, there are still many inequalities between men and women, a key inequality of which is gender-based violence (Judd et al., 2009). The prevalence of violence can vary between cultures as can the likelihood of women disclosing their experiences (Judd et al., 2009). Violence is associated with anxiety and depression, eating disorders and substance abuse, with up to 50% of women who have experienced violence suffering from these disorders (Judd et al., 2009). Physical and sexual abuse during childhood may also lead to vulnerability to mental illness (Judd et al., 2009). There needs to be an acute response to women who suffer sexual assault with ongoing counselling being made available. Similarly those suffering domestic violence also require access to culturally appropriate mental health services.

Recommendation 4:

Improved coordination of acute health services and mental health services with regards to women who suffer sexual assault and/or domestic violence.

3.2.2 Indigenous Australians and Immigrants

The focus on the health of Aboriginal and Torres Strait Islander women is highlighted in the Consultation Discussion Paper policy and, in order to bridge the gap in health inequalities that Aboriginal and Torres Strait Islander women face, it is vital that any policy developed gives this area priority. All mental health professionals should undertake regular cultural awareness training in order to develop a better understanding of the social and emotional needs of Aboriginal and Torres Strait Islander women. Further, if services are to be more effective in future, increasing the availability of tailored services to Indigenous Australians and other groups whose needs are not well met by mainstream services is also warranted.

Australia experiences a number of immigrants each year but the mental health of female immigrants in these situations can often be overlooked. Many of these women have suffered the stress of separation from family and familiar surroundings. Asylum seekers and refugee women in particular may have experienced trauma, loss and sexual assault and are a vulnerable group with high rates of psychological distress. Appropriate treatment requires an understanding of an individual's cultural background and experiences, for example, the meaning one gives to violence and trauma can vary depending on culture (Creamer, Burgess, & McFarlane, 2001). Similarly, ways of healing may differ amongst cultures and

some will have cultural groups with resources that support such healing (Judd et al., 2009). Immigrant women may also suffer pregnancy related mental illness and many are single-parents. Pregnancy resulting from rape, and the stigma associated with that, can also increase the incidence of mental illness, and prevent those women from seeking help. Further information on this can be found in section 2.1 on prevention and early intervention.

Immigrant women often end up working and living in conditions which are far from optimal, including shared housing and 'sweat shop' style working which, along with poor pay and working conditions and lack of social support, can increase anxiety and depression in these populations.

Recommendation 5:

Development of specific strategies that focus on the mental health needs of Indigenous and immigrant populations.

3.2.3 Older Women

Menopausal women often experience depressive illness that goes unrecognised. Menopause is associated with a number of changes, such as body changes, that frequently combine with depressive symptoms. Women with an ongoing illness can experience an exacerbation of the illness during the perimenopausal time (Judd et al., 2009; Kulkarni, 2008). These women are often an unnoticed group within the spectrum of mental disorders, and there are often associated adverse economic and social factors both for the individual and society.

Also, first-episode late-onset schizophrenia is more common in women than men (Kulkarni, 1997; Kulkarni et al., 2008) requiring different treatment strategies to maximise outcomes.

The fifth leading specific cause of health loss in women is dementia, ranked behind anxiety and depression, Ischaemic heart disease, stroke and type 2 diabetes (Begg et al., 2008). There is also evidence to suggest that mental disorder predisposes to dementia. It is therefore important that dementia is given further and serious consideration in the development of a women's mental health policy.

Recommendation 6:

Development of specific strategies that focus on the mental health needs of older women.

4. Services

Of people who seek help for a mental disorder, 77% consult their general practitioner (Department of Health and Ageing, 2007). It is important that there is integration and coordination of services at primary, secondary and tertiary care levels to deliver the best outcomes.

The Better Access to Psychiatrists and General Practitioners through the Medicare Benefits Schedule (MBS) program significantly increased access to the mental health workforce by the funding of Medicare items that allow patients to be referred to psychologists, social workers and occupational therapists. However as the evaluation is ongoing regarding the quality of care provided through this initiative, it is difficult to comment on whether the funding investment has helped address the burden of disease in the long term, though it has most likely helped in the short term.

4.1 Standardised service models

Currently, there are no standardised service models within the mental health service system within Australia, with levels of care varying significantly across the country. The different governance structures further complicates service delivery issues and would be improved with the development of a single integrated health system, the removal of structural barriers at the State and Australian Government levels, and with substantial reform in both. There is also a need to better coordinate and connect other relevant community supported services needed by patients with severe mental illness and complex needs with their clinical care (e.g. general health care, financial support, housing, substance abuse, rehabilitation etc). The current National Policy Guidelines on gender sensitivity and treatment provides a broad framework but has no specific implementation actions.

Providing well integrated services to a population with widely differing and complex needs is inherently difficult and resource intensive. However, the alternative is likely to be a set of interventions that focus on symptomatic rather than causal factors, perpetuates service gaps, cost shifting pressures and ineffective commitment of resources.

Recommendation 7:

Development and implementation of a national female sensitive, safe service model in relation to women's mental health services.

Recommendation 8:

Identification and coordination of different levels of service, including primary, secondary and tertiary levels.

4.2 Availability and location of services

The lack of appropriate services, particularly in rural communities, can mean that women move to locations where support exists but where there are at a considerable distance from the communities where they are known, and are away from family or other informal care that might best be provided. Similarly, many women may not seek assistance due to a lack of local services or services that are not culturally appropriate e.g. insufficient translators. Rural and remote settings are almost inevitably areas of unmet need, leading to a situation where a significant number of International Medical Graduates (IMGs) are employed. This can introduce additional cultural and language issues, which may be

particularly accentuated in relation to sexual health, contraception and pregnancy related issues. Women's mental health services need to be community based and available where they are needed in areas of high risk population. The significant burden of disease makes this necessary.

Recommendation 9:

An increase in the number of community services that can provide holistic longer term care for women and that are proficient in recognising mental health issues in high risk women and children.

4.3 Patient safety

Safety and privacy for women in the public mental health sector, particularly the inpatient treatment facilities, remains a major concern. As highlighted in a recent report "Nowhere to be safe: Women's experiences of mixed-sex psychiatric wards" (Clarke, 2008), there are still unacceptable major incidents in our hospitals. Rape, other physical attacks and verbal assaults on women all still occur while they are receiving treatment in our hospital systems.

In 2006, the National Patient Safety Agency in the UK published a detailed analysis of patient safety incidents related to mental health between November 2003 and September 2005 (National Patient Safety Agency (UK), 2006). Of great significance is that the UK has adopted a policy of gender segregation on psychiatric wards with strict financial penalties for any non – adherence to this policy by the UK National Health Service providers and improved safety within psychiatric wards.

Any allegations of assault should be properly investigated. It has been found that many women who have disclosed sexual assault whilst in mental health care have been met with disbelief and trivialisation (Judd et al., 2009). Ensuring a decrease in assaults on women in inpatient units would also lessen the impact of potential associated medico-legal issues. A robust monitoring system for the safety of patients in adult inpatient units is essential for reducing the risk of harm in such facilities. This should be by central collection of data of incidents with each State being mandated to implement a process for improvement.

An important sub group of women needing special care in hospital are women who are pregnant and are experiencing serious mental illness. Current acute adult inpatient units are not appropriate or safe environment for such women. The development of inpatient psychiatric care for these women should be provided within maternity hospitals. These services should be suitably set up and staffed to provide both obstetric and mental health care for women who are pregnancy and have a serious mental illness.

Recommendation 10:

An urgent review of the safety of women in adult inpatient units, following by a framework for the construction of, and upgrading of, inpatient units to ensure segregation and increased patient safety.

Recommendation 11:

Implementation of national data monitoring regarding women's safety in inpatient and outpatient units/practices.

Recommendation 12:

Establishment of psychiatric inpatient services within maternity hospitals, to provide both obstetric and mental health care for women with serious mental illness who are pregnant.

4.4 Service information

There is currently no mechanism for women to find appropriate female centric services, for example, a helpline. Whilst the Victorian-based Post and Antenatal Depression Association (PaNDa) provides confidential information, support and referral to anyone affected by post and antenatal mood disorders, including partners and extended family members, there are not similar organisations in all States and Territories. Referrals can often be hit and miss. There is a need for a central repository of information across the spectrum, age and cultural issues of women's mental health. This could include a list of female GPs with an interest in mental health issues, as well as other referral and factual information. This could be delivered via new technologies including a website or via SMS.

Recommendation 13:

Development of a national information portal for women seeking appropriate female centric mental health services.

5. Training and Workforce

Serious workforce shortages remain across all mental health professional groups. A long term, adequately funded process to address this workforce shortage needs to be implemented. There are a number of short-term initiatives to improve the psychiatric workforce, however more long term investment is required if such strategies are to be successful.

Currently, only 7% of psychiatrists in Australia are based in rural areas. While another 11% carry out some work in rural areas through visiting services and there are a number of overseas-trained doctors working in rural Australia, this represents a significant workforce shortage (Australian Institute of Health and Welfare, 2005; Australian Medical Workforce Advisory Committee, 1999). The rural workforce is also ageing faster than its urban counterpart and stands to lose 20% of its number to retirement within the next five years, a number unlikely to be balanced by the currently low recruitment rate.

There also needs to be a significant up-skilling of the existing workforce as knowledge of women's mental health issues is currently very generic. There is a need for more specialist training in psychiatry and the other medical professions about women's mental health. Equally, more health professionals from primary health care specialists to allied health professionals need greater proficiency in women's mental health and recognising potential issues arising in children. Greater attention also needs to be paid to women's physical health as well as their mental health and vice versa. It has been found that

mental health clinicians vary in the degree to which they enquire about or address general health issues (Judd et al., 2009).

There also needs to be greater support of female psychiatrists and their research into women's mental health. Such research will naturally lead to the development of well informed policy.

Recommendation 14:

A significant upskilling for the health workforce regarding women's mental health.

Recommendation 15:

Increased support for female psychiatrists and research into women's mental health.

6. Conclusion

An effective National Women's Health Policy that adequately addresses the mental health needs of women is vital to ensure that appropriate and effective services are provided to all women who have, or are at risk of developing, a mental disorder. This policy should allow for flexibility across catchment areas, be able to respond quickly to crisis and changing needs, and address the specific needs of women in an individualised and non-stigmatising manner.

The National Women's Health Policy should be developed and implemented following wide consultation with consumers and carers. The RANZCP has a long history of working with, and providing expert advice and guidance to, consumers and carers on mental health matters and offers leadership and practical support to such groups though its Board of Practice and Partnerships. As a priority, the outcomes of the National Women's Health Policy should focus on improving the lives of consumers, and research should be aimed at identifying changes that best meet the needs both consumers and carers.

The Royal Australian and New Zealand College of Psychiatrists thank the Department of Health and Ageing for the opportunity to make a submission to this important consultation document and looks forward to working with the Australian Government in the development of the policy, and the implementation of the adopted policy.

7. Summary of Recommendations

1 That parenting support for women with children from 0-5 years be provided in an ongoing coordinated manner, particularly for women with, or at risk of, developing severe mental disorders. This should focus on early intervention of ongoing disorders in the mother and prevention of mental health problems in the infant/child.

2 Provision of incentives for General Practitioners and health services to provide regular health checks for people with a mental illness including pap smears, breast screening, and tests for sexually-transmitted diseases.

3 Increased funding for research into eating disorders and, in particular, early intervention and prevention.

4 Improved coordination of acute health services and mental health services with regards to women who suffer sexual assault and/or domestic violence.

5 Development of specific strategies that focus on the mental health needs of Indigenous and immigrant populations.

6 Development of specific strategies that focus on the mental health needs of older women.

7 Development and implementation of a national female sensitive, safe service model in relation to women's mental health services.

8 Identification and coordination of different levels of service, including primary, secondary and tertiary levels.

9 An increase in the number of community services that can provide holistic longer term care for women and that are proficient in recognising mental health issues in high risk women and children.

10 An urgent review of the safety of women in adult inpatient units, following by a framework for the construction of, and upgrading of, inpatient units to ensure segregation and increased patient safety.

11 Implementation of national data monitoring regarding women's safety in inpatient and outpatient units/practices.

12 Establishment of psychiatric inpatient services within maternity hospitals, to provide both obstetric and mental health care for women with serious mental illness who are pregnant.

13 Development of a national information portal for women seeking appropriate female centric mental health services.

14 A significant upskilling for the health workforce regarding women's mental health.

15 Increased support for female psychiatrists and research into women's mental health.

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