Submission to ACT Comorbidity Strategy

From: Women's Centre for Health Matters Inc.

February 2010

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Introduction

The Women's Centre for Health Matters Inc. (WCHM) is a community-based organisation that works in the ACT and surrounding region to improve women's health and wellbeing. WCHM focuses on groups of women who experience disadvantage and uses social research, community development, advocacy and health promotion to empower these women to achieve the highest possible standard of health and wellbeing.

WCHM believes that health is determined not only by biological factors, but by a broad range of social, environmental and economic factors known as the 'social determinants of health'. We acknowledge that that the environment and life circumstances that each woman experiences have a direct impact on her health, and in many cases, women's poor health is rooted in social disadvantage. For these reasons, WCHM is committed to taking a 'whole of life' and social approach to women's health, that is also firmly situated within a human rights framework.

Response to ACT Comorbidity Strategy

WCHM welcomes the opportunity to provide feedback on the draft ACT Comorbidity Strategy. In writing this submission WCHM has chosen to limit its responses to those areas in which it has the most knowledge and expertise. This response is supported with evidence published by the Centre and its partners on the specific needs of ACT women, and with feedback from a variety of ACT women through focus groups and other consultation processes.

1. Gender, women, health and mental health

Women and men are different, both as a result of biological differences and because of the differences in the ways that they live, work and play. Because of these differences, men and women have different health needs. For this reason, women's health can only truly be understood by considering not only the biological and physiological, but also the social, cultural, economic and personal contexts of a woman's life.[1] Evidence suggests that practitioners who implement this knowledge into their services, that is those who are 'gender-sensitive', achieve better health outcomes for women. In contrast, 'gender neutral' or 'gender blind' approaches have neglected the unique needs of women with health problems and perpetuated health inequalities between men and women. To ignore the wider context of a woman's life and the potential for it to negatively affect her health and wellbeing is not smart practice.

WCHM believes that gender sensitive health service delivery is essential in order to achieve the best possible outcomes for women experiencing ill health. Too often health research has been conducted by men, about men, and the results have been applied to women, sometimes leading to inappropriate or ineffective interventions for women and a health system not free from the traditional gender bias.[2] In the case of mental health, gender differences have an impact on the experience and course of women's mental illness. Research has found, for example, that the prevalence of psychiatric disorders, particularly mood, anxiety and eating disorders, is greater in women than in men. [3] Moreover, looking at mental health through a gender lens also reveals differences in the course of illness and the different impact of biological, psychological and social factors in the causation of illness. There are differences between men and women when it comes to age of onset, symptoms, comorbidity with other illnesses and ways in which mental illnesses are expressed.[4] For example, depression in women is more often characterised by appetite, sleep disturbance and fatigue,[5] and is more likely to be accompanied by anxiety.[6] Women are more likely than men to seek help from, and/or to disclose mental health problems to their primary health physician, but then conversely, are less likely than men to disclose problems relating to drug and alcohol use[7].

Gender-stereotyping and bias in relation to identifying and treating mental illness is another factor that may further impede good mental health outcomes for women.[8] For example, stereotypical conceptualizations of women as 'emotional', menopausal or suffering from 'PMS' may engender bias in the identification and treatment of mental illness. Women are more likely than men to be diagnosed with depression, "… even if they have similar scores on standardized measures of depression or present with identical symptoms.[9]

> *"I've got bi-polar and my partner has clinical depression and I've noticed that when I go and get treatment, I am often over medicated, or forced to have treatment, um, when [in my opinion] it's really like a hormonal, PMS sort of thing. Whereas he has severe depression and they just kind of overlook him."*

Furthermore, social and cultural circumstances have a unique impact upon women's mental health. There is a strong inverse relationship between social status, and physical and mental health outcomes.[10] This greatly affects women, as in almost every society, women's status remains lower than men's. Women's low status is reflected in the high incidence of violence against women; women's lower socio-economic status; an under-representation of women in positions of power; and an over-representation of women in part-time and casual work, amongst other things. A consequence of violence against women for example, is that they are more likely to experience mental health problems, particularly depression, anxiety, eating disorders and substance abuse.[11] Financial insecurity also appears to predispose women to mental illness, as demonstrated in the findings of the WCHM commissioned report, *Social Determinants of Women's Health and Wellbeing in the Australian Capital Territory.*

> *"I've been in a position where I've needed to see the GP for depression and anti-depressants but because they don't bulk bill I haven't been able to afford to go and get the care that I needed, even with the Medicare rebate or whatever, you've still gotta [pay] because they don't bulk bill and then you've gotta have the money to get your prescriptions. You come out and you've spent a hundred dollars. Then you think 'I'll just put it aside' and it gets worse."*

1.1. Considering gender sensitive principles in health service delivery

WCHM believes that health policy, including comorbidity strategies, need to be better informed by the gendered experiences of men and women, their unique experiences of ill health, the different ways their symptoms manifest and the different kinds of interventions that would best suit the individual. For example, mental health services provided to women who have experienced trauma must be aware that those services that involve restraint, seclusion or institutionalisation, may unintentionally trigger feelings of powerlessness and cause the woman to become re-traumatised.[12] Gender sensitive health service delivery would also understand that in times of crisis, women with children are particularly vulnerable. Separation from children due to hospitalisation, remand or detox obligations can lead to further deterioration in mental health. The use of advanced directives, parenting support groups, self help models of support, community development initiatives and services to assist with access and reconciliation of families, could all assist in supporting women with children in times of crisis.

Gender sensitive health services are more than just 'women only' services. After talking to women service users, providers and reviewing a wide range of literature, WCHM has

identified four key qualities that must inform gender sensitive health service delivery: availability, accessibility, affordability and appropriateness. Gender sensitive health service delivery understands that 'women are their own experts' and that women are best placed to make decisions about the issues that affect their health and well-being.

1.2. Characteristics of Gender Sensitive Mental Health Service Delivery

Health strategies, policy and procedures that informed by gender sensitive principles are likely to have the following characteristics:

They have a holistic approach to mental health, where women are treated as whole individuals rather than as their illness or diagnosis – they use a social model rather than a medical model.

> *"Once you tell them the medication you're on, they naturally assess you by the medication, they don't assess you by who you are or what you're presenting with or what you wanna discuss with them."*

They offer women choices about the type of support they receive, and who provides it to them (i.e. a choice between a male or female doctor). This is of particular importance for some CALD women, Aboriginal and Torres Strait Islander (TSI) women and for women who have suffered trauma, and/or for women who may feel uncomfortable disclosing personal information to a male practitioner.

They provide women with opportunities to be actively involved in their own care and treatment, including service planning and delivery. (i.e. advanced directives)

> *"I have tried many times to write an advanced agreement, or an advanced directive and have it put on MHAGIC and noted that these are the people that are supporting me, these are my carers, these people know exactly what's going on, coz they live with. And still, they just ignore it."*

They offer women choice in treatment options, which may include medication, talking therapy and/or other community-based services like peer support.

> *"I've had a similar thing. I've been seeing my GP for depression for ten years and I've been on anti-depressants and all that but not once have I ever been offered any free therapy."*

They have staff that treat women with respect, give them time to talk and listen to what they have to say, including the provision of long consultations and more preventative health measures and counselling where needed.

They have staff and practitioners with qualifications in women's health and/or are trained to understand the impact of gender on mental health and well-being.

They are culturally sensitive.

They understand that all health issues and life events may affect men and women differently across their lifespan and use a life course approach in service planning and delivery.

They take into account the 'social determinants of health', that is, they acknowledge the way that women's personal circumstances and socio-economic status affects their mental health. For example, a woman's child and/or other caring responsibilities, her relationships, housing status, income, age, sexuality, ethnicity, religion and cultural and linguistic background, all have the potential to negatively impact upon a her mental health and wellbeing.

> *"They never get to the root of the problem, they just treat the symptoms."*

> *"Yeah, I had a roof over my head – but I've lost my job, I've lost my house, I've lost my pets, I've lost my partner, I've lost my friends, I've lost my family but hey, I've got a roof over my head in a psychiatric facility. What would I prefer?"*

They employ a holistic, individual approach to service delivery that recognises that women often have a multitude of concurrent challenges, which then often lead into a cycle of difficulties.

They have 'women only' spaces within their buildings.

> *"At the PSU, in LDU there is a women's only area but every time I've been there, there have been men in there."*

They provide family-friendly and more specifically child-friendly environments, and services are inclusive of family.

They keep women's personal information confidential at all times.

> *"I'd been exploring issues of sexual abuse and I think I told one of the nurses one night, she told Doctor X, he spoke to my mother. When they had the um, the um, Tribunal… when they issue the court order…he asked me about sexual abuse and the guy who was recording it was my [family friend], luckily he wasn't in the room, and one of my [relative's friend] was the consumer advocate."*

> *"…although there is [a specialised health service] - its services, a lot of Aboriginal people in Canberra do not use [it], for a lot of reasons. One of them is, um, confidentiality isn't really well respected."*

Pathways of care are easy to navigate, information is provided in preferred formats, and for those women who experience difficulty in understanding and/or navigating the health system, assistance is provided.

> *"If you're really unwell and really traumatised and they dump you with that book [MHF Directory of Services] – a woman at [a local community service] just dumped me with this book, and I think there is over three hundred services in it. And I was like, you gotta be joking, how am I going to work out which is which?"*

> *"The information sessions that the Mental Health Foundation runs, um, those happen at the inpatient facilities every month or every couple of months and a lot of people aren't in there for very long, um, so maybe we can have some sort of group who tells people what's going on, maybe have some regular forum in the community, at a community centre, alternate between north and south and city areas and say, look, advertise in the Chronicle, advertise in The Canberra Times… on the internet…"*

They have a stable and secure funding base, which allows them to offer consistency and longevity in the support they provide. [13]

1.3. Education and Training in Gender Sensitive Health Service Delivery

If we are to improve women's access to gender sensitive mental health services, we must first invest in the education of our mental health staff and practitioners. The draft ACT Comorbidity Strategy hasn't highlighted the need for training and education on gender sensitive health service delivery, and therefore WCHM urges the Government to incorporate this into the final draft.

It is essential that all staff understand the impact of gender on health and mental health, the concept of 'gender sensitive health service delivery', and the ways in which social determinants impact on women's health and well-being. Whilst it is important to teach health professionals and staff about traditional 'women's issues', such as pregnancy, menopause and reproductive issues, this alone is not sufficient in creating gender sensitive practitioners. Health education must also equip training practitioners with an understanding that *all* health issues and life events can affect men and women differently across their lifespan. Health practitioners need to be able to recognise and respond to a broader range of factors which impact upon women's health, including but not limited to, domestic violence, mental health, eating disorders, the effects of ageing and disability, and women's multiple and often conflicting roles as workers, mothers and/or carers.

1.4. Recommendations

WCHM believes that gender sensitive health service delivery is an integral and necessary part of good healthcare and mental healthcare, for women of all ages, not simply those over the age of eighteen and this belief is supported by the preliminary findings of the WCHM *2009 Women's Health Information Survey*. If health providers have an increased knowledge of how gender interacts with health and health care they will better be able to reduce the burden of illness for women and their families.[14]

WCHM strongly urges the Government to consider incorporating the following gender-sensitive recommendations into the strategy.

2. A recovery approach

Firmly situated within this idea of gender sensitive health service delivery is the idea of a recovery approach to understanding and treating health issues. Traditionally, mental illness, for example, has been understood within the context of a *medical* framework. Within this framework, mental health consumers are subject to a medical interpretation of their experiences and views. Mental illness is considered a biologically based illness[15] [16], and traditionally only the biological and cognitive processes have been addressed by mental health practitioners.[17] Traditional hospital and psychiatric settings have been criticised for the de-personalisation and de-contextualisation of an individual's struggles.[18] [19] [20] [21] [22] Attempting to understand the often convoluted and varied personal histories of individuals living with a mental illness creates a more complex problem for the medical profession to fix. Instead, it is easier to essentialise the experiences of people living with mental health issues, to focus on what they have in common – their symptoms. However, we all know it to be true that people living with a mental illness are not a homogenous group. This approach to understanding and treating mental illness has resulted in an under emphasis of social determinants and their impact on the health and wellbeing of mental health consumers[23].

Another consequence of the medical approach is that it often renders an individual powerless to contribute to his or her own recovery process. The diagnosis and treatment of mental illness is strictly within the domain of a psychiatrist's (or other medical practitioner's) expertise and control.[24] Mental health consumers become passive recipients of services and their relationships are often characterised as uni-directional and dependent in nature. The result of this is the social construction of a disempowered "mental client" identity;[25] an "[object] of psychiatric knowledge… which has 'otherness' as its central feature."[26]

The medical model is epitomised in the question,

What is wrong with this person?

Conversely, an alternative way in which to understand and treat mental illness is within the *recovery* framework. Within this framework, the term recovery does not necessarily refer to an absence of symptoms or injury, but rather "…[recovery] is about having the opportunity to live a satisfying and fulfilling life (as defined by the person in recovery) in the presence or absence of ongoing symptoms." Mead, Hilton & Curtis go on to further assert that "…recovery lies in undoing the cultural process of developing careers as 'mental clients.'"[27] Instead, the recovery framework aims to transcend the limitations of the medical framework for understanding and treating mental illness and reorient the individual as an active participant in life, empowered to participate in their treatment and empowered to redefine and recognise themselves as unique individuals, and not (just) their mental illness.

The recovery framework is epitomised in the question,
What has happened to this person?

Although health services often promote their services as holistic and recovery-oriented, this is often not the case. Young women surveyed in WCHM's *2009 Women's Health Information Survey* commented that the focus of mental health consultations, for instance, was often solely on reaching the diagnosis and nothing more. They wanted these consultations to provide more information about their diagnosis, treatment pathways/options and symptom management.

> *"She [the doctor] referred me to a psychiatrist, and I saw the psychiatrist and she said… I think you might be depressed, and I'm like, I know that, I've been diagnosed with it many times, I want to know how to stop it, how to help it…"*

Moreover, this preoccupation with diagnosing and medicating often fails to treat the underlying factors that impact upon a person's mental health. For example, international literature on the subject of mental health and social connectivity identifies a lack of community support, rather than a person's symptomatology to be the dominant factor in re-admission[28], with up to half of all discharged psychiatric patients re-hospitalised within twelve months[29]. In the ACT, a lack of transition support (step up/step down programs) and poor psychiatric discharge practices are major contributors to recidivism[30]. Moreover, low levels of social support are intrinsically linked to poor mental and physical health outcomes in general. [31] [32] [33] [34] Comorbid clients no doubt experience these same problems. Assisting them to develop social networks, social skills and good relationships with others would greatly assist them post discharge.

2.1. Characteristics of a recovery framework

A recovery framework would incorporate the following characteristics into health service delivery (in addition to those gender sensitive characteristics mentioned previously):

- They focus on redefining self (i.e. being more than your mental illness);
- They promote hope and optimism (i.e. You **<u>can</u>** live a safe, happy, healthy and fulfilling life);
- They promote self-management and personal responsibility;
- They promote and protect human rights;
- They are non-judgemental and the language used by staff, clients and visitors reflects this[35];
- They incorporate illness and manage symptoms, and;
- They encourage people to support one another.

2.2. Recommendations

WCHM supports the aims of the ACT Comorbidity Strategy but believes that a recovery approach to understanding and treating mental health and AOD issues would better reflect best practice and the ideals set out in the ACT human rights legislation, and it should be incorporated into all strategies, polices and procedures.

The social determinants of health

WCHM believes that while treating the symptoms of mental illness and AOD usage is useful and necessary, the ACT Comorbidity Strategy must go beyond 'behavioural change' and address broader 'societal issues'. The main focus of this draft strategy is the categorisation and treatment of illness, and although it acknowledges social determinants in passing, WCHM does not consider this strategy to be properly informed of the significant impact social determinants can have on health outcomes.

Health is shaped by the environment in which we live. Consequently all government departments have a role to play in health promotion. The new ACT Comorbidity Strategy needs to be connected to other policies, and should consider long term change around the social determinants of health. Income security, employment status, transport, sport and recreation pursuits and family and community supports affect health. A system that strengthens both prevention and wellness should include the provision of suitable housing, affordable child care, adequate income support, accessible community and public transport systems, and a continuum of care; it should be affordable to all women, tailored to individual needs and be culturally appropriate.

> *"What we need is support for people with Housing to maintain their tenancy. If you've got a mental illness, you may not think to pay your rent or they've got comorbidity problems and may spend their money on drugs or they may have, uh, a problem with behaviour and everyone else complains about it – thinks like that. Y'know, well, maintaining the tenancy is important. And if they go into hospital they could lose out because they're in hospital and not paying their rent, they're not occupying their house."*

> *"I was homeless many times, but the period I was homeless the most was for a year and…Housing often thinks if you're in a car, you're safe, if you're couch-surfing, that's ok, uh, or if you're, say, in Northbourne Flats where there is drugs then that's ok, because you've got a house or somewhere to go. But I think it is really important to, um, kinda really stress safe and appropriate housing, coz I've heard stories where people… can't navigate a flight of stairs but that's ok because you've got a house! I think it's really important to stress appropriate and safe."*

2.3. Recommendations

WCHM supports a model of healthcare that properly understands, articulates and addresses the social determinants of health. This model of healthcare will ask the question; "why?" Why are these individuals experiencing co-occurring mental health and AOD issues? Are there any other factors influencing or exacerbating poor mental health and AOD usage? And if so, what can this strategy do to facilitate the improvement of these factors?

WCHM urges the Government to give greater consideration and weight to the social determinants model for developing health strategies policies and procedures. If the social determinants are properly addressed and prioritised the burden on primary health services will likely decrease in the future.

3. Evidence-based service delivery

ACT women overall are better educated, have higher incomes, and have higher housing standards than women nationally. However, there are a significant number of ACT women who are marginalised and isolated from their community and its wider standard of living, at a great cost to their health and wellbeing. Due to the lack of accurate, sex-disaggregated data on marginalised and isolated groups, it is almost impossible to quantify the number of women in the ACT that are experiencing marginalisation and isolation. Key issues in the ACT, including addiction and substance abuse, transportation issues, and poor mental health all impact negatively on health and wellbeing, and are significantly more common amongst the socially and economically disadvantaged.

WCHM invests a lot of its time and resources into gathering local evidence on the specific issues affecting ACT women. This localised evidence has proven to be a vital resource for other ACT community and Government organisations, particularly in designing, evaluating and sourcing funding for their services. By gathering local evidence, WCHM is developing a better understanding of our unique community. For example, while national statistics often portray Canberran's as relatively privileged (high incomes and levels of home ownership, low rates of homelessness etc.), localised research, such as that conducted by WCHM, has revealed pockets of disadvantage and groups at risk of social isolation. Gaps in service provision and policy exist with relation to all of the groups at risk of marginalisation and isolation. Insufficient respite for primary carers, inadequate exit points for women in refuges, not enough affordable, adequate and safe housing, transport issues, services for Aboriginal and/or Torres Strait Islander women, and support for institutionalised women with children are all issues that have arisen repeatedly.

3.1. Recommendations

Local evidence is necessary to help services better understand the impacts of local events in their community (i.e. the recent GP clinic closures and the opening of the new prison in the ACT). All ACT health polices, strategies and procedures should promote and prioritise evidence gathering at a local level in order to develop a sound evidence base.

4. Institutionalised Women

WCHM's *Marginalised and Isolated Women Report* defines institutionalised and post-institutionalised women as women who are currently, or have been, imprisoned, or detained in a detox facility, in girls' homes (i.e. the *Forgotten Australian's* and child migrants*)*, or have been institutionalised for mental health reasons. Women who have been institutionalised for

any reason are at high risk of social, economic, political, and legal marginalisation and isolation that extends beyond the institutionalised period.

Consultation with the ACT Women and Prisons Group identified three key issues for women who have experienced institutionalisation (particularly in prisons): rehabilitation, employment opportunities, and social inclusion. Moreover, mental health issues and dependencies are common problems in this group of women. The 1997 *NSW Inmate Health Survey* found that women in custody were twice as likely as male inmates to have been diagnosed with psychiatric problems and nearly three times as likely to be on psychiatric medication at the time of their reception into custody.[36] Five years later the Queensland Women Prisoners Health Survey found that 57 percent of women in QLD prisons had been diagnosed with a specific mental illness[37], compared to 5.8 percent of women nationally.[38] Furthermore, 69 percent of women in the same study demonstrated symptoms of depression, which was dramatically higher than the national average of 6.8 percent.

Post-institutionalisation, women ex-prisoners often find themselves socially isolated with limited support networks. As a result of their criminal records, employment opportunities are restricted to low paying positions, and yet they must navigate their mental health issues, caring responsibilities and employment effectively. Experiencing such challenges concurrently leaves a woman more susceptible to poverty and homelessness[39] and therefore, it is essential that Government's continue to improve discharge practices, and develop targeted health support and other supports for these women (i.e. step up/step down programs, social support groups, employment and housing assistance etc.). A holistic, person-centred approach to improving comorbid outcomes for this target population is likely to nurture a culture of trust, safety and social connectivity, all of which are critical protective factors for good health and wellbeing.

5. Conclusion

In conclusion, this submission aimed to highlight issues from the perspective of women of the ACT. WCHM looks forward to the development of the ACT Comorbidity Strategy.

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