Submission to:
Mental Health ACT

Submission to Preliminary Model of Care for SAMHIU and AYAHIU

From: Women's Centre for Health Matters Inc.

March 2010

Women's Centre for Health Matters

Submission to Preliminary Model of Care for SAMHIU and AYAMHIU

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 Preliminary Model of Care (AYAMHIU and SAMHIU)

WCHM welcomes the opportunity to participate in the consultation process for the development of two models of care, for both the Adolescent and Young Adult Mental Health Inpatient Unit (AYAMHIU), and the Secure Adult Mental Health Inpatient Unit (SAMHIU). In writing this submission WCHM has chosen to limit its responses to those areas in which it has the most knowledge and expertise, and to support its responses with evidence published by the Centre and its partners on the specific needs of ACT women.

1. Gender, Women 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.[i] 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.[ii] 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. [iii] 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.[iv] For example, depression in women is more often characterised by appetite, sleep disturbance and fatigue,[v] and is more likely to be accompanied by anxiety.[vi] 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[vii].

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.[viii] 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.[ix]

> *"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.[x] 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.[xi] 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."*

Considering gender sensitive principles in health service delivery

WCHM believes that health policy and planning, including preliminary models of care, 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.[xii] 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.

> *"I would rather talk to some one than taking four different medications before 10:00 during the day. That's all I needed to do, was talk to people, because I couldn't talk to the people that I had the problem with…but instead they wanted to feed me up with drugs. And now I won't even…address to the GP my problems because all they think to do is prescribe drugs when I know for a fact all I needed to do was talk to someone."*

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.

Characteristics of Gender Sensitive Mental Health Service Delivery

A mental health inpatient facility informed by gender sensitive principles is 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."*

  > *"I think the thing with a lot of health issues is that they don't believe in saying what's gonna work best for you, they say what works best for most people. A friend of mine just had a baby last week and like, first thing she said was "you know, I'm not gonna say what worked best for me I'm gonna try and find what's gonna works best for you". And like, um, with midwives it's like "you do this" - it's not "this might work better for you."*

- 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.

  'You're treated as though you're ignorant and you know nothing about yourself or your history…maybe that doctor patient relationship will never change.'

- 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.

  'I don't know what it is…they think that if you don't answer them they have to shout at you. And it is because you don't understand what they're saying, not because you're deaf.'

- 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.

  "If you've got someone who is not just treating you now, but looks at you as a whole person and is helping you manage your health now, intermediate and for the future…you're in a relationship [with your doctor] to help manage and plan for your health."

- 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 deal with the problem that you talk about, but not with the problem that's within. That's why X is so good because she looks at you and she will spend that extra fifteen minutes asking questions…to see if there is anything else behind the scenes.'

- 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. [xiii]

Education and Training in Gender Sensitive Mental Health Service Delivery

> *"I think some doctors are only able to communicate at a medical level, and they forget that us ordinary people don't use medical terms…"*

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. Neither Preliminary Model of Care highlighted the need for training and education on gender sensitive health service delivery. WCHM urges the Government to incorporate this into the next 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.

Recommendations (Gender Sensitive)

WCHM commends the inclusion of women-only spaces in the SAMHIU preliminary model of care, however, we note that in stark contrast to the SAMHIU Preliminary Model of Care, the term 'gender sensitive' was used only once within the AYAMHIU document.

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*.

> *"The same doctor that I was talking about that I couldn't understand… he was really sexist, he was telling me when I was asking about anti-depressants, he was like "why are you so sad? You could make a great waitress or a flight attendant."*

> *"I always walk out of this place [The Junction] feeling like I've been listened to, I've been understood, that action has been taken, and that I feel somewhat loved…and having been taken care of."*

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.[xiv]

WCHM strongly urges the Government to consider incorporating the following gender-sensitive recommendations into both models of care.

Recommendations (Gender sensitive)

- Both HDU and LDU must have women-only bedroom wings/corridors.
- Women-only living spaces and courtyards must be **secure** (lockable).
- Only female staff should possess a lock override for rooms occupied by women.
- A knock-first policy (upon entering a patients room), as detailed in the AYAMHIU Preliminary Model of Care (5.2.4) should be included in the SAMHIU unit.
- Family-friendly and child-friendly spaces must be provided (i.e. separate to main living area for patients).
- Policies regarding the uni-sex bathroom (with bath) at SAMHIU need to be implemented to ensure the physical safety of female patients using this facility (i.e. men and women to have access to the bathroom at separate designated times during the day).
- All people accessing the unit (patients, staff or visitors) must be provided with a Code of Conduct that fully and properly details what is inappropriate language, behaviour and relations whilst in the unit, and the possible consequences of non-compliance.

Recommendations (Gender sensitive) cont.

- All staff and practitioners should complete training that aims to increase understanding and awareness of issues and sensitivities relating to gender, CALD/Indigenous backgrounds, trauma and disabilities.

2. A recovery approach

Firmly situated within this idea of gender sensitive mental health service delivery is the idea of a recovery approach to understanding and treating mental health issues. Traditionally, mental illness 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[xv] [xvi], and traditionally only the biological and cognitive processes have been addressed by mental health practitioners.[xvii] Traditional hospital and psychiatric settings have been criticised for the de-personalisation and de-contextualisation of an individual's struggles.[xviii] [xix] [xx] [xxi] [xxii] 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. 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[xxiii].

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.[xxiv] 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 patient" identity;[xxv] an "[object] of psychiatric knowledge… which has 'otherness' as its central feature."[xxvi]

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 patients.'"[xxvii] 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 mental health services, including inpatient units, 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 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[xxviii], with up to half of all discharged psychiatric inpatients re-hospitalised within twelve months[xxix]. In the ACT, a lack of transition support (step up/step down programs) and poor psychiatric discharge practices are major contributors to recidivism. Moreover, low levels of social support are intrinsically linked to poor mental and physical health outcomes in general.[xxx] [xxxi] [xxxii] [xxxiii] Assisting patients to develop social networks, social skills and good relationships with others would greatly assist them post discharge.

Characteristics of a recovery framework

A recovery framework would incorporate the following characteristics into mental 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 **can** 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, patients and visitors reflects this[xxxiv];
- They incorporate illness and manage symptoms, and;
- They encourage people to support one another.

Recommendations (Recovery)

WCHM supports the aims of the AYAMHIU Preliminary Model of Care to "…provide holistic evidence based quality care… [which will have] a family and recovery focus", however we also note that this approach is not posited in the SAMHIU document. WCHM believes that a recovery approach to understanding and treating mental health issues better reflects best practice in mental health and the ideals set out in the ACT human rights legislation and should be incorporated into all mental health services.

Recommendations (Recovery)

- All staff and practitioners should complete training that aims to increase understanding and awareness of holistic and recovery-oriented practices in relation to understanding and treating mental health issues.
- Patients are given the opportunity to enjoy activities and training exercises that aim to improve social connectivity, life skills and relationships.
- Discharge practices are regularly reviewed and improved as necessary, making sure that proper connections and active referrals are made with community based services.

Recommendations (Recovery) cont.

- All staff and practitioners are trained to use non-judgemental language.

  "Attention seeking has a basic cause… there is some reason why they're attention seeking. Maybe they really are sick?!"

Attention seeking	They are trying to build relationships and find it hard to be alone with their thoughts and feelings.
Paranoid	They experience the world as very threatening and can feel very unsafe.
Secretive	They protect their privacy.
Suspicious	They are not at the point of trusting us yet.
Untreatable	We are finding it difficult to treating her.

3. Additional Recommendations

Further findings from WCHM's *2009 Women's Health Information Survey* highlighted the need for medical practitioners and staff to have greater knowledge and experience in dealing with issues specific to young people so as to properly understand existing correlations between mental illness onset, and the social determinants specific to that person, and their age.

WCHM would also like to see greater consistency across the different Preliminary Models of Care. WCHM understands that some aspects of each unit will be unique for that unit, but overwhelming the underlying principles and practices of each unit appear to be the same, and therefore should be articulated as such.

Additional Recommendations

- All staff and practitioners working with young people should complete training that aims to increase understanding and awareness of youth-specific issues, and how best to work with young people.
- A standardised approach to formatting plans, models of care and other documentation should be employed so as to better enhance and demonstrate the consistency of principles, aims, examples and information provided.

4. Conclusion

In conclusion, this submission aimed to highlight issues from the perspective of women of the ACT. WCHM looks forward to participating further in the consultation process, and the development of these new inpatient units.

References

[i] D.E. Stewart, "Social Determinants of Women's Mental Health" in *Journal of Psychosomatic Research*, Sep 2007

[ii] The Women's Health Council, 2007, *A Guide to Creating Gender-Sensitive Health Services.*

[iii] F. Judd, S. Armstrong, J. Kulkarni, "Gender-sensitive mental health care" in *Australasian Psychiatry,* Vol 17 (2) 2009

[iv] Ibid

[v] M.A. Young, W.A. Scheftner, J. Fawcett, G.L Klerman, "Gender differences in the clinical features of unipolar major depressive disorder" in *Journal of Nervous and Mental Disease*, Vol. 178 (1990)

[vi] S.G. Korstein, G.M. Sloane, M.E. Thase, "Gender-specific differences in depression and treatment response" in *Psychopharmacology Bulletin,* Vol. 36 (2002)

[vii] World Health Organisation, "Gender and women's mental health"

[viii] I. Broverman, S. Vogel, D. Broverman, F. Clarkson, P. Rosenkrantz, "Sex-role stereotypes: A current appraisal" in Journal of Social Issues, Vol. 28, No. 2 (1972)

[ix] E.J. Callahan, K.D. Bertakis, R. Azari, L.J. Helms, J. Robbins, J. Miller, "Depression in primary care: client factors that influence recognition" in Family Medicine, Vol 29 (1997); G. Stoppe, H. Sandholzer, C. Huppertz, "Gender differences in the recognition of depression in old age" in Maturitas, Vol 32 (1999)

[x] B.P. Dohrenwend, "Socio-economic status and psychiatric disorders" in *Social Psychiatry and Psychiatric Epidemiology*, Vol. 25 (1990)

[xi] K.K. Danielson, T.E. Moffitt, A. Caspi, P.A. Silva, "Comorbidity between abuse of adult and DSM-III-R mental disorders: Evidence from an epidemiological study" in *American Journal of Psychiatry,* Vol. 155 (1998)

[xii] F. Judd, et. al., op. cit.

[xiii] M. Barnes, A. Davis, S. Guru, L. Lewis, H. Rogers, "Women-only and women-sensitive mental health services: A summary report" (University of Birmingham: UK, 2002)

[xiv] The Women's Health Council, "A Guide to Creating Gender-Sensitive Health Services" (2007)

[xv] S. Mead, D. Hilton & L. Curtis, "Peer Support: A Theoretical Perspective", in *Psychiatric Rehabilitation Journal,* Vol. 5 (2001) 134 - 141

[xvi] S. Zinman & H.T. Harp, "Reaching Across: Mental Health Clients Helping Each Other (California Network of Mental Health Clients: CA, 1987)

[xvii] A.L. Adame & L.M. Leitner, "Breaking out of the mainstream: The Evolution of Peer Support Alternatives to the Mental Health System" in *Ethical Human Psychology and Psychiatry,* Vol. 10, No. 3 (2008)

[xviii] J. Chamberlin, "On our own: Patient-controlled alternatives to the mental health system" (Hawthorn Books: NY, 1978); 333 – 354

[xix] O. Cohen, "How do we recover? An analysis of psychiatric survivors'' oral histories" in *Journal of Humanistic Psychology,* Vol. 45 (2005)

[xx] D. Fisher, "People are more important than pills in recovery from mental disorder" in *Journal of Humanistic Psychology,* Vol 43 (2003)

[xxi] S. Mead & M.E. Copland, "What Recovery means to us: Consumers Perspectives" in *Community Mental Health Journal,* Vol. 36, No.3 (2000)

[xxii] R. Unzicker, "On my own: A personal journey through madness and re-emergence" in *Psychosocial Rehabilitation Journal,* Vol. 13 (1989)

[xxiii] A.L. Adame et al., op. cit.

[xxiv] Ibid

[xxv] S. Mead et al., op. cit.

[xxvi] M. White & D. Epston, "Narrative Means to Therapeutic Ends" (W.W. Norton & Company: NY, 1990)

[xxvii] S. Mead et al., op. cit.

[xxviii] L. Davidson, M. Chinman, B. Kloos, R. Weingarten, D. Stayner, J.K. Tebes, "Peer support among individuals with severe mental

illness: a review of the evidence" in *Clinical Psychology Science and Practice,* Vol. 6 (1999)

[xxix] W.D. Klinkenberg and R.J. Calsyn, "Predictors of receipt of aftercare and recidivism among persons with severe mental illness: a review" in *Psychiatric Services*, Vol. 47, No. 5, (1996)

[xxx] L. Berkman, "The relationship of social networks and social support to morbidity and mortality" in *Social support and health,* (eds) S. Syme & S.L. Syme (Academic Press: OL, 1985)

[xxxi] J.R. Bloom, "The relationship of social support and health" in *Social Science and Medicine,* Vol. 30 (1990)

[xxxii] S. Cohen, "Psychosocial models of the role of social support in the etiology of physical disease" in *Health Psychology,* Vol. 7 (1988)

[xxxiii] J.S. House, K.R. Landis & D. Emberson, "Social relationships and health" in *Science,* Vol. 241 (1988)

[xxxiv] S. Scott and J Williams "Closing the gap between evidence and practice: the role of training in transforming women's services" in *Working Therapeutically with Women in Secure Mental Health Settings (*London, 2004)