AUSTRALIAN HEALTH POLICY COLLABORATION

Investing in Women's Mental Health:
Strengthening the Foundations for Women, Families and the Australian Economy

Policy Issues paper No. 2016-02
April 2016

Maria Duggan
Australian Health Policy Collaboration

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About the Australian Health Policy Collaboration

The Australian Health Policy Collaboration was established at Victoria University in 2015 to build from the work of the health program at the Mitchell Institute over the previous two years. The Collaboration is an independent think tank that aims to attract much required attention to the critical need for substantial and urgent health policy reform focused on addressing chronic disease on a national scale.

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Foreword

Everyone knows that there are differences between women and men. The marketing and retailing industries spend many millions of dollars on market research to understand the needs and preferences of men and women so that they can gender-target their messages to both adults and children. They wouldn't do it if the evidence told them that gender-blind strategies would work just as well.

That there are differences between men and women with regard to reproduction is clear. Popular culture and even scientific research is characterised by debates about specific sex-related issues such as pregnancy, infertility, contraception, menstruation and prostate disorders. Yet reproductive differences are not the only biological differences between men and women. A steadily increasing body of evidence has revealed disparities in incidence, complaint presentation, symptoms and prognosis in many health problems, such as HIV/AIDS, sexually transmitted diseases, cardiovascular diseases and auto-immune disorders and in the incidence, prevalence and experience of mental ill health. Rapid progress in molecular biology has led to the discovery of a genetic and molecular basis for sex-related differences in diseases. As we move towards the era of personalised medicine, biological sex differences, amongst other variations, will need to be taken into account in formulating treatments, including pharmacological interventions.

Yet even this broader understanding of the differences between men and women does not get to grips with the complexity of gender and the way in which it influences health and wellbeing. Gender differences encompass biology, the roles and responsibilities that society assigns to men and women and their position in the family and community. Evidence confirms that these factors all have a great influence on the causes, consequences and management of diseases and ill-health and on the efficacy of health promotion policies and programmes. Gender is recognised as a risk factor in the development of mental disorders. Women and men have marked variations in patterns of distress and in service utilisation. Depression is presently the leading cause of the non-fatal burden of disease for women in Australia

In spite of all of this evidence about the importance of gender, mental health policy in Australia is gender-blind. If gender matters to marketeers, helping them to be more effective and profitable, surely it should also matter to governments who have a responsibility for the policies which support the health and well-being of the population? The message of this paper is that gender matters in policy and in practice. The paper cites the extensive evidence that women's mental health is influenced by biological, psychosocial, economic and environmental factors. The high prevalence of mental distress amongst women and girls of all ages is bound up in the totality of women's experiences including social and economic inequality. There is an urgent need to counter the gender-blindness of mental health policy which serves to make these experiences invisible. Policies which reinforce this invisibility are not only ineffective; they are part of the problem. It is time to change course.

Rosemary Calder AM

Director

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Executive Summary

Evidence shows that certain mental illnesses are more prevalent in women, that women use mental health services more frequently than men, and that women would like a broader range of treatment options than are available currently. It is an undisputed fact that women's mental health needs are significantly different from those of men and therefore require different responses. To date, the insights from evidence have mostly not been translated into mainstream health policy or practice. Lack of recognition of gender at policy level and in the provision of services is tantamount to ignoring critical factors in both the development and progression of diseases and in developing effective, preventative interventions, diagnoses and treatments. This has serious implications for the health of the nation, contributing to sub-optimal outcomes of mental health treatment for women, notwithstanding increasing investment in services of all kinds in recent years.

Key Facts

- Mental disorders represent the leading cause of disability and the highest burden of non-fatal illnesses for women in Australia
- 43% of women (3.5 million) have experienced mental illness at some time.
- Australian women are more likely than men to have experienced symptoms of a mental disorder during the previous 12 months (22% of women compared to 18% of men)
- Young women report the highest rates of mental disorder of any population group (30% for women aged 16 to 24)
- Women are more likely than men to have (or report symptoms of) the following conditions:
    - anxiety disorders – 18% (11% of men)
    - affective disorder such as depression - 7% (5% of men
    - eating disorders – 15% of young women have had an eating disorder at some point in their lives, and eating disorders are the third most common chronic illness amongst young women in Australia
    - deliberate self-harm – females record higher age-adjusted rates of hospitalisation due to intentional self-harm than males across all age groups (10–14 to 60–64)
- Perinatal depression – one in five mothers of children aged 24 months or less are diagnosed with depression. More than half of these mothers reported that their diagnosed depression was perinatal (that is, the depression was diagnosed between pregnancy and the child's first birthday). This represents an estimated 111,000 Australian mothers being diagnosed with depression, and 56,000 with perinatal depression annually.
- Multimorbid physical illnesses – women are 1.6 times as likely as men to suffer coexisting mental and physical illness. These multimorbidities are associated with increased severity of mental illness and increased disability
- The number of hospital admissions for specialised psychiatric care following a principal diagnosis of recurrent depressive disorders and specific personality disorders was substantially higher for females than males during 2007–08
- In the same period, females aged 35–44 were the highest consumers of Medicare-subsidised mental health-related GP services

- Women in Aboriginal and Torres Strait Islander communities have much poorer physical and mental health than other Australians including
    - much higher rates of mental health condition and higher rates of morbidity and premature mortality associated with comorbid conditions, including diabetes and cervical and ovarian cancers
    - Anxiety and depression are the foremost health problems reported by indigenous women in Australia
    - The suicide rate of Aboriginal and Torres Strait Islander women is highest within the 20-24 years old age group (21.8 per 100,000), which is more than five times higher than their corresponding non-indigenous counterparts (4.0 per 100,000

The Consequences of Mental Ill Health Amongst Women

Adverse social and economic consequences arise directly and indirectly from the burden of mental ill health amongst women.

- Direct effects include disability, reduced life expectancy and impoverishment of individual women, with knock-on effects for children and other family members.
- Indirect impacts include unemployment, reduced productivity increasing costs of healthcare and welfare transfers.
- $10.7 billion annually associated with child abuse and neglect
- Numerous credible commentators have argued that without fundamental reform the entire mental health system will become unaffordable and unsustainable

The Causes

Women's mental health is shaped by structural inequalities of wealth and power. The determinants of mental ill health amongst women include:

- social inequalities (Including poverty, social exclusion, racism and geography)
- impact of negative life experiences (in particular intergenerational trauma, racism and violence and abuse)
- gender expectations

There is a burgeoning evidence base which illuminates the complex connections between women's mental ill health and social and economic circumstances. It is particularly important to understand more about the risks to good mental health posed by women's unequal social and physical power and the ways in which these risks intersect and interact with others to delineate a steep social gradient in the epidemiology of women's mental distress.

Service Context

Whilst there are pockets of good practice in the provision of current services to women with mental health problems, there is little cohesion or collaboration across the various sectors, agencies and practitioners involved with women experiencing mental distress. Women seeking help at key transition points in the life course – when they may have to deal with overwhelming interactions between biological, social, emotional and economic risk factors that require integrated and holistic responses – often experience extremely negative consequences.

Most services are designed around women's mental health from an individual pathology perspective, whereas the women who need these services consistently ask for a more holistic view of their lives. This is a major challenge for the current service model.

Evidence suggests that services should include women-only spaces and women-only inpatient facilities; attend to physical and mental health in an integrated way; provide better community support; increase overall responsiveness to the person, not the illness; offer better learning and employment opportunities, and more talking therapies among other initiatives. There needs to be shift in service ethos. Instead of asking 'What is wrong with this woman?' it is time to begin to ask 'What does this woman need in order to be as emotionally, socially, economically and physically well as she can be?

These problems are reflected and compounded by the lack of 'parity of esteem' for mental health services compared with those for physical health. Mental health services have historically received a lower proportion of federal and state budgets than physical health services and Medicare only covers certain kinds of mental health services. The result is a two-tiered system in which people with financial resources and/or health insurance can access a wider range of service options and for a longer period of time, whilst those who have no coverage must rely on the public health system. This has negative and discriminatory impacts on women. Women's concentration in lower wage sectors and in part-time employment makes them more likely to be ineligible for employee assistance programs and extended healthcare coverage.

Policy Context

Mental health policy in Australia is gender-blind and does not consider women's mental health across the life course. Recent reviews highlight that services and programs based on scientific advances in treatment are not yet routinely available to meet women's needs. Multiple, interconnected barriers prevent the mainstreaming of best practice and the kind of fundamental reform in structures and services that might make a real difference.

There is unequivocal evidence that some groups of women are more vulnerable than others, yet policy and services are not only gender blind, there is growing evidence that they exacerbate inequalities between groups of women with mental distress and between women and men. It is time to redefine the nature of the challenges women's mental ill health poses for health systems and society more broadly, and for an entirely new approach to preventing and responding to it.

The Needed Reform

This paper makes a case for a new and comprehensive policy approach to improving women's mental health across the life course. This requires a commitment to identifying gendered risk factors and tackling them through protective public policy measures. The following actions are proposed to federal, state and territories governments, primary health networks, service providers and all local, regional and national bodies in order to translate that commitment into meaningful and measurable policy implementation.

Establishing Three Underpinning Drivers

Within one year – further investment in the evidence base, through research into the causes and consequences of women's mental distress and what works to prevent and manage it more effectively.

Within two years – development and preliminary implementation of a strategic approach to embedding capability for gender-sensitive practice for mental health specialists, primary care clinicians and staff in community and secondary health care, including maternal and child health services and hospitals.

Within three years – development of locally/regionally-relevant, gender-sensitive care pathways, including integrated service models capable of responding holistically to girls and women across the life course

Achievement of Five Major Policy Goals

Goal 1: Responding to the life-course mental health needs of women

Goal 2: Integrating responses to physical and mental health

Goal 3: Meeting the needs of women with severe mental illnesses

Goal 4: Mainstreaming a preventative approach

Goal 5: Investing in research and service innovation

Figure 1 : Protective public policy

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List of Acronyms

ABS	Australian Bureau of Statistics
ACTU	Australian Council of Trade Unions
AHPC	Australian Health Policy Collaboration
ALSWH	Australian Longitudinal Survey of Women's Health
ATSI	Aboriginal and Torres Strait Islander
AWHN	Australian Women's Health Network
AIHW	Australian Institute of Health and Welfare
CALD	Culturally & Linguistically Diverse
COAG	Council of Australian Governments
COPD	Chronic Obstructive Pulmonary Disease
DoHA	Department of Health and Ageing
GDP	Gross Domestic Product
HILDA	Household, Income and Labour Dynamics in Australia Survey
LBT	Lesbian, bi-sexual, transgender
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NICE	National Institute for Health and Care Excellence
NMHC	National Mental Health Commission
NREPP	National Registry of Evidence Based Programs and Practices
NRHA	National Rural Health Association
OECD	Organisation for Economic Co-operation and Development
PHN	Primary Health Network
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RoI	Return on Investment
UK	United Kingdom
UN	United Nations
USA	United States of America
VicHealth	The Victorian Health Promotion Foundation
VMIAC	Victorian Mental Illness Awareness Council
VISES	Victorian Institute for Strategic Economic Studies
WHO	World Health Organization

1.Introduction

This paper sets out the case for a new approach to improving the mental health of women and girls. The rationale for this approach is that there exists unequivocal evidence that women are disproportionately affected by certain kinds of mental disorders and associated patterns of physical ill health. However, very few evidence-based services, either preventative or treatment-related, are available to meet the specific mental health needs of women in Australia. This is paradoxical when set against the volume of world-leading research on women's health, including mental health, which is being conducted across Australia. The absence of a gender lens in federal and state mental health policy appears to be acting as a brake on service and practice innovation; this applies across the field of health policy and in service delivery. Gender is mostly absent, whether the focus is on the promotion of good mental health or the prevention and treatment of high-prevalence disorders, such as depression and anxiety, which affect large numbers of women of all ages, or less common severe mental illnesses, including psychosis and associated conditions such as suicide.

This paper is one of a series developed by the Australian Health Policy Collaboration (AHPC) setting out a roadmap for reversing the rising tide of chronic disease. A significant proportion of the chronic disease burden can be prevented, and another significant proportion can be managed much more effectively than at present. Women's mental health is especially critical, because the evidence reflects particularly poor prevention and management at most stages of the life course. These systemic deficiencies lead to severe mental and physical suffering, disability and impoverishment for individual women; they also have broader social and economic impacts. There is strong national and international evidence about the 'long shadow forward' which mothers' mental illness casts on their children's development; similarly, economic evidence reinforces the vital and growing economic contribution of women's participation in the workforce. Women's economic productivity is one of the keys to the success of modern economies, as well as to family prosperity. Strong social and economic policy should seek to enhance women's productivity and tackle the factors and forces that reduce it, including poor mental and physical health. Additional evidence highlights the avoidable costs that accrue when women are so disabled by mental and physical ill health that they cannot perform the range of caring tasks that are currently part and parcel of gendered social roles.

It is now time to act on the evidence to tackle the scourge of chronic mental ill health amongst women. Improving women's health – and in particular taking specific, evidence-based action to tackle mental illnesses amongst women and girls most at risk – will also strengthen the wellbeing of children, families and communities, representing a high social return on investment.

2. The Evidence Base

This paper draws primarily on the evidence set out in important reports from the Australian Women's Health Network (AWHN) (Kulkarni 2012) and the Australian Longitudinal Survey of Women's Health (ALSWH) (Holden et al. 2013). The authors of these reports reviewed the evidence about the trends in and impacts of mental illness amongst women, and its relationship with a range of chronic physical illnesses. These reviews provide evidence for broadening the policy frame to encompass the range of risks to mental health which women face at various points across the life course.

The ALSWH and AWHN reports provide important contemporary evidence about the risk factors that shape the mental health trajectories of girls and women in Australia, and the factors that influence outcomes at different stages of the life course. This work makes a contribution towards filling gaps in the evidence base. To date there has been little, if any, policy action reflecting the influence and impacts of gender as measured in longitudinal and other studies of mental health. In addition, treatment and other service level data are frequently not gender-disaggregated, making it difficult to judge the appropriateness of interventions for women as well as for men (Kulkarni 2012). Lack of data extends to issues that have been key goals of federal policy, including perinatal and postnatal mental health initiatives (Austin et al. 2012).

This paper considers the accumulating evidence of 'what works' – interventions that are effective in tackling the causes and ameliorating the negative outcomes of mental illness. However, much of this is undifferentiated by gender or relates to outcomes for men or boys. Stronger evidence exists in relation to the maternal transition than in all other areas. Australian and international outcome-focused evaluation of services for women at risk is very limited. Alarmingly, there is a gap in the empirical literature on the determinants of mental illness in Aborigine and Torres Strait Islander women. Similarly, evidence on the cost-effectiveness of interventions is limited (though accumulating) in mental health and what exists is mostly gender-neutral. These limitations are significant and have implications for the development and implementation of future policy.

Finally, it was not possible to locate data relating to:

- direct costs of treating comorbid mental and physical illness amongst women, although multimorbidity is highly prevalent and there are distinctive gender differences in patterns of illness and treatment; and
- robust economic analyses of the indirect costs of women's mental disorders to the Australian economy.

The AHPC has commissioned research from the Victorian Institute for Strategic Economic Studies (VISES) at Victoria University to begin to address these important gaps. In the interim, the financial impacts are inferred from other resources.

3. Mental Illness or Mental Health?

One of the problems in attempting to shape a new approach to addressing mental health and mental illness in the population is that the terms themselves are often not well-understood and are used interchangeably. There is general agreement among those affected by mental health problems, or working in the field of mental health, that there is no universally acceptable lexicon for or cultural understanding between all the people affected by the experience of mental health problems. The result is that language in this field is particularly contested, revisited and renewed. This has particular salience in the Australian context given the recognition of the range of factors that may affect the validity of mental illness diagnoses in cultural groups such as the Aboriginal and Torres Strait Islander populations. These include the standards of what constitutes scientific evidence, the meaning and uses of ethnic and racial categories, interpretations of differences in prevalence rates for mental disorders, and the tension between universal and group-specific approaches to mental health research and policy (Chang 2003). Notwithstanding this contested terrain, for the purposes of this paper AHPC proposes broad, inclusive and critically, *population-focused definitions*, in order to clarify the required scope of new policy.

Box 1: Definitions of mental health and mental illness. Source: Davies (2014)

Mental Health and Mental Illness – Population-Focused Definitions

Mental health – This overarching term denotes the mental health variations in populations. It includes mental health promotion, mental illness prevention and treatment and rehabilitation, and social and emotional wellbeing. It is important to acknowledge that these terms may be influenced by culture, particularly those which have more holistic views of health than Western culture. Mental health generally relates to the ability to enjoy life, be happy, fulfil goals and potentials, cope with adversity and be connected to others.

Mental illness – This is a description of the experience, defining attributes or diagnosis of those who meet ICD-10 or DSM-5 (established international classifications of mental illness) criteria for mental disorders. It includes common or high-prevalence mental disorders (eg. anxiety, depression) which affect nearly one in four of the population, and severe mental illnesses (eg. psychosis) which are less common, affecting 0.5–1%.

On the basis of these definitions, a case is made for a comprehensive new policy approach to improving women's mental health involving the following dimensions:

- responding to the life-course mental health needs of women;
- effectively meeting the needs of women with mental illnesses;
- integrating responses to the physical health consequences of mental illness in women;
- mainstreaming preventive approaches; and
- investing in research and service innovation.

4. Women's Contribution to Australia

Over 50% of the Australian population is female. Trends over the last 30 years in Australia demonstrate that women have increased their education, employment, hours worked and earnings both absolutely and relative to men. They have moved in large numbers from the low to high education groups, and into higher-status occupations (Richardson et al. 2014). In 2014-15, the labour force participation rate of people aged 20-74 years was 65.1% for women and 78.3% for men. Moreover, women are working longer. Between 2001-02 and 2014-15, the participation rate for women aged 55-64 increased from 38.3% to 56.5%, an increase of 18.2%: the highest increase in all age groups for both men and women over this time (ABS 2016).

Australian women now represent almost 46% of employees and contribute 36% of employee earnings. They are the breadwinners for a quarter of employed couples with children (Richardson et al 2014). Women's contributing in these ways is good for the Australian economy. It has been estimated that increasing women's participation in the labour force to 62.4% (the same level as Canada) would lift Australia's gross domestic product (GDP) by $25 billion in the next decade (Daley et al. 2012). These profound social changes, whilst reflecting positive achievements by Australian women, have a wide range of important social as well as economic consequences. Enhanced choices about reproduction, family composition and family formation create an increasingly complex social context influencing the health and wellbeing of women. Women's abilities to make their vital contributions as workers, mothers, carers and citizens are enabled or undermined by a range of structural conditions (Daley et al. 2012) including many which also affect their mental health (WHO 2000).

The female population of Australia is ageing, with significant implications for the Australian health system. Increasing prevalence of poor health and disability among older women translates into a stronger demand for Medicare services (DoHA 2010). There is extensive evidence, summarised in the subsequent discussion, that chronic diseases of all kinds will drive this demand without effective action targeted at specific risk factors and disease patterns amongst women and earlier intervention to prevent, treat and manage chronic diseases, including mental health conditions of all kinds. It is vitally important that ways are found to maximise the possibility of maintaining good health, both physical and mental, into older age so that disability and dependency is reduced and women can remain active participants in society for as long as possible. This is in the interests of individual women, families and society as whole.

5. Mental Illness in Australian Women

5.1 Introduction

Mental health, like other dimensions of health, has gender based characteristics and patterns. Women are exposed to a particular range of social, economic and biological risk factors that can increase the risk of poor mental health. Women disproportionately experience some mental health disorders and are more frequently subject to the social causes that lead to mental illness and psychosocial distress. These gendered dimensions, are important and complex and have implications for policy, service models and professional practice.

5.2 Overall Burden of Disease

Mental disorders represent the leading cause of disability and the highest burden of non-fatal illnesses for women in Australia (Begg et al. 2008, Commonwealth of Australia, 2010). In Australia in 2007, 43% of women (3.5 million) had experienced mental illness at some time. Moreover, Australian women are more likely than men to have experienced symptoms of a mental disorder during the previous 12 months (22% of women compared to 18% of men although men have a higher lifetime prevalence), with young women reporting the highest rates (30% for women aged 16 to 24) (ABS 2012). Women are more likely than men to have (or report symptoms of) the following conditions:

- anxiety disorders – 18% (11% of men) (AIHW 2014);
- affective disorder such as depression - 7% (5% of men) (AIHW 2014);
- eating disorders – 15% of young women have had an eating disorder at some point in their lives, and eating disorders are the third most common chronic illness amongst young women in Australia (National Eating Disorders Collaboration 2012);[1]
- deliberate self-harm – females record higher age-adjusted rates of hospitalisation due to intentional self-harm than males across all age groups (10–14 to 60–64) (AIHW 2104);
- perinatal depression – one in five mothers of children aged 24 months or less are diagnosed with depression. More than half of these mothers reported that their diagnosed depression was perinatal (that is, the depression was diagnosed between pregnancy and the child's first birthday). This represents an estimated 111,000 Australian mothers being diagnosed with depression, and 56,000 with perinatal depression annually. Further, of all the cases of diagnosed depression, just over one in five were diagnosed for the first time perinatally (AIHW 2012a); and
- multimorbid physical illnesses – women are 1.6 times as likely as men to suffer coexisting mental and physical illness. These multimorbidities are associated with increased severity of mental illness and increased disability (AIHW 2007).

In addition, the number of hospital admissions for specialised psychiatric care following a principal diagnosis of recurrent depressive disorders and specific personality disorders was substantially higher for females than males during 2007–08 (AIHW 2014). In the same period, females aged 35–44 were the highest consumers of Medicare-subsidised mental health-related GP services (Britt et al. 2012).

1 Men also suffer from eating disorders. Large population studies suggest that up to a quarter of people suffering with anorexia nervosa or bulimia nervosa are male, and almost an equal number of males and females suffer with binge eating disorder. We also know that under-diagnosis and cultural stigma mean that the actual proportion of males with eating disorders could be higher. However, eating disorders of all kinds predominantly affect females.

Tables 1 and 2 below outline the prevalence of mental illness and physical illness comorbidity in Australia by gender. Table 2 presents particularly compelling evidence about the heavy burden of physical illness borne by women with high-prevalence mental health conditions such as anxiety.

Table 1: Summary of mental health and physical condition comorbidity, 2007

	Men		Women		Persons	
		Median Age		Median Age		Median Age
Group	**%**	**age**	**%**	**age**	**%**	**age**
No lifetime mental disorder	51.9	44	57.1	47	54.5	45
Any lifetime mental disorder	48.1	42	42.9	41	45.5	41
Any 12-month mental disorder	17.6	38	22.3	37	20.0	37
Comorbidity of 12-month mental disorder and physical condition	8.9	42	14.5	42	11.7	42
All persons aged 16–85	**100**	**43**	**100**	**43**	**100**	**43**

Source: Slade et al. 2009

Table 2: Prevalences of selected specific mental and physical comorbidities, 2007

Comorbidity	Males	Females	Persons	Males	Females	Persons
	('000)			(%)		
Affective disorder, any physical condition	249	395	644	3.1	4.9	4.0
Anxiety disorder, any physical condition	456	966	1,422	5.7	12.0	8.9
Substance use disorder, any physical condition	255	149	404	3.2	1.8	2.5
Arthritis, rheumatism or gout, any mental disorder	155	301	455	1.9	3.7	2.8
Asthma, any mental disorder	139	257	396	1.7	3.2	2.5
Cancer, any mental disorder	40	51	91	0.5	0.6	0.6
Diabetes, any mental disorder	58	82	140	0.7	1.0	0.9
Heart problem, any mental disorder	167	224	391	2.1	2.8	2.4
Stroke, any mental disorder	12	15	27	0.1	0.2	0.2

Source: Slade et al. 2009

5.3 Women's Mental Health Across the Life Course

Women's mental health needs are different across the life course. During child-bearing years women may require mental health supports related to pregnancy and post-partum depression, especially if they have pre-existing mental disorders (Arnold et al. 2002, Cohen et al. 2004). Women of all ages, including peri and post-menopausal women, struggle with body image and eating disorders although they are more prevalent in younger women (Power & Parsons 2002).

5.3.1 Young Women

Studies of high school students suggest that gendered patterns of mental illness begin in youth. The second Australian Child and Adolescent Survey of Mental Health and Wellbeing provides worrying, contemporary evidence about the mental health of young women (Lawrence et al. 2015). Nearly one in five teenage girls was found to meet the clinical criteria for depression (based on their own reports). Around one quarter of teenage girls in the 16–17-year age range reported deliberately injuring themselves at some point in their lives. Whilst rates of suicide amongst men are markedly higher than amongst women in all age cohorts, it is of concern is that the trend in increased suicide and suicidality is amongst younger women. Five years ago, three-quarters of deaths by suicide were men. In 2013, 637 Australian women and girls died by suicide. Suicide is the leading cause of death among women aged between 20 and 34 years old. The suicide rate is highest among women aged 40 to 44 years old at 9.4 deaths per year per 100,000 women (Harrison & Henley 2014). Overall, the mental health of young Australian women appears to be worse than that of young men (Mission Australia 2015). Data from the ALSWH shows an alarming prevalence of poor mental health in the most recent cohort of participants and reinforces these findings.

5.3.2 Adult Women

This gendered diagnostic pattern continues into adulthood although with marked fluctuations across the lie course. The ALSWH data on symptoms of psychological distress, depression, and anxiety show that the prevalence of mental distress for the older and mid-aged cohorts of women involved in the study decreased over time. The overall pattern of decreased prevalence with age found in this study is consistent with other Australian (Slade et al. 2009) and overseas studies (Martin-Merino et al. 2010). For example, the Australian 2007 National Survey of Mental Health and Wellbeing reported the prevalence of mental health disorders decreased from nearly 30% amongst young women aged 16–24 years to approximately 7% amongst women aged 75+ (Slade et al. 2009). It is important to acknowledge that the mental health of adult women is an evolving focus for research. These data need to be understood in the context of a number of variables including history of exposure to violence, poverty, transition to caring and the impacts of menopause amongst others. One study reports a number of significant health-related quality of life impacts on women during the menopausal transition including depression and stress (Avis et al. 2009)

5.3.3 Older Women

The pattern for much older women appears to be different again, with an increase in psychological distress in late old age (>85 years of age). Older women also have particular mental health needs related to loss, multimorbidity, depression and dementia. The likelihood of dementia increases with age, and women are twice as likely as men to develop dementia, in part because of their greater longevity (Alzheimer's Disease International 2015). Despite this, little research exists on the progress of depression and other mental disorders in older women in Australia and services and interventions are gender-blind and scarce, particularly

in rural areas (Alston et al. 2006). A recent systematic review (Luppa et al. 2012) reported increasing rates of psychological disorders in the oldest age groups (85–89 years and >90 years) yet particularly low utilisation of treatment (Byles et al. 2011). National and international data point to high rates of hospital admission for mental health needs and high rates of depression in clinical and aged care settings (Rich et al. 2013).

International evidence suggests that this is a global challenge and at the international level calls to acknowledge and prioritise dementia as a global women's health issue are emerging. Policies designed to address issues around gender and ageing have been developed by the United Nations (UN) amongst other global institutions, along with a more specific focus on the challenges faced by older women, given the changing demographics of this population world-wide; however, a recent review (United Nations 2015) shows that very little has been done anywhere to address the challenges of older women since the publication of the first UN report on gender and ageing in 2002 (United Nations 2002). In the dementia literature, men and women are compared but rarely in the context of gender roles and identities (Baker & Robertson 2008). Baker and Robertson's review highlighted that very few research reports mentioned the health challenges faced by older women; none referred to dementia or other mental health issues experienced by older women. It is hardly surprising that older women, and in particular women with dementia, have been termed 'a marginalised majority' (Alzheimer's Disease International 2015).

These figures suggest a biological contribution to mental states, however, this does not discount evidence, much of it cited in the same studies, that these states are highly influenced by a range of psycho-social factors including social support, quality of family and other relationships, level of income, access to childcare, access to health services and the quality of employment.

5.4 Women's Physical and Mental Health are Linked

5.4.1 Multimorbidity

Multimorbidity – or the coexistence of more than one disease in the same individual – is common among people with a mental disorder, and as might be expected, people with multiple disorders are more disabled and consume more health resources than those with only one disorder (ABS 2008). Data from the 2007 National Survey of Mental Health and Wellbeing indicates that 12% of Australians aged 16–85 had a mental disorder and a physical condition concurrently, and that these people were more likely to be female and aged in their early forties (ABS 2008). The most commonly seen cluster of conditions (9%) was an anxiety disorder combined with a physical condition, affecting about 1.4 million Australian adults (ABS 2008). In general, comorbidity increased with increasing disadvantage. For example, people living in the most disadvantaged areas of Australia were 65% more likely to have comorbidity than those living in the least disadvantaged areas (AIHW 2012b).

The ALSWH highlights the potential for poor mental health, particularly anxiety and depression, to compound physical health problems for women (Holden et al. 2013). There is evidence that the relationship between mental and physical health is 'bi-directional', and in situations involving multiple disease conditions affecting both physical and mental health, one is a risk factor for the other (Moussavi et al. 2007). Poor mental health appears to put both men and women at risk of developing or exacerbating a range of health conditions which are recognised as high priority, including diabetes, stroke, cardiovascular disease and arthritis (Naylor et al. 2012), suggesting strongly that greater emphasis should be placed on treating the psychological components of multimorbidity. There are some worrying indications in the ALSWH's findings that the well-documented associations between poor mental health and long-term, chronic physical conditions, including diabetes and stroke, are strong (and increasing) even amongst the younger cohort of women. If these trends are not halted or reversed they represent a ticking time-bomb of chronic physical and mental ill health in women that

will have significant societal and economic consequences into the future (Holden et al. 2013). The AHPC has set out the extensive data on the detrimental impacts of poor mental health on chronic disease outcomes in a recent paper. This paper, *Beyond the Fragments: the Costs & Consequences of Chronic Physical and Mental Diseases* (Duggan 2015) proposes a series of policy measures to establish an integrated, approach to the identification, treatment and management of chronic physical and mental conditions.

5.4.2 Life Expectancy and Severe Mental Illness

There is particular cause for concern about the physical health and life expectancy of women with severe mental illness. It is known that people living with serious mental illness have higher rates of major physical illnesses than their counterparts in the general population and significantly shorter lives, only partly due to the higher rate of suicide amongst this group (Bagnall 2014). Increasingly, the evidence points to the alarming fact that most of this premature mortality is associated with deaths from chronic physical diseases such as cardiovascular disease, cancer and respiratory disease rather than suicide as previously thought (Colton & Manderscheid 2006, Robson & Grey 2007).

One recent study estimated the life expectancy of psychiatric patients in Western Australia using linked mental health information systems and death registration records over the period 1985 to 2005 (Lawrence et al. 2013). A disturbing finding was that the gap in life expectancy between psychiatric patients with a primary diagnosis of schizophrenia and the general population had widened for both men and women. During this period the gap in life expectancy for males in the state increased from 13.5 years in 1985 to 15.9 years in 2005 for all mental disorders combined. For females, the gap increased from 10.4 years in 1985 to 12.0 years in 2005. Similar gaps were observed for men and women with other diagnoses. Table 3 shows an increase in death rates for men and women with primary mental health diagnoses found in this study.

Table 3: Changes in death rates amongst men & women with mental health diagnoses in WA, 1983 to 2007

Primary diagnoses	Males				Females			
	1983-87		2003-07		1983-87		2003-07	
	Active cases	Deaths	Active cases	Deaths	Active cases	Deaths	Active cases	Deaths
Alcohol or drug disorders	5,198	438	8,163	764	1,665	95	4,191	209
Schizophrenia	3,440	228	8,073	399	2,733	182	5,027	283
Affective psychosis	2,995	130	8,798	537	5,402	160	14,537	660
Other psychoses	1,973	178	2,753	531	1,823	182	1,941	456
Neurotic disorders	2,732	97	4,988	372	5,153	129	8,633	561
Stress or adjustment reaction	3,918	67	9563	381	6,032	44	13,673	312
Depressive disorder	3,501	193	7,630	719	6,891	213	13,813	750
Other mental disorder	5,312	79	17,888	444	3,824	56	19,743	310
Total	29,069	1,410	67,856	4,147	33,523	1,061	81,558	3,544

Source: Lawrence et al. 2013

Recent international reviews demonstrate that people with psychosis receive sub-optimal health care despite being at high risk for serious physical disorders (De Hert et al. 2011a, Thornicroft 2009). In this context, it is unsurprising that people with mental illnesses find it difficult to seek clinical and other forms of support for their multiple health needs. Lawrence et al (2013) found that only 35% of people with a mental disorder had sought advice or treatment for a mental health problem in the 12 months prior to the survey, and most had seen a general practitioner. Only half of those who were disabled or had multimorbidities had consulted a professional. The literature strongly implicates negative and discriminatory attitudes of health care staff in primary and secondary care as well as in specialist settings as inhibitors of help-seeking by people with mental illnesses and associated physical health needs (De Hert et al. 2011a). This may be a contributory factor to premature mortality amongst people with severe mental illness. A recent study in New Zealand (see Box 2) found that women with breast cancer and a history of mental illness have much poorer survival rates than other women under 65. Women with mental illnesses need gender-sensitive specialist and non-specialist services, capable of addressing the complex relationship between mental and physical health needs in integrated, non-judgmental ways (Judd et al. 2009). This presents significant challenges for health service cultures, ethos and professional training in all disciplines. Further gender-specific research into the prevention and management of multimorbidity in women is urgently required.

Box 2: Mental illness and breast cancer survival

Breast cancer is one of the most common causes of premature mortality among women in developed countries. Women with a history of mental illness tend to have poorer outcomes from medical conditions than women without such a history, but until recently, it was not known if this was also the case for breast cancer.

A New Zealand-based research project, led by Dr Ruth Cunningham at the University of Otago, investigated the survival differences between these groups of women in order to improve outcomes for women with mental illnesses. Research in this area is complex as psychiatric illness is not homogenous, and both survival and its contributing factors vary by the type of mental health problem experienced.

Dr Cunningham and her colleagues aimed to quantify the effect of recent serious mental illness on survival from breast cancer. They examined the influence of psychiatric diagnosis and factors such as other medical conditions and late stage at diagnosis on survival. To achieve this, they analysed data from New Zealand's Cancer Registry on all breast cancers diagnosed between January 2006 and December 2010 in women under 65 and linked this data to national specialist mental health service records (inpatient and community) from January 2001 to December 2010.

A total of 8,762 women with a diagnosis of breast cancer were identified, of whom 440 had had contact with mental health services in the five years prior to cancer diagnosis. These women were divided into two groups, those with a diagnosis of functional psychosis (mainly schizophrenia, bipolar affective disorder, and schizoaffective disorder) (Group A) and those with service use but either another diagnosis or no recorded diagnosis (Group B). One quarter (112) of the women studied were in Group A. The authors compared the cancer-specific survival of those with recent mental health service use and those without, and investigated the contribution of demographic confounders and individual factors likely to be on the causal pathway (deprivation, comorbidity, and stage at diagnosis).

The analysis found that women with a history of mental health service use (Groups A and B combined) were nearly twice as likely to die from their cancer than other women without such a history after adjusting for confounding by age and ethnicity, and women in Group A had two and half times the risk. The factors contributing to poor survival differed across the two groups. Comorbidity was a contributor for both groups, but stage was only an important contributor to survival differences for Group A. For women using mental health services without a diagnosis of a psychotic disorder (Group B), stage was not a factor in survival differences, and there was no sole reason for their poorer survival.

After adjustment for all available factors, a substantial survival difference remained, and was similar in magnitude for Group A and Group B. The results were not substantially different when all-cause survival was used as an outcome measure. The study concluded that women with a history of recent mental health service use have poorer survival after diagnosis with breast cancer than other women under 65, even after adjusting for individual confounding and mediating factors. It is likely that failure to provide equal cancer care is an important factor in the remaining differences in survival, and this possibility requires further exploration. Women with experience of psychotic disorders (Group A) have much poorer survival than women who have not used mental health services, which is largely attributable to later stage at diagnosis.

Source: Cunningham et al. 2010

6. Influences on of Women's Mental Health

6.1 Introduction

Mental health (like physical health) is clearly gendered. Men and women have different patterns of mental illness and other forms of mental distress and they are exposed to different risk factors and vulnerabilities. Various theories have been proposed for the gender differences in the prevalence of mental health problems and women's greater vulnerability to depression, anxiety and physical comorbidities. These can be summarised in three broad categories: '*women's bodies*' or biological theories, '*women's personalities*' or psychological theories, and '*women's lives*' or social theories (Stoppard 2000).

Recent evidence, including that of the ALSWH and the AWHN, indicates that a fuller understanding of the causes and patterns of women's mental illness requires a synthesis of all of these perspectives. This enables a distinction to be made between sex differences (those which are biological) and gender differences (those which result from the social roles, expectations and structures that differ for women and men). Contemporary evidence generally points to the greater importance of a gender-based than a sex-based explanation for the differences between men's and women's mental health; that is that these differences arise from the social roles and cultural expectations of men and women, rather than their biology (Kulkarni 2012, WHO 2012).

6.2 Gender and the Shaping of Risk

Gendered explanations are relevant to understanding the variations of health and disease amongst men and women in the population and are particularly helpful in understanding why certain groups of girls and women are at risk of poor mental health. It is suggested that three key gendered factors in interaction shape risks across the life course for women. These are defined in Figure 2 below. Some women are at particularly high risk of mental illness due to the interrelated dynamics of *social inequalities*, the *impact of negative life experiences* (in particular violence and abuse) and *gender expectations*. The ways in which these risks affect mental health are considered in the subsequent discussion.

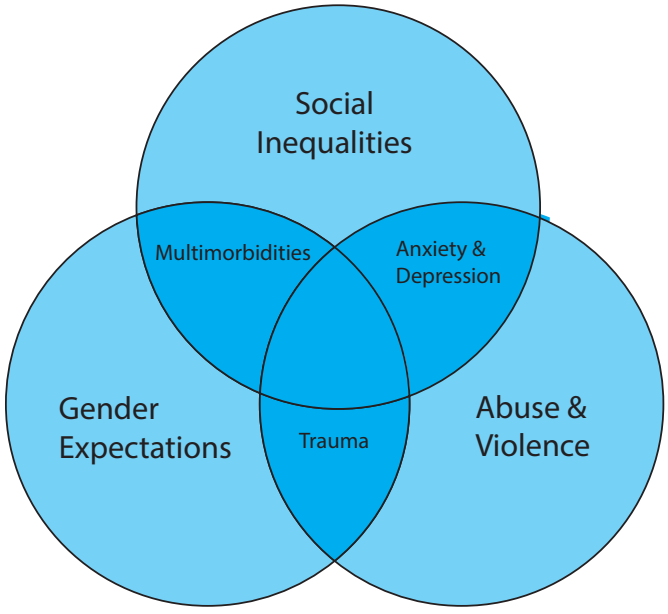

Figure 2: Gendered risk factors for women. Source: McNeish & Scott (2014)

6.3 Social Inequalities

Girls are born into a world structured by inequality – where by virtue of their gender they are likely to earn less money than men, have less freedom than men, undertake certain kinds of work and spend more time looking after other people than men. It is worth noting that recent Australian statistics on economic security show that the average female wage is 87% of the average male wage and that figure has remained constant for over a decade (ABS 2016). These Australian Bureau of Statistics data also show the following:

- In 2014-15, over two in five employed women worked part time (43.8%), compared with 14.6% of employed men. This number rose to 62.2% for employed women with a child under 5 (while part-time rates for fathers of young children were just 7.7%).
- Men aged 55-64 in 2013-14 had a much higher average superannuation balance than women the same age: $321,993 compared with $180,013. There was less discrepancy between men and women aged 44 years and younger but male superannuation balances were still higher in every age group. Just under a quarter (24.6%) of women aged 15-54 years had no superannuation, compared with 20.5% of men this age. Around 32% of women born overseas had no superannuation coverage.

These and other data illustrate the scale of women's economic disadvantage. Gender inequality affects all women, but there is a gradient of gendered disadvantage, with most white, middle-class women higher on the scale and poor women and those from culturally & linguistically diverse (CALD) or Aboriginal and Torres Strait Islander communities lower down (Platt 2010).

6.4 Negative Life Experiences

Women in disadvantaged circumstances are at greater risk of some kinds of abuse. It has been argued that the experience of domestic violence is ubiquitous, cutting across social class divisions. Whilst this is an important point to make, there is evidence that poverty and unemployment increases the vulnerability of women to both domestic violence and sexual assault (Humphreys 2007). Poor women are more likely to experience more extreme domestic violence and to experience sexual and physical abuse as both children and adults (Edwards et al. 2007). Women in the least advantaged groups are the most likely to suffer the most extensive abuse across the life course (Scott et al. 2015). Gendered violence and abuse is a product of gendered power relations. Hence, some of the most severe abuse of girls and women, such as trafficking and involvement in gangs, occurs within the most male-dominated families, subcultures and coercive contexts (Beckett et al. 2013). Research shows that girls are at greater risk of most kinds of abuse, including severe maltreatment by a parent during childhood and child sexual abuse (McNeish & Scott 2014). Compared with the sexual abuse of boys, the sexual abuse of girls is more likely to be perpetrated by family members, to begin at an earlier age and to occur repeatedly. The sexual abuse of boys is more likely to be perpetrated by non-family members, to occur later in childhood and to be a single incident (Pereda et al. 2009, Radford et al. 2011).

Responses to adversity, including abuse, tend to be differentiated by gender, with boys more likely to externalise problems (and act out anger and distress through antisocial behaviour) and girls more likely to internalise their responses in the form of depression and self-harming behaviours (Green et al. 2002). These findings are reflected in the 2015 Survey of Child and Adolescent Mental Health and Wellbeing (Lawrence et al. 2015). Responses to the abuse of girls and boys also tend to be different, with girls more often regarded as complicit in or to blame for their own abuse (Green et al. 2002).

Childhood sexual abuse is strongly linked to poor physical and mental health in adulthood (Coles et al. 2015) and the negative outcomes of violence and abuse increase the risk of further victimisation. For example, women who become homeless, misuse drugs and/or become involved in criminality are highly likely to

experience further violence (McNeish & Scott 2014). It is argued that to really understand and respond to the impacts of violence and abuse within our communities, it is important to move "beyond the silos of 'child abuse' and 'intimate partner' violence to address the lifetime experience of girls and women affected by it" (Coles et al. 2015, p.1940). This requires a new framework for policy and action involving investment in a comprehensive research framework and innovative, locally-focused, partnership-based approaches to upstream prevention as well as long-term collaboration between health services, particularly primary health care providers, community agencies, specialist mental health, women's health and violence services and legal and protective services.

6.4.1 Gendered Expectations

Attitudes to violence against women are tied up with gender expectations which shape beliefs and attitudes about what it is to be either a man or a woman. It is suggested that gender socialisation normalises inequality – it makes it simply the way things are (McNeish & Scott 2014). There is considerable evidence that girls and boys are socialised differently from infancy and that there are differences in how parents behave towards them (Lytton & Romney 1991). Children learn gender stereotypes early and begin to be anxious about behaving in ways that are gender-appropriate (Pomerleau et al. 1990). Gendered hierarchies are discernible within children's relationships at an early age and later in teenage relationships (Firmin 2013). Girls in particular set limits to self-expression and behaviour and appear to be resigned to the experience of 'everyday sexism' and sexual harassment including by social media (Renold 2013). Indeed, in a deeply sexualised culture, girls are more likely to wear 'concealing' clothes, not revealing ones, in an effort to avoid harassment (Renold 2013). Not all women and girls conform with gender expectations fully and some reject them completely, but such rejection has consequences and the responses of others can be unsupportive and involve social exclusion, extreme intolerance and violence (Moore 1994). Hardly surprisingly, both young men and young women feel an inexorable pressure to be 'normal' irrespective of the costs to personal identities and mental wellbeing (Martino & Pallotta-Chiarolli 2005). 'Normality' for women can involve subordination to men and the development of 'acceptable' female behaviours that include being useful, pleasing and compliant and caring for others. These same characteristics can be risk factors for women's mental health as they make it harder for women to put their own needs first, to look after their own interests and respond to life stress and exploitation in self-protective ways (Williams 1996).

6.5 Specific Risks to Women's Mental Health

The ALSWH points to complex associations of social demographic factors and health behaviours that affect mental health outcomes (Fan et al. 2009, Beydoun & Wang 2010).

- *Lower education and low income* are associated with greater risk of psychological distress (Tooth & Mishra 2013), with particular impacts on young women who achieve lower levels of education than their parents.
- *Sole parents, most of whom are women, are particularly vulnerable to poor mental and physical heath and poverty* (Loxton et al. 2006). This, in turn, impacts on children (AIHW 2012b). *Parental poverty* is associated with adult mental and physical ill health and with child mental health conditions, youth delinquency, and attention problems in children aged five years and older. Additionally, mental health problems in children frequently continue into adulthood (De Genna et al. 2006).
- *Non-participation in the workforce* is associated with increased odds of poor mental health in women (Fan et al. 2009). These findings are also supported by recent Household, Income and Labour Dynamics in Australia (HILDA) survey data (Cvetkovski et al. 2012).

- A variety of *lifestyle factors* affect the mental health of women over time. For example, smoking is implicated in a bi-directional way in mental health problems. Poor mental health is associated with subsequent smoking and smoking is associated with poor mental health (Leung et al. 2011). Dietary patterns appear to be associated with mental health status (Rienks et al. 2013). Recent research also indicates that women are experiencing increasing rates of alcohol, ecstasy and both legal and illegal drug abuse (Fan et al. 2009). Low levels of physical activity are also associated with poorer mental health (Beydoun & Wang 2010). All of these behaviours are risk factors for the development of chronic physical illness.
- *Interpersonal factors* play an integral role in the onset, maintenance and remission of mental health conditions (King-Casas & Chiu 2012). Intimate partner violence (an estimated 23% of Australian women have experienced some form of domestic violence) is strongly associated with long-term mental ill health, with effects persisting long into the future, even when violence has ceased (Goodman et al. 2009, Dillon et al. 2013).
- *Trauma*, in particular childhood sexual abuse (CSA), can have lifelong impacts on women's mental health. The ALSWH cite evidence suggesting that 18% of Australian women report CSA experiences before they were 16 years old (Coles et al. 2015).
- *Social support* is important for maintaining mental health; however, mental health also affects the nature and quality of interactions with friends and family. Poor social support can lead to poor mental health, and likewise, poor mental health can lead to poor social support (Rosenquist et al. 2011, Van Lente et al. 2012, Holden et al. 2014).
- *Geography can influence health.* Women who live in regional, rural and remote areas face disadvantages that can reduce both mental and physical health compared to their urban counterparts, including greater difficulty in accessing both primary care and specialist mental health services (Alston et al. 2006, Dolja-Gore et al. 2014). While men and women with mental disorders were equally likely to use the services of a psychologist for mental health problems, people from major cities were almost twice as likely to have used a psychologist (15%) as those from other areas (8%). This may be related to lack of access to such services in more remote areas or to a perceived lack of confidentiality in a small community. Other factors include disproportionate exposure of women living in remote and rural areas to other risk factors, including domestic and family violence and alcohol consumption (National Rural Health Alliance 2014).
- *Carers* experience poorer mental and physical health than non-carers. Those who provide live-in care have particularly poor mental health and associated economic disadvantages (Hirst 2005, Cummins et al. 2007, Edwards et al. 2008, Access Economics 2010, Tooth & Mishra 2011).
- *Life events and their timing, including biological life-cycle events such as childbirth and menopause, may trigger mental illness.* Women who had their first child at an early age (<25 years of age) can experience ongoing poor mental health, particularly if contending with other measurable stress factors such as moving house, the death of a family member and starting a new job (Yelland et al. 2010). Amongst widowed women, mental health is lowest within the first year following the death of the spouse. Separation from partner and/or divorce is associated with persistent, negative impacts on mental health (LaPierre 2012).
- *Women who are refugees or from CALD backgrounds* have substantially raised levels of mental illness, with higher incidence rates of all clinically relevant mental disorders across the whole life course (Rich et al. 2013). Other evidence suggests that there is a 'dose-response' impact on mental health. Refugees who have been exposed to multiple forms of trauma exhibit significantly higher levels of mental distress and associated comorbidities and that these can be long-lasting post-migration (Steele et al. 2002).
- *Lesbian, bisexual, transgender (LBT) women and intersex people* have significantly higher levels of psychiatric

illness than heterosexual women, as well as deliberate self-harm, and use of alcohol and other substances. LBTI people report that there are few services that are non-discriminatory and inclusive (Warner et al. 2004, McNair et al. 2011).

- *Women with personality disorders.* Recent research has discounted earlier findings that a higher proportion of women than men suffer from borderline personality disorder (BPD), but suggests there are profound differences in the ways in which men and women with BPD express their distress. There is, additionally, a growing challenge to the value and uses of this classification with its accompanying stigma. It is suggested that clinical attention needs to refocus on the causes of these developmental conditions, which are almost always associated with trauma. Recognition of gendered differences in the manifestations of these disorders is clearly important in guiding clinicians in assessment and offering appropriate treatments (Sansone & Sansone 2011).

6.6 Maternal Mental Health

Whilst it is essential to broaden the way in which women's mental health is conceptualised to reflect the evidence regarding its complexity along the life course, this should not lead to a diminished focus on the mental health needs of mothers and children. The data here is sobering. Suicide is a leading cause of death among women in pregnancy and the first year following childbirth in Australia (AIHW 2010). In line with other developed countries, the prevalence rate for clinically significant maternal perinatal mental health issues in Australia is around 15%. This figure does not include antenatal mental health problems, mental health problems other than postnatal depression (such as postpartum psychosis), or postpartum issues in the context of pre-existing mental illness (Austin & Kildea 2007).

6.7 Mental Health of Aboriginal and Torres Strait Islander Women

There is a worrying lack of culturally-relevant research on the mental health of Aboriginal and Torres Strait Islander women. This is a gap that needs rectifying as a matter of urgency. The literature provides some critical parameters for this research, clarifying aboriginal concepts of health and identifying the conditions in which health is either optimised or undermined on the basis of this definition. Swan and Raphael (1995) comment that '*(T)he aboriginal concept of health is holistic, encompassing mental health and physical, cultural and spiritual health. This holistic concept does not just refer to the whole body but is, in fact, steeped in harmonised inter relations which characterise cultural wellbeing. These inter-relating factors can be categorised largely into spiritual, environmental, ideological, political, social and economic, mental and physical. Crucially, it must be understood that when the harmony of these interrelations is disrupted, aboriginal ill health will persist (p.19).*

This and other analyses provide some of the context for understanding the data about the extent of continuing aboriginal disadvantage in Australia. There is evidence that the determinants of this disadvantage include inter-generational trauma, imbalanced power relations and limited access to services within the mainstream population and systemised and individualised discrimination and racism (Henderson et al. 2007). These contribute greatly to the perpetuation of lower income and standards of living, including poor quality and overcrowded housing and community infrastructure, and poorer outcomes in health, education, employment and the justice system. Indigenous Australians continue to experience higher levels of poverty, incarceration and ill health than the rest of the Australian population (Dudgeon et al. 2010). Much more information is needed about the gendered determinants of this burden and ways of alleviating it.

The National Aboriginal and Torres Strait Islander Social Survey (NATSISS) (ABS 2008) showed that nearly one-third (32%) of Aboriginal and Torres Strait Islander people aged 18 years and over had experienced high or very high levels of psychological distress, more than twice the rate for non-Indigenous people. Women in

these communities have poorer physical and mental health than other Australians in almost every way. They experience much higher rates of mental health conditions, and have higher rates of morbidity and premature mortality associated with comorbid conditions, including diabetes and cervical and ovarian cancers (ABS 2011). Anxiety and depression are the foremost health problems reported by indigenous women in Australia (AIHW 2011). The suicide rate of Aboriginal and Torres Strait Islander women is highest within the 20-24 years old age group (21.8 per 100,000), which is more than five times higher than their corresponding non-indigenous counterparts (4.0 per 100,000)(ABS 2014) (AIHW 2011).

The same inequities in outcomes are evident in the perinatal period, where there is a disproportionate burden of adverse outcomes for Aboriginal and Torres Strait Islander mothers and their babies, including increased maternal mortality (Sullivan & King 2007) – four times that of non- Aboriginal and Torres Strait Islander women, pre-term birth (13.5 versus 8.0), low birth weight (12. versus 6.0) and perinatal deaths (17.1 versus 8.8 per 1,000 births) (Li et al. 2011). The National Plan to Reduce Violence against Women and Their Children 2010-2022 (the National Plan) recognises that Aboriginal and Torres Strait Islander women experience much higher levels of violence than non-indigenous woman In 2012-13, indigenous women were 34.2 times more likely to be hospitalised for family violence-related assault (SCRGSP 2014).

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing provides the basis for a dedicated Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing plan. This Plan sits within the overall COAG Closing the Gap Strategy and articulates with a number of other strategies for tackling disadvantage amongst Aboriginal and Torres Strait Islander communities and improving outcomes across a wide range of targets and indicators. These include the National Aboriginal and Torres Strait Islander Health Plan 2013-2022, the Aboriginal and Torres Strait Islander Suicide Prevention Strategy and the National Aboriginal and Torres Strait Islander People's Drug Strategy 2014-2019. This complex strategic architecture has had partial progress in achieving some the key targets. The specific health needs of women within this policy web are addressed in relation to family violence and maternal and child health but are not identified or discussed across the life course. The lack of a comprehensive, gendered perspective is unfortunate. Aboriginal and Torres Strait Islander women have been especially marginalised by processes of colonisation and discrimination in which key dimensions of women's distinct and different heritage and beliefs have been disregarded. The lack of a gendered life-course, perspective in policy is particularly problematic when set against the importance of both gender and age within the cultures of Aboriginal and Torres Strait Islander people (Dudgeon et al. 2010). Arguably the pace of progress in closing the gap would be enhanced if there was much better data and deeper analyses of the risk and protective factors for the mental health of Aboriginal and Torres Strait Islander women to inform more powerful, culturally relevant, health promoting and illness-prevention approaches.

6.8 Women with Extreme Vulnerability and Complex needs

It is important to recognise that there are groups of women and girls who share clusters of extreme vulnerabilities, often living in very damaging circumstances, who have very complex needs and experience particularly poor health outcomes. There is an alarming paucity of research in relation to the trajectories of these girls and women in Australia. The existing national and international literature suggests that these highly vulnerable women and adolescent girls have one or more of the following characteristics:

- growing up in out-of-home care;
- contact with the justice system as adults or young women;
- experience of homelessness;

- involvement in prostitution or sexual exploitation;
- severe mental health problems; and
- serious drug and/or alcohol problems (Tarren-Sweeney et al. 2006, McNeish & Scott 2014).

The evidence suggests that there is a relationship between the poor outcomes experienced by these women and the accumulation of negative and abusive experiences across the life course, including physical abuse, sexual abuse, neglect, disrupted or poor attachments, exposure to family violence and being in care, and that these outcomes have different, gendered characteristics (Walker et al. 1999, Scott et al. 2015).

6.8.1 Women with physical disability

There is a lack of research related to mental health and disability overall, and a particular gap regarding the complex interactions of gender, disability and mental health. Women with disabilities experience the double impact of being female and disabled. As women, the evidence shows that they have greater risks of psychosocial health problems than men (Hughes et al. 2005). The risks posed by gender and disability interact with risks from age, socio-economic status, abuse, lifestyle, life transitions and the availability of health services. Compared to women in general, women with disabilities report higher rates of depression and stress (Hughes et al. 2005). Women with intellectual disabilities suffer particularly high levels of severe disorders involving aggression and self-harm (Cooper et al. 2007). The evidence points to a cascade of avoidable, chronic health problems amongst women with disabilities that begin early in life. Girls with attention deficit hyperactivity disorder (ADHD), for example, are more than twice as likely as other girls, and boys with ADHD, to be obese (Aguirre Castaneda et al. 2015). There is an urgent need to fill the gap in information about the needs of the most vulnerable girls and women in Australia and to recognise and respond to the life-course factors that influence the mix of risks to both physical and mental health and which, paradoxically, may also provide opportunities for prevention.

7. Social and Economic Impacts

7.1 Introduction

Women's mental ill health carries a high cost in suffering, family dysfunction and breakdown and impoverishment to individual women and children. In addition, poor mental health amongst women involves high costs, directly and indirectly, to society and the economy. These costs arise from the use of health care services and social welfare by women and their families, the consequences of poor parenting of children including delayed development and failure to achieve educational goals, the inability to willingly carry out informal caring tasks and the loss of women's contribution to productive work. The evidence summarised below sets out the economic case for further, strategic investment in women's health. Improving women's mental health will have a range of social and economic as well as individual benefits including enhancing the long term development of children and the well-being of families and supporting and enabling women's contributions to productivity and growth and to the range of caring tasks that occur across the lifecycle.

7.2 Gender Sensitive Economic Analysis

Australian data on the direct and indirect costs of women's mental illness across the life cycle is not available, but it is possible to infer from prevalence data that both direct and indirect costs are high and are likely to increase without effective action. In addition, there is a paucity of Australian research related to the costs and benefits of reducing harms associated with mental disorders (Doran 2013). Moreover, Doran cites the WHO in stating *"remarkable as it may seem, no country has yet been able to link mental health strategic policy or investment decisions to a credible, consistent and evidence-based assessment of what actually works"* (Doran 2013, p24). In part, this is to do with the lack of economic evidence. It is of note that Doran's review of 50 international intervention studies carried out for the New South Wales Mental Health Commission was also (almost) gender blind. Only one gendered study, of postnatal depression, was included (Paulden et al. 2009).

7.3 Disability

Mental health problems – specifically anxiety and depression – have been identified as the largest single set of contributors to disability-adjusted life-years lost amongst Australian women (ABS 2010a). This burden results in premature mortality, unemployment, under-employment and reduced quality of life.

7.4 Increasing Costs of Healthcare Services

Mental health services have been expanded consistently over the past two decades in Australia through substantial increases in funding, a larger mental health workforce, and increased use of pharmacological and psychological services and treatments. As a result, the unmet need for mental health services has reduced.

According to the 2013 National Mental Health Report (DoHA 2013), **total government expenditure on mental health increased by 178%** in real terms between 1993 and 2011. The increase over this period is 245% for the federal government and 151% by state and territory governments. The national mental health workforce has also increased on a per capita basis, from 80 full-time equivalents per 100,000 in 1993 to 108 full-time equivalents per 100,000 in 2011, or **an increase of 35% in the workforce** (DoHA 2013). Total government expenditure on mental health is currently about $10 billion dollars per annum (NMHC 2015).

The National Mental Health Commission (NMHC) believes that much of the funding for mental health from the Australian Government is neither effective nor efficient. The Commission draws attention to the five major programmes that are involved in responding to mental ill health and consume $8.4 billion or 87.5% of total Australian Government mental health funding. These largely 'downstream' programmes provide the following income support and crisis responses, benefits and activity-related payments:

- Disability Support Pension;
- carers' payments;
- payments to the states and territories for hospitals;
- mental health-related Medicare Benefits Schedule payments (including the Better Access Initiative which allows people with a mental health condition to receive up to 10 individual mental health consultations a year, with eligible professionally qualified staff); and
- Pharmaceutical Benefits Scheme payments (Byles et al. 2011, NMHC 2015).

Much of this expenditure, it is suggested, is 'payment for failure', and could be reduced with a greater emphasis and investment 'upstream' in prevention, early detection and a focus on suicide prevention and recovery from mental ill health. Important as this assessment is, the lack of a gender lens, leading to gender-blind data and gender-blind proposals for reform, is problematic. Women are more likely than men to have used a mental health service (41% vs 28%) (ABS 2006); this is consistent with the fact that women are more likely than men to use health services in general and tend to suffer from more severe disorders than men (ABS 2006).

Recent data from the ALSWH points to under-utilisation of medical items by women who report poor mental health, suggesting that access to help and support is a problem for many women (Byles et al. 2011). Women who are socioeconomically disadvantaged are less likely to access any of the services listed above, despite the prevalence of mental health needs (Carey et al. 2009). There is particularly low uptake of services by older women, consistent with research that shows under-treatment of mental health amongst older people (Zhang et al. 2010). Additionally, data indicates better take-up of mental health treatments by better-educated women and those living in urban or inter-regional areas than by those living in rural or outer-regional areas (Dolja-Gore et al. 2014).

Gendered patterns of service utilisation are illustrated in Table 4 below.

Table 4: Health services used by women and men for mental health problems

People with mental disorders[a] by health services used for mental health problems[b] — 2007

	General practitioner	*Psychologist*	*Other(c)*	*Total who used services for mental health problems*	*People who had a need not fully met*
	%	%	%	%	%
Sex					
Male	18.0	13.1	15.1	27.5	25.2
Female	29.9	13.2	19.9	40.7	28.9
Age group (years)					
16–34	20.3	11.8	14.7	28.6	26.2
35–54	27.7	16.2	21.0	40.5	30.3
55–85	28.9	8.7	17.6	37.3	22.1
Geography					
Maior Cities of Australia	25.5	15.5	18.6	36.9	29.4
Other areas of Australia	22.9	8.3	16.0	30.8	22.7
Number and type of mental disorders					
Mood disorder only	41.9	*21.0	23.0	49.7	33.5
Anxiety disorder only	12.2	6.5	10.4	22.0	15.8
Substance-use disorder only	*6.9	**4.5	*5.6	*11.1	7.2
One mental disorder only	15.8	8.4	11.3	24.0	16.7
Two or more mental disorders	39.3	21.0	28.3	52.7	44.6
Physical conditions					
Mental disorder(s) with physical condition(s)	27.1	12.7	17.8	37.4	29.3
Total aged 16–85 years	**24.7**	**13.2**	**17.8**	**34.9**	**27.3**

* estimate has a relative standard error of 25% to 50% and should be used with caution
** estimate has a relative standard error of greater than 50% and is considered too unreliable for general use
(a) People aged 16–85 years with mental disorders within the previous 12 months
(b) Health services used within the previous 12 months
(c) Includes consultations with: psychiatrist, mental health nurse, social worker, counsellor, medical specialist, and complementary/alternative therapist

Source: ABS 2007 National Survey of Mental Health and Wellbeing

8. Service Barriers

8.1 Introduction

A substantial proportion of adults with common mental disorders fail to receive any treatment, even when these conditions are quite severe and disabling. Furthermore, many who do receive treatment drop out before completing treatment. Because individuals with psychiatric disorders would often benefit from a full course of treatment, the gap between the prevalence and treatment of disorders contributes to unmet need for care and to poor outcomes. An important step in reducing unmet need for mental health care and improving outcomes for those who use mental health services involves understanding the reasons why individuals with mental disorders either do not seek treatment or drop out of care. Some of the barriers to treatment and support are discussed below. Despite measurable differences in patterns and levels of service utilisation between men and women, most research into barriers is gender-blind and it is therefore difficult to isolate factors which may particularly inhibit treatment for mental ill health amongst women.

8.2 Stigma and discrimination

Numerous, repeated studies show that despite higher levels of ill-health, people with mental illness are less likely to use all health services and this is particularly the case for both men and women with serious mental illnesses (Andrews et al. 2001, Motjabai et al. 2011). The 2015 report by the Royal Australia and New Zealand College of Psychiatrists, *Keeping Mind and Body Together* (RANZCP 2015), summarises extensive national and international evidence which makes it clear that women and men with serious mental illness:

- are less likely to seek assistance to manage either mental or physical health problems;
- have difficulties adhering to medication, particularly when they require multiple pharmaceutical treatments; and;
- have different patterns of service use, including more complex approaches to their health care, and are likely to be more particular about their health care providers.

There is evidence (mostly gender-blind) of systematic discrimination against people with severe mental illness in all clinical settings. This is arguably, likely to contribute to the under-utilisation of treatment and other services (Thornicroft 2008, Reavley & Jorm 2011).

8.3 Affordability

The RANZCP has emphasised that affordability is a considerable barrier to service access (RANZCP 2014). ALSWH data show that there are steep and rising costs to individual women and governments when mental health needs are being addressed by services. Uptake of medical items for a mental health condition is estimated to incur yearly increases of >$100–$150 for individual women and >$600–$800 for government (Byles et al. 2011). It is imperative, therefore, that the impact and equity of current arrangements are assessed, not only because they represent considerable, potentially avoidable, increasing costs to government and involve resources that may be more effective if they were redirected. They also add economic stress for many of the poorest women, who may already have difficulty managing on their incomes and may lack the educational and other resources to choose bespoke ways and means of managing their mental health. Arguably, current arrangements have the potential to increase health inequalities between women and may, in fact, be damaging to both individual and population health.

8.4 Lack of women-centred services

Barriers to treatment and support are compounded for women by the scarcity of women-only services or of services configured to meet the distinct and different needs of both men and women. There is good evidence to support this contention, even in relation to the perinatal period – which is a current national priority, with identified shortages of beds in maternity units, patchy implementation of proactive antenatal screening for depression, and piecemeal implementation of intervention programmes (Queensland Mental Health Commission 2013). The findings of a recent survey of women's health information needs, undertaken by the Jean Hailes Foundation, reinforce data about service gaps. When asked to identify a major service change aimed at improving women's health, one third of respondents wanted more women's health clinics and one quarter wanted more doctors trained in women's health; only a small minority wanted more female doctors (Jean Hailes for Women's Health 2015). Seventy-eight per cent of health professionals who responded to the same survey thought that the current health system could serve the needs of Australian women better. Three main areas for improvement were identified:

- increased access to healthcare in rural and remote areas;
- increased health promotion, education and preventative measures; and
- increased mental health support.

8.5 Service and funding fragmentation

The RANZCP suggests that "In Australia, complex funding sources and the separation between primary and acute health care, and between the mental and general health 'systems' have created a particularly fragmented and complex health system" (RANZCP 2015, p. 15). The navigation challenge this imposes on people with serious mental illness is so significant that the *White Paper on the Reform of the Federation: Roles and Responsibilities in Health* highlighted it as an example of a systemic barrier in Australia's health service arrangements (Department of the Prime Minister & Cabinet 2014). The findings of the NMHC's recent review reinforces this analysis and calls for the establishment of new 'system architecture' to provide 'stepped care' or coordinated pathways of treatment and care which can respond to fluctuating levels of need and functional impairment. A fundamental element of the 'stepped care' approach is the delivery of care through general practice and the primary health sector. This call has been endorsed by the AHPC in a recent paper on the need for new, integrated approaches to address the increasing prevalence of multimorbid chronic disease in Australia (Duggan, 2015). The evidence summarised in this paper suggests that the development of a gendered perspective within the stepped care approach will be one of the keys to improving outcomes for women.

9. Evidence for a Return on Investment in Women's Mental Health

9.1 Introduction

The evidence offers at least three compelling reasons to invest more in women's mental health:

1. The needs are substantial and will continue to remain substantial without corrective action
2. Current costs are very high; and, while some costs are necessary and cannot be avoided there are many avoidable costs and better ways of spending money currently spent on poor mental health
3. Not acting on the strong evidence for what works will cost even more.

It is important to acknowledge that the gender-blindness of policy and service provision is mirrored in the relative lack of gendered evidence into effective interventions. Absence of such evidence in this, as in so many contexts, is not evidence for maintaining the current status quo. There is a critical need to develop the evidence base as a primary driver of policy. In the interim, a number of approaches appear to promise a sound return on investment in women's mental health.

9.2 Supporting Mothers and Children

Between 11% and 13% of mothers of preschool children in Australia are estimated to experience moderate/high levels of psychological distress, with one in four lone mothers experiencing high psychological distress (Edwards & McGuire 2012, Loxton et al. 2006). Findings from the last three reports on maternal deaths in Australia (covering the period 1994–2002) suggest that maternal psychiatric illness is one of the leading causes of maternal death, with the majority of suicides occurring by violent means, and that there are additional, long-term consequences of maternal mental illness (Austin et al. 2007). The economic consequences of poor mental health across different sectors, which persist into adulthood, mean that effective home support and parenting programs can have very favourable cost-benefit ratios (McDaid & LaPark 2011). The UK National Institute of Health and Care Excellence (NICE), recognising the volume of evidence in this area, particularly the long-term impacts on children from exposure to poor maternal mental health, has updated its guidelines to identify the benefits for both women and children of more assertive and proactive screening and support for pregnant women with existing mental illness and other complex social needs (NICE 2014). Evidence from multiple sources suggests that effective early intervention in perinatal and infant mental health could reduce many substantial clinical, social and economic costs, such as:

- $310.3 million annually in lost productivity associated with perinatal depression (Deloitte Access Economics 2012);
- $10.7 billion annually associated with child abuse and neglect (almost three times the $3.8 billion associated with obesity) (Access Economics 2008)
- $1.4 billion per year associated with out-of-home placement of children (Richardson et al. 2010). Out-of-home placement is associated with a range of increased vulnerabilities in children including depression, suicidal ideation, inattention and aggression (Sawyer et al. 2007);
- $20 million per year in direct healthcare costs for children aged 4–8 with internalising or externalising disorders. This figure does not include indirect costs of childhood mental illness, such as lost productivity for parents (Lucas et al. 2013);
- Costs associated with future psychopathology of children. 'Childhood adversity' includes abuse, neglect and out-of-home placement, all events in which parent and infant mental health problems and poor

attachment are implicated. Childhood adversity has been found to account for more than 30% of psychosis in adulthood (Varese et al. 2012);

- The cost of substance abuse in Australia (estimated to be $55.5 billion in 2004/05) (Collins & Lapsley 2008). Early adverse experiences before age five predict the onset of cannabis use by age 15, other illicit drug use by age 15 and smoking by age 17 (Schiff et al. 2014)
- $32 billion a year associated with crime and young people in the criminal justice system (Mayhew 2013).

At least one study has demonstrated that pre-natal and infancy home-visiting by maternal and child health nurses in homes where mothers had low education, low incomes, mental health or substance abuse problems and low levels of social support had positive results. These included higher intellectual functioning and receptive vocabulary in children and benefits to mothers including more stable relationships with partners and fewer subsequent pregnancies (Olds et al. 2004). Other social impacts of untreated perinatal and infant mental health problems are more difficult to quantify in monetary terms, but have significant negative effects on individuals, families and society.

- *Infanticide*. Most infanticides are committed by the natural mother, who in half of all cases is suffering from a severe mental health disorder (Oates 2003, Porter & Gavin 2010). While childhood mortality in general is decreasing throughout the Western world, infanticide has not decreased over the past 100 years (Oates & Cantwell 2011). Despite difficulties of measurement and likely underreporting, in Australia, the annual rate of infanticide is estimated at 2.68/100,000 (De Bortoli et al. 2013)
- *Future maternal mental illness*. One-third of women whose postnatal depression goes untreated are still depressed one year after the birth, and up to 23% remain depressed four years after the birth (Woolhouse et al. 2014). An episode of perinatal mental illness is a major risk factor for further episodes, particularly for puerperal psychosis.[2]
- *Delayed infant development*. Maternal anxiety and depression during pregnancy are associated with increased complications during pregnancy and birth, poorer obstetric outcomes, difficult infant temperament, and behavioural problems in infancy (Glover & O'Connor 2002, Bonari et al. 2004, Austin et al. 2005, Priest et al. 2008. Maternal mental illness in the months following birth contributes to developmental delays in motor function, language acquisition, cognitive skills, emotional self-regulation, and behaviour in the child (DeGangi et al. 2000, Milgrom et al. 2005, Verbeek et al. 2012).
- *Disrupted attachment relationships*. Parental mental illness can interfere with the development of healthy attachment, leading to poorer outcomes in later childhood across a range of domains including emotional, social and behavioural adjustment, scholastic achievement and peer-rated social status. Disorganised attachment is a predictor of significant later psychopathology (Green & Goldwyn 2002, Weinfield et al. 2004).
- *Poor health*. Improving early environments can significantly reduce negative health outcomes longer-term (Anda et al, 2006).

2 Puerperal psychosis or postpartum psychosis affects about 1 in every 1000 women (0.1%) who have a baby. It is a severe episode of mental illness which begins suddenly in the days or weeks after having a baby. Symptoms vary and can change rapidly. They can include high mood (mania), depression, confusion, hallucinations and delusions. Postpartum psychosis is a psychiatric emergency. Postpartum psychosis can happen to any woman. It often occurs 'out of the blue' to women who have not been ill before.

- *Intergenerational effects.* A child who does not develop a healthy attachment relationship with parents fails to internalise working models of healthy relationships, particularly parenting relationships. This curtails the ability to function in relationships and can severely impair future parenting, contributing to intergenerational cycles of mental health problems and social disadvantage (Steele et al. 1996, Fonagy 2010).

Nobel prize-winning economist James Joseph Heckman has demonstrated that returns on investment for early intervention programs for perinatal and infant mental health, measured in terms of reducing costs to the health, education, child safety and criminal justice systems over the life of the child from birth to early adulthood, can be as high as $17 per dollar invested (Heckman 2008a). Remediation programs in adolescence may achieve similar outcomes to early years programs, but have lower success rates and cost 35–50% more (Heckman 2008b

9.3 Targeted interventions

There is strong evidence that mental health promotion, prevention and early intervention targeted at children and families can produce significant net cost benefits. (Knapp et al. 2011, Roberts & Grimes 2011). A few notable examples follow. In the United Kingdom, preventing conduct disorders in a single child through early intervention programming has been found to result in lifetime savings – from the criminal justice system, health system, and increases in lifetime earnings – of £230,000 (>$400,000) (Friedli & Parsonage 2007). With 84,000 children and adolescents in Australia currently estimated to experience a conduct disorder (Lawrence et al. 2015), if proven programs were to prevent just 10% of this incidence (8,400 conduct disorder cases) as much as $3.6 billion in potential lifetime savings could be realized. Conduct disorders and other mental disorders are associated with parental mental illnesses (Mensah & Kieman 2010). Another UK study estimates that improving a single child's mental health from moderate to high has been found to result in lifetime savings of $140,000 (Smith & Smith 2010). An Australian study has estimated that Triple P Parenting, a program that aims to break dysfunctional patterns of parent child interaction, can reduce the number of conduct disorder cases by 25-48% (Mihalopolous 2007). Parent education and family support programs, such as home visits combined with early childhood education have been demonstrated to result in better outcomes for people living with mental health problems and illnesses such as depression and anxiety, with return on investment ratios ranging from $1.80 to $17.07 for every dollar invested (Doran et al. 2011)

9.4 Early Intervention

Programs that help people access treatment early, or help them stay out of hospital or out of the criminal justice system appear to be very cost effective. Most of these studies are, however, gender-blind and further research into the gendered impact of early intervention programs or diversionary schemes would assist in the design and targeting of such initiatives and generate a better understanding of how to maximise the return on investment (ROI). One study of early psychosis intervention using Australian data found that its participants were much more likely to be in paid employment than their peers who had not received this service, and that the health care costs to treat each person were about $6,300 less per year ($3,566 for those in early psychosis program compared to $9,836 for those not in the program) (Mihalopolis et al. 2009). Studies report how prevention programs for juvenile offenders have been demonstrated to produce net cost benefits ranging from $1,900 to $31,200 per youth (Lieb et al. 2004). A Canadian research study on outcomes following a long-term hospital stay evaluated the impact of transitional discharge planning combined with peer support. Individuals in the group receiving peer support were discharged on average 116 days sooner from hospital than the control group who did not have access to this program resulting in an estimated saving

of $12 million (Forchuk et al. 2005). A 2011 United Kingdom Department of Health study found that providing supported housing after discharge from hospital for people with moderate mental health needs generated estimated savings of £22 000 ($35,000) for each person per year across the wider health and social care system (UK Department of Health 2011).

9.5 Enhancing Employability and Workplace Mental Health

Whilst the majority of Australian women participate in the labour force to some degree, the literature on the contribution of paid employment to Australian women's mental health is sparse. There is, additionally, a lack of detailed research into the role played by the conditions of employment in supporting or undermining women's mental health, including in the post-partum period, despite an increasing proportion of mothers returning to work after childbirth. Employment conditions are key social–structural determinants of employed adult's health and wellbeing, especially their mental health (Stansfield and Candy 2006). While job participation is generally regarded as benefiting mental health by increasing social support and financial resources (Lee and Powers 2002), the degree of benefit may be closely dependent on the quality of the job. Epidemiological studies of Australian employees confirm an association between adverse employment conditions, such as poor job quality and greater psychological distress including depression and anxiety symptoms (Bryson and Warner-Smith 1998; Broom et al. 2006; Cheng et al. 2006, Strazdins et al. 2007).

Gender-blind evidence demonstrates that employees' mental health conditions present substantial costs to organisations. Recent modelling by PwC Australia for the Mentally Healthy Workplace Alliance (PwC 2014) measured the cost to Australian workplaces of employees' mental health conditions and found this to be at least $10.9 billion annually. This comprises $4.7 billion in absenteeism, $6.1 billion in presenteeism (reduced productivity at work) and $146 million in compensation claims a year. The PwC modelling further suggests that for every dollar spent on implementing an appropriate mental health-promoting action successfully, there is on average $2.30 ROI to be gained by the organisation. The $2.3 ROI figure was calculated by investigating the cost of introducing seven workplace mental health actions such as worksite physical activity program and resilience training and measuring their subsequent impact on absenteeism, presenteeism, and compensation claims. The results of this analysis are conservative as they do not consider the full range of costs to an organisation caused by employees' untreated mental health conditions, such as high staff turnover. Also, estimates do not include the many intangible benefits of a mentally healthy workplace for all employees, such as improved morale.

It is notable that neither the PwC report nor the website for the Mentally Healthy Workplace Alliance www.headsup.org.au mentions the particular needs of women employees despite clear evidence that the impact of work stressors on common mental disorders differs for men and women (Stansfield & Candy 2006). Gendered evidence on the potential ROI from a wide range of employment-related interventions is not available. A notable exception is provided by a recent survey of employers' experiences of paid domestic violence leave in the workplace, which documents overwhelmingly positive results for companies and the one in four workers affected by domestic violence (McFerran et al. 2013). This research appears to show that paid domestic leave can be delivered at minimal costs as leave requests are at modest levels. The introduction of paid domestic violence leave and workplace measures to support employees experiencing domestic violence also widens understanding and increases sensitivity to this complex issue. The survey commissioned by the Australian Council of Trade Unions (ACTU) and conducted by the University of New South Wales and Gendered Violence Research Network, found that employers reported virtually no problems granting paid domestic violence leave or changes to work arrangements. In fact, employers overwhelmingly reported the positive benefits of providing paid domestic violence leave - including improvements to their relationship with their employees.

Other kinds of evidence, for instance from controlled intervention trials, have shown that employment rates and earnings can both be increased among people with severe-persistent mental illness, the vast majority of whom have a history of psychosis, using such methods as prevocational training and supported employment (Crowther et al. 2001, Dewa et al. 2007). However, these are almost all gender-blind studies. It is important to note, though, that only a minority of people with serious mental illness have severe persistent mental illness (Kessler et al. 1996, Wang et al. 2007). Little is known about the effects of employment–related interventions on occupational outcomes among the much larger proportion of people with serious mental illness who do not have severe persistent mental illness, the majority of whom are women and who suffer from chronic anxiety, behavioral disorders or recurrent depression. A handful of other non-gender-specific controlled studies have documented that such interventions can reduce job loss and sickness absence (Rost et al. 2004). People with serious mental health problems and illnesses who receive individualized support to find employment are nearly three times more likely to be in competitive employment than those who did not receive this support. This is particularly significant in light of the fact that as many as 90% of people with serious mental health problems and illnesses have traditionally been excluded from the labour force (Latimer et al. 2006).

In the absence of research to quantify ROI in this area, it is only possible to suggest that future policy and workplace interventions aiming to maximise women's ability to participate in work should aim to ameliorate the interactions between the employment and domestic life. Conditions that may be critical to women's mental health in the workplace (particularly in the post-partum period), include flexible work hours, paid family leave, job security and job control (Cooklin et al. 2010). There may be much to gain from interventions designed to support women's re-entry to the workforce after childbirth, illness or time spent in a caregiving role.

9.6 Supporting Carers

There is evidence that providing better support to Australia's estimated 2.9 million informal carers has a sound business case, as well as being a compassionate recognition of the sacrifices which carers make to support people with disabilities, mental illness, chronic conditions, terminal illness and the frail aged. This contribution comes at a cost to the health and wellbeing of carers, ratcheting up additional healthcare costs to respond to the well-documented burden of caring-related health conditions such as depression, stress-related illness, sleep deprivation and musculoskeletal problems (Access Economics 2010). Young carers also make enormous sacrifices, giving up what can be millions of dollars of lifetime earnings in order to care for family members (Warren 2007).

A recent report by Access Economics for Carers Australia draws on ABS data to highlight that the majority of Australian carers are female (54.1%), with most carers being middle-aged (35 to 54 years) although over three quarters are of working age (18 to 64 years). Primary carers provide the majority of informal assistance to care recipients and as such are usually living in the same household (78%). Women represent a far greater proportion of primary carers, at 69.3% of the total (Deloitte Access Economics 2015).

That report found that, 10 years ago, the annual 'replacement value' of informal care would be $60.3 billion (equivalent to 3.8% of gross domestic product and 60% of the health and social work industries. The growth in the value of informal care derives largely from demographic ageing, which is increasing the number of Australians who require and receive care, together with growth in the replacement cost of care. Informal carers provide 1.9 billion hours of care each year, and represent a precious economic resource given the growing health and aged care workforce shortage (Deloitte Access Economics 2015). Innovative, gender-sensitive policy and targeted support is required for carers to enable Australia to respond better, and much

more cost-effectively, to a range of demographic shifts, including an ageing population, increased incidence of dementia and other chronic diseases.

The ALSWH data shows that the transition to caring for mid-aged women takes place irrespective of the previous history of paid employment and that women carers are more likely to be unemployed than men (Bereki-Gisolf et al. 2008). Future policies need to be configured to support women's continuing labour force participation during caregiving by creating flexible working arrangements and re-employment measures to support women who quit work in getting back to paid employment after a period of caregiving

9.7 Promoting Mental Health and Preventing Mental Disorder in Women

Assessment of impact in this area is particularly contested and at times claims may have been made that run ahead of the evidence (Davies 2013). While some recent studies identify significant benefits from actions focused on mental health promotion, mental disorder prevention and early intervention across the life course, both within and external to the mental health system (McDaid 2011, Knapp & Iemmi 2014), most of this evidence is gender-blind. Some recent evidence from Europe points to a significant, measurable relationship between population health improvement and increased participation in the labour force and in productivity. Prior to the global financial crisis it appeared that better health was also a major contributor to economic growth (Suhrcke et al. 2006). Conversely, there is evidence that prolonged austerity has reduced the mental health of both men and women, with alarming spikes in suicide rates in austerity-affected countries (Kentikilenis et al. 2014). The link between health and economic development has long been recognised in low-income countries but has been contested in rich ones (OECD 2015). The rapid reversals in mental health status in developed countries as a consequence of austerity suggest that economic policy is, universally, an important determinant of mental health. Whilst the economic argument for investing in health may differ between rich and poor countries, as may the priorities for investment, there is considerable empirical evidence that improving the health of poor people, women and older people is one important means of meeting economic objectives (Chirikos & Nestel 2001, Lindholm et al. 2001, Gambin 2004, Cawley 2005).

10. The Need for Gendered Mental Health Policy

The evidence, from multiple sources, points to compelling links between the gendered nature of exposure to various risks and poor mental and physical health amongst women of all ages. The evident social gradient in health and life expectancy suggest that some individuals, groups and communities are caught in a web of risk conditions which can overwhelm them (Labonte 2001). Evidence suggests that being female is, in itself, a risk factor for poor mental and physical health in certain social contexts or in conditions of adversity (Astbury 2001). Extensive international evidence points to the powerful influence of social, economic, cultural and familial relationships in shaping women's psychosocial health (Moss 2002).

Mental health policy in Australia is framed by the National Mental Health Strategy (Commonwealth of Australia, 2009a) and the Fourth National Mental Health Plan (Commonwealth of Australia 2009b); the Fifth Plan is being developed currently. Notably, none of these have a specific gendered perspective. The Strategy does address maternal and infant health, and outlines proposals to support parents in relation to the mental health needs of children and young people. This information is also gender-blind, as is the section on prevention.

Whilst progress has occurred in recent years to address gender sensitivity within service provision and improve the safety of women, particularly in acute inpatient units, this falls short of comprehensive recognition that gender influences the risks, impacts and consequences of mental illness. Overall, the service landscape remains extremely fragmented and gender-blind at best and in certain situations, particularly in in-patient units and prisons, lack of gender-sensitivity and specialist provision can amplify and perpetuate the risks of abuse and violence which may have already had adverse impacts on mental health. Moreover, there is clear evidence that women often do not receive appropriate mental health services whether they are in hospitals, prisons, nursing homes, addiction programmes or community settings. Ineffective treatment is costly in terms of money expended and in the perpetuation of human suffering (Luborsky et al. 1998, Kulkarni 2012).

Blanch et al (1998) attributed the failure of mental health delivery to women to three factors.

- the current structure of mental health delivery systems;
- conceptual inability to integrate psychosocial factors into the medical model; and
- the fragmentation of health and social services, leading to segregated and discontinued care.

Blanch et al completed their work in 1998. More recent evidence, discussed in this paper, suggests that very little positive change has taken place in over two decades.

11. Women-Centered Mental Health Services

A comprehensive mental health service for women should be based on the provision of dedicated, specialist, coordinated and fully inclusive responses to the full range of needs which women manifest across the life course, including the complex needs of women with severe mental illness and social comorbidities. They should include culturally sensitive services which are tailored to the distinct needs of communities including Aboriginal and Torres Strait Islander women and need to be developed and planned in honest partnerships with local communities and service-users. These dedicated services need to be clearly identifiable within a network of well-integrated, tiered services ranging from local self-help and voluntary groups to community facilities and general practice surgeries. They need to be staffed by multi-disciplinary teams of professionals with the required capabilities to respond to the biological, social and emotional needs of women in clinically effective, culturally sensitive and non-judgemental ways. Moreover women's community mental health or

specialised rehabilitation services should be closely linked to inpatient and outpatient services, social services and secondary and tertiary care providers and all of these services should function in gender and culturally sensitive ways, incorporating gender transformative approaches[3] and feminist perspectives in practice (Kohen 2000). These proposals are closely aligned with the primary-care-driven, stepped-care proposals of the NMHC (2014) but also attempt to ensure that the future does not continue to be gender-blind.

12. Patients or Populations?

Improving the mental health of Australian women across the life course requires strategies which go beyond individual approaches. Treating one patient at a time can have only limited success in improving population mental health overall (De Hert et al. 2011b). In order to improve the mental health of large numbers of people, a totally new approach is necessary which gives equal priority to the development of evidence-based treatments and management regimes and to strategies for effective prevention (Di Matteo et al. 2000, Marmot & Bell 2012, WHO 2012).

Applying these principles to improving the mental health of Australian women will require broad-based approaches that foster personal resilience within supportive community environments. There is evidence that creating supportive environments has the greatest lasting positive impact on health (Marmot & Bell 2012). This may be particularly efficacious in improving the health of Aboriginal and Torres Strait Islander women (Swan & Raphael 1995; Dudgeon et al. 2010). Addressing issues of poverty, gender-based violence, racism and inequalities in housing, education, social justice and community safety, access to healthy food outlets, decent employment, responsive healthcare and community participation will foster a more supportive community environment. These all involve whole-of-government action and sustained implementation of policy. It is essential that both the public and policymakers understand the strong and accumulating evidence about the factors that impact on health, including mental health, and begin to see health as more than the mere absence of disease.

The tensions observed between current policy and the policies required to really make a difference to women's mental health are illustrated in Figure 3 below.

3 , The transformative paradigm is a framework of belief systems that directly engages members of culturally diverse groups with a focus on increased social justice and human rights. Transformative approaches apply at the intersections of multiple social divisions including gender, race, class, sexuality and culture. Gender-mainstreaming in policy and in service provision is a potentially powerful transformative tool.

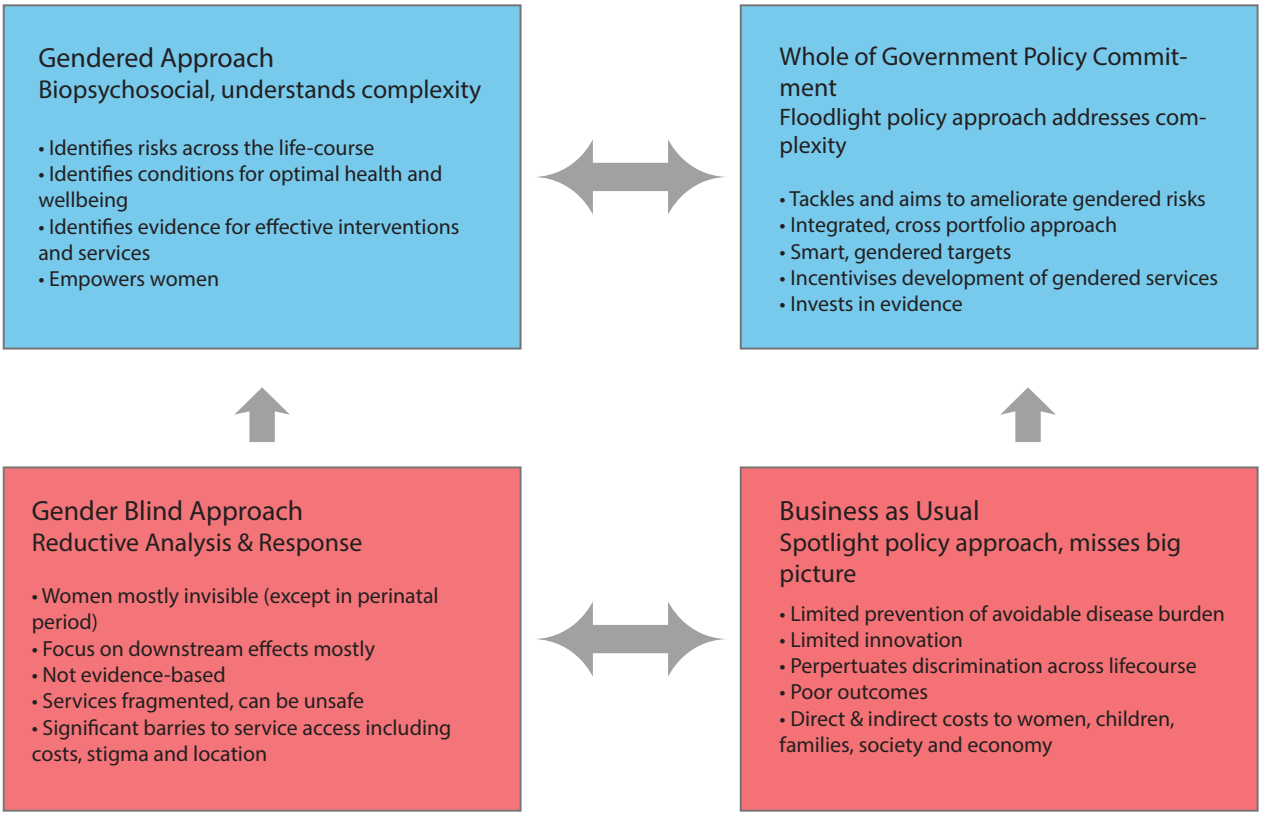

Figure 3: Policy Tensions and Possibilities

A whole of government commitment to improving women's mental health will require social policy interventions at the community level to ensure equity, including liveable wages, safe housing and neighbourhoods, attractive and safe places for physical activity and access to affordable and healthy food (Freidli & Parsonage 2007). There is a critical need for governments to articulate the need transform gender stereotypes and reflect this in practice and to take effective action to tackle discrimination against girls and women. Schools and workplaces offer highly productive settings for these approaches (Davies 2014, NMHC 2014). Forty per cent of Australian women resume employment in the first year postpartum, and poor quality employment (without security, control, flexibility or leave) is a strong social determinant of maternal psychological distress and therefore a determinant of the overall wellbeing of children (Cooklin et al. 2011). At the individual level people need to be educated about the importance of positive mental health and ways to manage mental wellbeing, including ways to cope in the face of gendered risks.

Further efforts to challenge the social stigma of mental illness are also needed, with particular emphasis on attitudes amongst health care staff (Brohan et al. 2012). This approach should include the identification of non-discriminatory policies that address the financial barriers to mental health care for women, as well as education programmes and campaigns to better educate the public (Astbury 2001).

Further to this, the evidence reviewed in this paper suggests that new models of care are required to respond to women's mental health needs across the life course. This requires new, gender-informed health policy and the establishment of incentives and supports to enable health systems, health professionals and service providers to scale up innovation in line with evidence.

13. The Policy Framework

The Australian Health Policy Collaboration proposes a framework for a comprehensive new policy approach to improving women's mental health across the life course. The framework identifies three underlying drivers and five major policy goals. These actions address the risk factors that occur at critical life-stages for girls and women highlighted in the evidence and illustrated in Figure 4 below.

Figure 4: Lifecourse risks and protections , AHPC 2016

14. Implementing the Framework: agenda for action

Policy change frequently takes place stepwise and comprehensive implementation can be slow and fragmented. It is likely that the policy framework proposed in this paper will take many years to embed given the complexity of the implementation task and the persistence of the entrenched systemic barriers to reform, including those which are cultural and require transformations in existing gender-based norms and power inequities. As a consequence, no timetable is suggested for the achievement of most of the steps discussed below as many of these will require interpretation and design at state, territory, regional and local levels. Nevertheless, the federal government should act swiftly to ensure that the opportunity presented by the development of the forthcoming Fifth National Mental Health Plan is not lost, with continuing consequences for the mental health of Australian women.

An ambitious timetable is proposed for the development and embedding of the three underlying drivers within the forthcoming Fifth National Mental Health Plan. This is because visible and effective policy action is necessary to demonstrate the commitment of governments to rebuilding the architecture which frames women's mental health. Unless these drivers are in place, it will be impossible to achieve the required, shift in population health outcomes.

14.1 Five major policy goals

14.1.1 Goal 1: Responding to the life-course mental health needs of women

A proactive, gendered, primary care- driven approach is required to identify women at risk of mental ill health across the life course and to implement evidence-based supportive interventions. Federal, state and territory policies can support this development by considering the incentives required to promote and scale effective models so that they move from the margins to the mainstream. Primary Healthcare Networks (PHNs), the new Australian primary health care organisations established to coordinate primary health care delivery and tackle local health care needs and service gaps tailored to meet the needs of local communities are well positioned to lead in this endeavor but will need to build their own gender-related capabilities in order to do this effectively.

Next Steps

- It is noted that the federal government, in collaboration with the state and territories governments has begun to draft the Fifth National Mental Health Plan. The federal government is urged to see this as a critical opportunity for mainstreaming gender in mental health policy in Australia and to consult on detailed proposals for improving women's mental health across the life course when consulting on the new Plan. It is vital that there is consultation with expert women's' health organisations in developing the Plan.
- The AHPC endorses the call by the National Mental Health Commission for the establishment of new 'system architecture' to provide 'stepped care' or coordinated pathways of treatment and care which can respond to fluctuating levels of need and functional impairment (NMHC 2014). A fundamental element of the 'stepped care' approach is the delivery of care through general practice and the primary health sector with strategic oversight and commissioning by PHNs. The Mental Health Commission suggested that these should be renamed Primary and Mental Health Networks and provided with bundled funding for planning and purchasing mental health services and integrated care pathways that are tailored to individual needs and different communities. PHNs are well placed to collaborate with hospital networks

and community-based specialist services to develop gender–sensitive services and they should work with local and regional partners to bring forward locally and regionally relevant proposals, reflecting the evidence discussed in this report, for improving women's mental health across the life course.

- Federal, state and territories governments, PHNs and other bodies should, as a matter of routine, undertake a gender-impact assessment of all relevant policy and service developments and make this information publicly accessible, for example through publication on the Women's Health Hub, the information service provided by Australian Women's Health Network. Making this information easily accessible and shareable will assist in strengthening the evidence base regarding the impact of gender on mental health and ensuring there are no unintended, inequitable or discriminatory consequences of policy or service change.

14.1.2 Goal 2: Integrating responses to physical and mental health

Women's experiences of both mental and physical illness are different from men's. Women tend to live longer than men but in general take more medications and have more contact with health services. Physical illness in women is a major risk factor for mental illness (Kulkarni 2012).

Numerous barriers exist to achieving fully integrated services capable of addressing physical and mental health adequately for both men and women. Some of these barriers exist at the policy level, relating to lack of policy integration and vision, lack of resources and underlying disinterest in mental illness, continuing stigma and/or procedural discrimination against people in terms of limitations on or lack of health insurance. Others are found at the level of the health system and include lack of funding for innovation and under-investment in community services, lack of integration between mental health with the general health care system, lack of integration between health and social support services including poor coordination with housing, welfare and employment services, lack of coordinated partnership between providers and inadequate or inappropriate staff training (De Hert et al. 2011a, WHO 2011). Stigma and discrimination are still considerable barriers (Lawrence et al. 2015). As important, the lack of gender specificity in policy, service delivery and clinical practice is clearly detrimental to improving outcomes (Doyal 2002, Kulkarni 2012).

Next Steps

- Federal, state and territory governments and PHNs should set ambitious, gendered targets to close the gap in life expectancy between women and men with mental illness and the rest of the population. This should include including additional, gendered actions in relation to Aboriginal and Torres Strait islander women.
- Federal, state and territory governments, PHNs and service providers should identify barriers to service access by women and develop options developed for removing these. The investigation should include barriers arising from out-of-pocket/co-payment costs, caps on Medicare rebates and geographic location of services.
- Federal, state and territory governments should collaborate with PHNs and service providers to invest in evidence-based models of integrated mental and physical health care in primary care and specialist services.
- Professional and registration bodies should work with the medical royal colleges and to ensure that the health workforce has the required capabilities to respond to the complex linkages between mental and physical health in women

14.1.3 Goal 3: Meeting the needs of women with severe mental illnesses

Women with mental illnesses often experience disjointed, incomplete and disjointed care (Kulkarni 2012). The evidence summarised in this document documents the many barriers and hurdles to be navigated within the mental health care systems that can be confusing to vulnerable women and their families (RANZCP 2015; National Mental Health Commission 2015). There is often poor or non-existent communication between primary care practitioners, inpatient psychiatry units, community mental health facilities and non-government support services (Sweeney & Shi 2015; Bagnall 2014; RANZCP 2015). Different treatment approaches with varied goals are characteristics of the system. Individual women can experience with the mental health system as a series of 'cliff edges' (RANZCP 2015).

Psychological and psychiatric treatments are broadly gender-blind or, in relation to medication, both dosages and guidelines have been derived from clinical trials that have predominately involved male subjects (Kulkarni 2010). Women are more likely than men to receive psychotherapy or other form of talking treatment but feminist or women-centred perspectives and theories are not mainstreamed in most service provision. This is particularly problematic given the evidence regarding the contribution of trauma in the aetiology of mental illness in women. It is critical that techniques, which can take account of the abusive background, are involved in the therapeutic regime. Similarly the use of cognitive behaviour therapy has been demonstrated as effective in women with a range of persistent symptoms of number of mental illnesses, including equipping women to return to work when recovering from mental illness (Notman & Nadelson 2006). A range of gender-sensitive therapies and social and educational interventions that are specifically designed to enable women to understand their circumstances have been proven to be effective but are often not available (Kulkarni 2012).

Since the 1960s, psychiatry inpatient units in Australia have housed male and female patients together. Mixed gender wards are common practice in both the public and private sectors leading to a number of incidents of assault on women patients (Kulkarni 2012). It is thought that levels of abuse and violence in inpatient units have worsened in recent years, in part to do with the increasing level of disturbance seen in people admitted to hospitals and treated in mixed gender wards. At the same time, lengths of stay have shortened and rates of readmission have increased (Quirk et al. 2006). In a 2006 survey of women treated in public psychiatry inpatient units in Victoria a high number of women reported feeling unsafe or having experienced aggressive behaviour from male patients including sexual and physical assault (VMIAW 2008). The continued practice of treating male and female patients in mixed settings flies in the face of best practice in treating women patients with severe mental illness. This requires urgent, corrective action at federal and state levels.

Next Steps

- Federal, state and territory governments, PHNs and service providers should ensure that all existing and new psychiatric inpatient facilities be redesigned or designed to provide gender segregation and ensure the safety, privacy and dignity of both male and female inpatients
- Federal, state and territory governments, PHNs and service providers should take steps to ensure that the increasing numbers of women with severe mental illnesses being managed in community settings have access to appropriate, non-discriminatory and culturally-sensitive services and set out plans for gender-mainstreaming in all mental health provision, to the benefit of both men and women. Women need dedicated, integrated, empowerment orientated services at every level if they are to have the best chance of overcoming their mental health difficulties

14.1.4 Goal 4: Mainstreaming a preventative approach

New policy needs to incentivise a proactive approach to preventing mental illness amongst the small population of extremely vulnerable girls and women most at risk of mental illness as a consequence of abuse and trauma. There are some serious limitations in the evidence base in this area; nonetheless there is a compelling case for a strategic approach capable of diverting these women from life-long trajectories of severe illness and continued exposure to multiple risks. Some of the strongest evidence relates to the early years, including some findings which suggest that early years' interventions may particularly benefit girls. However, current interventions in the early and primary years appear to be particularly 'gender-blind' (McNeish and Scott 2014). The evidence from service evaluations and research with women at risk supports a model of integrated, holistic, one-stop, women-centered services as effective in promoting and sustaining engagement and being highly valued by women at risk even though the evidence for achieving specific outcomes is underdeveloped currently (Kulkarni 2012).

There is strong evidence for the effectiveness of preventative interventions, targeted on women experiencing stress or relationship difficulties in the perinatal period. These interventions, which may divert women and children from long mental ill health 'careers' should be drawn into routine practice in maternal and child health services (Judd et al. 2009).

Integrated service responses and new ways of working provide the corner-stone of a strategic prevention initiative with major implications for workforce capabilities and composition including a review of the prevention role of maternal and child health nurses, midwives and others. Practice needs to shift to integrate preventative interventions including proactive identification, monitoring, screening and medications management as well as health education and health promotion, particularly smoking cessation support in mainstream primary care settings, maternal and child health settings and in hospitals as well as in specialist mental health settings (WHO 2012)

Next Steps

- PHNs and service providers should work together to support the development of locally relevant strategic prevention initiatives, paying particular attention to workforce capabilities and composition, including a review of the mental health promotion and illness -presentation roles of maternal and child health nurses, midwives and others. Identification of effective models is also needed for both primary and secondary prevention in mainstream primary care settings, maternal and child health settings and in hospitals.
- PHNs and service providers should work together to develop options for integrating preventative interventions, including proactive identification of women at risk of poor mental health, monitoring, screening and medications management as well as health education and health promotion, particularly smoking cessation support at all levels of mental health care and treatment.
- State and territories governments should incentivise PHNs and local councils in establishing effective partnerships to assess the feasibility of developing population–focused, gendered mental health improvement strategies and place-based prevention initiatives.

14.1.5 Goal 5: Investing in research and service innovation

A strategic national mental health research strategy is required to provide a framework to ensure better accountability in spending on public mental health and primary care services. This can be achieved through identification and evaluation of preventative measures and treatments and management regimes that are cost-effective, sustainable and publicly credible. New policy will be strengthened by a commitment to invest

in a strategic gender-sensitive research plan to clarify and, if possible, quantify the gender-based risks for chronic mental and physical illness and the impact of gender-based primary and secondary prevention initiatives. There is a particular paucity of information about the risk and protective factors for Aboriginal and Torres Strait Islander women's mental health which needs to be addressed as a matter of urgency to support the Closing the Gap initiatives (COAG 2016). Much better information is required about the effectiveness of interventions in diverse settings and locations and for key groups including Aboriginal and Torres Strait Islander women, migrants, LBTI women and older women. This should include evaluation of policies and programs and their impacts.

Federal, state and territory governments should invest in research to identify the numbers and characteristics of women and girls most at risk of mental illness and collaborate with PHNs and specialist services to support, evaluate and showcase integrated, holistic women-centered services for women at risk. The following steps are proposed in translating that commitment into policy action.

Next Steps

- Federal, state and territory governments should invest in research to identify the numbers and characteristics of women and girls most at risk of mental illness and collaborate with Primary Care and Mental Health network and specialist services to support, evaluate and showcase integrated, holistic women-centred services for women at risk. The following steps are proposed in translating that commitment into policy action.
- Increase PHNs' access to health and service utilisation informatics. This should include proposals and incentives for making full use of existing datasets, including the Australian Longitudinal Survey of Women's Health and other longitudinal studies, as well as Medicare, prenatal and hospital data and investment in data collection and data sharing. This would support the development of a stepped care approach, determine the characteristics of women most at risk of poor mental health and specify, plan, commission and deliver clinically and cost-effective services and interventions and assess the equity of current arrangements.
- Encourage routine analysis and reporting of gender differences in research findings.
- Influence the agendas of research funders to give a higher priority to studies that explore issues of gender and risk and the experiences of different groups of culturally and linguistically diverse women and girls, Aboriginal and Torres strait Islander women and girls, and to older cohorts women.
- Invest in pilots of interventions based on existing evidence (some cited in this paper) to expand the evidence base on effective services for women and girls across the whole life course.
- Implement sustainable long-term funding strategies for well-evaluated programmes.
- Develop outcome frameworks across services for girls and women at risk to enable more substantial evaluation to be implemented.
- Advocate for replication of initiatives which have been robustly evaluated elsewhere (largely in the US) to assess their suitability to the Australian context and likely impact on girls and women

14.2 Three underpinning drivers

Within one year - to have committed further investment into building the science base through research into the causes and consequences of women's mental distress and the evidence for what works and to provide support for transition from pilot projects to full-scale implementation of new approaches.

Within two years - to have developed and begun to implement a strategic approach to embedding capability

for gender-sensitive practice for mental health specialists, primary care clinicians and staff in community and secondary health care services including maternal and child health services and hospitals.

Within three years - to have developed locally/regionally and culturally-relevant gender-sensitive care pathways including integrated service models capable of responding holistically to individual girls and women across the life course.

15. Endnote

Not all unhappiness can be prevented. Sadness, grief and loss are as integral to the experience of both women and men as joy, elation and fulfilment. The function of the new social policy proposed in this paper is not the regulation of human emotion but to create the conditions for the well-being of the whole population and establish protections against a range of risk factors. Whilst individual resilience is essential to overcoming the obstacles that inevitably occur along the life course, the development of resilience cannot be left to chance. A range of factors are involved in the development of both individual and community resilience including a good start in life, good education, access to good healthcare, freedom from poverty, abuse and violence and meaningful employment. There is a critical need for high-quality treatment and other forms of support when individuals, groups and communities are overwhelmed. Conversely, an equally broad range of risk factors bear down on individuals, groups, communities and populations. These include the experience of childhood trauma, poverty and lack of access to health and education services, economic insecurity, homelessness, intimate partner violence, racism, gender-discrimination, misogyny –and many more. These all have the potential to undermine resilience and the potential for good population mental health and wellbeing. Many of these risks can be prevented or ameliorated through social policy.

This paper cites the extensive evidence that the risks for and patterns of mental illness vary amongst men and women and argues for an explicit commitment to new policy aimed at improving mental health amongst women in Australia. This does not mean that women and men need to compete with each other for attention or resources on this issue but reflects the fact that that there is, currently, particularly poor understanding of women's mental health needs and poor prevention, treatment and management as a consequence. The gendered nature of vulnerabilities and exposure to risks derives from biological differences and socially and economically-constructed differences including the different social roles and expectations of both men and women. Women in modern Australia bear a relentless burden of complex responsibilities; especially those who attempt to combine a working life with motherhood or care-giving.

It is vital that future policy is gendered and takes a life course approach, recognising that risks fluctuate across the life course and that good mental health is important to women of all ages. Good mental health amongst women is an important asset for Australian society and economy as well as to individuals. Gender-blind policy approaches stem from incomplete analyses of causes and consequences and, as a result, lead to poor targeting of resources and ineffective policy. This is costly and inefficient and impacts on women's productivity in both the formal and informal economies. Australia has much to gain from improvements in mental health outcomes amongst women. There is an opportunity now, with the development of the Fifth National Mental Health Plan, to take advantage of decades of world-leading research and innovation and commit to making a measurable improvement in women's mental health in the future. Making the most of this opportunity requires ground-breaking policy, capable of addressing the full complexity of the risk and protective factors for women's mental health and robust commitment to changing course.

References

Abhayaratna, J. and Lattimore, R. 2006, Workforce Participation Rates – How Does Australia Compare? Staff Working Paper, Productivity Commission. http://www.pc.gov.au/research/supporting/workforce-participation/workforceparticipation.pdf. Viewed 25th February 2016

Access Economics. 2008, The cost of child abuse in Australia, Report prepared for Australian Childhood Foundation and Child Abuse Prevention Research Australia, Monash University, Clayton.

Access Economics 2010, The economic value of informal care in 2010, Report for Carers Australia, ,

http://carersaustralia.com.au/storage/Economic-Value-Informal-Care-Oct-2010.pdf , viewed 4th November 2015

Aguirre Castaneda, R, Kumar, S, Voigt, R, Leibson, C, Barbaresi, W, Weaver, A, Killian, J & Katusic, S 2015, Childhood Attention-Deficit/Hyperactivity Disorder, Sex, and Obesity, Mayo Foundation for Medical Education and Research, viewed February 8th 2016, http://www.mayoclinicproceedings.org/article/S0025-6196(15)00770-3/pdf.

Alston, M, Allan, J, Dietsch, E, Wilkinson, J, Shankar, J, Osburn, L & Harris, J 2006, Brutal neglect: Australian rural women's access to health services, Rural and Remote Health, vol. 6, no. 1, p. 475.

Alzheimer's Disease International 2015, Women and dementia: a global research review, viewed November 4th 2015, Alz-http://www.alz.co.uk/sites/default/files/pdfs/Women-and-Dementia.pdf.

Anda, RF, Felitti, VJ, Bremner, JD, Walker, JD, Whitfield, CH, Perry, BD & Giles, WH 2006, The enduring effects of abuse and related adverse experiences in childhood, European Archives of Psychiatry and Clinical Neuroscience, vol. 256, no. 3, pp. 174–186.

Annandale, E., & Hunt, K. 2000, Gender inequalities in health: Research at the crossroads. In E. Annandale, & K. Hunt (Eds.), Gender inequalities in health (pp. 1–35). Buckingham: Oxford University Press

Arnold, AF, Baugh, C, Fisher, A, Brown, J & Stowe, ZN 2002, Psychiatric aspects of the postpartum period, in S. Kornstsein & A. Clayton (eds.), Women's mental health: A comprehensive textbook, New York, The Guilford Press (pp. 91–113).

Astbury, J 2001, Gender Disparities in Mental Health, WHO Round Tables, Geneva, pp. 73–92.

Austin, M-P, Hadzi-Pvalovic, D, Saint, K & Parker, G 2005, Antenatal screening for the prediction of postnatal depression: validation of a psychosocial Pregnancy Risk Questionnaire, Acta Psychiatrica Scandinavica, vol. 112, pp. 310–317.

Austin, MP & Kildea, S 2007, Maternal mortality and psychiatric morbidity in the perinatal period: challenges and opportunities for prevention in the Australian setting. Medical Journal of Australia, vol. 186, no. 7, pp. 364–367.

Austin, MP, Reilly, N & Sullivan, E 2012, The need to evaluate public health reforms: Australian perinatal mental health initiatives, Australian and New Zealand Journal of Public Health, vol. 36, no. 3, pp. 208–211.

Australian Bureau of Statistics -2004b, 2003 Disability, ageing and carers: summary of findings, Australia, ABS Cat No 4430.0, Canberra, 15 September-2004c, Population by age and sex, Australian states and territories, ABS Cat No 3201.0, Canberra, 17 December.

Australian Bureau of Statistics 2006, 2004-05 National Health Survey: Summary of Results (ABS cat. no. 4364.0), p. 13.

Australian Bureau of Statistics (ABS) 2007, National Survey of Mental Health and Wellbeing: Summary of Results, ABS, cat. no. 4326.0.

Australian Bureau of Statistics (ABS) 2008, National Survey of Mental Health and Wellbeing: Summary of Results, viewed 4th November 2015, http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/$File/43260_2007.pdf.

Australian Bureau of Statistics (ABS) 2010a, Measures of Australia's Progress, 2010, viewed November 5th 2015, http://

www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1370.0~2010~Main%20Features~Home%20page%20(1)

Australian Bureau of Statistics (ABS) 2010b, Year Book Australia, 2009–10, viewed 5th November 2015, http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/1301.0Chapter11082009%E2%80%9310

Australian Bureau of Statistics (ABS) 2011, Australian Health Survey: First Results, viewed 5th November 2015, http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4364.0.55.001main+features12011-12

Australian Bureau of Statistics (ABS) 2012, 1310.0 Year Book Australia. Health Viewed 25th February 2016 http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1301.0~2012~Main%20Features~Health%20status~229

Australian Bureau of Statistics (ABS) 2013a, Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012–13, viewed 5th November 2015, http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/9F3C9BDE98B3C5F1CA257C2F00145721?opendocument

Australian Bureau of Statistics (ABS) 2013b, Defining the data challenge for family, domestic and sexual violence, 2013, viewed 5th November 2015, http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4529.0~2013~Main%20Features~Home%20page~1

Australian Bureau of Statistics. 2014, Causes of Death, Australia 2012. ABS Cat. No. 3303.0. Canberra, ACT: Australia. http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2012~Main%20Features~External%20Causes%20(V01-Y98)~1002 . Viewed February 24 2016

Australian Bureau of Statistics (ABS) 2016, 6202.0 - Labour Force, Australia, Jan 2016 http://www.abs.gov.au/ausstats/abs@.nsf/mf/6202.0

Australian Government. Department of Health, 2013, National Aboriginal and Torres Strait Islander Health Plan 2013–2023 http://www.health.gov.au/internet/publications/publishing.nsf/Content/oatsih-healthplan-toc

Australian Government. Department of Health, 2013 National Aboriginal and Torres Strait Islander suicide prevention strategy. Viewed April 8th 2016, http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pub-atsi-suicide-prevention-strategy

Australian Government. Department of Health, 2014. National Aboriginal and Torres Strait Islander People's Drug strategy, 2014-2019. Viewed April 8th 2016, http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/natsipds2014-19

Australian Institute of Health and Welfare (AIHW) Johnson S, Bonello MR, Li Z, Hilder L & Sullivan EA. 2014. Maternal deaths in Australia 2006– 2010, Maternal deaths series no. 4. Cat. no. PER 61. Canberra: AIHW. Viewed February 25th 2016. http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129548375

Australian Institute of Health and Welfare (AIHW) 2008, Indicators for chronic diseases and their determinants, 2008. Cat. no. PHE 75. Canberra: AIHW. Viewed 1st March 2016 http://citeseerx.ist.psu.edu/viewdoc/download;jsessionid=DB0745AC49FF4EA2BBF1A37B8EB0F04C?doi=10.1.1.663.1045&rep=rep1&type=pdf

Australian Institute of Health and Welfare (AIHW) 2012a, Experience of perinatal depression: data from the 2010 Australian National Infant Feeding Survey, Information Paper, cat. no. PHE 161, AIHW, Canberra, viewed 16th February 2016, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737422202.

Australian Institute of Health and Welfare (AIHW) 2011,The health and welfare of Australia's Aboriginal and Torres Strait Islander people, an overview 2011. Cat. no. IHW 42. Canberra: AIHW. Viewed 25th February 2016. http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737418955

Australian Institute of Health and Welfare (AIHW) 2012b, Comorbidity of mental disorders and physical conditions 2007, cat. no. PHE 155, AIHW, Canberra, viewed 4th November 2015, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737421142.

Australian Institute of Health and Welfare (AIHW) 2014, Mental health services – in brief, 2014, cat. no. HSE 154, AIHW, Canberra, viewed 14th February 2016, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129549620.

Avis, N. E, Colvin, Bromberger, J. T, Hess, R., Matthews, K. A, Ory, M, & Schocken, M. 2009, Change in health-related quality of life over the menopausal transition in a multiethnic cohort of middle-aged women: Study of Women's Health Across the Nation (SWAN). Menopause (New York, NY),16(5), 860.

Bagnall, C 2014, The physical health of people with a serious mental illness and/or addiction: an evidence review, viewed 20th October 2015, http://www.tepou.co.nz/resources/the-physical-health-of-people-with-a-serious-mental-illness-and-or-addiction-an-evidence-review/515

Baker, KL & Robertson, N 2008, Coping with caring for someone with dementia: reviewing the literature about men, Aging & Mental Health, vol. 12 no. 4, pp. 413–422.

Bartley, M, Popay, J, & Plewis, I. 1992, Domestic conditions, paid employment and women's experience of ill-health. Sociology of Health and Illness, 14, 313–343.

Bartley, M., Sacker, A., Firth, D., & Fitzpatrick, R. 1999, Social position, social roles and women's health in England: Changing relationships 1984–1993. Social Science & Medicine, 48(1), 99–115.

Blanch, A. K. and Lubotsky Levin, B. 1998, Organisation and Delivery in women's mental health services: a public health perspective. (Eds, Lubotsky Levin, B., Blanch, A. K. and Jennings, A.). Thousand Oaks, CA: Sage Publications.

Beckett, H, Brodie, I, Factor, F, Melrose, M, Pearce, JJ, Pitts, J & Warrington, C 2013, It's wrong – but you get used to it": a qualitative study of gang-associated sexual violence towards, and exploitation of, young people in England, University of Bedfordshire, UK, viewed 4th November 2015, http://www.oijj.org/en/docs/report/it-s-wrong-but-you-get-used-to-it-a-qualitative-study-of-gang-associated-sexual-violence

Begg, SJ, Vos, T, Barker, B, Stanley, L & Lopez, AD 2008, Burden of disease and injury in Australia in the new millennium: measuring health loss from diseases, injuries and risk factors, Medical Journal of Australia, vol. 188, no. 1, p. 36

Berecki-Gisolf J, Lucke J, Hockey R, Dobson A. 2008, Transitions into informal caregiving and out of paid employment of women in their 50s. Social Science & Medicine. 67(1):122-7. Viewed March 10th 2016 http://www.sciencedirect.com/science/article/pii/S0277953608001652

Beydoun, MA & Wang, Y 2010, Pathways linking socioeconomic status to obesity through depression and lifestyle factors among young US adults. Journal of Affective Disorders, vol. 123, no. 1, pp. 52–63, viewed 4th November 2015, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2860015/

Bonari, L, Pinto, N. Ahn, E. & Einarson, A. 2004. Perinatal risks of untreated depression during pregnancy. Canadian Journal of Psychiatry,49(11), 726.

Breckenridge, J, Rees, R, Valentine, K & Murray, S 2015, Meta-evaluation of existing interagency partnerships, collaboration, coordination and/or integrated interventions and service responses to violence against women: state of knowledge paper, ANROWS, Sydney, viewed 5th November 2015, file:///C:/Users/e7009582/Downloads/Integrated%20Responses%20Meta-Evaluation%20-Landscapes%20(State%20of%20knowledge)%20Issue%20Eleven.pdf/

Britt H, Miller GC, Henderson J, Charles J, Valenti L, Harrison C, Bayram C, Zhang C, Pollack AJ, O'Halloran J & Pan Y 2012, General practice activity in Australia 2011–12, General practice series no. 31, Sydney University Press, Sydney, viewed 5th November 2015, http://prijipati.library.usyd.edu.au/bitstream/2123/8675/4/9781743320198_ONLINE.pdf

Brohan, E, Henderson, C, Wheat, K, Malcolm, E, Clement, S, Barley, E. A & Thornicroft, G 2012. Systematic review of beliefs, behaviours and influencing factors associated with disclosure of a mental health problem in the workplace. BMC psychiatry, 12(1), 1.

Broom D, D'Souza R, Strazdins L, Butterworth P, Rodgers B 2006, The lesser evil: bad jobs or unemployment? A study of mid-aged Australians. Soc Sci Med 63:575–586

Bryson L, Warner-Smith P 1998, Employment and women's health. Just Policy 14:3–14

Byles, JE, Dolja-Gore, X, Loxton, DJ, Parkinson, L & Stewart Williams, JA 2011, Women's uptake of Medicare Benefits

Schedule mental health items for general practitioners, psychologists and other allied mental health professionals, Medical Journal of Australia, vol. 194, no. 4, pp. 175–179.

Carey, T. A., Rickwood, D. J., & Baker, K. 2009, What does $ AUD27, 650,523.80 worth of evidence look like? Clinical Psychologist, 13(1), 10-16.

Caspi A, McClay J, Moffitt TE, Mill J, Martin J, Craig IW, Taylor, A & Poulton, R 2002, Role of genotype in the cycle of violence in maltreated children, Science, vol. 297, pp. 851–854

Cawley J. 2000, Body weight and women's labor market outcomes, National Bureau of Economic Research, Cambridge, MA (working paper No. 7481).

Champagne, FA & Curley JP 2005, How social experiences influence the brain, Current Opinion in Neurobiology, vol. 15, pp. 704–9.

Chang, D 2003, An introduction to the politics of science: culture, race, ethnicity, and the supplement to the Surgeon General's report on mental health, Culture Medicine and Psychiatry, vol. 27, pp. 373–83.

Cheng Y, Kawachi I, Coakley EH, Schwartz J, Colditz G 2006, Association between psychosocial and work characteristics and health functioning in American women. Br Med J 320:1432–1436

Chirikos, TN & Nestel, G 1985, Further evidence on the economic effects of poor health, Review of Economics and Statistics, vol. 67, pp. 61-9.

Cohen, LS, Nonacs, R, Bailey, J, Viguera, A, Reminick, A, Altshuler, L, Stowe, Z & Faraone, S 2004, Relapse of depression during pregnancy following antidepressant discontinuation: a preliminary prospective study, Archives of Women's Mental Health, vol. 7, no. 4, pp. 217–221.

Commonwealth of Australia 2009a, National Mental Health Policy 2008, viewed 8th March 2016, http://www.health.gov.au/internet/main/publishing.nsf/content/B4A903FB48158BAECA257BF0001D3AEA/$File/finpol08.pdf

Commonwealth of Australia 2009b, Fourth National Mental Health Plan— an agenda for collaborative government action in mental health 2009–2014, viewed 8th March 2016 http://www.health.gov.au/internet/main/publishing.nsf/content/9A5A0E8BDFC55D3BCA257BF0001C1B1C/$File/plan09v2.pdf

Commonwealth of Australia 2010, National Women's Health Policy 2010, Publications Number: D0102, viewed 4th November 2015, http://www.health.gov.au/internet/main/publishing.nsf/Content/3BC776B3C331D5EECA257BF0001A8D46/$File/NWHP.pdf

Cole, SW, Hawkley, LC, Arevalo JM, Sung CY, Rose, RM & Cacioppo, JT 2007, Social regulation of gene expression in human leukocytes, Genome Biology, vol. 8, R189.

Coles, J, Lee, A, Taft, A, Mazza, D, & Loxton, D. 2015, Childhood Sexual Abuse and Its Association With Adult Physical and Mental Health Results From a National Cohort of Young Australian Women. Journal of interpersonal violence, 30(11), 1929-1944.

Collins, D. & Lapsley, H 2008 The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004-05. National Drug Strategy Monograph Series no. 66. Canberra: Australian Government Department of Health and Ageing

Colton, CW & Manderscheid, RW 2006, Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states: preventing chronic disease, Public Health Research, Practice, and Policy, vol. 3, no. 2, pp. 1–14.

Cooklin, AR, Canterford L, Strazdins, L & Nicholson, JM 2010, Employment conditions and maternal postpartum mental health: results from the Longitudinal Study of Australian Children, Archives of Women's Mental Health, vol. 14, no. 3, pp. 217–225.

Cooper, SA, Smiley, E, Morrison, J, Williamson, A, & Allan, L 2007, Mental ill-health in adults with intellectual disabilities: prevalence and associated factors, The British Journal of Psychiatry, vol. 190, no. 1, 27–35.

COAG (Council of Australian Governments) 2008 National Integrated Strategy for Closing the Gap in Indigenous Disadvantage. National Indigenous Reform agreement. Viewed April 8th 2016, https://www.coag.gov.au/node/65

COAG (Council of Australian Governments) 2010, The National Plan to End Violence Against Women and their Children. 2010-2022. Viewed April 8th 2016, https://www.dss.gov.au/sites/default/files/documents/08_2014/national_plan1.pdf

Covington, SS 2008, Women and addiction: a trauma-informed approach, Journal of Psychoactive Drugs, vol. 40(sup5), pp. 377–385.

Crowther RE, Marshall M, Bond GR, Huxley P 2001, Helping people with severe mental illness to obtain work: systematic review, British Medical Journal, vol. 322, pp. 204–8.

Cummins, R, Hughes, J, Tomyn, A, Gibson, A, Worener, J & Lai, L 2007, Australian Unity Wellbeing Index Survey: 17.1. The Wellbeing of Australians: Carer Health and Wellbeing, Deakin University, Melbourne.

Cunningham R, Shaw C, Blakely T, Atkinson, J & Sarfati, D 2010, Ethnic and socioeconomic trends in breast cancer incidence in New Zealand, BMC Cancer vol. 10, p. 674.

Cvetkovski, S, Reavley, NJ & Jorm, AF 2012, The prevalence and correlates of psychological distress in Australian tertiary students compared to their community peers, Australian and New Zealand Journal of Psychiatry, vol. 46, no. 5, pp. 457–467.

Daley, J, McGannon, C & Ginnivan, L 2012, Game-changers: economic reform priorities for Australia, Grattan Institute, Melbourne, Viewed on October 27 2015, http://grattan.edu.au/wp-content/uploads/2014/04/Game_Changers_Web.pdf. Viewed 25th February 2016

Davies, SC 2014, Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence, London: Department of Health, Viewed 14th August 2014, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413196/CMO_web_doc.pdf

De Bortoli, L., Coles, J., & Dolan, M. (2013). Maternal infanticide in Australia: mental disturbance during the postpartum period. Psychiatry, Psychology and Law, 20(2), 301-311. Viewed 7th April , 2016, http://www.tandfonline.com/doi/abs/10.1080/13218719.2012.719103

De Genna, NM, Stack, DM, Serbin, LA, Ledingham, JE & Schwartzman, AE 2006, From risky behavior to health risk: continuity across two generations, Journal of Developmental & Behavioral Pediatrics, vol. 27, no. 4, pp. 297–309.

De Hert, M, Cohen, D, Bobes, J, Cetkovich-Bakmas, M, Leucht, S, Ndetei, DM & Correll, CU 2011b, Physical illness in patients with severe mental disorders. II. Barriers to care, monitoring and treatment guidelines, plus recommendations at the system and individual level, World Psychiatry, vol. 10, no. 2, pp. 138–51.

DeGangi, GA, Breinbauer, C, Roosevelt, JD, Porges, S & Greenspan, S 2000, Prediction of childhood problems at three years in children experiencing disorders of regulation during infancy, Infant Mental Health Journal, vol. 21, no. 3, pp. 156–175.

Deloitte Access Economics 2012, The cost of perinatal depression in Australia: final report, Report prepared for the Post and Antenatal Depression Association (PANDA). Viewed 25th February 2016 https://www.deloitteaccesseconomics.com.au/uploads/File/PANDA%20Exec%20Summ%20pdf.pdf

Deloitte Access Economics. 2015, The economic value of informal care in Australia in 2015. Carers Australia, viewed March 2nd 2016 http://www.carersaustralia.com.au/storage/access-economics-report-2015.pdf

Department of Health and Ageing (DoHA) 2010, National Women's Health Policy 2010. Commonwealth of Australia, Canberra. Viewed 25th February 2016. https://www.health.gov.au/internet/main/publishing.nsf/Content/3BC776B3C-331D5EECA257BF0001A8D46/$File/NWHP_access_final.pdf.

Department of Health and Ageing (DoHA) 2013, National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993 – 2011, Commonwealth of Australia, Canberra, viewed 5th November 2015, http://www.health.

gov.au/internet/main/publishing.nsf/content/B090F03865A7FAB9CA257C1B0079E198/$File/rep13.pdf.

Department of the Prime Minister and Cabinet, Australian Government 2014, Reform of the Federation White Paper: Roles and Responsibilities in Health, Issues Paper 3, viewed 20th October 2015, https://federation.dpmc.gov.au/sites/default/files/issues-paper/Health_Issues_Paper.pdf

Dewa, CS, McDaid, D & Ettner SL 2007, An international perspective on worker mental health problems: who bears the burden and how are costs addressed? Canadian Journal of Psychiatry, vol. 52, pp. 346–356.

Di Matteo, MR, Lepper, HS & Croghan, TW 2000, Depression is a risk factor for noncompliance with medical treatment: meta-analysis of the effects of anxiety and depression on patient adherence, Archives of Internal Medicine, vol. 160, no. 14, pp. 2101–7.

Dillon, G., Hussain, R., Loxton, D., & Rahman, S. 2013, Mental and physical health and intimate partner violence against women: a review of the literature. International journal of family medicine, 2013.

Doal, J 2008, How Corston style 'one stop shop' women's centres can be rolled out nationally including an action plan based upon the experience of Anawim, viewed 25th February 2015 http://www.anawim.co.uk/documents/Rolling_out_Womens_Centres_Based_on_Anawim.pdf

Dolja-Gore, X, Loxton, D. J, D'Este, C. A, & Byles, J. E. 2014, Mental health service use: Is there a difference between rural and non-rural women in service uptake? Australian Journal of Rural Health, 22(3), 92-100.

Doran CE, Jacobs P, Dewa CS 2011, Return on Investment for Mental Health Promotion: Parenting Programs and Early Childhood Development. Edmonton: Institute of Health Economics Viewed March 9th 2016 http://childandyouth.com/wp-content/uploads/2012/02/Economic-Model-of-Early-Investment-Final-Report-Nov-20111.pdf

Doran, CM 2013, The costs and benefits in the area of mental health, An evidence check rapid review brokered by the Sax Institute (www.saxinstitute.org.au) for the Mental Health Commission of NSW, viewed 5th November 2015, https://www.saxinstitute.org.au/wp-content/uploads/MH-costs-and-benefits-of-intervention_FINAL2.pdf

Doyal, L 2002, Putting gender into health and globalisation debates: new perspectives and old challenges, Third World Quarterly, vol. 23, no. 2, pp. 233–250, viewed 5th November 2015, DOI: 10.1080/01436590220126612

Dudgeon, P, Wright, M, Paradies, Y, Garvey, D, & Walker, I. 2010. The social, cultural and historical context of Aboriginal and Torres Strait Islander Australians. Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice, 25-42. Viewed 8th April 2016 http://dro.deakin.edu.au/eserv/DU:30058500/paradies-socialculturalhistorical-2010.pdf

Duffy, S & Hyde, C 2011, Women at the centre: innovation in community, The Centre for Welfare Reform, viewed 25th February 2015 http://www.centreforwelfarereform.org/uploads/attachment/273/women-at-the-centre-summary.pdf

Duggan, M 2015, Beyond the fragments: Preventing the costs and consequences of chronic physical and mental diseases, Australian Health Policy Collaboration Issues paper No. 2015-05, Australian Health Policy Collaboration, Melbourne, viewed 5th November 2015, https://www.vu.edu.au/sites/default/files/AHPC/pdfs/beyond-the-fragments.pdf

Easton, H & Matthews, R 2012, Evaluation of the Inspire Women's Project, viewed 5th November 2015, https://www.glasgow.gov.uk/CHttpHandler.ashx?id=9497&p=0.

Edwards, J., Hemphill, S. A., Tresidder, J., Humphreys, C., Toumbourou, J. W., & Murray, D. 2007, Mental health promotion and socioeconomic disadvantage: lessons from substance abuse, violence and crime prevention and child health. Health Promotion Journal of Australia: Official Journal of Australian Association of Health Promotion Professionals, Vol. 18, No. 3, 2007 Dec: 184-90.

Edwards, B, Higgins, D, Gray, M, Zmijewski, N & Kingston, M. 2008, The nature and impact of caring for family members with a disability in Australia, Australian Institute of Family Studies Research Report No. 16, Canberra.

Edwards, B & Maguire, B 2012, Parental mental health, 7. Australian Institute of Family Studies Research Report. Viewed 2nd March 2016 http://www.growingupinaustralia.gov.au/pubs/asr/2011/ch2asr2011.pdf

Fan, AZ, Strine, TW, Jiles, R, Mokdad, AH, Huang, Y, Murray, MR & Musingo, S 2009, Self-rated depression and physician-diagnosed depression and anxiety in Florida adults: behavioral risk factor surveillance system, 2006, Preventing Chronic Disease, vol. 6, no. 1, A10.

Firmin, C 2013, Something old or something new: do pre-existing conceptualisations of abuse enable a sufficient response to abuse in young people's relationships and peer groups? In M. Melrose & J. Pearce (eds), Critical perspectives on child sexual exploitation and related trafficking, Palgrave Macmillan, Hampshire (pp. 38–51).

Forchuk, C, Martin, M.L, Chan, Y.L, & Jensen, E.2005, Therapeutic relationships: From psychiatric hospital to community. Journal of Psychiatric and Mental Health Nursing, 12, 556–564.

Fonagy, P 2010, Attachment theory and psychoanalysis, Other Press, LLC.

Friedli, L & Parsonage, M 2007, Building an economic case for mental health promotion: part I, Journal of Public Mental Health, vol. 6, no. 3, pp. 14–23.

Gambin L 2004, Gender differences in the effect of health on wages in Britain, Department of Economics and Related Studies, University of York, viewed March 1st 2016 http://www2.eur.nl/ecuity/public_papers/ECuity3wp20GambinGender-healthonincome.pdf

Glover, V & O'Connor, T 2002, Effects of antenatal stress and anxiety: implications for development and psychiatry, British Journal of Psychiatry, vol. 180, pp. 389–391.

Goodman, LA, Smyth, KF, Borges, AM & Singer, R 2009, When crises collide: how intimate partner violence and poverty intersect to shape women's mental health and coping? Trauma, Violence, & Abuse, vol. 10, no. 4, pp. 306–329.

Green, J & Goldwyn, R 2002, Annotation: attachment disorganisation and psychopathology: new findings in attachment research and their potential implications for developmental psychopathology in childhood, Journal of Child Psychology and Psychiatry, vol. 43, no. 7, pp. 835–846. Viewed March 2nd 2016 http://onlinelibrary.wiley.com/doi/10.1111/1469-7610.00102/full

Harrison, JE & Henley, G 2014, Suicide and hospitalised self-harm in Australia: trends and analysis, Injury research and statistics series no. 93, cat. no. INJCAT 169, AIHW, Canberra, viewed 16th Feb 2016, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129549727

Heckman, JJ 2008a, Role of income and family influence on child outcomes, Annals of the New York Academy of Sciences, vol. 1136, no. 1, pp. 307–323.

Heckman, JJ 2008b, Schools, skills, and synapses, Economic Inquiry, vol. 46, no. 3, pp. 289–324.

Henderson, G, Robson, C, Cox, L, Dukes, C, Tsey, K, & Haswell, M. 2007, Social and emotional wellbeing of Aboriginal and Torres Strait Islander people within the broader context of the social determinants of health. Beyond bandaids: exploring the underlying social determinants of Aboriginal Health, 136-164.Viewed April 8th 2016, http://researchonline.jcu.edu.au/2977/

Hirst, M 2005, Carer distress: a prospective, population-based study, Social Science & Medicine, vol. 61, no. 3, pp. 697–708.

Holden L, Dobson A, Byles J, Chojenta C, Dolja-Gore X, Harris M, Hockey R, Lee C, Loxton D, McLaughlin D, Mishra G, Pachana N, Reilly N & Tooth L 2013, Mental health: findings from the Australian Longitudinal Study on Women's Health, Report prepared for the Australian Government Department of Health and Ageing, viewed 27th October 2015, http://www.alswh.org.au/images/content/pdf/major_reports/2013_major%20report%20H.pdf

Hughes, RB, Taylor, HB, Robinson-Whelen, S & Nosek, MA 2005, Stress and women with physical disabilities: identifying correlates, Women's Health Issues, vol. 15, no. 1, pp. 14–20.

Humphrey MD, Bonello MR, Chughtai A, Macaldowie A, Harris K & Chambers, GM 2015, Maternal deaths in Australia 2008–2012, Maternal deaths series no. 5, cat. no. PER 70, AIHW, Canberra, viewed March 2nd 2016 http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129551117

Humphreys, C. 2007, A health inequalities perspective on violence against women. Health & Social Care in the Community, 15: 120–127. doi: 10.1111/j.1365-2524.2006.00685.x

Jean Hailes for Women's Health 2015, What do women want to know? Women's health information needs in Australia survey 2015, viewed 5th November 2015, https://jeanhailes.org.au/contents/documents/News/Jean_HailesWomensHealth-Survey_2015_Report_FINAL.pdf

Judd, F, Armstrong, S & Kulkarni, J 2009, Gender-sensitive mental health care, Australasian Psychiatry, vol. 17, no. 2, pp. 105–111. Viewed March 2nd 2016 http://www.tandfonline.com/doi/abs/10.1080/10398560802596108#.VtZbult9670

Kentikelenis, A, Karanikolos, M, Reeves, A, McKee, M & Stuckler, D 2014, Greece's health crisis: from austerity to denialism, The Lancet, vol. 383, no. 9918, pp. 748–753. Viewed March 2nd 2016 http://www.sciencedirect.com/science/article/pii/S0140673613622916

Kessler, R.C., Berglund, P.A., Zhao, S., Leaf, P.J., Kouzis, A.C., Bruce, M.L., Friedman, R.M., Grosser, R.C., Kennedy, C., Narrow, W.E. and Kuehnel, T.G., 1996, The 12-month prevalence and correlates of serious mental illness (SMI). Mental Health, United States, pp.59-70.

Kessler, RC & Üstün, TB 2004, The World Mental Health (WMH) Survey Initiative Version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI), International Journal of Methods in Psychiatric Research, vol. 13, pp. 93–121.

Kilbourne, AM, Welsh, D, McCarthy, JF, Post, EP & Blow, FC 2008, Quality of care for cardiovascular disease-related conditions in patients with and without mental disorders, Journal of General Internal Medicine, vol. 23, no. 10, pp. 1628–1633.

King-Casas, B & Chiu, PH 2012, Understanding interpersonal function in psychiatric illness through multiplayer economic games, Biological Psychiatry, vol. 72 no. 2, pp. 119–125.

Knapp, M & Iemmi, V 2014, The economic case for better mental health, in S. Davies (ed), Public mental health priorities: investing in the evidence, Annual Report of the Chief Medical Officer 2013, Department of Health, London (147–156).

Kohen, D. 2000, Psychiatric services for women In Women and mental health. (Ed, Kohen, D.). London: Routledge

Kulkarni, J 2012, Women and Mental Health, Position paper, Australian Women's Health Network, viewed 20th October 2015, http://awhn.org.au/wp-content/uploads/2015/03/100_AWHNWomenMentalHealthPositionPaper2012.pdf

Labonte, R & Laverack, G. 2001, Capacity building in health promotion, Part 1: For whom? And for what purpose? Critical Public Health, vol. 11, no. 2, pp. 111–127.

Lee C, Powers J 2002, Number of social roles, health and well-being in three generations of Australian women. International Journal of Behavioural Health Med 9:195–215

LaPierre, TA 2012, The enduring effects of marital status on subsequent depressive symptoms among women: investigating the roles of psychological, social and financial resources, Journal of Epidemiology and Community Health, doi:10.1136/jech-2011-200383

Latimer, E.A, Lecomte, T, Becker, D.R, Drake, R.E, Duclos, Piat, M, Lahaie, St-Pierre, M.S, Therrien, C. and Xie, H. 2006, Generalisability of the individual placement and support model of supported employment: results of a Canadian randomised controlled trial. The British journal of psychiatry, 189(1), pp.65-73. Viewed March 9th 2016, http://bjp.rcpsych.org/content/189/1/65.long.

Lawrence, D, Hancock, KJ & Kisely, S 2013, The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers, British Medical Journal, vol. 346, f2539, doi:10.1136/bmj.f2539

Lawrence, D, Johnson, S, Hafekost, J, Boterhoven De Haan, K, Sawyer, M, Ainley, J & Zubrick, SR 2015, The mental health of children and adolescents, Report on the second Australian Child and Adolescent Survey of Mental Health and Well-being, Department of Health, Canberra, viewed 4th November 2015, http://apo.org.au/research/mental-health-children-and-adolescents-report-second-australian-child-and-adolescent-survey

Leung, J, Gartner, C, Dobson, A, Lucke, J & Hall, W 2011, Psychological distress is associated with tobacco smoking and quitting behaviour in the Australian population: evidence from national cross-sectional surveys, Australian and New Zealand Journal of Psychiatry, vol. 45, no. 2, pp. 170–178.

Lewinsohn, PM, Hops, H, Roberts, RE, Seeley, JR, & Andrews, JA 1993, Adolescent psychopathology: I. Prevalence and incidence of depression and other DSM-III—R disorders in high school students, Journal of Abnormal Psychology, vol. 102, no. 1, pp. 133–144.

Lieb, R., Mayfield, J., Miller, M., & Pennucci, A. 2004, Benefits and costs of prevention and early intervention programs for youth (No. 04-07, p. 3901). Olympia, WA: Washington State Institute for Public Policy. Viewed March 9th 2016, http://courses.washington.edu/pbaf513m/prevention%20tech%20appendix.pdf

Li, Z, Zeki, R, Hilder, L & Sullivan, EA 2013, Australia's mothers and babies 2011, Perinatal statistics series no. 28, cat. no. PER 59, AIHW, Canberra, viewed 5th November 2015, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx-?id=60129545698

Lindholm, C, Burström, B & Diderichsen, F 2001, Does chronic illness cause adverse social and economic consequences among Swedes? Scandinavian Journal of Public Health, vol. 29, no. 1, pp. 63-70.

Loxton, D, Mooney, R & Young, AF 2006, The psychological health of sole mothers in Australia, Medical Journal of Australia, vol. 184, no. 6, pp. 265–268.

Luborsky, L, Diguer, L, Seligman, DA, Rosenthal, R, Krause, ED, Johnson, S, Halperin, G, Bishop, M, Berman, J & Schweizer, E 1999, The researcher's own therapy allegiances: A "wild card" in comparisons of treatment efficacy, Clinical Psychology: Science and Practice, vol. 6, no. 1, 95–106.

Lucas, N, Bayer, JK, Gold, L, Mensah, FK, Canterford, L, Wake, M, Westrupp, EM & Nicholson, JM 2013, The cost of healthcare for children with mental health difficulties, Australian and New Zealand Journal of Psychiatry, vol. 47, no. 9, pp. 849–858.

Luppa, M, Sikorski, C, Motzek, T, Konnopka, A, König, HH & Riedel-Heller, SG 2012, Health service utilization and costs of depressive symptoms in late life - a systematic review, Current Pharmaceutical Design, vol. 18, no. 36, pp. 5936–57.

Lytton, H & Romney, DM 1991, Parents' differential socialization of boys and girls: A meta-analysis, Psychological Bulletin, vol. 109, no. 2, pp. 267–296.

Main M, Kaplan N, Cassidy J. 1985, Security in infancy, childhood, and adulthood: A move to the level of representation. Monographs of the society for research in child development. 1:66-104.

Marmot, M & Bell, R 2012, Fair society, healthy lives (The Marmot Review): the strategic review of health inequalities in England post-2010, viewed 20th October 2015, http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

Martín-Merino, E, Ruigómez, A, Johansson, S, Wallander, MA & García-Rodriguez, LA 2010, Study of a cohort of patients newly diagnosed with depression in general practice: prevalence, incidence, comorbidity, and treatment patterns, Primary Care Companion to the Journal of Clinical Psychiatry, vol. 12, no. 1. e1-e8. Viewed 8th March 2016, http://www.psychiatrist.com/pcc/article/Pages/2010/v12n01/08m00764blu.aspx

Martino, W. & Pallotta-Chiarolli, M. 2005, 'Being normal is the only thing to be': Boys and Girls' perspectives on school. Sydney, Australia: University of New South Wales Press.

Mayhew, P 2003, Counting the costs of crime in Australia, Australian Institute of Criminology: Trends and Issues in Crime and Criminal Justice, viewed March 8th 2016 http://www.aic.gov.au/publications/current%20series/tandi/241-260/tandi247.html

McDaid, D 2011, Making the long term economic case for investing in mental health to contribute to sustainability, European Pact for Mental Health and well Being, viewed March 8th 2016 http://ec.europa.eu/health/mental_health/docs/long_term_sustainability_en.pdf

McDaid, D & La Park, A 2011, Investing in mental health and well-being: findings from the DataPrev project, Health Promotion International, vol. 26(suppl 1), pp. i108-i139, http://heapro.oxfordjournals.org/content/26/suppl_1/i108.full.pdf+html

McFerran, L, Cortis, N, Trijbetz, (2013) Domestic and Family Violence Clauses in your workplace: Implementation and good practice. Social Policy Research Centre & Centre for Gender Related Violence Studies, University of New South Wales. Viewed 7th April 2016, https://www.arts.unsw.edu.au/media/FASSFile/Domestic_and_Family_Violence_Clauses_in_your_Workplace__Implementation_and_good_practice.pdf

McNair, R, Szalacha, L & Hughes, T 2011, Health status, health service use and satisfaction according to sexual identity of young Australian women, Women's Health Issues, vol. 21, no. 1, pp. 40–47.

McNeish, D & Scott, S 2014, Women and girls at risk: evidence from across the lifecourse, Lankelly Chase Foundation, viewed 27th October 2015, http://lankellychase.org.uk/wp-content/uploads/2015/10/Women-and-Girls-at-RiskEvidence-Review.pdf http://lankellychase.org.uk/wp-content/uploads/2015/10/Women-and-Girls-at-RiskEvidence-Review.pdf

Mensah FK, Kiernan KE. 2010, Parents' mental health and children's cognitive and social development: families in England in the Millennium Cohort Study. Soc Psychiatry Psychiatr Epidemiol 45: 1023-1035.<PubMed

Messina, N, Grella, CE, Cartier, J & Torres, S 2010, A randomized experimental study of gender-responsive substance abuse treatment for women in prison, Journal of Substance Abuse Treatment, vol. 38, no. 2, pp. 97–107.

Michie, S, & Williams, S. 2003, Reducing work related psychological ill health and sickness absence: a systematic literature review. Occupational and Environmental Medicine, 60(1), 3-9. Viewed 8th March 2016, http://oem.bmj.com/content/60/1/3.full.pdf

Mihalopoulos, C. 2007, Does the triple P-positive parenting program provide value for money? Australian and New Zealand Journal of Psychiatry, 41(3), 239-246

Mihalopoulos, C, Harris, M, Henry, L., Harrigan, S, & McGorry, P. 2009, Is early intervention in psychosis cost-effective over the long term?.Schizophrenia bulletin, sbp054. Viewed 9th March 2016, http://schizophreniabulletin.oxfordjournals.org/content/35/5/909.full

Milgrom, J, Negri, L, Erickson, JE & Gemmill, AW 2005, Screening for postnatal depression in routine primary care: properties of the Edinburgh Postnatal Depression Scale in an Australian community, Australian and New Zealand Journal of Psychiatry, vol. 398, pp. 745–751.

Mission Australia 2015, Young people's mental health over the years: youth survey 2012-14, Mission Australia, viewed 27th October 2015, https://www.missionaustralia.com.au/content/item/632-worrying-increase-in-psychological-distress-in-young-women

Moore, H 1994, The problem of explaining violence in the social sciences in Harvey, P. and Gow, P. (eds) Sex and violence: Issues in representation and experience 1994, Routledge London & New York pp. 138-155.

Moss, NE 2002, Gender equity and socioeconomic inequality: a framework for the patterning of women's health, Social Science & Medicine, vol. 54, no. 5, pp. 649–661.

Mojtabai, R, Olfson, M, Sampson, N. A, Jin, R, Druss, Wang, P. S, Kessler, R. C. 2011, Barriers to Mental Health Treatment: Results from the National Comorbidity Survey Replication (NCS-R). Psychological Medicine,41(8), 1751–1761. Viewed March 9th 2016, http://doi.org/10.1017/S0033291710002291

Moussavi, S, Chatterji, S, Verdes, E, Tandon, A, Patel, V & Ustun, B 2007, Depression, chronic diseases, and decrements in health: results from the World Health Surveys, The Lancet, vol. 370, pp. 851–858.

Najavits, LM 2007, Seeking Safety: An evidence-based model for substance abuse and trauma/PTSD, in K.A. Witkiewitz & G.A. Marlatt (eds), Therapist's guide to evidence based relapse prevention: Practical resources for the mental health professional, Elsevier Press, San Diego (141–167).

National Eating Disorders Collaboration 2012, Eating Disorders in Australia, viewed 16th January 2016, http://www.nedc.com.au/eating-disorders-in-australia

National Institute for Health & Care Excellence (NICE) 2014, Antenatal and postnatal mental health: clinical management and service guidance, viewed 5th November 2015, http://www.nice.org.uk/guidance/cg192/resources/antenatal-and-postnatal-mental-health-clinical-management-and-service-guidance-35109869806789

National Mental Health Commission (NMHC) 2014, Contributing Lives, Thriving Communities, The National Review of Mental Health Programmes and Services, NMHC, Sydney.

National Rural Health Alliance 2014, Submission to the National Mental Health Commission on the Review of Mental Health Services and Programmes, viewed on 4th November 2015, http://ruralhealth.org.au/sites/default/files/documents/nrha-policy-document/submissions/mental-health-submission-final-14-april-2014-submitted.pdf

Naylor, C, Parsonage, M, McDaid, D, Knapp, M, Fossey, M, & Galea, A. 2012, Long-term conditions and mental health: the cost of co-morbidities. The King's Fund. London. Viewed 25th February 29016. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf

Notman, M, & Nadelson, C. (2006). Psychoanalytic perspectives. In S. Romans & M. Seeman (Eds.), Women's mental health, a life cycle approach (pp. 13–15). Ontario, Canada: Lippincott Williams & Wilkins.

NREPP 2014, Trauma Recovery and Empowerment Model (TREM), National Registry of Evidence-based Programs and Practices, http://homeless.samhsa.gov/channel/national-registry-for-evidence-based-programs-and-practices-nrepp-449.aspx

Oates, M & Cantwell, R 2011, Deaths from psychiatric causes, Centre for Maternal and Child Enquiries. Mission Statement, 132. http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2010.02847.x/pdf#page=134. Viewed March 2nd 2016

O'Connor, TG, Heron, J & Glover, V 2002a, Antenatal anxiety predicts child behavioral/emotional problems independently of postnatal depression, Journal of the American Academy of Child and Adolescent Psychiatry, vol. 41, pp. 1470–1477.

OECD 2015, In It Together: Why Less Inequality Benefits All, OECD Publishing, Paris, viewed November 5th 2015, DOI: http://dx.doi.org/10.1787/9789264235120-en

Passannante, M. R, & Nathanson, C. A. 1985, Female labour force participation and mortality in Wisconsin, 1974–1978. Social Science & Medicine, 21(6), 655–665

Olds, DL, Kitzman, H, Cole, R, Robinson, J, Sidora, K, Luckey, DW & Holmberg, J 2004, Effects of nurse home-visiting on maternal life course and child development: age 6 follow-up results of a randomized trial, Pediatrics, vol. 114, no. 6, pp. 1550–1559.

Paulden, M, Palmer, S, Hewitt, C & Gilbody, S 2009, Screening for postnatal depression in primary care: cost effectiveness analysis, British Medical Journal, vol. 339, b5203, doi: 10.1136/bmj.b5203.

Pereda, N, Guilera, G, Forns, M & Gómez-Benito, J 2009, The international epidemiology of child sexual abuse: a continuation of Finkelhor (1994), Child Abuse & Neglect, vol. 33, no. 6, pp. 331–342.

Platt, L 2011, Inequality within ethnic groups, Joseph Rowntree Foundation, York.

Pomerleau, A, Bolduc, D, Malcuit, G & Cossette, L 1990, Pink or blue: Environmental gender stereotypes in the first two years of life, Sex Roles, vol. 22, nos. 5-6, pp. 359–367.

Porter, T & Gavin, H 2010, Infanticide and neonaticide: a review of 40 years of research literature on incidence and causes, Trauma, Violence, & Abuse, vol. 11, no. 3, pp. 99–112.

Power, C & Parsons, T 2002, Overweight and obesity, in D. Kuh & R. Hardy (eds), A life course approach to women's health, Oxford University Press, Oxford (304–328).

Priest, SR, Austin, MP, Barnett, BB & Buist, A 2008, A psychosocial risk assessment model (PRAM) for use with pregnant and postpartum women in primary care settings, Archives of Women's Mental Health, vol. 11, nos. 5-6, pp. 307–31.

PwC 2014, Creating a Mentally Healthy Workplace. Return on investment analysis. Viewed 8th March 2016, https://www.headsup.org.au/docs/default-source/resources/beyondblue_workplaceroi_finalreport_may-2014.pdf?sfvrsn=6

Queensland Mental Health Commission 2014, Discussion paper: perinatal and infant mental health service enhancement, viewed 5th November 2015, http://www.qmhc.qld.gov.au/wp-content/uploads/2014/08/QMHC-Discussion-paper-Perinatal-and-Infant-Mental-Health-Service-Enhancement.pdf

Quirk, A, Lelliott, P & Seale, C 2004, Service users' strategies for managing risk in the volatile environment of an acute psychiatric ward, Social Science & Medicine, vol. 59, no. 12, pp. 2573–2583.

Radford, L, Corral, S, Bradley, C, Fisher, H, Bassett, C, Howat, N & Collishaw, S 2011, Child abuse and neglect in the UK today, NSPCC, London, UK, viewed 4th November 2015, http://clok.uclan.ac.uk/6022/1/child_abuse_neglect_research_PDF_wdf84181.pdf/

Reavley, NJ & Jorm, AF 2011, Stigmatizing attitudes towards people with mental disorders: findings from an Australian National Survey of Mental Health Literacy and Stigma, Australian and New Zealand Journal of Psychiatry, vol. 45, no. 12, pp. 1086–1093.

Renold, E 2013, Girls and boys speak out; a qualitative study of children's gender and sexual cultures, NSPCC & Children's Commissioner for Wales, viewed 4th November 2015, https://www.nspcc.org.uk/globalassets/documents/research-reports/boys-girls-speak-out-report.pdf

Rich, JL, Byrne, JM, Curryer, C, Byles, JE & Loxton, D 2013, Prevalence and correlates of depression among Australian women: a systematic literature review, January 1999-January 2010, BMC Research Notes, vol. 6, no. 1, p. 424.

Richardson, S, Healy, J & Moskos, M 2014, From "gentle invaders to breadwinners": Australian women's increasing employment and earnings shares, NILS Working Paper Series No 210, viewed October 27th 2015, http://www.flinders.edu.au/sabs/nils-files/publications/working-papers/Breadwinner%20Women.pdf

Rienks, J, Dobson, AJ & Mishra, GD 2013, Mediterranean dietary pattern and prevalence and incidence of depressive symptoms in mid-aged women: results from a large community-based prospective study, European Journal of Clinical Nutrition, vol. 67, no. 1, pp. 75–82.

Robson, D & Gray, R 2007, Serious mental illness and physical health problems: a discussion paper, International Journal of Nursing Studies, vol. 44, no. 3, pp. 457–466.

Rosenquist, JN, Fowler, JH & Christakis, NA 2011, Social network determinants of depression, Molecular Psychiatry, vol. 16, no. 3, pp. 273–281.

Rost, K, Smith, JL & Dickinson M 2004, The effect of improving primary care depression management on employee absenteeism and productivity. A randomized trial, Medical Care, vol. 42, pp. 1202–10.

Royal Australian and New Zealand College of Psychiatrists (RANZCP) 2014, Keeping your head above water: affordability as a barrier to mental health care, RANZCP, viewed 16th February 2016, https://www.ranzcp.org/Files/Resources/Media_Centre/FINAL-RANZCP_Affordability-Mental-Health.aspx

Royal Australian and New Zealand College of Psychiatrists (RANZCP) 2015, Keeping body and mind together: improving the physical health and life expectancy of people with serious mental illness, RANZCP, viewed 20th October 2015, https://www.ranzcp.org/News-policy/Policy-and-advocacy/Physical-health-and-mental-illness.aspx

Sansone, RA & Sansone, LA 2012 Chronic pain syndromes and borderline personality, Innovations in Clinical Neuroscience, vol. 9, no. 1, pp. 10–14.

Sawyer, MG, Carbone, JA, Searle, AK & Robinson, P 2007, The mental health and wellbeing of children and adolescents in home-based foster care, Medical Journal of Australia, vol. 186, no. 4, pp. 181–4.

Schiff, M, Plotnikova, M, Dingle, K, Williams, GM, Najman, J & Clavarino, A. 2014, Does adolescent's exposure to parental intimate partner conflict and violence predict psychological distress and substance use in young adulthood? A longitudinal study, Child Abuse & Neglect, vol. 38, no. 12, pp. 1945–1954.

Scott, S, Williams, J, Kelly, L, McNaughton Nicholls, C, Lovett, J & McManus, S 2015 Violence, abuse and mental health in England: responding effectively to violence and abuse (REVA) Briefing 1, NatCen, London. Viewed, 7th April 2016 http://www.natcen.ac.uk/REVAbriefing1

SCRGSP. 2014, (Steering Committee for the Review of Government Service Provision). Overcoming Indigenous Disadvantage: key indicators 2014, Canberra Viewed 8th April 2016, http://www.pc.gov.au/research/ongoing/overcoming-indigenous-disadvantage/key-indicators-2014/key-indicators-2014-overviewbooklet.pdf

Slade, T, Johnston, A, Oakley Browne, MA, Andrews, G & Whiteford, H. 2009, 2007 National Survey of Mental Health and Wellbeing: methods and key findings, Australian and New Zealand Journal of Psychiatry, vol. 43, no. 7, pp. 594–605.

Smith, J.P, & Smith, G.C. 2010, Long-term economic costs of psychological problems during childhood. Social Science & Medicine, 71 (1), 110–115

Sorensen, G, & Verbrugge, L. M. 1987, Women, work, and health. Annual Review of Public Health, 8, 235–251

Stansfeld, S, & Candy, B. 2006, Psychosocial work environment and mental health—a meta-analytic review. Scandinavian journal of work, environment & health, 443-462. Viewed March 8th 2016, http://www.jstor.org/stable/40967597?seq=1#page_scan_tab_contents

Steele, H, Steele, M, & Fonagy, P. 1996, Associations among attachment classifications of mothers, fathers, and their infants. Child development, 541-555.

Steel, Z, Silove, D, Phan, T, & Bauman, A. (2002). Long-term effect of psychological trauma on the mental health of Vietnamese refugees resettled in Australia: a population-based study. The Lancet, 360(9339), 1056-1062. Viewed, 7th April 2016 http://www.sciencedirect.com/science/article/pii/S0140673602111421

Stoppard, JM 2000, Understanding depression, Clays Ltd, New Jersey, USA.

Strazdins L, Shipley M, Broom D 2007, What does family-friendly really mean? Well-being, time and the quality of parents' jobs. Aust Bull Labour 33:202–225

Suhrcke, M, McKee, M, Stuckler, D, Arce, RS, Tsolova, S & Mortensen, J 2006, The contribution of health to the economy in the European Union, Public Health, vol. 120, no. 11, pp. 994–1001.

Sullivan, EA, Hall, B & King, JF 2007, Maternal deaths in Australia 2003–2005, Maternal deaths series no. 3, cat. no. PER 42, AIHW National Perinatal Statistics Unit, Sydney.

Suomi, SJ 1999, Developmental Trajectories, Early Experiences, and Community Consequences: Lessons from Studies with Rhesus Monkeys, In DP. Keating & C. Hertzman (eds), Developmental health and the wealth of nations: social, biological, and educational dynamics, The Guilford Press, New York (185–200).

Swan P, Raphael, B. 1995, Ways Forward. National Aboriginal and Torres Strait islander Mental Health Policy, Canberra

Sweeney, K & Shi, H (in press), Serious mental illness and comorbidities in Australia and New Zealand, Report to the Royal Australian and New Zealand College of Psychiatrists and the Australian Health Policy Collaboration, Victoria Institute of Strategic Economic Studies.

Taft, A 2003, Promoting women's mental health: the challenge of intimate partner/domestic violence, Issues Paper No. 8, Australian Domestic and Family Violence Clearing House, Sydney.

Tarren-Sweeney, M., & Hazell, P. 2006, Mental health of children in foster and kinship care in New South Wales, Australia. Journal of Paediatrics and Child Health, 42(3), 89-97.

Thornicroft, G 2008, Stigma and discrimination limit access to mental health care, Epidemiologia e Psichiatria Sociale, vol. 17, no. 1, pp. 14–19.

Tooth, L & Mishra, G 2013, Intergenerational educational mobility on general mental health and depressive symptoms in young women, Quality of Life Research, vol. 22, no. 7, pp. 1589–1602.

Turkheimer, E, Haley, A, Waldron, M, D'Onofrio, B & Gottesman, I 2003, Socioeconomic status modifies heritability of IQ in young children, Psychological Science, vol. 14, no. 6, pp. 623–62.

UK Department of Health 2011, No Health Without Mental Health. A cross-Government mental health outcomes strategy for people of all ages. Supporting Document. The economic case for improving efficiency and quality in mental health . Viewed March 9th 2016, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215808/dh_123993.pdf

United Nations 2002, Gender dimensions of ageing, viewed 5th February 2016 http://www.un.org/womenwatch/daw/public/ageing-final.pdf

United Nations 2015, The World's Women 2015: Trends and Statistics. New York: United Nations, Department of Economic and Social Affairs, Statistics Division. Sales No. E.15.XVII.8. Viewed 25th February 2016 http://unstats.un.org/unsd/gender/downloads/WorldsWomen2015_report.pdf

Van Lente, E, Barry, MM, Molcho, M, Morgan, K, Watson, D, Harrington, J & McGee, H 2012, Measuring population mental health and social well-being, International Journal of Public Health, vol. 57, no. 2, pp. 421–430.

Varese, F, Smeets, F, Drukker, M, Lieverse, R, Lataste, T, Viechtbauer, W, Read, J, van Os, J, Bentall, R 2012, Childhood adversities increase the risk of psychosis: a meta-analysis of patient-control, prospective- and cross-sectional cohort studies, Schizophrenia Bulletin, DOI:10.1093/schbul/sbs050.

Verbeek, T, Bockting, CL, van Pampus, MG, Ormel, J, Meijer, JL, Hartman, CA & Burger, H 2012, Postpartum depression predicts offspring mental health problems in adolescence independently of parental lifetime psychopathology, Journal of Affective Disorders, vol. 136, no. 3, pp. 948–954.

VicHealth 2004, The health costs of violence: measuring the burden of disease caused by intimate partner violence, VicHealth, viewed March 2nd 2016 https://www.vichealth.vic.gov.au/media-and-resources/publications/the-health-costs-of-violence

Victorian Mental Illness Awareness Council (VMIAC) 2008, Zero tolerance of sexual assault: a safe admission for women, viewed 5th November 2015, http://www.abc.net.au/reslib/201305/r1115028_13591277.pdf

Walker, EA, Gelfand, A, Katon, WJ, Koss, MP, Von Korff, M, Bernstein, D & Russo, J 1999, Adult health status of women with histories of childhood abuse and neglect, The American Journal of Medicine, vol. 107, no. 4, pp. 332–339.

Wang, PS, Simon, GE, Avorn, J, Azocar, F, Ludman, EJ, McCulloch, J, Petukhova, MZ & Kessler, RC 2007, Telephone screening, outreach, and care management for depressed workers and impact on clinical and work productivity outcomes: a randomized controlled trial, Journal of the American Medical Association, vol. 298, pp. 1401–11.

Waldron, I, & Jacobs, J. A. 1988, Effects of labour free participation on women's health: New evidence from a longitudinal study. Journal of Occupational Medicine, 30(12), 977–983.

Walters, V, Denton, R, French, S., Eyles, J, Mayr, J, & Newbold, B. 1996, Paid work, unpaid work and social support: A study of the health of male and female nurses. Social Science & Medicine, 43(11), 1627–1636.

Warner, J, McKeown, E, Griffin, M, Johnson, K, Ramsay, A, Cort, C, & King, M 2004, Rates and predictors of mental illness in gay men, lesbians and bisexual men and women, The British Journal of Psychiatry, vol. 185, no. 6, pp. 479–485.

Warren, J 2007, Young carers: conventional or exaggerated levels of domestic and caring tasks, Children & Society, vol. 21, pp. 136–146.

Weinfield, NS, Whaley, GJ & Egeland, B 2004, Continuity, discontinuity, and coherence in attachment from infancy to late adolescence: sequelae of organization and disorganization, Attachment & Human Development, vol. 6, no. 1, pp. 73–97.

Williams, J 1996, Social inequalities and mental health: developing services and developing knowledge, Journal of Community & Applied Social Psychology, vol. 6, no. 5, pp. 311–316.

Williams, J & Watson, G 1996, Mental health services that empower women, in T. Heller, J. Reynold, R. Gomm, R. Muston & S. Pattison (eds), Mental health matters, Macmillan, London, UK. pp. 242-251

Woolhouse, H, Gartland, D, Perlen, S, Donath, S & Brown, SJ 2014, Physical health after childbirth and maternal depression in the first 12 months post-partum: results of an Australian nulliparous pregnancy cohort study, Midwifery, vol. 30, no. 3, pp. 378–384.

World Health Organization (WHO) 2000 Women's mental health: an evidence-based review, viewed 4th November 2015, http://apps.who.int/iris/bitstream/10665/66539/1/WHO_MSD_MDP_00.1.pdf

Yelland, J., Sutherland, G., & Brown, S. J. (2010). Postpartum anxiety, depression and social health: findings from a population-based survey of Australian women. BMC Public Health, 10(1), 1. Viewed 7th April 2016 http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-10-771

Zhang, Y, Chow, V, Vitry, AI, Ryan, P, Roughead, EE., Caughey, GE, & Luszcz, M. A. 2010, Antidepressant use and depressive symptomatology among older people from the Australian Longitudinal Study of Ageing. International Psychogeriatrics, 22(03), pp. 437-444.

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