

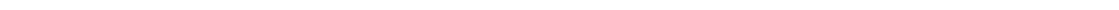
health

Department of Health

Service guideline on
gender sensitivity and safety
Literature review

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Literature review



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Introduction

This literature review provides an overview of the literature relevant to the *Service guideline for gender sensitivity and safety*. It is intended to be read in conjunction with the guideline, in particular to inform those responsible in leading organisational change. Equally, practitioners responsible for following the practice guideline will find this informative background reading in conjunction with applying the guideline.

The review examines the concepts of gender sensitivity and provides an overview of gendered differences as they relate to mental illness and alcohol and other drug (AOD) dependency. The concepts of gender, gender sensitivity and gender-sensitive practice are defined and conceptualised within the service system.

Gender-sensitive care provision needs to address the diversity of population groups including Aboriginal people, those from culturally and linguistically diverse (CALD) backgrounds, gay, lesbian, bisexual, transgender and intersex (GLBTI) people, people with a disability and those who are hearing impaired or deaf. Issues associated with the wellbeing of these population groups and how they interplay with gender in the context of service provision are explored.

Trauma is a risk factor in relation to mental illness and AOD problems. The prevalence of interpersonal violence and abuse in the population of people with diagnosed mental illness and substance addiction is examined. The effects of abuse, torture and trauma is significant and it manifests differently in people. This section also provides a discussion of trauma-informed care and considers the notion of trauma-specific services.

The review examines the interaction of physical health issues and homelessness on people diagnosed with a mental illness or substance abuse issue. The factors associated with physical health and homelessness impact differently on men and women and may exacerbate a person's emotional or mental distress and increase vulnerability to a range of risks. Finally, the review analyses sexual vulnerability and survival including the sex industry in Australia, the link with low-socioeconomic status and sexual assault.

Gender sensitivity and analysis

This section provides an overview of key concepts within the area of gender sensitivity and analysis. It provides an overview of some of the gendered differences as they relate to mental illness and AOD issues. The section also addresses sensitive practice beyond gender sensitivity in order to make connections with other relevant issues such as cultural and sexual diversity, family-sensitive practice and client vulnerability.

Gendered policy and gender analysis

Before examining organisational policies and considering 'gender sensitivity', it is suggested that leaders within organisations familiarise themselves with the terminology relating to 'gendered' policy.

- *Gender-blind* policies lack any recognition of difference between genders.
- *Gender-specific* policies recognise differences in need of and practice responses to the different genders; data collection then includes aggregated data according to gender and ideally in relation to other cultural markers.

Gender analysis examines the relationship, as well as the role differences, between women and men as well as intersex and transgender individuals and seeks to investigate the ways in which gender roles impact on people's mental health and how to address these differences. Such analysis takes gender and diversity into account and is linked to the organisational planning cycle (Department of Human Services 2008). A gender analysis is an in-depth inquiry about the way assumptions and beliefs are held, often unconsciously by individuals, teams and organisations. It includes preparedness to question the way that services are provided and to reflect on questions such as 'who is the main focus of our service provision?'

The Victorian Government provides guidance on this issue through the *Gender and diversity lens for health and human services, a step-by-step guide to addressing gender and diversity issues* (Department of Human Services 2008).

The following definition by Afifi (2007, p. 389) highlights reasons for the need for gender awareness

It should be a standard practice to disaggregate all epidemiological data by sex and age for all disease over the lifetime. Besides documenting differences in prevalence rates of mental disorders and other disease, it is crucial to examine how women's and men's differences – such as their roles and responsibilities, their knowledge base, their position in society, their access and use of health resources – influence the vulnerability to mental disorders.

Gender sensitivity

‘Gender is conceptualised as a structural determinant of mental health and mental illness that runs like a fault line, interconnecting with and deepening the disparities associated with other important socioeconomic determinants such as income, employment and social position’ (WHO 2010, p. 2)

Sensitivity to gender is the ability to recognise different perceptions, experiences and needs that women and men, or those identifying as transgender or intersex may have because of their gender/identification. Research and literature on gender sensitivity has been predominately focused on increasing sensitivity towards women (Moller-Leimkuhler, 2002; Horsfall 2001, p. 422). While this focus on women is understandably connected to an acknowledgement of a previous lack of recognition and consideration of the needs of women, such an approach to gender sensitivity is limited in scope.

For the purposes of this guideline, gender sensitivity is defined as the ability to recognise differences between genders and the appreciation of the need to attend to these differences in service planning and practice. Furthermore, it acknowledges different perceptions, experiences and interests arising from women’s and men’s and others’ different social positions and access to mental health care.

Providing gender-sensitive AOD and mental health care includes consideration and implementation of quality improvement strategies to address the different needs of women and men, as well as those who do not identify with these two genders. Gender-sensitive practice validates childhood and adult life experiences (such as interpersonal violence and abuse) as well as the ‘day-to-day social, cultural, family and economic realities’ (Judd et al. 2009). Such care needs to include awareness of migration/refugee experiences and the dispossession of Aboriginal people. Therefore, integrating gender-sensitive practice means a reorientation of focus, including an inspection of currently held beliefs and assumptions about the way mental health care is provided and who it is provided for. Through a process of reflection, service providers can begin to increase awareness about changes that need to occur to integrate gender-sensitive care into all aspects of service provision.

Sensitive practice

Gender-sensitive practice cannot be applied in isolation from other issues relevant to those accessing services. Each individual's situation within their community, culture and family (both biological and social) will also determine their needs. To ensure 'sensitive' care, services need to promote a culture of interest and openness to each person's particular experiences, rather than providing stereotypical responses which are not based in the reality of people's lived experience. Gender cannot be considered separate from ethnicity, class, socioeconomic status, poverty, sexual orientation, the construct of family and community.

Humanistic and holistic care encompasses a willingness and openness to inquire about each individual's situation. This would include their needs and experiences, while assisting in making connections between their current situation and life experiences. When considering gender-sensitive practice, it is equally necessary to refrain from an assumption that those belonging to a specific gender are a homogenous group. In reality, there are many aspects that impact on the need for support. The provision of services in a thoughtful and respectful way takes a broad range of issues connected to identity and need into account. Examples of other types of identity 'markers' include, age, class, ethnicity, migration, sexual preference, socioeconomic status and (dis)ability.

Culturally-sensitive practice

Victoria's population is culturally diverse. Aboriginal people constitute approximately 2.5 per cent of the Australian population (ABS, 2000). A further 24 per cent of people were born overseas and for a third of this group English is their second (or third/fourth) language.

The word 'culture', when used to define 'ethnicity', refers to 'shared history, practice, beliefs, and values of racial, regional or religious groups of people' (d'Ardenne & Mahtani 1998, p. 4). Others suggest that culture refers to the values and practices which particular groups of people share as well as the things that people value, believe and do due to their cultural identity (Acharyya 1992; Sue & Sue 1990).

Culture is defining for people who belong to a particular cultural group and at the same time is ever changing. Culture was once thought of as relatively 'fixed', the influences of migration, globalisation and the mix of cultures at this time in Australia highlight the contested nature of culture as a fixed concept. Culture in the 21st century is increasingly seen as being more fluid, although certain aspects of culture remain less changeable.

Whenever conceptualising service provision as culturally sensitive, other factors, such as gender, age and ability need to be taken into account, as well as issues around specific experiences and interpretations of each person relating, but not limited to, their 'cultural self' as well as their experience and conceptualisation of their gender within their own culture.

For example, it is necessary for service providers to be cognisant of the terminology and concepts preferred by Aboriginal and Torres Strait Islander communities in Victoria. While terms such as 'mental health' and 'mental illness' refer to a western concept of health and illness, Aboriginal people generally prefer the concept of 'social and emotional wellbeing' (SEWB) which includes broader concepts about the connection between an individual and their community's historical and social contexts. Social, emotional, spiritual and cultural wellbeing does not only relate to the individual but takes the wellbeing of the whole community into account.

Equally, the connection and relationship between the individual, their community and land contribute greatly to the SEWB of Indigenous people. A rupture to the connection with land, community or identity can have a significant impact on the individual or the community's SEWB (Garvey 2008).

The concept of SEWB shifts the focus from the western terminology of 'sickness' to 'wellbeing'. While the concepts of mental illness and SEWB may be different ways of conceptualising what occurs for people when they seek help, it is necessary for those working in mainstream services to familiarise themselves with the Aboriginal concept of SEWB to be able to understand the views and experiences of Aboriginal people. It is this sensitivity to and respect for cultural differences and concepts that can contribute to an improved understanding of different viewpoints, and ways of understanding and responding to Aboriginal clients and their families.

Family-sensitive practice

'Working with families and carers of consumers is integral to the provision of high-quality specialist mental health care' (Department of Human Services 2005a).

Research evidence shows that the inclusion of families and carers increases wellbeing for both, the person with mental illness as well as the family (Department of Human Services 2005a).

Family members include those people who are involved in caring for the person with a mental illness even if they do not clearly identify with the term 'carer'. This is especially relevant for children of parents with mental illness, who frequently take on caring responsibilities, but do not always identify as such and, equally, are not always identified by others as carers (for example, by the service system and professionals) (Department of Human Services 2007a). Equally, it is important to understand who the person with mental illness/AOD issue identifies as their family members. It may include a range of people not biologically related, but considered by the person to be family.

In providing family-sensitive practice it is necessary to understand families as biological, blended or (social) families as identified by the person receiving the service. Family members include those identified as parents (biological or non-biological), partners (same or different sex), siblings, extended family and kinship groups, as well as children and young people. Children may be living with their family or parent, may be in part-time or full-time care, or may have occasional access with their parent/family.

While family- and carer-sensitive practice is one cornerstone of good mental health practice, there are occasions where different paradigms come together, such as where family violence or sexual abuse of a person has or is occurring¹. Safety is also paramount and mental health and AOD services have a responsibility to ensure the safety of their clients. It is also necessary to keep in mind that decisions should be made in the best interests of and in consultation with the client/consumer. This may mean that, taking client wishes into account, there may be a limit to the involvement of family members, at the direction of the client.

¹ This refers to adults who are living with or have experienced such violence, if professionals become aware of a child being abused, this needs to be reported to the appropriate authorities (Child Protection) and the *Child, Youth and Family Act 2005* is to be followed (State of Victoria, 2005).

Aiming to provide family-sensitive care may be challenging where abuse within the family has been disclosed. There is a need to thoughtfully balance this tension and to carefully consider the person's rights and best interests. The best outcome for the person with mental illness/AOD problem must be paramount and sensitivity paid to understanding how the person may wish to proceed.²

Practice sensitive to diversity

The concept of diversity encompasses understanding and respect for individual differences relating to a range of dimensions, including ethnicity, sexual orientation, socioeconomic status, age, physical and cognitive ability and disability, religious and political beliefs. People accessing mental health and AOD services come from all walks of life, as do those working within services and in the broader community. Organisations need to consider how these dimensions impact on a person's vulnerability in conjunction with gender.

Within the context of this guideline, addressing diversity also means that organisations need to be proactive in promoting responsiveness to the diverse needs of those accessing services. They must also support staff through providing an organisational culture respectful of 'diversity' and one that promotes and encourages inspection of held beliefs.

Those with a disability or who are hearing impaired or deaf will require additional support and sensitivity to their specific needs need to form part of any treatment and support plan. While this guideline does not address disability and deafness in particular detail, it is acknowledged that organisations need to ensure that staff either have the skills to work with those who have additional needs or that collaborative partnerships are formed with specialist services that are able to assist with such work. This may include sign-language interpreters, dual disability services (intellectual and psychiatric disability) and services specialising in acquired brain injury.

Recovery

Victorian services providing mental health and AOD services do not only focus on the treatment of mental illness or drug and alcohol problems, but also on recovery. Recovery in this context relates to a collaborative effort to support people to define and work towards achieving their personal goals and best possible outcomes. Recovery does not mean 'being cured' from mental illness; rather it refers to the integration of strategies which promote leading meaningful and productive lives while living with the impacts of mental illness. Recovery-orientated care promotes self-determination and individualised care with a focus on the particular strengths, needs and preferences of the individual. Recovery-orientated care also acknowledges and works with factors which impact on a person's wellbeing; including housing; education; employment and other factors such as gender, sexuality and socioeconomic status; ultimately resulting in a more holistic approach.

² It is expected that organisations will have supervisory arrangements and support by senior staff in place to discuss and reflect upon these tensions, in order to provide best possible care for the person with mental illness/AOD issue.

Vulnerability

A range of issues are pertinent to providing gender-sensitive care. These issues reflect key aspects of client vulnerability. People with a mental illness, AOD problems or dual diagnosis experience a range of issues which impact on their wellbeing. Sensitive practice creates an opportunity to be aware of such issues in order to assess for them and to provide services that take these into account or address them directly. The following list of issues have been identified as featuring commonly in the lives of those accessing mental health and AOD services. While these issues may contribute to a person's vulnerability, the way services, systems and individuals within services respond, or indeed fail to respond can exacerbate responses or mitigate stressors.

Sensitive practice also encompasses an understanding that issues related to vulnerability are not static in their manifestation for the individual: rather that the person may react to and be impacted by the same circumstances differently at different times.

Issues related to vulnerability have been identified as:

- trauma: both interpersonal and systemic forms (including childhood, adulthood, sexual violence, child abuse and family violence; as well as torture and trauma)
- housing: inadequate/insecure housing and homelessness
- poor physical health
- sexual orientation
- gender identity issues
- cultural diversity issues (lack of cultural understanding or appreciation, racism, discrimination)
- safety (sexual/physical/psychological and cultural safety in particular relating, but not limited, to residential, acute inpatient, withdrawal and other bed-based services).

Gender differences in mental health

‘Sex and gender are both important determinants of health. Biological sex and socially-determined gender interact to produce differential risks and vulnerability to ill health, and differences in health-seeking behaviour and health outcomes for women and men’ (Vikram 2005, p. 2).

Women and men experience mental illness differently. Equally, psychiatric diagnosis and the course of mental illness varies between genders. The way mental illness manifests and impacts people's lives is also variable. For example, depression in women frequently includes eating and sleeping disturbances, the onset of schizophrenia occurs later for women than men, and women tend to have fewer hospitalisations than men (Judd et al 2009).

The prevalence of mental illness is different for women and men, for example, certain types of psychiatric disorder occur disproportionately in women, including mood, anxiety and eating disorders (Meadows, Singh & Grigg 2007). Substance use disorders are more common in men, while personality disorders occur at relatively equal rates for women and men. However, antisocial, schizoid and paranoid personality disorders occur more frequently in men, while women are more likely to be diagnosed with borderline personality disorder (Falconer & Grigg 2007; Judd et al. 2009).

It is not only gender that influences diagnosis, the course and impact of mental illness, age, ethnicity, class and sexual orientation of the person receiving, as well as the person providing, the diagnosis have been found to impact also (Horsfall 2001). The interplay of gender and culturally-based stereotypes regarding how women and men ought to behave and how they are meant to express distress may occur between those giving and those receiving services. An analysis of one's own beliefs as suggested in the section on 'gender sensitivity and analysis', is necessary to limit one's own biased responses.

Gender differences in 'help-seeking' behaviour

'In 2007, around 28 per cent of men with a mental disorder in the previous 12 months had accessed services compared with over 40 per cent of women. The proportion of men with a mental disorder accessing services was lowest among men aged 16 to 24 years (13 per cent) and highest among men aged 45 to 54 years (39 per cent)' (Department of Health 2010).

Marked gender differences can be observed in requests for support and accessing health services in general, with studies showing gender differences of help-seeking behaviour at 1:2 (men: women) (Moller-Leimkuhler, 2002).

Similar differences according to gender can be observed within mental health care with men being less-likely to ask for assistance, especially for depression but also for other types of mental illness/AOD problems. Help-seeking behaviour has been associated with stereotypical roles, with women tending to be more likely to discuss problems with friends and family as well as with professionals. Similarly, men are expected to be strong with help-seeking viewed as weak. Equally, men can be more 'stoic and more likely to feel personally discredited (personal stigma) by mental illness than women' (Judd, Komiti, & Jackson 2008). This sentiment is echoed by others who suggest that 'men experience illness as a threat to their masculine identity, because weakness and need for help are believed not to be masculine' (Moller-Leimkuhler, 2002, p. 6). In this way it is easier for women to seek help, as it is in line with gender stereotypical behaviour and associated expectations.

Specific issues for people with mental illness/AOD dependency

Those diagnosed with mental illness or substance dependency experience a range of disadvantages associated with mental illness/substance use either as a precursor, composite or side-effect of such diagnosis. Those with mental illness experience poor physical health and often lack adequate health care; are more likely to be homeless; are likely to have experienced trauma at some stage in their life; are exposed to prejudices and experience discrimination about their illness. While not all people with a mental illness/substance dependency experience all of these issues, many who access public mental health and AOD services experience many of the above which impacts on their mental health, recovery and their lives (Department of Health 2009a; Osborn 2001). Services should consider these issues and the way in which they can interplay with a person's gender and gender identity.

Population groups

Gender-sensitive care needs to be provided within a framework that also addresses and is thoughtful of other diversity issues. This section provides an overview of issues pertaining to Aboriginal people, CALD and LGBTI communities.

Aboriginal people

‘Health does not simply mean the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole community. For Aboriginal people this is seen in terms of the whole of life view incorporating the overall concept of life-death and the relationship to the land. Health care services should strive to achieve the state where an individual is able to achieve their full potential as a human being of their community (National Aboriginal Health Strategy 1996).

Aboriginal people conceptualise mental health as social, spiritual and emotional wellbeing; not only relating to the individual person but to the whole community. Fostering connection to community, land and family is critical to a holistic approach to care for Aboriginal people, as many suffer from loss, grief and trauma and associated mental health issues as well as social, spiritual and emotional wellbeing issues.

Aboriginal people experience higher rates of disadvantage than other population groups in Australia experience a range of social disadvantages, including poverty, inadequate housing, and physical health problems. Aboriginal people are often reluctant to access mainstream services due to a lack of cultural awareness of service providers, experiences of discrimination, racism and past practices of institutionalisation and forced removal. Care that is provided in a less than culturally sensitive and appropriate way can inadvertently further contribute to distress and (while unintended) discrimination, which in turn can contribute to exacerbating poor social and emotional wellbeing in some Aboriginal people.

Because mental health matters: Victorian mental health reform strategy 2009–2019 (Department of Health 2009a) aims to address holistic care for Aboriginal people, inclusive of strategies for services to increase cultural sensitivity and culturally-responsive service provision. These issues are also necessary to consider within the provision of gender-sensitive care that addresses issues of safety and vulnerability.

Culturally and linguistically diverse communities

‘International research indicates that rates of mood and anxiety disorders may be higher in immigrant than host communities as a result of the stresses of migration, settlement in a new country and low proficiency in the predominant language’ (Department of Human Services 2006b, p. 3).

Victoria is home to people from more than 200 countries, who speak at least 200 different languages and dialects (Department of Human Services 2006b; Stolk, Minas, & Klimidis, 2008). More than 850,000 people (17.9 per cent of the Victorian population) were born in a country where English was not their first language. Moreover 20.4 per cent of the population (or more than one million people) spoke a language other than English at home in 2006. Similarly in 2001, 72.1 per cent of Victorians followed a combined total of 116 religions and 21 per cent spoke a language other than English at home (Department of Human Services 2006b, p. 1).

Research demonstrates that many types of mental illness are similar across cultures (such as schizophrenia) while others vary between countries and cultures. Specific groups within CALD communities are at higher risk of developing mental health problems and mental illness. The effects of migration combined with the reasons for leaving (or having to leave) one’s country of origin has an effect on mental health and refugees or asylum seekers may experience specific mental health impacts. Additionally, those who have spent time in detention centres are likely to experience additional psychological and mental health impacts from such an experience. Trauma and loss experienced prior to leaving one’s own country contributes to the development of mental health problems. Experiences after resettlement and arriving in Australia also constitute a risk factor for the development of mental health problems (Department of Human Services 2006b).

Children and young people from families who had to seek asylum in Australia due to war or intolerable situations in their country of origin are also at risk of developing mental health problems and mental illness associated with their own experience (of torture or trauma) and/or witnessing their parents being exposed to such trauma.

Equally, older people who migrated to Australia after the Second World War may still suffer from the impact of war and migration, as suicide rates of older people born in non-English speaking countries are significantly higher than among their Australian-born peers (Department of Human Services 2006b).

People from CALD backgrounds tend to come into contact with mental health services at a later stage. The reasons for this are multifaceted, they relate to stigma and shame about having a mental illness and potential reluctance to seek assistance outside the family; family support systems which provide necessary support for long periods of time; differences in understanding and meaning of mental illness; and barriers which keep people from accessing services when needed. Equally, services are not always provided in the best culturally sensitive ways, making it difficult for people to obtain mental health care, which is culturally and spiritually appropriate or safe (Department of Human Services 2006b, p. 1069).

The cultural diversity plan for specialist mental health services provides a more in-depth framework on addressing the needs of CALD communities (Department of Human Services 2006b).

Gay, lesbian, bisexual, transgender and intersex people (GLBTI)

‘While many issues for gay, lesbian, bisexual, transgender and intersex (GLBTI) people are different, prejudice and misunderstanding can be a common experience. There is enormous pressure from society to adopt the behaviours typically associated with being male or female, and people can be subjected to ridicule, intimidation and even violence just because they don’t fit into someone else’s ideal of a man or a woman’ (beyondblue 2009, p. 1).

It is important to consider the needs of individuals who do not identify or neatly fit the female/male gender category, or do not identify as heterosexual.

GLBTI people are as diverse as the rest of the community and make up between 10 and 15 per cent of the overall population. While many positive changes have occurred in Australia over the past 50 years, GLBTI people are still exposed to greater rates of marginalisation and discrimination. The fact that many GLBTI people need to consider whether they ‘come out’ – tell about their sexual preference – or not to family, friends, colleagues, doctors, and other service providers is just one expression of the tension which can have a detrimental effect on health and wellbeing.

Same-sex attracted young people and young people questioning their sexuality may be particularly vulnerable to discrimination and homophobic abuse. Adolescence is in itself a turbulent time for many young people, and being confronted by those who do not approve of, or understand a young person questioning their sexuality, can put additional pressure on a young person.

Although some individuals or services claim that they treat everyone the same or that sexual preference does not matter to their service provision, such statements do not reflect sensitivity or thoughtfulness about the particular needs GLBTI people may have or a willingness to provide the type of support they would like. Indifference does not necessarily express respect towards difference and can discriminate against GLBTI people by making them invisible and assuming that it is up to the individual to declare their sexuality. In contrast, communicating openness and respectful and appropriate inquiry can assist in alleviating any worries that the individual may have about ‘coming out’ to the professional. A clear link to the impact of overt or more subtle forms of discrimination have been established and it has been found that ‘discrimination is bad for your health’ - including mental health (Ministerial Advisory Committee on Gay Lesbian Bisexual Transgender and Intersex Health and Wellbeing 2009).

The GLBTI community is not a homogenous group and some subgroups, such as transgender and intersex people, and their respective needs, are often not well understood by service providers. While GLBTI people tend to experience poorer health, this does not mean that this health status is linked with their sexual preference. Rather, as research evidence suggests, this status is connected to a range of issues such as discrimination, abuse, access or lack of access to health services, or stigma which can, in turn, trigger or compound risk factors such as alcohol use, violence, isolation, high rates of depression and homelessness (Ministerial Advisory Committee on Gay Lesbian Bisexual Transgender and Intersex Health and Wellbeing 2009).

Research studies over more than 25 years provide evidence about the higher rate of suicide attempts or completed suicides among GLBTI people, as well as increased rates of anxiety, depression and substance misuse, particularly among young people (Corboz et al. 2008; Couch et al. 2007; Dyson et al. 2003; McAndrew & Warne 2010; Ministerial Advisory Committee on Gay Lesbian Bisexual Transgender and Intersex Health and Wellbeing 2009; Pitts, Smith, Mitchell & Patel 2006). 'Gay and bisexual men are four times more likely to report a serious suicide attempt than their heterosexual counterparts' (McAndrew & Warne, 2010, p. 92). Australian data confirms these trends with the National Survey of Mental Health and Wellbeing (2007) reporting higher levels of anxiety disorders (31.5 per cent vs. 14.1 per cent), affective disorders (19.2 vs. six per cent) and substance use disorders (8.6 vs. five per cent) for those identifying as homosexual or bisexual (ABS 2007).

Trauma

The following section provides an overview of the literature on trauma as a risk factor in relation to mental illness and AOD problems. It also provides a summary of key aspects of trauma-informed care.

Trauma – a risk factor

‘Trauma has been defined as the personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence, terrorism and/or disasters’ (NASMHPD 2004).

Prevalence rates of interpersonal violence are high within the general population, with one in three Australian women having suffered intimate partner violence in their lifetime and one in four young people having witnessed family violence (ABS 1996, 2005). Almost 80 per cent of reported family violence victims are women and girls.

Prevalence rates for interpersonal violence are higher in the population of people with diagnosed mental illness, with between 49 and 90 per cent³ of women psychiatric inpatients having experienced abuse (sexual and/or family violence) at some stage in their lives (Hawthorne, Mc.Kenzie & Dawson 1996; Morrow 2002). The seminal work by Golding (1999), who undertook a meta-analysis of research studies on the impact of family violence, indicates that within the cohort of women captured in the studies, just under half (47.6 per cent) suffered from clinical depression. Research studies in this area have, with few exceptions, mostly focussed on women. One exception is the work by Read and colleagues which demonstrates that prevalence rates are twice as high for men with a mental illness compared to the general population, with one study showing that 40 per cent of men in an inpatient unit had experienced childhood sexual abuse (Read 1997; Read et al 2005).

Prevalence rates of lifetime abuse for those with substance addiction are comparable to those with a diagnosed mental illness. Similar to those with mental illness, women tend to show higher rates of abuse histories. It has, however, been established that men with substance addiction also show relatively high rates of lifetime abuse histories. The rate of interpersonal trauma for those with substance addiction is between 25 and 66 per cent (Ouimette et al. 2000). One study found that over two-thirds of women and one-quarter of men seeking assistance with substance addiction had experienced physical and/or sexual abuse (Ouimette et al. 2000). Women not only experience higher rates of abuse, they are also more likely to have experienced more than one type of abuse, having been abused sexually, physically and emotionally, more frequently, by more perpetrators and for longer periods of time than women without addiction to substances (Covington 2008; Covington & Kohen 1984; Ouimette et al. 2000).

A person’s reaction to trauma has been defined as the unique experience by an individual of an event or enduring conditions, in which the person’s ability to integrate their emotional experience is overwhelmed, or the person experiences a threat to life, bodily integrity, or mental health (Warshaw 2007).

3 Data on prevalence rates vary considerably; while a number of factors contribute to these differences, they predominately relate to ‘definitions’, the ‘settings’ in which research is undertaken (with samples from acute settings showing higher rates) and age ranges (the age a person is to be considered a child or included in such a study). Research has historically excluded men, with more recent studies being more inclusive of men and their experience of interpersonal violence.

While trauma includes events of a 'private' nature (.such as sexual assault, child abuse, family/domestic violence) as well as a 'public' nature (war, terrorism, natural disasters) (Moses et al. 2003), the types of trauma experienced by those accessing mental health and AOD services tend to be interpersonal in nature, are intentional, often prolonged and repeated, occur in childhood and adolescence as well as in adult life, and may extend across many years or over a person's life. 'They include sexual abuse or incest, physical abuse, severe neglect, and serious emotional or psychological abuse. They may also include the witnessing of violence, repeated abandonment, and sudden and traumatic losses' (Jennings 2004b, p. 6).

Those who have experienced trauma in early life are more likely to be revictimised as adults through interpersonal violence. Furthermore, unsafe housing, homelessness and lack of safety within residential and inpatient settings can all be factors which increase the likelihood of assault and exposure to witnessing such assaults on others (Jennings 2004b; Saakvtine et al. 2000). Coercive interventions can, unintentionally, further traumatise those with trauma histories (Cusacket al. 2003; Frueh et al. 2005; Jennings 2004b).

Interpersonal abuse

'Partner violence contributes more than any other risk factor to preventable depression, anxiety and other mental health issues for Victorian women aged 15 to 44 years' (VicHealth 2004a).

The impact of abuse, especially childhood (sexual) abuse can be profound and can persist long after the abuse has stopped. Those who have experienced interpersonal violence are more likely to suffer from a range of health problems, including chronic pain (headaches, back pain, pelvic pain) and other health problems (Astbury 2002; Campbell 2002; Falconer & Grigg 2007; Morrow & Chappell 1999; WHO 2002). Many of the 'most important risk behaviours are increased following violence; these include higher rates of smoking, drinking alcohol and using other drugs' (Astbury 2002, p. 411).

Childhood sexual abuse has been described as a disruption to the core self of a child or young person which ultimately can lead to difficulties in managing stressful situations and increase the likelihood of developing mental illness (Herman 1992; Molnar et al. 2001).

A great number of research studies have found a connection between childhood sexual abuse and depression, anxiety, increased suicidality and post-traumatic stress symptoms or post-traumatic stress disorder (Briere 2001; Briere & Jordan 2004; Briere & Elliott 1994; Paolucci et al. 2001; Read et al. 2001; Zlotnick et al. 1996) Meta-analytical reviews of studies investigating the long-term sequelae of such abuse found a significant relationship to psychological distress (Neumann et al. 1996; Paolucci et al. 2001). Others have found a connection between childhood sexual abuse and the development of eating disorders, as well as those with sexual abuse histories having more serious presentations compared with those with a mental illness who have not experienced such abuse (Leverich et al. 2002; Tobin & Griffing 1996). A high number of those diagnosed with borderline personality disorder, predominately women, have experienced childhood abuse and such abuse has frequently been prolonged and severe. Research shows a prevalence rate of 45 to 86 per cent for those diagnosed with borderline personality disorder (Everett & Gallop 2001); as well as higher rates, earlier onset and prolonged abuse within the cohort of those diagnosed with borderline

personality disorder, along with higher lifetime victimisation, chronic abuse and a higher rate of intrafamilial sexual abuse: generally by a parent (Heffernan & Cloitre 2000; Herman, Perry & van der Kolk 1989; McLean & Gallop 2003).

Childhood sexual abuse has been found to be related to greater use of mental health services and earlier engagement with those services, as well as a higher rate of admission into psychiatric inpatient care than if no abuse was present (Molnar et al. 2001; Mullen et al. 1993).

Similarly to the sequelae of childhood sexual abuse, experiencing family violence can have profound short and long-term effects. Research studies show that an experience of family violence impacts on a person's mental health and wellbeing, with an increase in depression, post-traumatic stress symptoms or disorder, anxiety, dissociation, and substance dependency (Campbell 2002; Mullen et al. 1988; Briere 2001; Dienemann et al. 2000; Golding 1999; Roberts et al. 1998; Briere & Jordan 2004). While symptoms may subside once the woman is safe (Campbell et al. 1995; Warshaw & Barnes 2003), a correlation has been found between the severity, frequency, chronicity and recency of interpersonal violence and greater levels of psychopathological distress (Briere & Jordan 2004). Prolonged violence is likely to produce long-term effects (Moracco et al. 2004; Mullen et al. 1988).

Impact of abuse – considerations

Abuse has a profound and often long-lasting effect, especially if it occurred during childhood. Abuse has been documented as having social (schooling, loss of housing), physical (health) and psychological (emotional and mental health) effects, often long after the abuse has stopped. The impact of abuse is not always recognised by the person themselves or by service providers. At times, behaviour or health issues seem unrelated and the possible impacts of abuse are not considered. This may be a lost opportunity for both the person with an abuse history and the professional to make these links and address the underlying issues of abuse in the interests of the person's wellbeing.

Experience of abuse, especially abuse during childhood, is a predictor of drug and alcohol abuse. Various studies indicate that substance use as a coping strategy to minimise psychological distress is relatively common. Salasin and Rich (in Bloom 2000, p. 2) found that women who had experienced intimate partner violence were 15 times more likely to develop an alcohol dependency (Salasin and Rich 1993); while Briere found that 27 per cent of adults who had experienced sexual abuse had a history of such dependency and 21 per cent a history of problematic drug use (in Green, 1993). Herman found that 35 per cent of women who had experienced childhood sexual abuse by a family member had problematic drug use dependencies. When taking inpatient unit populations into account, these figures rise significantly.

'Substance use agencies are showing particularly high rates of service users reporting domestic violence'; when experiences of family violence in adulthood also include childhood abuse (physical, sexual) and neglect the likelihood of problematic drug and/or alcohol dependency increases (Finkelstein 1993 in Humphries et al. 2005, p. 1305).

Torture and trauma

Approximately seven out of 10 refugees in Australia have been tortured or experienced some kind of war-related trauma. While some types of torture harm the body (such as beatings, rape and burns) and the emotional wellbeing of a person, other types of torture, such as starvation or being forced to stand for long periods of time, do not cause physical scarring (Better Health Channel 2010). Despite the fact that such traumatic events may precede migration and are the reason for seeking asylum in Australia, 'people rarely identify themselves as survivors of torture and trauma' (Kaplan 1998). While people who have experienced such trauma may be diagnosed with post-traumatic stress disorder, or display symptoms of the disorder, the effects of trauma go beyond this diagnosis and may present differently in men and women.

Psychological effects include fear and overwhelming helplessness, grief and loss of loved ones and, frequently, the loss of 'the most basic unit of human civilisation – trust [which] is often destroyed' (Kaplan 1998, p. 32). Individuals and families, who migrate, have often lost contact with surviving family members and communities and have lost their connection to their country of origin and its cultural systems.

Torture has a profound impact on both individuals and families, but the reaction to torture varies from person to person and can be physical, mental, emotional or behavioural in manifestation. Physical manifestations include headaches, hearing loss, shaking or trembling muscles, dizziness, fatigue, aches and pains, and increased heart rate. *Mental* reactions include confusion and disorientation, nightmares, poor concentration, difficulty making decisions or plans. *Emotional* reactions include fear, guilt (including survivor guilt), depression, anxiety, and feeling detached, numb or apathetic. *Behavioural* reactions include sleeping problems, use of drugs, alcohol, cigarettes or other substances and a change in appetite (either eating more or less).

Within families the impact of torture can manifest in many ways. Parents may feel unsure about how to assist their children, children may not want to attend school, and communication may become problematic as each family member comes to terms with their experience in their own way (Better Health Channel 2010).

Traumatic experiences in mental health and AOD settings

Sexual harassment or assault, and physical threat or abuse can occur within any setting, including residential and inpatient settings. Studies suggest that both women and men under-report such threats and assaults. In the event that they do report, service staff do not always have the necessary skills to deal with these situations.

A recently published Chief Psychiatrist's guideline (Department of Health 2009c) addresses safety issues for psychiatric inpatient units. However, it is important to note that those admitted to an inpatient unit, also frequently witness distressing events that fall outside the realm of sexual assault, namely physical or verbal assaults, which can be equally distressing, if not traumatising. Studies demonstrate a high level of enduring trauma occurring within psychiatric settings either from being assaulted, witnessing such assaults or being around frightening or violent patients (Frueh et al. 2005). It has been established that those with previous assault experiences (especially sexual assault) report higher rates of vulnerability or retraumatisation than those with no previous assault

experiences (Frueh et al. 2005). While individuals can promote their own sexual safety by engaging in protective behaviours, assertive communication and respectful relationships; some people may experience difficulty with this for a number of reasons.

Systems can promote sexual safety by developing and implementing policies and procedures which:

- support the right to physical and psychological safety
- encourage and facilitate monitoring of professional boundaries
- expect staff to participate in professional development
- respond appropriately to breaches (New South Wales Health 2004).

Assessment and identification of persons as being at risk of potential to harm, or of increased vulnerability to sexual assault are also important to the promotion of sexual safety. Identification of risk should be made at initial assessment and regularly reviewed throughout any period of hospitalisation (refer to the Chief Psychiatrist guidelines). A clear plan outlining how any risk is to be dealt with must be articulated as part of that person's care plan.

It has been demonstrated that retraumatisation or triggering of previous assault impacts on the mental health of this population and contributes to increased vulnerability.

Revictimisation

People who have experienced childhood abuse (physical, sexual or otherwise) are more likely to be revictimised as adults and people with mental illness are more vulnerable to interpersonal abuse. Factors that may increase the potential for revictimisation and threat to personal safety, especially for those with mental illness, include unsafe environments, such as unstable housing or homelessness, mixed-gender facilities (Davidson 1997; Graham 1994; Victorian Women and Mental Health Network 2008) and drug or alcohol use/abuse.

Those with a diagnosed mental illness, and especially women, are more likely to experience further violence. Briere and Jordan (2004) found that women who already have a mental illness or other psychological problems may be more vulnerable to abuse than those without mental illness. They (p. 1257) found that 'women with chronic psychotic illness (schizophrenia) are easier prey for sexually or physically assaultive men'. Mouzos & Makkai (2004 p. 87) found that women 'who experienced abuse during childhood were one and a half times more likely to experience any violence in adulthood'. Women with a mental illness are at greater risk of experiencing such violence (Banyard, Williams & Siegel 2002, p. 35). While it is recognised that this is a stereotype, gender-sensitive care should consider reducing the risk of revictimisation and reducing the risk of behaviour that would revictimise.

It has been found that mixed-gender facilities are places where women in particular may experience revictimisation, ranging from behaviour that is challenging, intimidating or a form of harassment, to sexual or physical abuse (Davidson 1997; Graham 1994; Stamp 2009; Victorian Women and Mental Health Network 2008). Inappropriate or abusive behaviour or assault may involve patients, family members, visitors, members of the public or staff (Department of Health 2009c, p. 8). Services need to address and reduce gender vulnerability through the application of policies and procedures.

Comorbidity

A high number of people diagnosed with mental illness also experience substance dependency problems at some point in their life. For example, for people diagnosed with schizophrenia up to 50 per cent will have a substance problem⁴ at some stage (Meadows, Singh, and Grigg 2007).

Equally, those diagnosed with problematic substance use frequently also suffer from psychiatric conditions, especially mood and anxiety disorders, post-traumatic stress disorder, and personality disorders (Bernstein 2000; Harris 1996).

Depressive and anxiety disorders often co-exist with other conditions such as substance use dependence and physical health problems or illness. Those diagnosed with borderline personality disorder often also suffer from depression.

An increase in problems with general health or illness is often associated with a diagnosis of mental illness or substance use dependency. This may be due to factors such as poor access to health care and a single focus on mental illness or substance use-recovery rather than addressing general health issues (Department of Human Services 2009a; Osborn 2001).

Connections

‘It is almost impossible to treat chronically mentally ill women who abuse drugs or alcohol and who have been episodically homeless without also treating women who are survivors of sexual and physical abuse’ (Harris 1996, p. 317).

While this statement recognises the high prevalence rates of abuse among women, it is likely that it could also be applied to men. As discussed earlier, many men accessing mental health and AOD services have also experienced (childhood) abuse, although to a lesser degree than women.

People with a diagnosis of mental illness and those with a substance addiction have experienced traumatic events to a higher degree than those without such diagnoses. Many people with mental illness have a substance use problem and vice versa. In general those with substance addiction and mental illness (or both) are some of the most disadvantaged members of society. Poverty, trauma, homelessness, poor general health status, grief and loss issues (both connected to receiving a diagnosis and other life events) all feature greatly in the lives of people with mental illness, substance addiction or indeed for those who experience both.

While both women and men experience many of the above issues, gender differences can be observed; for example, a higher prevalence of abuse for women than for men. However, it may still be harder for those men who have experienced abuse to disclose their experiences due to stigma and the lack of recognition by service providers. There are many intersecting factors which can contribute to heightened vulnerability in a person, for example, sexual abuse during childhood and adolescence lead to an increase in homelessness, which, in turn, can lead to an increase in vulnerability to experiencing abuse – both physical (more likely for men) and sexual (more likely for women). Equally, many people who have problematic drug or alcohol dependencies have

⁴ Use of alcohol, cannabis, heroin, and amphetamines are included here.

experienced trauma. Drug and alcohol use can contribute to increased risk of experiencing unsafe housing and traumatic events of an interpersonal nature, which all impact on mental health and pre-existing mental illness. It is these interconnections and interdependencies that need careful consideration in order to provide more holistic care.

Trauma-informed and trauma-specific services

Trauma-informed services utilise integrated practices; addressing the symptoms of trauma and the consequences of addiction within a single system and by a single model of care. In keeping with trauma-informed principles, an integrated approach addresses the needs of the whole person and is based on the assumption that the problems of substance abuse and trauma interact in a complex way within the life and the psyche of a single individual (Harris & Fallot 2001a, p. 57).

Trauma-informed and trauma-specific services in health, mental health and substance abuse services have been developed and successfully operated in the USA and Canada for some time.

Trauma-specific services are those designed to directly address the effects of trauma, with the goal of health and recovery (Moses et al. 2003). They are designed to treat the actual sequelae of sexual or physical abuse trauma. Trauma-informed services recognise that traumatic experiences often cause mental health, substance abuse, and physical health concerns and have processes to address trauma-related issues for their client group thoughtfully and respectfully.

Trauma-informed services are not specifically designed to treat symptoms or syndromes related to trauma however they are informed about, and sensitive to trauma-related issues present in clients.

The multiple, varied and complex impacts of violence are often not well understood by service providers as symptoms related to trauma may not be immediately apparent, especially when behaviour does not appear to be linked with trauma (hence masking the underlying issue). Equally, some practices may inadvertently contribute to retraumatising clients, contributing negatively to their recovery process or indeed their refusal of care.

To be trauma-informed means that the history of past and current trauma is known to the professional and forms part of the understanding of current status with regard to mental health and substance use issues. To be trauma-informed also means that professionals understand and appreciate the role that trauma can play in the lives of those accessing services, and also the connection between trauma and mental illness, alcohol and other drug use, and dual diagnosis (Harris & Fallot 2001b).

In a trauma-informed service professionals will ensure the current safety of the client as well as their safety from retraumatisation, and have a clear understanding and professional approaches to the impact of trauma on a person (including their mental and physical health and their coping strategies). Such a shift in focus would include, for example, a redirection of enquiry to asking the person 'what has happened to you?' rather than 'what is wrong with you?' Staff sensitive to the impacts of trauma are better able to understand the behaviour of a person as trauma-related rather than as a symptom of mental illness or substance dependency. Thus they are able to reconceptualise behaviour such as self-harm as one way to express help-seeking or as the release of pain rather than as manipulative behaviour, for example. Trauma-informed care means applying a trauma lens rather than a sickness lens (Jennings 2004b).

A trauma-informed system is one in which all components of a given service system are reconsidered and evaluated in light of a basic understanding of the role that violence plays in the lives of people seeking mental health and addiction services (Harris & FalLOT 2001b). A trauma-informed system uses this understanding to design service systems that accommodate the vulnerabilities of trauma survivors, and allows services to be delivered in a way that will avoid inadvertent retraumatisation and facilitate consumer participation in treatment. It also requires collaborative relationships with other specialist-trauma services (Harris & FalLOT 2001b; Jennings 2004b).

Trauma-informed organisations, programs and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatisation (SAMHSA).

Trauma-informed services acknowledge the lived experiences as the bedrock for therapeutic decision making and promote consumer choice and empowerment as vital to successful treatment. A trauma-informed approach is based on the recognition that many behaviours and responses (often seen as symptoms) expressed by survivors and consumers are directly related to traumatic experiences that often cause mental health, substance abuse, and physical health concerns (National Centre for Trauma-Informed Care n/a, p. 1).

Harris and Landis (1997, p. 58) suggest that 'in a parallel treatment model, a woman [person] receives separate trauma and addictions services simultaneously at the hands of two distinct sets of providers. Each provider is trained and committed to addressing only one set of problems'. This way of operating and/or addressing issues in the lives of those who have a dual diagnosis perpetuates the view that parts of self can be separated and compartmentalised and hence dealt with separately, when in reality this is not the case. Trauma and addiction/mental health are interwoven and interconnected issues that need to be addressed together.

It is suggested that trauma-informed services have screening and assessment processes in place, so that regardless of where a person enters the service they experience the same processes in relation to trauma inquiry. Concurrently, others suggest that trauma-informed services ought to work from a premise of assuming that all clients have experienced trauma, rather than undertaking specific screening and assessment processes.

Trauma-informed services involve understanding, anticipating, and responding to the issues, expectations, and special needs that a person who has been victimised may have in a particular setting or service. At a minimum, trauma-informed services should endeavour to do no harm in order to avoid retraumatizing survivors or blaming them for their efforts to manage their traumatic reactions (Moses et al. 2003, p.19).

Trauma screening

‘...trauma-informed services assume that everyone is likely to be a survivor of trauma and implement universal screening and precautions for trauma and related symptoms within their standard screening processes’ (Moses et al. 2003, p.22).

Trauma is often overlooked in routine care in mental health and AOD services despite there being a high prevalence of trauma histories of those engaged with care. Trauma histories may involve psychological, sexual, torture or other abuses.

During the assessment process the under-reporting of trauma by consumer/clients and a lack of recognition by service providers contribute to the lack of recognition of trauma (Fallot & Harris 2001; Agar & Read 2002; Cavanagh, Read & New 2004; Read, Hammersley & Rudegair 2007). If screening is undertaken it ought to occur close to admission and if a positive response is provided, then a trauma-assessment ought to be carried out. To understand trauma experiences and how they impact on a person’s wellbeing and mental health provides part of a clinical picture. This should be followed by explaining options for referral to trauma-specific services (such as CASA, family violence, Foundation House) (Jennings 2004a).

Screening for a trauma history has been suggested as one way of implementing trauma-informed care. The introduction of trauma-screening is not without its challenges and needs careful and systematic introduction, inclusive of comprehensive staff training, in order to be able to conduct screening sensitively and appropriately.

Those being asked questions about previous or current trauma experiences may worry about stigmatisation, may not remember the traumatic event, may not understand their experience as violence and may not trust the professional, due to trust issues as a result of experiencing such violence. Organisations that have instituted routine screening suggest that the concept of screening and the associated questions need to be explained clearly and respectfully, and that explanations need to be given about why these questions are asked and what will be done with the information gathered.

It must also be made clear that the person is under no obligation to answer the questions and reassured that they can raise the issue at a later time should they wish to do so. Allow the respondent to provide as much or as little information as they choose and to be in control as much as possible.

Notwithstanding the potential issues, which need to be addressed through policy and practice reviews, ‘...screening and assessment for violence acknowledges its importance and signals a preparedness to hear about and deal with these painful experiences’ (Moses et al. 2003, p. 23).

Trauma survivors may not report traumatic experiences for a number of reasons. Immediate safety concerns (...) may lead some to withhold salient information. Some trauma survivors fear stigmatization, or service system responses that disbelieve or blame the victim or pathologize attempts to cope with violence. Some feel ashamed about being victimized and about their

attendant vulnerability. Some, perhaps especially men, tend to withdraw and isolate themselves rather than talk to others. Childhood experiences of abuse may not be readily remembered, let alone discussed with a clinician who is not yet trusted (Fallot & Harris 2001, p. 23).

Inquiring about trauma requires sensitivity and skill, and those who oppose universal screening raise concerns about the lack of skills of practitioners and the potential for further harm. Others question the purpose of such screening, if it is not accompanied by an appropriate response and/or referral to trauma-focussed services. 'trauma survivors are often in agreement with clinicians; it may be better not to ask about trauma if no helpful responses are forthcoming' (Fallot & Harris 2001, p. 23).

Trauma screening refers to a brief, focused inquiry to determine whether an individual has experienced specific traumatic events. As a result of both under-reporting and under-recognition, trauma-informed service systems have increasingly adopted universal screening, asking all consumers about trauma, as part of initial intake or assessment process (Elliott et al. 2005, p. 24).

Trauma assessment

'Is a more in-depth exploration of the nature and severity of traumatic events, the sequelae of those events, and current trauma-related symptoms. In the context of a comprehensive mental health assessment, the trauma information may contribute to a formal diagnostic decision...trauma-informed assessment often sets an important tone for the early stages of consumer engagement. It is built on the development, rather than the assumption, of safety and trust' (Elliott et al. 2005, p. 25).

If trauma-sensitive care is truly the underlying principle of care, then an organisation has developed a trauma-sensitive culture. This is a culture in which 'it is understood that most human behavioural pathology is related to overwhelming experiences of exposure to abusive power, disabling losses and disruptive attachment, usually beginning in childhood' (Sanctuary Web 2008). Those working within a culture that is trauma-sensitive, apply a less punitive and judgmental response to clients/patients/consumers, and understand the 'complex biopsychosocial and developmental impact of trauma and abuse with implications for response' (Sanctuary Web 2008). Van der Kolk and Ducey (1989) talk about traumatic re-enactment and go on to explain that the memories of the traumatic experience are dissociated, non-verbal, and unintegrated. It is then understandable that those with such trauma experiences find themselves in situations similar to earlier trauma and lack awareness of how this may have occurred. This way of conceptualising such repeated patterns is a much less judgmental way of understanding this behaviour than talking about learned helplessness which tends to be more victim/survivor blaming than an approach that appreciates the complex nature and manifestation of trauma. Van der Kolk suggests that the lack of awareness is due to dissociative blockade that places the behaviour out of the context of verbal and conscious control.

Health issues

People diagnosed with a mental illness tend to have comorbid physical health problems at a much higher rate than the general population (Jones et al. 2004). National and international evidence suggests that people with severe mental illness die on average 25 years earlier than the general population. Deaths of people with mental illness attributable to common physical health conditions are some 2.5 times the average in the general population (Department of Health 2009a, p. 40).

While many of the health issues related to people with mental illness are the same regardless of gender, some of the health outcomes or manifestations of health issues may be experienced differently by women and men. Women with severe and persistent mental illness tend to have 'higher rates of multiple or comorbid medical problems due to history of trauma (such as sexual abuse or domestic violence), barriers to treatment of mental illness (including poverty, lack of insurance, misdiagnosis or under-diagnosis), lifestyle choices (for example, high smoking prevalence and substance misuse), effects of medication (such as obesity and diabetes mellitus related to certain psychiatric medications), and consequences of the illness itself (for example, neglect of personal care)' (Vandiver 2007, p.161).

Weight gain leading to obesity is a problematic side-effect for many people who take antipsychotic medication (for the treatment of schizophrenia for example), which in turn is associated with higher rates of diabetes, heart disease and arthritis (Bennett 2007). Concurrently, weight gain, which often occurs rapidly, contributes to low-self esteem and the need to frequently obtain new clothes, which is difficult for people on a low income. While many of the effects of weight gain will be equally detrimental for women and men, women tend to experience added pressure due to social conditioning about women's bodies and pressures to conform to certain body shapes. Weight gain can have a range of impacts on a person's health and wellbeing, increasing the risk for diabetes, coronary artery disease, and endocrine disorders (Vandiver 2007).

Similarly, people with substance dependency as well as those with a dual diagnosis (mental illness and AOD problems), have higher rates of physical health problems. At the same time, the interplay between AOD, mental illness and physical health problems can pose a particular difficulty in addressing all issues simultaneously. Furthermore, people with dual diagnosis are more likely to be socially isolated, have inadequate housing or are homeless, and are at higher risk of experiencing violence. All of these factors contribute to a more complex situation that needs attention, for both the individual and those involved in their care.

While many people with mental illness, substance dependency or dual diagnosis have comorbid health problems or illness, many do not access or receive the health care they need. There are multiple reasons for this – some relate to the fragmented service provision and the separation between mental health care and physical health care; other factors relate to help-seeking behaviour, with men being less likely to access health services than women. Some researchers have suggested that 'psychiatrists and family physicians are poor at recognizing and treating physical conditions in psychiatric patients' (Vandiver 2007). Osborn (2001) also suggests that, at times, physical complaints may also be pathologised and complaints may be ignored and seen as psychological problems rather than physical ones. Lack of availability or difficulty in accessing general health care may also be connected to low-income or poverty, making it harder for the individual to get to health practitioners (for example, lack of access to transport) or other, more pressing needs, take precedence. Parents with a mental illness, in particular single parents, may put their children's care before their own health care.

Homelessness

During any one night approximately 100,000 people across Australia are homeless (Australian Government 2008). In 2006, a national census found that 20,500 people in Victoria were homeless. Within the homeless population, men generally outnumber women. The 2006 census showed that 56 per cent of the homeless people were men and 44 per cent were women; with women only outnumbering men in the 12 to 18 year age group (Chamberlain & McKenzie 2009).

While having access to secure and safe housing is an essential part of a person's wellbeing, many people experience temporary or ongoing homelessness during their lifetime.

The Australian Bureau of Statistics defines homelessness as the following (Chamberlain, 2009, p. 6)

- *Primary homelessness* describes the situation of all people without conventional accommodation, such as people living on the streets, sleeping in parks, squatting in derelict buildings, living in improvised dwellings (such as sheds, garages or cabins), and using cars or railway carriages for temporary shelter.
- *Secondary homelessness* describes the situation of people who move frequently from one form of temporary shelter to another.
- *Tertiary homelessness* describes the situation of people who live in boarding houses on a medium to long-term basis, operationally defined as 13 weeks or longer⁵.

Across Australia women constitute 65 per cent of those accessing homelessness services, with many homeless as result of family violence (AIHW 2008). It has been established that family violence is the largest single cause of homelessness in Australia (Australian Government 2008).

During 2000–2001, two per cent of those accessing public mental health services in Victoria were recorded as having no usual residence (or were accessing a homelessness service) and a further eight per cent were in unstable accommodation, such as boarding houses and caravans. While it is difficult to obtain accurate data, research studies show that up to 50 per cent of homeless people have a mental illness (Department of Human Services 2002). Another Australian study identifies that up to 75 per cent of homeless people have a mental illness (Teeson, Hodder & Burich 2004). Many women experience sexual assault during homelessness, with studies indicating that more than one in two homeless women have been sexually assaulted (Parkinson 2004). Similarly, men also experience high levels of violence, often physical violence, during homelessness.

Mental illness and homelessness are intertwined and while mental illness may be a risk factor for homelessness and homelessness may contribute to a deterioration of mental health, at the same time homelessness also complicates the treatment of mental illness (Department of Health and Ageing 2005; Mental Health Council of Australia 2008). People with a mental illness are confronted with stigma, fewer employment opportunities, poverty and discrimination, all of which can contribute to a person or a family becoming homeless. Homelessness may exacerbate a person's mental illness, adding further to emotional and/or mental distress.

People with a dual diagnosis are also less likely to remain in stable housing. The complex interplay of substance dependency, mental illness and other factors, such as previous trauma, poverty and fewer chances of employment, can also contribute to homelessness.

⁵ Residents of boarding houses are homeless because their accommodation does not have the characteristics identified in the minimum community standard: they do not have a separate bedroom and living room; they do not have kitchen and bathroom facilities of their own; their accommodation is not self-contained; and they do not have security of tenure provided by a lease (Chamberlain & McKenzie, 2009, p. 6)

While fewer women are recorded as homeless, some argue that women's homelessness is less visible than men's, with studies in this area tending to focus on men and homelessness. Nevertheless, a high proportion of women who are homeless have had disrupted housing in early life, with one study finding this to be as high as 78 per cent (Tacchi & Scott 1996). Many women, with and without children, who are homeless have experienced family violence and have become homeless as a result. Similarly, many women and young people have experienced abuse by a family member, including sexual abuse, and have consequently become homeless. High levels of sexual assault before or during periods of homelessness are common. An Australian study found high prevalence rates of sexual abuse with 70 per cent of young women and 20 per cent of young men having been sexually assaulted. Other studies confirm these high rates of sexual abuse among homelessness populations (Buhrich et al 2000; Morrison 2009).

One of the biggest obstacles in the lives of people with mental illness is the absence of adequate affordable and secure accommodation. Living with a mental illness – or recovering from it – is difficult even in the best circumstances. Without a decent place to live it is virtually impossible (Human Rights and Equal Opportunity Commission 1993, p. 337).

With the complex inter-relationship between mental illness, homelessness and other risk factors such as abuse (sexual abuse and family violence), stigma, poverty and lack of employment opportunities, many people with mental illness live in insecure, temporary and/or inadequate housing. This lack of stable housing does not only contribute negatively to mental health or exacerbate existing mental illness; it also means that those with mental illness and limited housing options are more vulnerable to a range of risks. Such risks include, but are not limited to:

- exposure to (further) abuse
- exposure to people who have a detrimental impact on the person's mental health
- lack of opportunities to gain employment
- lack of options for keeping children safe and in a stable environment
- engaging in behaviour that may support them to keep accommodation but has a negative impact on their wellbeing.

People in insecure, inappropriate or unsafe housing not only experience a 'housing crisis' but are also vulnerable to a range of crisis events which affect housing relationships or capacity to maintain housing. They are at an increased level of risk and are more 'vulnerable to sexual abuse and assault, experiences of family and random violence, relationship breakdowns, household (...) and neighbourhood relationship breakdowns or violence, periods of mental illness, problems with substance addiction, and hospitalization or incarceration' (Robinson 2005, p. 4).

Sexual vulnerability and survival

While accurate figures about sex work are difficult to obtain, it has been estimated that in any one year there are approximately 20,000 people engaged in the sex industry in Australia (New South Wales Department of Planning 2006).

Harcourt and Donovan (2005) define sex work as ‘the provision of sexual services for money or its equivalent’. Those engaged in the exchange of sex for money or goods may be women, men, or transgender, heterosexual, bisexual, gay or lesbian. At the same time ‘sex work is a heavily gendered economy where the demand for commercial sex is almost exclusively from men’ (Quadara 2008, p. 32) and much of the work provided is by women.

In the past the term ‘prostitution’ prevailed when referring to such activity, however, advocates and researchers in this area promote the less judgemental terminology of ‘sex work’ in order to move away from a pejorative view to a view that situates those engaged in such work within an industry, earning an income.

When referring to sex work it is generally ‘clear that the primary purpose of the interaction is to exchange sex for a fee’ (Harcourt & Donovan 2005). This is also referred to as ‘direct sex work’. Different types of such work are associated with varying levels of potential for harm. In general those engaging in sex work which is regulated, such as legal brothels or escort services, experience higher levels of protection than those engaged in street or private work, where safety is far less guaranteed.

Another aspect of exchange of sex for money or goods has been termed indirect sex work; and includes performing sexual favours for cigarettes, food, rent or drugs. Such engagement is often (though not always) linked to poverty and survival for people of low-socioeconomic status and/or those who live in situations where providing sex has become a way of survival. Homeless people, in particular homeless women, are especially vulnerable to exploitation and may engage in the exchange of sex for protection, housing, food or other goods. This way of exchanging sex for payment tends to be more hidden, rather than articulated as sex work, and poses many more risks for the person providing such sexual favours.

It has been established that many people who engage in sex work have previously experienced sexual assault and that many will experience (further) sexual assault when engaging in sex work. While no clear correlation has been established between childhood sexual assault and participation in sex work, high figures indicate that it is advisable to take possible sexual assault into account when considering the needs of people who have or are engaging in sex work (whether ‘direct’ or ‘hidden’).

Reasons for entering sex work or engaging in sexual behaviours for goods vary greatly. Research studies show that ‘many women engage in sex work because of child-care responsibilities, or to support family income (...) or following relationship breakdown and finding themselves as single income earners. Young people (those under 18 years) may start sex work as a matter of survival after leaving home or state care’ (Quadara 2008, p. 3). The range of people engaging in such work is vast and includes university students seeking to support themselves during studies. There is great diversity among people engaging in such work and it is not confined to particular socioeconomic groups, suburbs or parts of society that can be seen as different from the rest. ‘Sex workers are members of the community as residents, colleagues, peers, patients and citizens rather than some ‘other’ category of people’ (Quadara 2008, p. 4).

Identifying as a sex worker is risky due to social stigma, and such disclosure can ‘have implications for family relationships, custody of children, relations with police’ (Perkins 1991 cited in Quadara, 2008). Equally, disclosing the exchange of sex for goods, rent, drugs or other items, when not identified as sex work, but as a survival strategy, can result in social exclusion, stigma and vilification.

Relevant policies, guidelines and legislation

Aboriginal mental health

Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice

<http://www.apo.org.au/research/working-together-aboriginal-and-torres-strait-islander-mental-health-and-wellbeing-principi>

Victorian aboriginal suicide prevention and response action plan 2010–2015

<http://www.health.vic.gov.au/mentalhealth/suicide/vasrap.htm>

Aboriginal cultural competency framework

<http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/plans-and-strategies/children,-youth-and-family-services/aboriginal-cultural-competence-framework-2008>

Alcohol and other drugs (AOD)

Victorian AOD client charter

<http://www.health.vic.gov.au/aod/pubs/>

Koori alcohol action plan 2010–2020

<http://www.health.vic.gov.au/aboriginalhealth/programs/alcohol.htm>

Cultural diversity

Cultural diversity plan for Victoria's specialist mental health services 2006–2010

<http://www.health.vic.gov.au/mentalhealth/cald.htm>

Cultural responsiveness framework

<http://www.health.vic.gov.au/cald/cultural-responsiveness-framework>

Use of language services in area mental health services

<http://www.health.vic.gov.au/mentalhealth/pmc/language.htm>

Use of language services in psychiatric disability rehabilitation and support services – information and guidelines

<http://www.health.vic.gov.au/mentalhealth/pmc/language-pdrss.htm>

Family violence

A right to respect: Victoria's plan to prevent violence against women 2010–2020

<http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/plans-and-strategies/women/a-right-to-respect-victorias-plan-to-prevent-violence-against-woman-2010-2020>

Victoria Police code of practice for the investigation of family violence

http://www.police.vic.gov.au/content.asp?Document_ID=288

Strong culture, strong peoples, strong families: towards a safer future for Indigenous families and communities

<http://www.dpcd.vic.gov.au/indigenous/strong-culture,-strong-peoples,-strong-families-ten-year-plan>

Children, Youth and Families Act 2005

<http://www.cyf.vic.gov.au/every-child-every-chance/home>

Family violence risk assessment and risk management: supporting an integrated family violence service system

http://www.dpcd.vic.gov.au/__data/assets/word_doc/0009/39663/FamilyviolenceIntro.doc

Identifying and responding to family violence: a guide for mental health clinicians in Victoria

<http://www.health.vic.gov.au/mentalhealth/family-violence/family-violence.pdf>

The Family Violence Protection Act 2008

<http://www.justice.vic.gov.au/wps/wcm/connect/DOJ+Internet/Home/Crime/Family+Violence/>

Gender and diversity

Gender and diversity lens for health and human services 2008

<http://www.health.vic.gov.au/vwhp/wellbeing/>

Human rights

Charter of Human Rights and Responsibilities Act 2006 (Vic)

<http://www.legislation.vic.gov.au/>

Men

Victorian men's health and wellbeing strategy (currently under review)

<http://health.vic.gov.au/mhws/index.htm>

National male health policy

<http://www.health.gov.au/internet/main/publishing.nsf/Content/national+mens+health-1>

Mental health

Victorian mental health reform strategy 2009–2019

<http://www.health.vic.gov.au/mentalhealth/reformstrategy/>

Creating safety: addressing restraint and seclusion practices project

<http://www.health.vic.gov.au/chiefpsychiatrist/creatingsafety/index.htm>

Families where a parent has a mental illness: A service development strategy

<http://www.health.vic.gov.au/mentalhealth/families/index.htm>

Chief Psychiatrist's guideline: Working together with families and carers

<http://www.health.vic.gov.au/mentalhealth/cpg/>

Caring together: a carer participation action plan

<http://www.health.vic.gov.au/mentalhealth/carers/carers-involve.pdf>

Chief Psychiatrist's guideline: Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units

<http://www.health.vic.gov.au/mentalhealth/cpg/sexual-safety.pdf>

Standards for psychiatric disability rehabilitation and support services

http://www.health.vic.gov.au/mentalhealth/pdrss/pdrss_standards.pdf

Tailoring services to the needs of women (Victorian Women's Mental Health Strategy)

<http://www.health.vic.gov.au/mentalhealth/gender-sensitivity/tailoring-services-women.pdf>

Statewide strategy for safety and quality

<http://www.health.vic.gov.au/mentalhealth/quality/whatsnew.htm>

Building partnerships between mental health, family violence, sexual assault services

<http://www.health.vic.gov.au/mentalhealth/family-violence/index.htm>

Patient rights booklets: About your rights

<http://www.health.vic.gov.au/mentalhealth/patientrights/downloads.htm#6>

Sexual assault

Victoria Police - sexual offences and child abuse

http://www.police.vic.gov.au/content.asp?Document_ID=757

Sexuality

Well proud. A guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services

http://www.glhv.org.au/files/well_proud.pdf

Depression and anxiety in people who are gay, lesbian, bisexual, transgender or intersex: factsheet for adults and young people

<http://www.beyondblue.org.au>

Women

Victorian Women's Health and Wellbeing Strategy 2010–14 (currently under review)

<http://www.health.vic.gov.au/vwhp/wellbeing/>

Victorian Women and Mental Health Network

<http://www.vicserv.org.au/policy-networks/networks/alias.html>

Abbreviations

AOD	Alcohol and other drugs
ATSI	Aboriginal and Torres Strait Islander
CALD	Culturally and linguistically diverse
CATT	Crisis assessment and treatment team
CCU	Continuing care unit (mental health services context)
CCU	Crisis care unit (sexual assault services context)
COPMI	Children of parents with a mental illness
CSA	Child sexual abuse/assault
DD	Dual diagnosis
DV	Domestic violence
FaPMI	Families where a parent has a mental illness
FV	Family violence
GBLTI	Gay, lesbian, bisexual, transgender, intersex
LOTE	Language other than English
IPU	Inpatient unit (psychiatric)
IPV	Intimate partner violence
MSTS	Mobile support and treatment service
NESC	Non-English speaking country
PDRSS	Psychiatric disability rehabilitation support service
PMHT	Primary mental health team
PTSD	Post-traumatic stress disorder
SA	Sexual assault/abuse
SEWB	Social emotional wellbeing
VAW	Violence against women
VFST	Victorian Foundation for the Survivors of Torture Inc.
VTPU	Victorian Transcultural Psychiatry Unit

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