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1. Introduction

Mental health refers to “a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”¹. Like physical health, it is influenced by biological and social determinants². These determinants are experienced differently by women and men. Biological determinants, such as personality traits, hormonal fluctuations and genetics impact on mental health outcomes¹. Mental health is also affected by one’s ‘place’ in the social world². This is because relative power determines one’s access to necessary resources and services that influence quality of life and health outcomes³. Being female or male greatly influences mental health outcomes⁴. Women’s mental health is unique because of biological differences (sex) and the social constructions of women’s lives (gender)⁴.

This Issues Paper examines the impact of the biological and social determinants on women’s mental health outcomes. The Paper contains information about the social determinants of health, specific mental health issues as experienced by women, mental health care, and at risk population groups.

2. The social determinants of mental health

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices¹.

The social determinants of health determine an individual’s access to resources and services that are vital for sustaining good health⁵. In order to understand and address any health issue, including mental health, it is important to recognise the social context that influences health outcomes⁶. This focus can inform treatment and prevention, and lead to a reduction in the recurrence and the severity of ill health⁵. The VicHealth has identified three social determinants of mental health: social inclusion, freedom from discrimination and violence, and access to economic resources⁶. To have the best possible chance of good mental health, the three determinants need to be met. The following section explores how these determinants influence women’s lives and underpin their mental health and wellbeing.

2.1 Social Inclusion

The term ‘social inclusion’ is used to describe the “the number and nature of a person’s networks and social ties, their participation in community life and their access to basic human entitlements”⁶. It can also be used as an umbrella term that covers social cohesion, social connectedness, social ties, social networks and social, economic and human capital within a particular group, community or society⁷. Social inclusion provides people with support networks that help them find solutions to problems, validate their identity and access information and comfort when needed⁸.

Women’s experience of social inclusion and what they draw from connections is unique. Social networks are valued and used for resource sharing and general assistance⁹. Young

women in particular rely on their friends for advice and emotional support⁹, while women living with mental illness report needing more social support in their lives, particularly friends⁸.

A number of factors influence women's levels of social connectedness, one of which is violence¹⁰. This is a significant issue with one in three women having experienced physical violence in her lifetime from the age of 15¹¹. In the case of intimate partner violence, perpetrators use violence to control women physically and mentally, which alienates them from valuable support networks. Women may not be allowed to leave the house, and may be forced to cut ties with family and friends¹⁰. Women who are exposed to violence also develop a heightened fear of violence. Australian women who have been victims of intimate partner violence report feeling fearful, 8 percent reporting that they feel fearful every day¹¹. These physical and psychological barriers subsequently limit women's freedom and independence, increasing their social isolation¹⁰.

Apart from violence, the perception of safety also influences women's levels of social connectedness. Many women in Victoria feel vulnerable to physical and sexual assault. Approximately 10 percent of Victorian women feel unsafe at home alone after dark, while 25 percent feel unsafe walking alone in their local area after dark¹². These fears can hinder social activities and perpetuate isolation¹³.

A number of other factors also influence women's levels of social connectedness. Geographical isolation can present a barrier for women in establishing and maintaining social connections¹⁴. Greater longevity means that women may experience the death of their partner and friends which reduce their social networks¹⁵. Living with disabilities can also compromise women's ability to participate in social activities¹⁶, as can having caring responsibilities for parents and children¹⁵.

There are strong links between social isolation and poor mental health. Social isolation often combines with discrimination, violence, poverty and other associated factors to create compounding effects on women's mental health and wellbeing. Women with limited social capital are at higher risk of depression and excessive alcohol consumption⁶, self-harm and suicide contemplation¹⁷. Women suffering from complex mental illness with limited support networks are also at increased risk of experiencing more negative health outcomes¹⁸.

2.2 Freedom from discrimination and violence

2.2.1 Discrimination

The term 'discrimination against women' shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field¹⁹.

'Discrimination' and 'violence' are terms commonly used together because discrimination is often expressed through violence. Violence due to discrimination tends to be targeted towards those in the minority or those who hold less power⁶.

Gender inequalities dictate the construction of social rules that place women in a disadvantaged position²⁰. Discrimination against women is deeply embedded in our culture and can therefore be subtle and remain unchallenged¹⁹. Traditional social norms limit women's capacity by valuing them principally for their sexuality and child-bearing ability²¹. However, there are other areas in which discrimination against women is more visible.

The workforce is one such area. Gender normative values dictate female employment opportunities, meaning women are encouraged to take on nurturing roles in the paid and unpaid workforce²². While women are expected to fulfil these duties, their responsibilities are not seen as prestigious or worthy of significant financial reward, especially when compared to traditional male employment. As a result, the gender pay gap between women and men in Australia is 17 percent²³.

Gender also intersects with other factors such as race and ethnicity, sexual preference, disability, age, religion and social class, thus exposing women to multiple forms of discrimination²⁴. While many women experience discrimination to some extent, some groups of women are particularly exposed to compounded discrimination, that is, discrimination on multiple or intersecting grounds.

Indigenous women experience social discrimination, stereotyping and cultural misunderstandings, all of which are barriers to fundamental resources including education, health services, and housing²⁵. Examples of barriers include Aboriginal and Torres Strait Islander women being unfairly evicted from homes, refused and given insufficient care in the health care system²⁵, and being disproportionately placed in maximum security prisons²⁶.

Same-sex attracted women also experience discrimination that influences their mental health. Heterosexist cultural norms extend to some state laws that refuse same-sex marriage, adoption rights and the use of assisted reproductive technology²⁷. These laws prevent same-sex attracted women from having equal rights or accessing resources that are enjoyed by others.

Discrimination against same-sex attracted people can interfere with their daily activities. Sixty-nine percent of same-sex attracted women report that the fear of prejudice or discrimination causes them to always modify their daily activities²⁸.

Discrimination undermines mental health and wellbeing on multiple fronts. The act of discrimination can result in individuals being denied services and employment opportunities with negative consequences on mental health and wellbeing²⁴. It can contribute to a heightened sense of anxiety and is associated with depression and substance misuse²⁴. Exposure to ongoing discrimination can also lead to increased risk of suicide²⁹. While discrimination can lead to poor mental health, people living with mental health conditions can become targets of further stigmatisation, making it difficult for them to access help. This can ultimately increase the severity of their mental health condition³⁰.

2.2.2 Violence

Violence against women is any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women. These include threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life³¹.

Violence is a serious crime and has a long lasting impact on the mental and physical health of victims, their loved ones and the community. For many women and children, being victims of violence can lead to social maladjustment, poor mental health, and poverty³². This is demonstrated by the fact that the majority of women in mental health inpatient care³³ and in prisons³⁴ have experienced physical, sexual or psychological abuse as children or adults.

Men's violence against women is the most pervasive form of violence against women in Australia¹⁰. Intimate partner violence occurs in close relationships and can be perpetrated by current or previous partners¹⁰. Men are most frequently the perpetrators while women are more frequently the victims of intimate partner violence, and are more likely to sustain severe injuries¹⁰. Intimate partner violence is the leading contributor to death, disability and illness in Victorian women aged 15-44 years³⁵ and nearly one in six women in Australia have experienced violence by a current or previous partner in their lifetime¹¹. Women who are victims of violence tend to be assaulted in their own home and repeatedly over a period of time¹¹.

Although the reported rates of intimate partner violence are high, it is suspected that the actual figures are much higher as intimate partner violence is largely an under-reported crime¹⁰. Even in cases where disclosure occurs, victims often prefer to seek the assistance of friends and families rather than from formal agencies such the Police or Family Services where data is officially recorded¹⁰.

There are a number of reasons why women do not report violence. Intimate partner violence is often viewed as a private matter and victims may feel that disclosing could cause shame on the family³⁶. The victims may fear that these actions can anger the perpetrators and lead to more violence³⁷. Leaving an abusive relationship may also mean losing financial security, and many women stay in abusive relationships in order to secure shelter for themselves and their children³⁸. Social stigma surrounding intimate partner violence can also make women feel that they have somehow contributed to the violence committed against them¹⁰. A 2006 survey found that 81 percent of Victorians do not understand why victims do not leave violent relationships, and over 1 in 10 believes that women who are sexually harassed should 'sort themselves out'³⁵. Unsupportive social attitudes, financial insecurity and the structure of the legal system can act as barriers to women coming forward.

Intimate partner violence occurs across geographical, socio-economic, age, ability, cultural and religious groups¹⁰. However, additional factors such as disability or language barriers can increase the power imbalance between perpetrators and victims and can increase women's vulnerability to violence¹⁰. For example, immigrant women are vulnerable to prolonged exposure to intimate partner violence³⁹. Indigenous women are more likely to become victims of violence compared to non-Indigenous women, and are more likely to sustain serious injuries⁴⁰. Women with disabilities are more likely to experience violence at a higher frequency, and at the hands of greater numbers of perpetrators including formal and

informal caregivers⁴¹. Many disadvantaged women suffer violence over a long period because they do not know where to turn to for assistance³⁹.

Violence has a profound impact on women's mental health and wellbeing, depriving women of a sense of control over their lives. Intimate partner violence involves the loss of a sense of self and destroys notions of what constitutes a safe, loving relationship⁴². Intimate partner violence is also a form of oppression, causing a sense of defeat and a loss of self-esteem⁴². All this contributes to the decline of mental health and wellbeing in many ways. A 2004 VicHealth study found that intimate partner violence is the greatest cause of women's poor mental health⁴³. Women with a history of physical abuse have significantly higher lifetime rates of major depression,⁴⁴ and illicit drug abuse than do women with no history of violence²⁰. Similarly, sexual violence causes one in three women to experience depression, excessively use drugs or attempt suicide^{20,45}.

2.3 Access to economic resources

The term 'access to economic resources' most often refers to employment, but it also encompasses job security, appropriate levels of pay and job satisfaction⁴⁶. Employment and job security provide people with a sense of purpose, security and independence, increase social inclusion and contribute to their identity - factors contributing to positive mental health⁶. They also provide a direct source of income to buy resources and services that are important for mental health and wellbeing⁶.

Australian women face significant inequality in their access to economic resources. It is estimated that an average 25 year old woman starting work today will earn \$900,000 less than a 25 year old man over her working life²². In Victoria, only 55 percent of women are employed and they are earning less than their male counterparts; women have a weekly median income of \$355, while men's is \$605⁴⁷. Less than 10 percent of senior executives in Australian companies are women and women comprise only 8.2 percent of directors of Australia's top 200 companies⁴⁸.

Caring responsibilities influence women's economic participation. Around 44 percent of employed Victorian women report that work and family life often interfere with each other⁴⁹. Many women who are carers have to reduce their hours of paid work, and as a result, part-time work is the most common form of employment for Australian mothers⁴⁷. In Victoria, women comprise 71 percent of people employed part-time⁵⁰. However, 63 percent of organisations in Australia that provide maternity leave do not extend the benefits for their part-time, non-permanent employees⁵¹. Women are therefore placed in a financially disadvantaged position because of their caring responsibilities. Reduced work hours and limited benefits mean that over a lifetime, women who raise children are economically worse off than women who do not have children⁵².

These factors together lead to women's reduced superannuation and fewer savings for retirement compared to men⁵³. Women tend to retire earlier than men and when they do, they usually rely on their partner's income (47 percent) or a government pension or allowance (33 percent)⁵⁴. Only 41 percent of retired Australian women over 45 years of age contributed to superannuation schemes while they were working compared to 67 percent of retired men⁵⁴. In addition, only 22 percent of those women contributed for 20 years compared to 51 percent of men⁵⁴.

Women also have greater longevity compared to men. The average life expectancy of women in Victoria is over 84 years of age, while Victorian men may expect to live to just under 80 years⁵⁰. A lifetime of lower earnings compounded with lower superannuation, higher dependence on a partner and increased longevity can mean women often find it difficult to have enough money to live on in later life⁵⁵.

Having lower average income and fewer job opportunities means that women are more likely to experience economic hardship and poverty⁵⁶. Socio-economic factors, such as lower rates of pay, part-time and casual employment, and unemployment increase vulnerability to depression, being victims of violence, substance misuse, poor physical health and homelessness⁵⁷. Adults living in the most socio-economically disadvantaged areas in Australia have a higher prevalence of mental or behavioural problems and psychological distress⁵⁸. Depression and other mental health conditions are more common among those who are economically vulnerable or who are living in poverty, and this population is largely made up of women and children²⁰.

Reasons for low levels of economic participation may be linked to discrimination and violence, and these may influence women's social connectedness. For example, there is evidence that women with low socio-economic status experience more severe life events than the general population⁴. These women are more likely to deal with chronic sources of social stress such as low quality housing and a dangerous neighbourhood¹, are more likely to become victims of violence⁵⁹, and are more likely to encounter problems with child care⁶⁰. For these reasons, the consideration of the three social determinants of health – social connectedness, discrimination and violence and access to economic resources – is crucial to understanding the context of mental health and wellbeing for women.

3. Mental health conditions

Mental health is a major concern for Victorian women as it makes up 15 percent of Victorian women's total disease burden⁶¹. Mental health conditions are separated into two major categories: mental illness, a medically diagnosable disorder that significantly interferes with an individual's cognitive, emotional and or social abilities⁶²; and mental health problems, which interfere with a person's cognitive, emotional and/or social abilities but to a lesser extent than the impact of a mental illness⁶².

Co-morbidity between two or more mental illnesses as well as the co-morbidity between mental illness and chronic physical illness are common. Women report high rate of co-morbidity between mental illnesses⁶³, and high rates of co-morbidity between chronic depression and one or more chronic physical illness⁶⁴. The following section explores specific mental health problems and mental illnesses and their impact on women.

3.1 Anxiety disorders

In Australia, anxiety disorders are one of the most common forms of mental illness and are more common in women^{65,66}, with 32 percent of Australian women having experienced at least one type of anxiety disorder in their lifetime⁶⁷. In Victoria, anxiety disorders account for 34 percent of the total disease burden for women⁶¹.

Anxiety and fear are part of the 'fight or flight' response that guides survival, however, excessive and irrational fear and anxiety over a period of six months that interferes with daily life are symptoms of anxiety disorders⁶³. There are several disorders that fall under the anxiety category. They include generalised anxiety disorder, social phobias, specific phobias, panic disorder and obsessive compulsive disorder⁶³. Panic or anxiety attacks are common among people with anxiety disorders⁶³.

Anxiety disorders can be difficult to diagnose as many of the symptoms are physical and similar to that of heart and respiratory conditions⁶⁸. Anxiety disorders frequently coexist with substance abuse, eating disorders and depression, and they can coexist with each other as well⁶⁹. People who have panic attacks, for example, are more likely to be diagnosed with another anxiety disorder⁶³. Anxiety disorders are debilitating and may lead to social isolation and clinical depression⁶³. They can impair women's capacity to work, study, socialise and perform routine activities⁶⁹.

Traditionally, there has been a focus on biological determinants to explain a high prevalence of anxiety disorders among women, including genetic and hormonal fluctuations⁶³. In recent years however, new evidence points to social factors that also contribute to the manifestation of anxiety disorders among women.

It has been suggested that women and girls are socialised to be more empathetic and attuned to the feelings of others, while men and boys are expected to be more independent and assertive⁷⁰. These social reinforcements may render women more susceptible to anxiety disorders²¹. This theory is supported by studies which conclude that women are more sensitive to threatening stimuli, as well as more likely to perceive threats that arouse anxiety⁶⁸.

An example of how gender influences anxiety disorders can be found in the prevalence of social phobia. Young women are prone to developing non-generalised sub-types of social phobia including excessive and irrational fear of activities such as speaking, writing or eating in public⁷¹. Self-confidence is seen as a protective factor against the onset and severity of social phobia, and it has been suggested that because females are taught to be more self-conscious, more sensitive to judgement of others, and less assertive than their male peers, they tend to be less confident and more likely to develop these sub-types of social phobia, particularly in their teens⁷⁰.

These gender differences are also pronounced in the manifestation of post traumatic stress disorder (PTSD), a form of anxiety disorder that is more commonly diagnosed in women⁶³. Post traumatic stress disorder is associated with exposure to physical and sexual assault, with symptoms including chronic fear, anxiety and depression as well as nightmares, sleep disorders, suicidal thoughts and suicide attempts⁶³. Women make up a large proportion of assault victims, and female victims make up the majority of PTSD sufferers⁷². Women who have been exposed to trauma have approximately twice the risk of developing PTSD compared to male victims⁷². Post traumatic stress disorder is also more long lasting among women sufferers⁷².

Gender differences in social conditioning also impact on the expression of obsessive-compulsive disorder (OCD). The essential features of OCD are recurrent obsessions or compulsions that are excessive or unreasonable, and severe enough to be time consuming

or cause marked distress or significant impairment⁶³. Obsessive Compulsive Disorders can be expressed in many ways, the most common including repeated doubts, fear of aggression and fear of contamination⁶³. Gender roles intersect with the expression of OCD – obsessive-compulsive behaviours can be displayed according to gender normative behaviours⁷³. For example, women are more likely to suffer from the fear of contamination which is expressed through excessive cleaning⁷³.

3.2 Mood disorders

Mood changes are a natural part of life as they reflect life events. However, severe and excessive moods changes can be incapacitating, and may become a mood disorder (also known as affective disorder)⁶³. Almost 18 percent of Australian women have experienced at least one form of mood disorders in their lifetime⁶⁷, while in Victoria, mood disorders account for 40 percent of the mental health disease burden in women⁶¹. Mood disorders are generally categorised into depressive disorders (depression, major depression, chronic depression), which refer to a prolonged period of low mood and loss of interest; and bipolar disorders, which are defined by intermittent periods of manic and depressive episodes⁶³. Apart from the overwhelming absence of joy, common symptoms of mood disorders may include disturbance to sleep patterns and appetite, and increased use of alcohol and other drugs⁶³.

3.2.1 Depressive disorders

Depression is the most common form of mood disorder. It is a major health problem for Australian women and is frequently accompanied by other psychological problems such as anxiety disorder and post-traumatic stress disorder⁷⁴. In Victoria, depression is the fourth highest cause of total disease burden for women⁶¹.

Women tend to be affected by depression more severely and over an extended period of time⁷⁵. Symptoms of depression that are more often found in women include guilt, poor body image, weight gain and excessive sleeping⁷⁵. Women are more likely than men to experience depression in association with other conditions such as eating disorders, anxiety and stress²¹. Married women are more likely to suffer from depression than married men, and mothers even more likely⁷⁶. In fact, the more children a woman has, the greater her chances of developing depression⁷⁶.

Women's reproductive health is linked with depression partly due to the fluctuation of hormones which can alter moods. The most well-known reproductive health related depression is post-natal depression which affects approximately 13 percent of mothers, while another 30 percent have some other form of psychological distress before or after childbirth⁷⁷. Other reproductive health related depression includes premenstrual dysphoric disorder, a severely debilitating depression and anxiety disorder related to menstruation that affects between three and five percent of women⁶³; depression related to infertility, miscarriage, or surgical menopause; and depression related to hormonal treatments such as oral contraceptive medication and some infertility treatments⁷⁸.

In addition to biological factors, there are also social explanations behind the higher prevalence of depression in women. The gender roles and relations that construct women's lives can contribute to their poor mental health outcomes and place women at risk of

developing depressive disorders. Competing demands between work and family responsibilities can lead to physical, emotional and psychological exhaustion. The feeling of a lack of autonomy and control over one's life is also associated with depression²¹. This can be expressed through the fact that women are largely responsible for ensuring positive outcomes in reproductive health, parenting, domesticity and formal employment, but are often not the principle decision makers in these realms²¹.

Women who are particularly at risk of depression are those with high levels of stressors in their lives. Women with low socio-economic status are more likely to be exposed to stressful life events such as illness and death of children or partners, imprisonment, job insecurity, dangerous neighbourhoods and hazardous workplaces⁷⁹. This places them at a significantly higher risk of depression²¹. Women who have been victims of violence are also at increased risk of major depressive illness⁸⁰. Research suggests that the relationship between violence and depression is causal – depression and anxiety increase when violence is ongoing⁸¹ and decrease once women stop experiencing violence^{82, 80}.

3.2.2 Bipolar disorders

Bipolar disorders are a group of mood disorders whereby individuals experience periods of abnormally elevated mood otherwise known as mania, interchanging with regular moods, mixed state, and/or depressive episodes. It affects around 3 percent of Australian women⁶⁷. Bipolar disorders share symptoms with depressive disorders and schizophrenia and are commonly misdiagnosed⁶³.

Women and men are diagnosed with bipolar disorders in similar numbers⁶³. However, women's bipolar experience is usually dominated by depressive episodes or mixed episodes⁶³. Women are also more likely to experience a major depressive episode as the first in their cycle and to experience rapid-cycling of interchanging moods⁶³.

The causal pathways for bipolar disorders are unclear, but it is generally understood that bipolar disorders are caused by a severe imbalance in the production and regulations of mood and hormone altering chemicals, such as oestrogen⁸³. For women, fluctuations of these chemicals are at their sharpest during pregnancy, the postpartum period⁸³ and around menopause⁸⁴, putting women at risk at these times.

Some women experience bipolar disorder for the first time during their pregnancy, usually expressed in the depressive state⁶³. These women have a high risk of becoming ill again in the postpartum period, and have an elevated risk of having postpartum psychosis (20-30 percent risk)⁸³. Post partum psychosis generally occurs within 24-48 hours after birth and is linked to 4 percent of infanticide⁸³. Therefore, pregnancy and birth can be a particularly critical time for women with bipolar disorders.

Women with bipolar disorders face a high risk of experiencing mild to major depression during their menopausal transition and the post menopausal periods. One study found that leading up to menopause, 33 percent of women with bipolar disorders experienced continuous cycling of mood states⁸⁴. However, among those in the post menopausal period, depressive symptoms dominate⁸⁴. For older women, it has been observed that apart from acute hormone fluctuation, factors such as social isolation also contribute to the severity of depression in bipolar sufferers⁸⁴.

3.3 Schizophrenia

Schizophrenia is a form of psychotic disorder that is characterised by a difficulty with the ability to differentiate between what is real and what is imagined⁶³. These false realities are referred to as delusions and hallucinations which can present vividly as sight, sound, smell or touch⁶³. These characteristics can be accompanied by disorganised speech which is difficult to comprehend, chaotic disorganisation, catatonic behaviour and/or depletion of emotional expression⁶³. Schizophrenia affects around one in a hundred people⁸⁵ and is categorised into a number of sub-types depending on the predominant features.

Schizophrenia severely impairs social and occupational functioning, along with capacity for adequate self-care. Extreme psychotic episodes can present danger to sufferers and those around them. These episodes may lead to refusal to eat or drink, and/or accept help⁶³. They may also lead to self-harm and suicide⁶³.

Women have a slightly lower incidence of schizophrenia compared to men. Women commonly have later onset in their mid 20s, whereas men tend to have onset in their late teens⁸⁶. Around 3-10 percent of women with schizophrenia have onset after 40 years of age, whereas late onset is much less common in men⁶³. Women with schizophrenia tend to express paranoid delusions and hallucinations, but are generally able to better function than men with schizophrenia⁸⁷. Women with early onset have a better prognosis than men and women with later onset, with fewer relapses and positive response to treatment⁸⁶.

Parenting is a significant issue for women with schizophrenia. Women with late onset schizophrenia may be caring for children during the time of first onset, which leads to significant disruptions to the family unit. Inability to adequately care for children can cause considerable guilt and anxiety for women⁸⁸. Hospitalisation in mental health facilities means that these women are unable to be with their children¹⁸. Women also fear losing the custody of their children due to their illness¹⁸.

3.4 Eating disorders

Eating disorders are characterised by severe disturbances in eating behaviour and a disturbance in perception of body shape and weight. They are more commonly found in women, particularly young women⁶³. One in 20 Australian women reported having suffered from an eating disorder⁸⁹. In Victoria, women account for 94 percent of the total disease burden related to eating disorders⁶¹. The two main types of eating disorders are anorexia nervosa and bulimia nervosa.

Trends in Australia show that the number of women and girls with eating disorders are increasing, and the age of sufferers is decreasing. A Queensland report shows that the number of 0 to 13-year-olds diagnosed with eating disorders at community mental health services jumped from 14 in 2002-2003 to 57 in 2007-2008⁹⁰.

All women with eating disorders are at greater risk of depression, and for pregnant women with eating disorders, postnatal depression is of particular concern. The postpartum period can be a dangerous time for women with eating disorders suffering from depression as the constant demand from the infant is a compound stressor⁹¹.

3.4.1 Anorexia nervosa

Anorexia nervosa is characterised by a refusal to maintain a minimum normal body weight, intense fear of gaining weight, and significant distortion in the perception body shape and size⁶³. The self-esteem of people with anorexia nervosa is highly dependent on their perception of their body shape and weight. Weight loss is viewed as an achievement and a sign of self-discipline, whereas weight gain is perceived as a failure of self-control⁶³. Usually weight loss is accomplished primarily through reduction in total food intake. Additional methods of weight loss include low calorie diets, purging and/or excessive exercising⁹².

Over 90 percent of anorexia sufferers are female⁶³. Typical age of onset is in the early to late teens⁶³, a critical time in emotional and physical growth. It is the third most common chronic illness for adolescent girls in Australia⁹³ and can have profound impact on these young women's lives.

There is a high co-morbidity between anorexia nervosa and a number of mental health conditions. These may include social phobia, obsessive-compulsive disorder, depression and displays of self-harm⁶³. Anorexia sufferers may exhibit obsessions and compulsions related to food, social fears unrelated to eating behaviour, intensely low mood from body dissatisfaction and self-loathing⁶³.

3.4.2 Bulimia nervosa

Bulimia nervosa is characterised by repeated episodes of binge eating followed by compensatory behaviours such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise⁶³. However, unlike individuals with anorexia nervosa, some bulimia nervosa sufferers are able to maintain body weight at or above a minimally normal level⁶³.

The incidence of bulimia in the Australian population is 5 in 100⁹⁴ and women make up around 80 percent of bulimia sufferers⁶³. Bulimia nervosa usually begins in late adolescence or early adult life⁶³, frequently during or after an episode of dieting⁶³. Bulimia sufferers are often secretive about their illness, which means that disturbed eating behaviour can often persist for a number of years before it is picked up by those around them⁹⁵.

Bulimia nervosa is linked to other mental health conditions including depression, borderline personality disorder, and alcohol and substance abuse. People with bulimia nervosa are often aware that something is wrong but are not able to seek help as they are ashamed of their condition, and feel a lack of control⁹⁵.

3.4.3 Eating disorders and body image

The social construction of body image plays a crucial role in the development of eating disorders. Body image refers to "the picture that a person forms of their body in their mind and is influenced by their own beliefs and attitudes as well as ideals in society"⁹⁶.

The development of positive or negative body image depends on a number of factors. Certain personality traits such as personal resilience can act as a protective factor against negative body image⁹⁷. Loving relationships and a sense of belonging can feed into self-

worth, cultivating positive body image⁹⁸. Societal idealisation of a certain body type can create personal desire to achieve the ideal body⁹⁸, thus creating a negative body image.

An average Australian child sees between 20,000 and 40,000 television advertisements per year⁹⁹. Children are bombarded with messages about how they should look, and many are suffering from anxiety and lower satisfaction of themselves⁹⁹. An Australian survey found that increasingly children are disturbed by the pressure of marketing aimed at them¹⁰⁰.

While western popular culture presents the ideal male body as muscular, it presents the ideal female body as thin and often underweight¹⁰¹. Print media regularly practice airbrushing to create even thinner images by erasing signs of 'imperfection'¹⁰² such as cellulite, trimming down waistlines and thighs, and vertically stretching images. Although this particular body type may be natural for some women, it is not a natural body type for many women¹⁰³. As a result, a sense of inadequacy and dissatisfaction creates a negative body image in some women¹⁰⁴. This can lead to low self-esteem and depression, and contributes to the development of eating disorders⁹⁸.

Young women are particularly susceptible to developing an eating disorder as they are still in the process of establishing their identity, self-worth, social network and sexuality while observing the drastic changes in their physical appearance⁹⁷. Evidence shows that the highest prevalence of eating disorders are found in cultures where beauty is equated with particularly thin women²⁰. The majority of these cultures are in developed nations, including Australia⁶³. An Australian study revealed that 67 percent of women aged 18-23 years had a body mass index within a healthy weight range, but only 22 percent of these women were happy with their weight¹⁰⁵.

3.4.4 Eating disorders and physical health

Although eating disorders are essentially mental illnesses, they have profound effects on women's physical health. Insufficient nutrient intake can cause kidney dysfunction, seizures, muscle spasms or cramps and strain on most body organs¹⁰¹. In extreme cases, eating disorders can lead to death caused by starvation, suicide, or electrolyte imbalance⁶³.

Osteoporosis is a physical health risk associated with anorexia nervosa. When the body is malnourished and underweight, it is unable to produce hormones and also becomes calcium deficient⁹². These factors lead to a loss in bone density, making the bones brittle and prone to breakage.

Recurrent vomiting practiced by bulimia sufferers can have serious impacts, including the permanent loss of dental enamel which leads to more frequent cavities, enlarged salivary glands and damage to the gag reflex⁶³. The loss of stomach acid through vomiting may produce metabolic alkalosis⁹⁵, a metabolic condition where the blood pH level is above the normal range. Severe alkalosis decreases blood flow which may lead to seizures and decreased mental status. Serious cases of metabolic alkalosis may end in death⁹².

The abuse of laxatives also has consequences on physical health. Women may become dependent on their use to stimulate bowel movements⁹². In some cases, this practice leads to gastric ruptures and rectal prolapses⁶³.

Eating disorders can interfere with women's fertility. Because the onset coincides with puberty, it can lead to amenorrhea which is the absence of menstrual periods in women of reproductive age¹⁰⁶. Disruption to the natural development of the menstrual cycle is linked to decreased fertility in adulthood.

In cases where women suffer from an eating disorder during pregnancy, their health and their foetus' health are at risk. During this critical period, women need to consume enough nutrients for themselves and their foetus. In the case where insufficient nutrients are consumed, the foetus continues to use the reserved nutrients from the mother⁹¹. As a result, mothers who are not receiving calcium may lose the calcium in their bones, and face complications with their heart, liver and kidneys⁹¹. Eating disorders are associated with stillbirth, greater chance of Caesarean birth, low birth weight and premature birth⁹¹. Other complications include low IQ, cerebral palsy and failure to thrive in the infant's first year¹⁰⁷.

4. Issues associated with poor mental health

4.1 Self-harm

Self-harm (also known as deliberate self-harm, intentional self-harm or self-injury) refers to an act of deliberately inflicting physical harm on oneself, usually in secret and often without anyone else knowing¹⁰⁸. Some examples are cutting, burning, biting or hitting the body, pulling out hair or scratching and picking at sores on the skin¹⁰⁹.

Self-harm is not a suicide attempt and engaging in self-harm may not mean that someone wants to die, rather it is a behaviour that is used to cope with difficult or painful feelings¹¹⁰. People who self-harm reported that inducing physical pain on the self temporarily alleviates emotional pain¹¹¹.

Self-harm is associated with mental health problems and mental illnesses, particularly depressive disorders, bipolar disorders and psychotic disorders⁶³. Traumatic life events can trigger self-harm behaviours. These events may include death of loved ones, physical or sexual abuse, discrimination, bullying, and social isolation¹¹². Studies have also found that teens who report problems in the home such as conflict with parent(s), parental abandonment, or conflicts between parents also show higher rates of self-harm¹⁰⁸.

Women make up approximately 62 percent of reported cases of self-harm in Australia¹¹³. Although Australian women of all ages self-harm, it appears to be most prevalent among women aged 25-44 years (44 percent) and 15-24 years (31 percent)¹¹³. However, these figures are believed to be conservative as they only account for reported cases and cases that end in hospitalisation.

A number of explanations have been put forward regarding higher self-harm rates among females. One reason is that men with mental health conditions are more likely to suicide¹¹⁴. Women with mental health conditions on the other hand, tend to self-harm without intention of suicide⁹⁶. Other studies suggest that more women engage in self-harm because they make up a higher proportion of people who have been exposed to ongoing physical and sexual abuse¹⁰⁹. Women are also more likely to endure discrimination and find themselves in subordinate positions which may lead to poor mental health outcomes¹⁹.

Women who self-harm may face social stigma stemming from the common belief that these acts are a form of attention seeking¹⁰⁹. The lack of social understanding and compassion about self-harm can hamper women's disclosure and help seeking behaviours¹¹⁵. As a result, many cases may go undetected unless hospitalisation is required due to injuries.

4.2 Suicide

Suicide is a deliberate act of taking one's own life, and is associated with psychological factors such as difficulty coping with depression, constant fear, or other mental health conditions and pressures¹¹⁶.

In Victoria, the male suicide rate is four times higher than the female rate¹¹⁷. This pattern is fairly consistent across all age groups with the exception of advanced old age where the male to female ratio is even higher¹¹⁷. Suicide rates among women and men with complex mental illnesses including bipolar disorder, schizophrenia and other psychotic disorders are more uniform^{118,119}.

Suicide figures reflect only the number of completed suicides and not suicide attempts. Women, in fact, attempt suicide more frequently than men but are less like to complete suicide¹²⁰. An important factor which contributes to this outcome is the method of suicide. Seventy percent of suicide attempts by women are through self-poisoning which has varying effectiveness¹²¹, while men tend to choose more violent and effective methods such as firearms and hanging¹²².

Suicide and attempted suicide rates are higher in women who have been the victims of violence than those who have not been exposed^{123,124}. Women who have experienced violence are five times more likely to attempt suicide than those who have not¹²⁵.

Suicide also has a strong correlation with discrimination. In an Australian survey, around 15 percent of same-sex attracted women report having had suicidal thoughts within the previous two weeks²⁸. Young women who are victims for bullying or those who are socially isolated are also at higher risk of attempting suicide¹²⁶. Cyber-bullying is a growing concern in Australia due to its anonymity and access, with 67 percent of female teens report having been bullied online¹²⁷.

4.3 Homelessness

Homelessness is a major problem for women with mental illness. The relationship between homelessness and mental health is interlinked; women with mental health conditions are at risk of being homeless while the conditions of being homeless also influence poorer mental health outcomes¹²⁸.

Data from the Supported Accommodation Assistance Program (SAAP) indicates that of the homeless people seeking assistance in Victoria, 65 percent are women¹²⁹. National SAAP data also found that 55 percent of women who seek their assistance have a mental health condition¹³⁰. Women who are in need of the most urgent of help are the ones who are most likely to be socially isolated. A study into homeless women with schizophrenia found that these women had more serious alcohol and drug problems compared with other women suffering from schizophrenia¹³¹.

4.4 Imprisonment

There is an overrepresentation of people with mental illness in the prison system and women with mental illness constitute a high proportion of female prisoners in Victoria. Similar to homelessness, the relationship between imprisonment and mental health is interlinked; women with mental health conditions are at risk of imprisonment and imprisonment negatively impacts on mental health.

There are currently 238 female prisoners in Victoria¹³². A survey conducted by the Department of Justice found that 35 percent of female prisoners have been medically diagnosed with a mental illness¹³³, and around 41 percent have received treatment for their mental health at some point in their lives¹³³. Of those, 17 percent have been admitted into psychiatric care and 24 percent are currently being treated with psychiatric medication¹³³. These figures suggest that women who need rehabilitation and mental health treatment may be inappropriately directed into the prison system.

5. Mental health care

Mental health care attempts to respond to and support people with mental health conditions. It consists of systems and structures that determine the delivery of primary care, acute care and mental health promotion. Women make up the largest group of mental health care users in Australia¹³⁴. In Australia, the first point of contact for women seeking mental health care is usually a general practitioner who may refer patients to a psychologist, psychiatrist or counsellor. Consumers are most often treated with cognitive behavioural therapy and/or medication¹³⁵. In serious cases, care is delivered in the acute care setting such as hospitals.

5.1 Primary care

Primary care is a term used for the activity of a health care provider who acts as a first point of consultation. General practitioners (GP) are the main primary care providers for women seeking mental and physical health care in Australia¹³⁵. Australian women make up 60 percent of mental health related GP encounters, with anxiety and mood disorders being the most commonly presented conditions¹³⁵.

Through GP referral, the Medicare Benefit Schedule (MBS) provides subsidised psychiatrist and allied health services, and for every 100 GP encounters, 12 encounters are referred¹³⁵. Women make up the majority of patients referred to mental health care specialists through the MBS. They constitute 55 percent of those referred to psychiatrists, 66 percent of those referred to psychologists, and 69 percent of those referred to other allied health services such as mental health nurses, counsellors, and occupational therapists¹³⁵.

Women who have experienced violence use higher levels of health care and are more likely to present with a mental health condition. However, some primary health care practitioners overlook routine screening of women's experience of violence¹³⁶.

5.2 Acute inpatient care

Acute inpatient care for serious mental health conditions refers to psychiatric facilities where patients receive intensive care, rehabilitation and/or have their conditions monitored over acute episodes. There are 120 mental health inpatient care facilities in Victoria, 8 of which are psychiatric hospitals, 34 are hospitals with specialised psychiatric units, and 78 are residential mental health services¹³⁵. Women represent 41 percent of patients in residential care, and make up the majority of patients over the age of 65 years¹³⁵. Residential care patients tend to present with ongoing complex illnesses.

In Victoria, many acute inpatient care units cater for women and men¹³⁷. In some facilities, living areas are shared. These can include the common room, the garden and visiting area, the exception being bedrooms which are single-sex. In a survey of Victorian facilities, 10 out of 26 facilities had women's and men's bedrooms located in the same corridor¹³⁸.

Due to safety concerns for the patients and convenience for staff, many facilities are not equipped with lockable doors for bathrooms, bedrooms or toilets¹³⁸. As a result, patients may accidentally or intentionally walk in on others while they are in the shower, toilet or bedrooms¹³⁹.

In Victoria, the lack of women-only spaces in mental health inpatient facilities compromises female patients' privacy, and leave them vulnerable to physical and sexual assault¹³⁹. Violation and re-traumatisation through assault of female patients can lead to further decline in these women's mental and physical health¹⁴⁰. A mixed-sex environment can undermine female patients' capacity to recuperate in the very setting in which they are to receive the most intensive of care. Changes that can be made to increase female patients' safety and privacy include staff training in administering gender sensitive care, providing female only spaces and lockable doors that can be over-ridden by staff¹³⁷.

5.3 Medication

There are a number of medications used to treat mental illness. Most aim to restore balance in the brain through the use of chemicals or hormones. Women and men regulate their hormones differently, and different chemicals and hormones have different effects on women and men¹⁴¹. Therefore, the effects of medication are different, and some treatments are better for women than for men and vice versa¹⁴².

A number of medications have not been tested on women prior to their release. The recommended dosage, benefits and possible side effects are primarily based on drug trials on men¹⁴³. The primary reason given for under-testing medication on women is the more frequent fluctuation of hormones caused by the menstrual cycle, and the risk of trial participants becoming pregnant during the test period¹⁴⁴.

Despite women's lack of inclusion in drug trials, women are more likely than men to use medication to improve mental wellbeing¹⁴⁵. In the treatment of depression, women are significantly more likely to be prescribed antidepressant drugs than men with the same diagnosis¹⁴⁶.

Because most mental health medications have been tested on men and not women, the recommended dosage is also based on trials on men¹⁴¹. Women experience side effects from antidepressant medication that must be managed differently, possibly because women

metabolise antidepressants in a different way to men¹⁴⁷. Women's medication needs are distinct from that of men's and prescriptions based on men-only trials can have negative consequences on women's health¹⁴⁸.

5.4 Health promotion

Health promotion is "the process of enabling people to increase control over their health and its determinants, and thereby improve their health"¹⁴⁹. The most popular methods for health promotion are social marketing and health education, aimed at behavioural change³. Health promotion also occurs through the development of programs and policy that address the determinants of health such as income, housing, food security, employment, and quality working conditions¹⁴⁹.

Health promotion programs aimed at improving mental health and wellbeing may address the previously discussed determinants of mental health, raise awareness or educate on health issues. Mental health promotion programs designed for the general population tend to be gender neutral even though mental health issues are largely influenced by gender. As a result, they may be less effective. Gender specific mental health promotion programs often focus on postnatal depression in women and suicide and depression in men²⁰. While postnatal depression is an important mental health concern for women, other gender specific mental health issues also need to be addressed.

6. At risk and diverse population groups

Women in disadvantaged social positions are particularly vulnerable to social exclusion, discrimination and violence, and poor access to economic resources. As a result, they are also more susceptible to having poor mental health with less access to mental health care.

6.1 Aboriginal and Torres Strait Islander women

Aboriginal and Torres Strait Islander women make up 2.3 percent of all Australian women¹⁵⁰, and 1.2 percent of Victorian women¹⁵¹. Women from Aboriginal and Torres Strait Islander backgrounds are at risk of having poor mental health outcomes as they are among the most disadvantaged populations in Australian society. The history of colonisation has a profound impact on Indigenous Australians, including the loss of land, the loss of spiritual and cultural traditions, the loss of lives through massacres and epidemics, removal of children from their families, and ongoing racism, social exclusion and poverty¹⁵².

Discrimination against Indigenous Australians is still prevalent today, with 40 percent of Indigenous people report having been physically or emotionally upset by treatments based on their race. In a 2006 survey, 25 percent of Victorians also admitted that they would be concerned if a close relative were to marry an Indigenous person¹⁵³. These experiences of discrimination lead to psychological distress and negatively impact on health outcomes¹⁵³.

Women from Aboriginal and Torres Strait Islander backgrounds are more susceptible to experiencing traumatic life events including family violence, sexual assault, and loss of a child¹⁵⁴. Indigenous women are almost 10 times more likely to die from assault than non-

Indigenous women and are 35 times more likely to be admitted to hospital as a result of family violence⁴⁰.

Access to economic resources can be particularly challenging for Aboriginal and Torres Strait Islander women. They have higher unemployment rates than other women and are more likely to live below the poverty line where their basic needs such as food and housing are not met¹⁵⁴. There are also higher numbers of teenage mothers in Indigenous communities, and one parent families headed by Indigenous women almost double that of other Australian women¹⁵⁵.

Poverty, physical violence, sexual abuse and social inequalities have direct impacts on the mental health of Indigenous women. Compared to Indigenous men, they report significantly higher level of psychological distress¹⁵⁵. They also have higher levels of morbidity and mortality due to mental illness compared to non-Indigenous women, and are hospitalised for mental health issues at a rate 1.6 times higher than other women¹⁵⁵. Twenty percent of young Indigenous women aged 12-17 years report that they have seriously considered ways to end their life and some have also attempted suicide¹⁵⁵.

6.2 Rural women

Issues that impact on women's mental health are compounded for women living in rural locations. These include economic hardship, negative experiences of labelling and stigma, greater risk of violence and social isolation¹⁵⁶.

Rural women report not being able to access required support because of limited availability of services. Rural women with mental health concerns are less able and less inclined to raise issues or complain about perceived inappropriate service provision or care, because of the limited services available and close-knit community living¹⁵⁷.

Service providers are often members of the same community which can lead to the perceived blurring of professional boundaries¹⁵⁸. This affects rural women's experience of primary mental health care.

6.3 Same-sex attracted women

In Australia, there are around 8,800 female same-sex couples recorded, of which 19 percent have children¹⁵⁹. Discrimination and violence are major concerns for same-sex attracted women. An Australian survey found 34 percent of same-sex attracted women report having been socially excluded or ignored, 9 percent report having been refused employment or promotion, and 3 percent have been refused housing due to their sexual orientation²⁸. These acts of discrimination make many same-sex attracted women reluctant to reveal their sexuality, with around 33 percent of women reporting that they either generally or always avoid disclosing²⁸. Discrimination can also lead to violence. Fifty-six percent of same-sex attracted women report having been verbally abused, 15 percent having received threats of violence and intimidation, while 7 percent have been physically attacked²⁸.

Intimate partner violence is also an issue of concern for same-sex attracted women, with 40 percent of surveyed women report having been in a relationship where they were abused by their partner²⁸. Of unique concern for same-sex attracted women is the abusive partner

threatening to 'out' women to their employers and the wider community. There are specific barriers for same-sex attracted women in seeking help for intimate partner violence. Secrecy around same-sex relationship can prevent women from confiding in family, friends and support services¹⁶⁰. Service providers may not recognise the nature of the relationship or have misconceptions that the abuse is mutual¹⁶⁰.

Social inclusion and supportive networks play an important role in cultivating positive mental health outcomes for same-sex attracted women. Women who are 'out', have their sexuality accepted by their family and friends, and/or are part of the gay and lesbian community report more positive mental health compared to same-sex attracted women who do not experience social acceptance¹⁶¹. Evidence also suggests that bisexual women are more likely to suffer poorer mental health outcomes compared to lesbians and heterosexual women¹⁶². This may be due to the difficulty faced by bisexual women in being accepted into heterosexual or lesbian communities¹⁶².

A decreased sense of belonging is linked with depression, lower levels of self-esteem, self-worth and self-sufficiency¹⁶³. Approximately 38 percent of same-sex attracted women in Australia suffer from depression and 62 percent have visited a counsellor or a psychiatrist in the past five years²⁸.

Poor mental health can increase risk-taking behaviours and same-sex attracted women report higher usage of alcohol and drugs than their heterosexual peers (risky alcohol use: 7 percent vs. 4 percent; marijuana use: 59 percent vs. 22 percent; and illicit drug use: 41 percent vs. 10 percent)¹⁶⁴.

6.4 Women with disabilities

Approximately 20 percent of Australian women have a disability¹⁵⁹. Women with disabilities face multiple forms of discrimination due to their gender and their disabilities. Discrimination can lead to violence, social exclusion and poor access to economic resources.

Current data in Australia is limited, but it is estimated that women with disabilities are subjected to levels of violence and abuse of at least double the rate experienced by other women, and the rates are estimated to be particularly high among women with intellectual disabilities¹⁶⁵. Violence can include physical, sexual, emotional and psychological abuse as well as neglect. Moreover, women with disabilities are more likely to be in violent relationships that exacerbate their disability and may have caused it¹⁶⁶. Many are subjected to violence from their carers and for some of these women there are extremely limited avenues of escape or support¹⁵.

Discrimination can also limit employment opportunities for women with disabilities, therefore many rely on a pension as the primary source of income¹⁶⁶. In fact, around 29,000 women with disabilities have median gross personal incomes of less than \$200 per week, and only 32 percent of women with disabilities earn income through employment¹⁵. Among those who are employed, women with disabilities are more likely to be employed in low-status, low-paid jobs with poorer working conditions¹⁶⁷. Inadequate access to economic resources leads to poverty and affects living conditions. There are extremely low rates of home ownership for women with disabilities, with a lack of secure housing particularly in the rural areas of Australia¹⁶⁸.

Women with disabilities experience social exclusion through a number of barriers including limited access to information and poor physical access to services. For example, some service providers do not have audio and tactile cues for women with visual impairments to obtain information¹⁶⁹. Many establishments fail to provide accessible parking, accessible toilets, and accessible examination tables for women with physical disabilities¹⁶⁹. These barriers limit women's independence as well as opportunities for them to stay informed, access services and maintain social connections. As a result, women with disabilities have poorer social connections with families and friends than women without disabilities.

Women who acquire physical disabilities later in life may also find it challenging to adapt to the change in life style and having to learn new skills. These changes along with the disabilities can take an emotional toll that may lead to depression¹⁶⁶. Fifty-five percent of women with disabilities also report mental health problems as a dual disability, and many suffer from poor self-esteem caused by social exclusion¹⁶⁶. This could also lead to risk-taking behaviour or alcohol and substance abuse.

6.5 Women from cultural and linguistically diverse (CALD) backgrounds

Of approximately 2.5 million women living in Victoria, over 25 percent speak languages other than English at home¹⁵⁰. Victoria women from culturally and linguistically diverse backgrounds comprise 19 percent of the total female population¹⁵⁰.

Leaving established social networks through migration means that many women from CALD backgrounds are at risk of social isolation¹⁷⁰. Customs and language can also be barriers in forming new social connections¹⁷¹. At the same time, women from CALD backgrounds may also be faced with discrimination and racism which further propels their social exclusion¹⁷². Conversely, being a part of a close knit ethnic community group can also be difficult for women from CALD backgrounds as there can be social expectations that put pressure on women within these communities¹⁷². Deviation from these normative expectations may lead to social exclusion¹⁷¹.

Women from culturally and linguistically diverse backgrounds may find it particularly difficult to participate in the workforce. This may in part be due to lower levels of English proficiency and limited labour market experience prior to migration. When age is standardised, migrant women have a lower participation rate in the workforce (52 percent) than Australian born women (60 percent)¹⁷³.

Some immigrant women are in a vulnerable position in relation to violence due to their unfamiliarity with English and the new country. In 2005, approximately 22 percent of women who had experienced partner violence in the past twelve months prior to survey were born outside of Australia. The lack of English proficiency has been identified as a risk factor for intimate partner violence as it increases women's levels of social isolation¹⁵⁷. Moreover, perpetrators with greater English proficiency may use English as a form of control over women by creating a relationship of dependency¹⁷⁴.

Culturally and linguistically diverse women's vulnerability to social isolation, poor access to economic participation and discrimination and violence can therefore put them at risk of having poor mental health. For many immigrant women with insufficient knowledge of

English, language barriers and a limited support network can make it difficult to seek help for mental health conditions and violence¹⁷⁵.

6.6 Carers and parents

Of 2.6 million carers in Australia, women account for 71 percent of primary carers and 54 percent of all carers¹⁵. While an average woman could expect to spend 17 years caring for a child, she is likely to spend 18 years caring for a parent¹⁷⁶. Women carers are more likely than men to be disadvantaged by low income and to experience social isolation, and are vulnerable to anxiety, depression, and substance misuse¹⁷⁶.

The relationship between parenting and mental illness is a complex one¹⁷⁷. Being or becoming a parent can increase the severity of women's mental illness due to hormonal changes and lifestyle demands¹⁷⁷. At the same time, mental illness also presents a challenge for mothers and their children as it can affect a woman's capacity to perform the parental role¹⁷⁷. Women may be unable to care for their children during a time of illness¹⁴³. Admission into acute care settings and prisons can also make it difficult for women to spend time with their children, and they face a risk of losing custody of their children¹⁴³.

6.7 Young women

Young women aged between 15 and 25 years are vulnerable to having poor mental health outcomes because the adolescent years are times of immense change. Physical changes and developing sexuality means that young women become more aware of their own body image. Social isolation, bullying, relationship issues and the popularisation of thinness increase young women's risk of having an eating disorder, attempting suicide and self-harm¹⁰¹.

An issue of a particular concern for young women is the use of illicit drugs, with almost 60 percent of female adolescents report that they have used drugs¹³⁴. There is a growing concern in Australia regarding the relationship between recreational drugs and mental health. Depression is associated with illicit drug use, and the probability of being diagnosed with depression increases with the use of illicit drugs¹³⁴.

6.8 Older women

There are twice as many women as men aged over 85 years. Women aged 65 and over make up the largest proportion of Australian women who access health services regarding their mental health¹³⁵. Older women are vulnerable to having mental health conditions perpetuated by social isolation and chronic physical conditions. Compared to men, women have greater longevity, but live more years with disability (20.7 years with disability, 8.3 years with severe or profound core activity limitation)¹⁷⁸. Therefore, although women spend a majority of their adult lives caring for others, they are more likely to find themselves living alone in their later life, suffering economic hardship while coping with ailing physical and mental health¹³⁴.

7. Conclusion

This Issues Paper has examined how the social construction of gender influences the determinants of mental health, and women's experience of mental illness and mental health care.

Mental health issues overlap with other areas of women's lives. Gender-based discrimination, violence, social inclusion and access to economic resources contribute to women's mental health outcomes. Additional factors including disabilities, Indigeneity, language and cultural barriers, and same-sex attraction also expose women to poor mental health outcomes.

The ways in which gender intersects with mental health have important implications for policy and service delivery. It is therefore necessary to tailor programs and services to meet the needs of women which differ to those of men. Incorporating gender sensitivity into policy and practice will ensure positive mental health outcomes for women, their families and the whole community.

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