

Gender analysis of the interim recommendations of the Royal Commission into Victoria's Mental Health System

About the Women's Mental Health Alliance

The Women's Mental Health Alliance was established in 2019 in the context of the Royal Commission into Victoria's Mental Health System.

There is international consensus that a gender-sensitive approach to mental health reform is necessary. However, there is a lack of awareness about the prevalence, risk factors and experience of poor mental health among women and girls, and limited evidence about how best to prevent and respond to mental ill health among women and girls and promote their mental wellbeing.

The Alliance undertakes collective advocacy to ensure the mental health of women and girls is prioritised in the recommendations of the Royal Commission and in current and future mental health reforms.

This analysis has been prepared by the Women's Mental Health Alliance in response to the [Interim Report](#) released by the Royal Commission into Victoria's Mental Health System.

Recommendation 1: Victorian Collaborative Centre for Mental Health and Wellbeing

The Royal Commission recommends that the Victorian Government establishes a new entity, the Victorian Collaborative Centre for Mental Health and Wellbeing. As a first step, the Mental Health Implementation Office should establish the governance of the Collaborative Centre and begin planning for a purpose-built facility in Melbourne. The Collaborative Centre will bring people with lived experience together with researchers and experts in multidisciplinary clinical and non-clinical care to develop and provide adult mental health services, conduct research and disseminate knowledge with the aim of delivering the best possible outcomes for people living with mental illness. The centre will work within a network of partners including service and research organisations in rural and regional areas. The Collaborative Centre will:

- a. drive exemplary practice for the full and effective participation and inclusion of people with lived experience across the mental health system
- b. conduct interdisciplinary, translational research into new treatments and models of care and support to inform service delivery, policy and law making
- c. educate the mental health workforce through practice improvement, training and professional development programs.

Models of care for the services the Collaborative Centre provides to its local community will reflect the Commission's final redesign of Victoria's mental health system.

Gender analysis of Recommendation 1

The Women's Mental Health Alliance (the Alliance) supports the establishment of the Victorian Collaborative Centre for Mental Health and Wellbeing (the Centre), bringing together a multidisciplinary team of researchers and experts, including people with lived experience of mental ill health.

It will be critical to ensure that the Centre's governing body includes representation from women with lived experience and other experts in women's mental health. Mental health carers should also be included, noting that approximately two-thirds of Australian mental health carers are female.

Research shows that while there is strong evidence establishing the need for a gender-responsive approach to mental health that addresses the specific needs and experiences of women and girls,¹ there appears to be little evidence of this approach being applied in practice. This is despite the fact that women and girls represent 50.4% of all clients in Victoria's mental health system (2018-2019).²

The Alliance recommends that a department and/or research unit be established within the Centre focusing on the mental health of women and girls, which would undertake and/or commission research, as well as developing the evidence base for effective gender-responsive and trauma-informed approaches to mental health promotion, treatment and recovery, including through pilot programs.

Research into the wellbeing of mental health carers is also critical, including in relation to overcoming barriers to educational and workforce participation and better understanding the experiences of migrant and Aboriginal and Torres Strait Islander women who care for family and friends experiencing mental illness.

The Centre should also analyse existing research and evidence (including clinical trials and treatments) to identify where it is either focused on males or where there are evidence gaps, including where there is an absence of evaluated gender-sensitive programs and treatments targeting women and girls.

All mental health-related data collected or generated by the Centre should be gender-disaggregated and analysed using an intersectional gender lens.

The Centre should also collaborate with other research institutes and multidisciplinary centres which focus on other policy areas impacting on women's mental health. This includes policy portfolios where the association with gender is clear, such as family violence and sexual violence, as well as those that currently apply little gender analysis, such as: income support; employment; housing and homelessness; and disaster impacts and response.

Recommendation 2: Targeted acute mental health expansion

The Royal Commission recommends that the Victorian Government, through the Victorian Health and Human Services Building Authority and the Mental Health Implementation Office, provides funding for

¹ [Investing in women's mental health: strengthening the foundations for women, families and the Australian economy](#) Australian Health Policy Collaboration, 2016 (Australian context) or for international context [Addressing unmet needs in women's mental health](#) BMC 2018

² State Government Victoria (2019). [Victoria's mental health services annual report 2018-19](#).

170 additional youth and adult acute mental health beds to help address critical demand pressures. The allocation should be as follows:

- a. 135 additional acute inpatient public mental health beds or equivalent beds, with the majority of these delivered by the end of 2021 and the remainder by mid-2022, proportionally provided to Barwon Health and to Melbourne Health, the latter in alliance with Western Health and Northern Health, using the following criteria: predicted population growth, forecast bed availability, socio-economic need and the availability of primary and community-based health services
- b. 35 additional acute inpatient mental health beds or equivalent beds procured by the end of 2021 from a private provider to deliver clinical treatment, care and support for public patients who would otherwise be treated in a public inpatient mental health unit.

The design and establishment of the additional beds should:

- a. be contemporary, co-designed with people with lived experience, and provide high-quality care in a hospital setting
- b. involve public, private and community health service partnerships. Assertive outreach should be used to enable acute care in a home or community residence, where possible, as a direct substitute for an inpatient bed.

Gender analysis of Recommendation 2

The Alliance recognises the need for immediate additional capacity within the mental health service system.

However, additional beds should not simply be 'bolted on' to the existing system. The Royal Commission has recognised the need for 'transformational change' within Victoria's mental health system, requiring 'fundamental redesign'. It is essential that a sex- and gender-based analysis is embedded in the implementation design from the outset, to ensure the additional beds meet the needs of female patients. It is much more difficult and costly to retrofit a gender-responsive design.

In implementing the recommendation for new acute mental health beds, the safety of patients should be paramount. Recent reports show that female patients still experience unacceptably high rates of sexual assault and sexual harassment within mental health services.³ One woman describes her experience as follows:

'The first time I got really sick I walked about 4kms to the (female dedicated) hospital thinking there would be a female only unit there. I was in a state; crying and not making sense so they called for a psych consult from the (general hospital) to come see me.

I couldn't stop crying and was so agitated they ended up paging a general doctor from emergency to see me. I was repeatedly asked if I'd been raped or if I was pregnant. I was neither, so I was escorted by two

³ [The right to be safe: ensuring sexual safety in acute mental health inpatient units: Sexual Safety Project report](#) Victoria. Mental Health Complaints Commissioner, 2018 and [Preventing gender-based violence in inpatient mental health units](#) ANROWS, 2020

male security guards to the IPU at the (general hospital). It was a mixed ward. I was given some sedatives, shown to my room and the door was locked behind me...

I was never sexually assaulted or molested but I got lots of comments like “you look good today” “I like your eyes”. The male patients were never asked to stop making those kinds of comments. Instead, staff told me off for allowing male patients to speak to me like that. I felt like I couldn't win.”⁴

Criteria for the allocation of the 170 new acute beds must include women-only wards to help ensure women's sexual safety. The Mental Health Complaints Commission's *Right to be Safe* report provides a range of options for implementing women-only wards, which prioritise safety while also allowing flexibility to manage demand.⁵

In order to support single gender wards, the Victorian mental health system needs more male staff and more gender diverse or minority gender staff. This will require a major recruitment drive. Furthermore, as discussed in more detail in response to recommendation 7, all staff will need rigorous trauma-informed gender sensitivity training on a regular and ongoing basis.

As it stands, half of Victoria's mental health services' clients cannot be guaranteed a safe service. This must change.

Recommendation 3: Expanding suicide prevention and follow-up care

The Royal Commission recommends that the Victorian Government, through the Mental Health Implementation Office, expands follow-up care and support for people after a suicide attempt by recurrently funding all area mental health services to offer the Hospital Outreach Post-suicidal after Engagement (HOPE) program. To facilitate access to HOPE, the statewide rollout should be complemented by:

- a. broad referral pathways to give people living with mental illness who are receiving care from clinical community-based teams within area mental health services access to HOPE
- b. additional clinical outreach services in each sub-regional health service, networked to a regional health service HOPE program, to provide support for people living in rural and regional areas
- c. extended service delivery that allows access to support whenever it is needed, including outside standard business hours.

The Commission also recommends the creation, delivery and evaluation of the first phase of a new assertive outreach and follow-up care service for children and young people who have self-harmed or who are at risk of suicide.

Gender analysis of Recommendation 3

The Alliance supports additional investment in and focused attention on suicide prevention.

⁴ Case study: Cis woman, white, 30s, married with dependants, presenting to hospital emergency department in psychiatric crisis, no date. Supplied by Victorian Mental Illness Awareness Council.

⁵ [The right to be safe: ensuring sexual safety in acute mental health inpatient units: Sexual Safety Project report](#) Victoria. Mental Health Complaints Commissioner, 2018

We strongly urge Mental Health Reform Victoria (MHRV) to apply a sex- and gender-based analysis to the implementation of recommendation 3. While suicide is often conceptualised as a 'men's' mental health issue, there is clear evidence that:

- Women and girls have higher rates of suicidal behaviour than men and boys⁶
- There has been a 47% increase in the suicide rate among young women over the last decade⁷
- Women are more likely to self-harm than men, with particularly high rates among young women⁸
- Rates of self-harm and suicidal behaviour are even higher among Aboriginal and Torres Strait Islander women, and lesbian, bisexual and trans women, and people with intersex characteristics⁹
- Those who self-harm are at an increased risk of suicide¹⁰

The Alliance supports the creation of a new program encompassing self-harm and suicidal behaviours – including self-harm, suicidal ideation, planning and suicide attempts – which women experience at higher rates than men.¹¹ Research is also needed to address the gap in knowledge about women's non-fatal suicide behaviour.

There is a tendency to take a 'gender-blind' approach to youth mental health. In practice, this means that youth mental health programs and services are generally oriented around the needs of young men. However, Australian research suggests that young women are around twice as likely as young men to meet the criteria for having a probable serious mental illness.¹² Young women report the highest rates of mental disorder of any population group (30% for women aged 16 to 24).¹³

⁶ Suicide and Suicidal Behaviour in Women – Issues and Prevention, Suicide Prevention Australia 2016.

⁷ ABS (2016) Intentional self-harm (Suicide) (Australia) : Table 11.3 - Intentional self-harm, age-specific death rates, 10 year age groups by sex, 2006–2015 [Excel download]. In: 3303.0 : Causes of Death, Australia 2015.

⁸ The Australian Longitudinal Study on Women's Health found that 45% of Australian women aged 18-23 years reported ever self-harming: ALSWH data book for first survey of 1989-95 cohort. Australian Longitudinal Study on Women's Health, 2016. The Victorian Women's Health Atlas shows that women are hospitalised for self-harm at about twice the rate of men: Self-harm Rate (per 1000), Victorian Women's Health Atlas, 2017.

⁹ Aboriginal and Torres Strait Islander women are hospitalised for self-harm at twice the rate of non-Aboriginal women: Suicide and hospitalised self-harm in Australia Trends and analysis :Hospitalised intentional self-harm: 2010-11 Australian Institute of Health and Welfare, 2014; For women in the 25 to 34 age group, death by suicide is three times as high for Indigenous women when compared to non-Indigenous women: Overcoming Indigenous disadvantage: Key indicators 2016, Steering Committee for the Review of Government Service Provision 2016; Lesbian and bisexual women, people with intersex characteristics and trans women are almost four times as likely as their cis/heterosexual peers to have tried to self-harm or suicide: Suicide and Suicidal Behaviour in Women – Issues and Prevention, Suicide Prevention Australia 2016.

¹⁰ Looking the other way: young people and self-harm, Orygen, The National Centre of Excellence in Youth Mental Health, 2016.

¹¹ Suicide and Suicidal Behaviour in Women – Issues and Prevention, Suicide Prevention Australia, 2016.

¹² Mission Australia, Black Dog Institute (2017) Youth mental health report: Youth Survey 2012-16. Mission Australia. Sydney. Available from: <https://www.missionaustralia.com.au/publications/research/young-people/706-five-year-mentalhealth-youth-report>

¹³ Duggan, Maria (2016) Investing in women's mental health: strengthening the foundations for women, families and the Australian economy. Australian Health Policy Collaboration, Melbourne. Available from: <https://www.vu.edu.au/sites/default/files/AHPC/pdfs/investing-in-womens-mental-health.pdf>

In this context, it is clear that a gendered approach to youth mental health is urgently needed. Suicide prevention programs should both capitalise on young women's greater likelihood of seeking help,¹⁴ and address negative attitudes among health professionals towards women who self-harm or attempt suicide. Women's suicidal behaviour is often conceptualised as non-lethal, non-violent, passive and women who attempt suicide are often described as 'attention-seeking', aiming to manipulate their loved ones. After hospitalisation for self-harm, women report feeling dissatisfied with emergency and psychiatric services due to negative attitudes directed towards them.¹⁵

It is also essential to acknowledge that carers – who are predominantly women – also experience trauma arising from supporting family members with suicidal ideation and the loss of those who have suicided. The program must engage and support mental health carers.

Recommendation 4: Aboriginal social and emotional wellbeing

The Royal Commission recommends that the Victorian Government, through the Mental Health Implementation Office, expands social and emotional wellbeing teams throughout Victoria and that these teams be supported by a new Aboriginal Social and Emotional Wellbeing Centre. This should be facilitated through the following mechanisms:

- a. dedicated recurrent funding to establish and expand multidisciplinary social and emotional wellbeing teams in Aboriginal Community Controlled Health Organisations, with statewide coverage within five years
- b. scholarships to enable Aboriginal social and emotional wellbeing team members to obtain recognised clinical mental health qualifications from approved public tertiary providers, with a minimum of 30 scholarships awarded over the next five years
- c. recurrent funding for the Victorian Aboriginal Community Controlled Health Organisation to develop, host and maintain the recommended Aboriginal Social and Emotional Wellbeing Centre in partnership with organisations with clinical expertise and research expertise in Aboriginal mental health. The centre will help expand social and emotional wellbeing services through:
 - i. clinical, organisational and cultural governance planning and development –
 - ii. workforce development—including by enabling the recommended scholarships
 - iii. guidance, tools and practical supports for building clinical effectiveness in assessment, diagnosis and treatment
 - iv. developing and disseminating research and evidence for social and emotional wellbeing models and convening associated communities of practice.

Gender analysis of Recommendation 4

Given the significant mental health gap between Indigenous and non-Indigenous Australians, the Alliance strongly supports the specific focus on the social and emotional wellbeing of Aboriginal and

¹⁴ [Are young female suicides increasing? A comparison of sex-specific rates and characteristics of youth suicides in Australia over 2004–2014](#) BMC Public Health 2019.

¹⁵ [Suicide and Suicidal Behaviour in Women – Issues and Prevention](#), Suicide Prevention Australia 2016.

Torres Strait Islander people and investment in Aboriginal Community-Controlled Organisations and the Aboriginal mental health workforce to support their own communities.

Professor Pat Dudgeon from the University of Western Australia summarises the mental health issues facing Aboriginal and Torres Strait Islander women as follows:¹⁶

Indigenous mental health has been negatively impacted by colonisation which has resulted in widespread trauma and poverty. However, it is also important to recognise that holistic social and emotional wellbeing approaches which nurture healthy connections to family, community, country, body, spirituality, mind, emotions, and culture, are a great source of Indigenous wellbeing and resilience...

As the primary carers of their families and extended families, the wellbeing of Indigenous women is central to the wellbeing of the community. Nevertheless, Indigenous women continue to experience high rates of mental health problems and disadvantage with findings demonstrating:

- *There has been less improvement in the life expectancy gap for Indigenous females compared to males.¹⁷*
- *Indigenous women are hospitalised for violent assaults 35 times more often than non-Indigenous women¹⁸ and Indigenous females are hospitalised for intentional self-harm at higher rates than Indigenous males.¹⁹*
- *For women in the 25 to 34 age group, death by suicide is three times as high for Indigenous women when compared to non-Indigenous women.²⁰*
- *Imprisonment rates for Indigenous females are escalating and several studies have found high rates of post-traumatic stress disorder and histories of child abuse in the imprisoned Indigenous female population.²¹*
- *Between 2014 and 2015 Indigenous females reported experiencing greater levels of stress (38.4 per cent) than Indigenous males (26.7 per cent).²² At this time Indigenous women reported a significant increase in stressors caused by a range of factors that impact on social and emotional wellbeing such as overcrowding in their homes and unemployment.²³*

Professor Dudgeon emphasises the importance of culturally appropriate services and programs taking into account the different needs of men and women.

¹⁶ [Aboriginal and Torres Strait Islander women and mental health](#), InPsych 2017 Vol 39: Issue 1.

¹⁷ [Closing the gap Prime Minister's report](#), Commonwealth of Australia 2016.

¹⁸ [Fast Facts: Indigenous family violence](#), ANROWS 2014.

¹⁹ [Overcoming Indigenous disadvantage: Key indicators 2016](#), Steering Committee for the Review of Government Service Provision 2016

²⁰ [Overcoming Indigenous disadvantage: Key indicators 2016](#), Steering Committee for the Review of Government Service Provision 2016

²¹ [The Family Business Improving the understanding and treatment of Post Traumatic Stress Disorder among incarcerated Aboriginal and Torres Strait Islander Women](#), BeyondBlue 2015

²² [Overcoming Indigenous disadvantage: Key indicators 2016](#), Steering Committee for the Review of Government Service Provision 2016

²³ [Overcoming Indigenous disadvantage: Key indicators 2016](#), Steering Committee for the Review of Government Service Provision 2016

She notes that the National Aboriginal and Torres Strait Islander Women's Health Strategy, developed through the Australian Women's Health Network Talking Circle,²⁴ 'found that Indigenous women want basic needs met, such as housing, employment and educational opportunities. Leadership and full inclusion in decision making about matters that are relevant to them were key concerns.'

Programs that promote wellbeing, in particular, cultural wellbeing, were seen as essential, and the necessity of a holistic and whole of community approach to addressing violence within the lives of Indigenous women, and within their communities was stressed. Family support and counselling was seen as critical. This needs to include support for the perpetrators of violence and the people who support them (sisters, brothers, mothers, aunties), not just the victims of violence.

Professor Dudgeon goes on to say that:

Although men and women's traditional gender roles were disrupted by the process of colonisation, distinct gender roles are still practised in Indigenous families and communities. Mutually respectful gender roles have been recognised as a protective factor and important for strengthening men and women's social and emotional wellbeing. Women's groups have also been recognised as important for nurturing women's social and emotional wellbeing.²⁵ Culturally appropriate therapeutic practices recognise that sometimes it is appropriate for women to see other women, men other men, and that it is culturally inappropriate for much younger people to counsel older people.²⁶

Aboriginal Torres Strait Islander culture can be said to be gendered. There are specific men and women's roles and responsibilities which have implications for mental health professionals and the services they offer. For the practitioner, it is prudent to seek advice from local Aboriginal services or mental health professionals to ensure that the services provided are culturally appropriate and take gender issues into account.

It is essential that Aboriginal and Torres Strait Islander women in Victoria are involved at every level in the establishment of the Aboriginal Social and Emotional Wellbeing Centre and advise on how the needs of Aboriginal women and their communities should be met.

Within an Indigenous context, the pressures of caring are also compounded by cultural norms. As noted in the analysis of recommendation 1, further research into the intersections between mental health caring and Indigenous families and communities would be beneficial.

Recommendation 5: A service designed and delivered by people with lived experience

The Royal Commission recommends that the Victorian Government establishes Victoria's first residential mental health service designed and delivered by people with lived experience. This should be facilitated through the Mental Health Implementation Office in co-production with people with lived

²⁴ [National Aboriginal and Torres Strait Islander Women's Health Strategy](#). Australian Women's Health Network 2010.

²⁵ [The role of an Aboriginal women's group in meeting the high needs of clients attending outpatient alcohol and other drug treatment](#). Drug and Alcohol Review, 32(6), 2013.

²⁶ [Voices of the peoples: The National Empowerment Project: National summary report 2014: Promoting cultural, social and emotional wellbeing to strengthen Aboriginal and Torres Strait Islander communities](#), University of Western Australia 2014.

experience. This service should provide short-term treatment, care and support in a residential community setting as an alternative to acute hospital-based care, and be:

- a. delivered and operationally managed by a workforce comprising a majority of people with lived experience, working across a range of disciplines
- b. facilitated through a partnership between an area mental health service and a mental health community support service or a community health service
- c. independently evaluated, with findings to inform continuous improvement and guide the expansion of similar services.

Gender analysis of Recommendation 5

The Alliance strongly supports the establishment of a mental health service designed and delivered by people with lived experience.

It is critical to recognise that people with lived experience of mental ill health and lived experience as carers are not a homogeneous group, and that the experiences of women, men and gender diverse people may differ significantly. Lived experience *within* these groups may also differ. MHRV should ensure that the workforce of people with lived experience includes an appropriate proportion and diversity of women with lived experience of mental ill-health (who make up half of Victoria's mental health service users) and women with lived experience of mental health caring (who make up at least two-thirds of Victoria's mental health carers) to enable targeted solutions to be delivered for women in all their diversity.

Any residential mental health service must ensure the safety of service users, including sexual safety. Women with lived experience should be involved in considering whether a women-only residential unit or service is needed. Consumers should be able to choose whether they wish to be in a mixed or single-sex residential unit, and women should be given the choice of receiving mental health support from female workers. A third space should be made available for gender diverse people as needed.

The evaluation must include the views of consumers, analysed by sex and gender, and examine perceptions of safety within the service.

Recommendation 6: Lived experience workforces

The Royal Commission recommends that the Victorian Government, through the Mental Health Implementation Office, expands the consumer and family carer lived experience workforces and enhances workplace supports for their practice. This program of work should be co-produced with people with lived experience and representatives of lived experience workforces and be implemented across area mental health services and identified non-government organisations comprising:

- a. the development and implementation of continuing learning and development pathways, educational and training opportunities and optional qualifications for lived experience workers, including adding the Certificate IV in Mental Health Peer Work to the free TAFE course list
- b. new organisational structures, capability and programs within services to enable practice supports, including coaching and supervision for lived experience workers

- c. delivery of a mandatory, organisational readiness and training program for senior leaders, and induction materials for new staff, that focus on building shared understanding of the value and expertise of lived experience workers
- d. implementation of ongoing accountability mechanisms for measuring organisational attitudes and the experiences of lived experience workers, including establishing a benchmark in 2020 of the experience of lived experience workers.

Gender analysis of Recommendation 6

The Alliance strongly supports expansion of lived experience workforces and the provision of additional support and development for these workforces.

It will be critical to ensure the safety both of lived experience workforces and those they are supporting. Recognising that many women consumers prefer to receive support from female workers (and this is also likely to reduce risk to female workers), it will be important to ensure that there is an adequate supply of female lived experience workers to meet demand (noting that women make up 50.4% of service users). The safety of lived experience workers and those they support should be measured through the proposed accountability mechanisms.

It is also important to highlight the gendered nature of mental health caring, recognising that the Carer Lived Experience Workforce (CLEW) in Victoria is predominantly female – with over 90% of CLEW members identifying as female. The overrepresentation of women in Carer Lived Experience roles and their experiences require further research and analysis.

Recommendation 7: Workforce readiness

The Royal Commission recommends that the Victorian Government, through the Mental Health Implementation Office, prepares for workforce reform and addresses workforce shortages by developing educational and training pathways and recruitment strategies by providing:

- a. public mental health services in areas of need, including in rural and regional locations, through an expression of interest process that each year offers a minimum of: – 60 new funded graduate placements for allied health and other professionals – 120 additional funded graduate placements for nurses
- b. postgraduate mental health nurse scholarships to 140 additional nurses each year that covers the full costs of study
- c. an agreed proportion of junior medical officers to undertake a psychiatry rotation, effective from 2021, with it being mandatory for all junior medical officers by 2023 or earlier
- d. overseas recruitment campaigns, including resources to assist mental health services to recruit internationally, new recruitment partnerships between organisations, and mentoring programs for new employees
- e. a 'mental health leadership network' with representation across the state and the various disciplines, including lived experience workforces, supported to participate collaboratively in new learning, training and mentorship opportunities
- f. the collation and publication of the profile of the mental health workforce across all geographic areas, disciplines, settings and sub-specialties

- g. mechanisms for continuing data collection and analysis of workforce gaps and projections, and the regular mapping of the workforce to meet these gaps.

Gender analysis of Recommendation 7

The Alliance supports the proposed initiatives to address workforce shortages within the mental health service system.

In addition to building the *supply* of mental health workers, there is also an urgent need to improve the *capability* of the mental health workforce to provide gender-responsive and trauma-informed care.

Staff report feeling unprepared to work with patients/consumers with histories of family violence and sexual abuse. They frequently do not ask about sexual violence, whether historical or experienced on the ward,²⁷ and often do not take disclosures seriously, minimise the experience or blame consumers.²⁸ Survivors of family violence report that the mental health workforce is ill-equipped to respond to their needs. As 'Mary' explains:

*'One thing that continually cropped up for me was – as DV survivors – we have no support for our mental health issues, the lack of understanding around DV issues such as PTSD, no structured support groups and that we may have a lifetime of mental health issues. But mental health practitioners seem to have a complete lack of understanding of the mental health impact of long-term domestic abuse.'*²⁹

A queer-identifying 22-year-old woman from a culturally and linguistically diverse background describes her experience as follows:

'I was on a mixed gender ward and had to consistently explain to the male mental health nurse... that I was feeling scared of my family's reaction to my hospitalisation. I did not want any relatives to visit me due to my fear of psychological family violence...

The mental health nurse spoke the same language as me. We shared cultural identity very strongly.

He kept trying to convince me that as a young woman I needed my father to protect me and for me to tell my father that I was in hospital. He threatened to call my father as his number was listed – my sister had given it to them.

I felt extremely coerced and only felt listened to once I smashed things. Due to my being young, female and CALD, I was positioned to do as the hospital system saw fit and they ignored my requests until I almost had to get violent. This was very damaging to my needs of attempting to harness agency and stability...

²⁷ O'Dwyer, C., Tarzia, L., Fernbacher, S., & Hegarty, K. (2019). [Health professionals' perceptions of how gender sensitive care is enacted across acute psychiatric inpatient units for women who are survivors of sexual violence](#). BMC Health Services Research,

²⁸ O'Dwyer, C., Tarzia, L., Fernbacher, S., & Hegarty, K. (2019). [Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units](#) BMC Health Services Research.

²⁹ Quote from 'Mary', supplied by Dr Rhian Parker, Academic convenor for the Melbourne Alliance to End Violence Against Women and their Children (MAEVe), who work with the WEAVERS, a group of women survivors of domestic and family violence who advise on research questions and co-produce research in collaboration with MAEVe.

In the end, I was put in the acute isolation ward until I calmed down. Also extremely damaging for my sense of safety and ability to negotiate what was already a terrifying environment. My family did come to visit, and it led to near estrangement. Bad ending.³⁰

Mental health curricula for new workers and professional development for existing workers should cover:

- the biological, social and environmental determinants of mental health, including sex, gender and trauma
- the prevalence of and risk factors for poor mental health among women and girls, including recognising that girls and women are at increased risk of developing or experiencing a mental illness at certain life stages, for example in adolescence, in the perinatal period, and at menopause
- the impact of experiences of violence, abuse and trauma on mental health
- prevention of assault by other patients and professionals
- family violence risk assessment and management using the Multi-Agency Risk Assessment and Management (MARAM) Framework
- identifying and responding to disclosures of violence, including violence experienced within mental health services
- supporting patients who have been sexually assaulted within mental health services
- addressing stigma and disparaging attitudes towards women who have experienced sexual or other abuse (within mental health services or previously)³¹
- preventing and managing inappropriate sexual behaviour
- skills to talk about sex, sexual health, safety and relationships, including what is a sexual offence
- reducing compulsory treatment, restrictive interventions and other coercive actions
- respecting and promoting the human rights of women and girls engaged with the mental health system
- appropriate medication and other forms of treatment for women and girls, recognising the historical (and ongoing) exclusion of women and girls from clinical trials and the common dismissal of women's concerns about side effects

Further, gender-responsive and trauma-informed practice should be mainstreamed across mental health services. A framework that is grounded in understanding and responding to trauma is important in any service that supports women, due to the links between poor mental health and experiences of gendered violence, including family violence and sexual abuse. A trauma-informed approach should recognise how socio-cultural factors such as gender inequality, power, colonisation and disenfranchisement give rise to victimisation and are barriers to seeking support. Using this

³⁰ Case study: Cis woman, CALD, queer identifying, 22 y.o., mixed gender mental health inpatient unit, circa 2000. Supplied by Victorian Mental Illness Awareness Council.

³¹ O'Dwyer, C., Tarzia, L., Fernbacher, S., & Hegarty, K. (2019). [Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units](#), BMC Health Services Research.

intersectional lens, behaviours that may be considered 'difficult' are understood as appropriate responses or adaptations to trauma.³²

One female consumer shared her experience:

*'I was told to stop crying in front of other patients as I was making everyone upset. All the staff just seemed really annoyed by me and I heard the term "personality disorder" spoken about me. Later that morning I was taken to clinical review. I had no idea what that was but when I opened the door and saw a room full (about 9) of men I just walked out. I was labelled non-compliant after that. I really hated the way the other female psychiatrists called the consultant "boss". "You want leave? Well, we'll have to see what the 'boss' has to say about that." I really did not like that.'*³³

A trauma-informed framework sets out how an understanding of the impact of trauma on an individual should inform not only service delivery, but also the organisational, structural and systemic levels of an agency.³⁴ However, recent research finds that:

*Despite training and education, health professionals continue to struggle to translate the values and principles into their day to day practice. Previous work in this area suggests that in order for a model of care to be effective, it must be integrated into all levels of policy and practice to influence how services and staff care for female consumers and be in line with the values of staff implementing it. Moreover, it needs to acknowledge and address the tensions that exist between the biomedical model, including compulsory treatment, control, risk and safety with the principles of gender sensitive and trauma-informed care, such as collaboration and choice. Yet, existing research would suggest that this has not yet occurred within the acute psychiatric inpatient setting in Australia.*³⁵

MHRV's workforce strategy also needs to address the representation of women and gender diverse people in senior roles. For example, the Interim Report acknowledges that in psychiatry there is a disproportionately low number of women in leadership positions.

It is also critical to ensure that any efforts to address workforce shortages within the mental health sector do not end up depleting other workforces within the social services sector which are also experiencing high demand. MHRV should work with related sectors (for example, family violence, disability, aged care) and relevant government committees (such as the Family Violence Industry Taskforce) to mitigate any unintended impacts on related workforces.

Recommendation 8: A new approach to mental health investment

The Royal Commission recommends that the Victorian Government designs and implements a new approach to mental health investment comprising:

³² [In the business of trauma: an intersectional-materialist feminist analysis of 'trauma informed' women's refuges and crisis accommodation services in Sydney and Vancouver \[Thesis\]](#) University of Sydney. Sydney Digital Theses. 2019.

³³ Case study: Cis woman, white, 30s, married with dependants, presenting to hospital emergency department in psychiatric crisis, no date. Supplied by Victorian Mental Illness Awareness Council.

³⁴ [Trauma-informed care in child/family welfare services](#) Australian Institute of Family Studies 2016.

³⁵ O'Dwyer, C., Tarzia, L., Fernbacher, S., & Hegarty, K. (2019). Health professionals' perceptions of how gender sensitive care is enacted across acute psychiatric inpatient units for women who are survivors of sexual violence. BMC Health Services Research.

- a. a new revenue mechanism (a levy or tax) for the provision of operational funding for mental health services
- b. a dedicated capital investment fund for the mental health system.

This new approach should support a substantial increase in investment in Victoria's mental health system, supplementing the current level and future expected growth of the state's existing funding commitments.

Gender analysis of Recommendation 8

The Alliance supports the proposed new approach to mental health investment. Investment in the mental health of women and girls should be prioritised, including:

- Research into women's mental health and appropriate clinical and non-clinical treatments
- Building the evidence base for how a gender-responsive and trauma-informed approach to mental health should be implemented in practice
- Women-specific services, including adequate funding for single sex wards in acute facilities

Recommendation 9: Mental Health Implementation Office

The Royal Commission recommends that the Victorian Government establishes a Mental Health Implementation Office—a new administrative office in relation to the Department of Health and Human Services under the Public Administration Act 2004 (Vic). The Implementation Office is to implement the Commission's recommendations as set out in the interim report. It will operate for two years while the Commission designs final governance arrangements for the mental health system and should:

- a. develop and publicly commit to a program of work and report annually through the Victorian Parliament on its progress against outcome measures and targets
- b. employ and commission people with specialist skills and diverse expertise, including people with lived experience, to respond to the Commission's recommendations
- c. work closely with the Commission to ensure implementation of the Commission's recommendations stay true to the original vision and intent.

Gender analysis of Recommendation 9

The Alliance supports the establishment of MHRV and welcomes the opportunity to work together.

As outlined in the Alliance's joint statement (November 2019),³⁶ the Alliance strongly recommends that MHRV or its successor develop a comprehensive and fully resourced mental health strategy dedicated to the mental health and wellbeing of women and girls. The strategy would incorporate all the elements described in this analysis, as well as other matters, such as addressing the social determinants of poor mental health among women and girls.

In relation to accountability, the Alliance recommends that outcome measures and targets for implementing the Royal Commission's recommendations include:

³⁶ The Women's Mental Health Alliance statement can be found at: <https://whv.org.au/resources/whv-publications/statement-womens-mental-health-alliance>



- gender-specific outcome measures (for example, addressing gendered discrepancies in mental health outcomes)
- targets for increased investment in research into women's mental health
- targets for implementation of women-specific services.

Data collection and reporting against all outcome measures and targets should be sex-/gender-disaggregated. The Alliance further recommends that MHRV engage staff with specialist expertise in women's mental health.

The Alliance looks forward to collaborating with MHRV to ensure the Royal Commission's recommendations are implemented in a way that best meets the needs of women and girls. We would welcome the opportunity to provide advice to MHRV on an ongoing basis.