Additional evidence on gender and mental health for the Royal Commission into Victoria's mental health system

Introduction

The Women's Mental Health Alliance (the Alliance) thanks the Royal Commission for the opportunity to provide further evidence on gender and mental health to inform the Commissioners' deliberations.

As requested, we have taken into account the submissions, input through meetings and witness statements from members of the Alliance that the Commission has already received, and focused on the three areas where the Commissioners have sought further information, namely:

1. Gender and diagnostic types
2. Trauma (including violence), gender and mental health
3. Gender and safety in the mental health system

Since these are broad topics, we have identified key questions to guide our evidence, based on our understanding of the Commissioners' areas of interest. We have also added one further theme: Gender and mental health promotion.

We have aimed to keep our responses short and would direct the Commissioners to other submissions and evidence provided by members of the Alliance for further information.

Theme 1: Gender and diagnostic types

1.1 Why do women experience higher rates of certain mental health conditions? Is this due to different manifestations of illness or different health-seeking behaviours (which mean women's mental ill-health is more likely to show up in the data) or other reasons?

There is a significant literature supporting the 'biopsychosocial' causal model of mental health. Illnesses like schizophrenia and bipolar disorder involve clear biological brain changes, and the neuroendocrine, neuroimmunology and brain circuitry disease changes are different for women compared with men.[1]

Research is increasingly demonstrating strong links between traumatic experiences, such as sexual abuse, and a range of mental health diagnoses. The diagnostic category most strongly associated with sexual abuse is 'borderline personality disorder' (BPD). Experiences of sexual abuse predicted BPD above all other potential etiological factors.[2] Experiences of sexual abuse have also been found to have strong

[1] Vigod, S and Stewart, D (2009) Emergent research in the cause of mental illness in women across the lifespan. *Curr Opin Psychiatry.* 22(4):396-400. doi:10.1097/YCO.0b013e3283297127.
[2] Sellick, K (2017) *Responding to sexual abuse survivors who hear voices: A challenge for mental health*. University of Melbourne, PhD.services, Department of Social Work, University of Melbourne, pp 15.

associations with psychosis.[3] Studies have consistently found higher rates of post-traumatic stress disorder (PTSD) and depression among survivors of intimate partner violence (IPV), compared to those who have not experienced IPV, and rates are higher still among survivors who experience other types of trauma in addition to IPV.[4]

From neuroscience findings, we now also know that there are gender differences in how the brain responds to trauma, and that there are genetic underpinnings for neurochemistry changes and the expression of such neurochemical changes in behaviours, cognition and emotion shifts. The gender differences seen in mental health data are not simply related to health-seeking behaviour, but represent the actual impacts of biological differences (such as hormonal shifts), social determinants (such as power differentials) and environmental factors (including early and later life trauma) all of which impact women differently.[5]

1.2 How do certain mental health diagnoses impact women differently? (e.g. stigma, treatment approach, medication)

The diagnosis of 'Borderline Personality Disorder' (BPD) is highly stigmatised. Women make up 75% of those given this diagnosis.[6] The diagnosis is seen as equivalent to being 'manipulative' or 'an attention seeker' and is very poorly treated. What is missed here is that 85% of women with BPD have significant early life trauma.[7]

Given the strong link to trauma and the stigma associated with being diagnosed with a disordered 'personality', some have argued that BPD should be renamed 'complex trauma disorder.' Treatment for BPD often includes far too many non-targeted psychotropics, which do not effectively treat the symptoms and which have significant side effects.[8] This means women with BPD end up with health

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[3] Sellick K, Rose D and Harms L (2017) *Hearing voices, sexual abuse and service system responses*. Psychosis. 12 (1): 11-22

[4] Oram S, Khalifeh H, Howard LM, Oram S, Khalifeh H, Howard LM (2017) *Violence against women and mental health.* Lancet Psychiatry. 4, 159-170.

[5] Young E, Korszun A, Altemus M, 'Chapter1: Sex Differences in Neuroendocrine and Neurotransmitter Systems'. In Kornstein S and Clayton A (eds) (2002) *Women's Mental Health – A Comprehensive Textbook.* The Guildford Press, New York. ISBN 1-57230 -699-8

[6] Aetiology of Borderline Personality Disorder, Australian Institute of Professionals Counsellors, 2013.

[7] Battle CL, Shea MT, Johnson DM, Yen S, Zlotnick C, Zanarini MC, et al (2004). *Childhood maltreatment associated with adult personality disorders: findings from a Collaborative Longitudinal Personality Disorders Study*. J Personal Disord. 18(2):193–211.

[8] Wasylyshen, A., & Williams, A. M. (2016). Second-generation antipsychotic use in borderline personality disorder: What are we targeting?. *The mental health clinician*, *6*(2), 82–88. and Karen E Moeller, Amad Din, Macey Wolfe, Grant Holmes. (2016) Psychotropic medication use in hospitalized patients with borderline personality disorder. *Mental Health Clinician*; 6 (2): 68–74.

issues such as obesity, diabetes and infertility related to the medications used,[9] their symptoms are not effectively treated, and the underlying trauma is ignored.

Family members, friends and carers, who are predominantly women, also experience the impacts of stigma and discrimination – both externally through contact with clinical services and a lack of community awareness, as well as internalised stigma, often linked to a lack of understanding of the diagnosis and what it does or does not mean for the person they care for and support. There are also persistent and harmful stereotypes such as 'the schizophrenogenic mother' that remain today, which place guilt and blame on the mother/ female caregiver. These harmful and unfounded stereotypes problematise the individual and their experience of mental distress, whilst simultaneously framing the female caregiver as a problem or causal factor. While it is true that some family members are harmful, it is not the experience of all consumers and should not be an assumption upon which services operate. Family, friends and carers require support and education in challenging experienced and internalised stigma.[10]

Theme 2: Trauma (including violence), gender and mental health

2.1 Do women and girls experience trauma differently from men? How?

As noted under Question 1.1 above, research is increasingly demonstrating strong links between traumatic experiences, such as sexual abuse, and a range of mental health diagnoses including 'borderline personality disorder' and PTSD.

Family and sexual violence can also have other significant negative impacts on women's mental health, including anxiety and depression, panic attacks, fears and phobias, sleep disruption, hyperarousal and hyper-vigilance, as well as alcohol and illicit drug use, and suicide.[11] Some survivors of family violence experience psychiatric symptoms for a brief period of time, while others develop chronic PTSD, a disorder that is a common response to overwhelming trauma and that can persist for years. Survivors

[9] Frankenburg, F. R., & Zanarini, M. C. (2006). *Obesity and obesity-related illnesses in borderline patients*. Journal of Personality Disorders, 20, 71–80.

[10] See: Van der Sanden R et al (2015), *Stigma by Association Among Family Members of People with a Mental Illness: A Qualitative Analysis*, Community and Applied Social Psychology, Vol 25(5), 400-417; Dr Margaret Leggatt's witness statement to the Royal Commission, paragraphs 30-34; Scheyett A (1990), *The Oppression of Caring: Women Caregivers of Relatives with Mental Illness*, Affilia, 5(1), 32–48; Johnston J (2013), *The ghost of the schizophrenogenic-mother*, AMA Journal of Ethics - Virtual Mentor; 15(9), 801-805.

[11] VicHealth (2017). Violence against women in Australia: research summary. Victorian Health Promotion Foundation. Melbourne. An Australian study found that approximately 77% of women who have experienced three or four types of gender-based violence had anxiety disorders, 56% had Post-Traumatic Stress Disorder and 35% had made suicide attempts: Rees S, Silove D, Chey T, Ivancic L, Steel Z, Creamer M, Teesson M, Bryant R, McFarlane AC, Mills KL, Slade T (2011), 'Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function', JAMA, vol. 306, no. 5, pp. 513–521.

are also at risk of developing depression, which has been found to significantly relate to the development of PTSD.[12]

Overall, women have a two to three times higher risk of developing PTSD compared to men. The lifetime prevalence of PTSD is about 10–12% in women and 5–6% in men. This difference is believed to be attributable to both psychosocial and biological factors (e.g. oxytocin related). Men and women experience different types of trauma, both in private life and at work (e.g. police officers), with women being exposed to more high-impact trauma (e.g. sexual trauma) than men, and at a younger age.[13]

The context in which women experience violence is also different from that of men. The root cause of IPV is gender inequality and involves the perpetrator exerting power and control over the victim-survivor. Women who have experienced IPV often face other stressors including access to housing and employment, and often lack the economic resources that men have access to. Women who have experienced IPV may also have chronic physical health conditions.[14]

While trauma has negative impacts on both women and men, their biological/psychological responses are different. Trauma early in life (which women are more likely to experience) has more impact, especially when it involves type II trauma (i.e. prolonged and repeated, rather than a single incident) interfering with neurobiological development and personality.[15]

Traumatic stress affects different areas of the brains of boys and girls at different ages. Trauma increases hypothalamic pituitary adrenal activation in females with resultant multiple effects in physical health, behaviour and cognition. For example, autoimmune diseases, infertility and obesity are all more common in traumatized girls and women.[16]

In addition, women handle stressful situations differently and tend to adopt different psychological defences in the face of adversity. They may use a tend-and-befriend, dependent and/or submissive response rather than the fight-or-flight response that is often assumed. Emotion-focused, defensive and palliative coping are more prevalent in women, while problem-focused coping is higher in men.[17]

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[12] Warshaw C, Sullivan CM, and Rivera EA (2013). *A Systematic review of Trauma-Focused Interventions for Domestic Violence survivors*, National Center on Domestic Violence, Trauma and Mental Health.
[13] Olff M. (2017). *Sex and gender differences in post-traumatic stress disorder: an update*. European Journal of Psychotraumatology, 8(sup4), 1351204.
[14] Dillon G, Hussain R, Loxton D, Rahman S. (2013) Mental and Physical Health and Intimate Partner Violence against Women: A Review of the Literature. International Journal of Family Medicine. 2013:313909.
[15] Olff M. (2017). *Sex and gender differences in post-traumatic stress disorder: an update*. European Journal of Psychotraumatology, 8(sup4), 1351204.
[16] Thomas N, Gurvich C, Kulkarni J (2019). *Borderline Personality Disorder, Trauma and the Hypothalamo-Pituitary-Adrenal Axis*. Neuropsychiatric Disease and Treatment.15: 2601–2612
[17] Olff M. (2017). *Sex and gender differences in post-traumatic stress disorder: an update*. European Journal of Psychotraumatology, 8(sup4), 1351204.

Different groups of women will also experience trauma differently. For example, migrant and refugee women's experience of violence and trauma is impacted by both racism and gender inequality,[18] and leads to specific mental health impacts:

- **Violence against women**: For migrant and refugee women, although health and wellbeing impacts of family violence occur across a continuum, women generally report stress, fear and anxiety during the relationship, regardless of the frequency or severity of the perpetrator's violence. Many migrant women also report feelings of isolation, depression, guilt and self-blame, low self-esteem, loss of confidence and in some cases suicidal thoughts.[19]
- **Settlement stress and trauma**: Settlement stress and migration-related trauma contributes to a higher likelihood of mental health conditions among migrants and refugees. Social isolation during the settlement period, lack of family and social support, discrimination, and longer length of migrants' residence in the host country can increase the likelihood of common mental health conditions.

2.2 What does the intersection between sex, gender and trauma and the biopsychosocial model mean for how women access/ experience help seeking?

2.2.1 Considerations for services

The overarching consideration is that services must recognise and address the connection between **violence, mental ill health, substance use and trauma** - and the **consequential impacts** of these mental health issues on relationships, education and employment - for women seeking help.

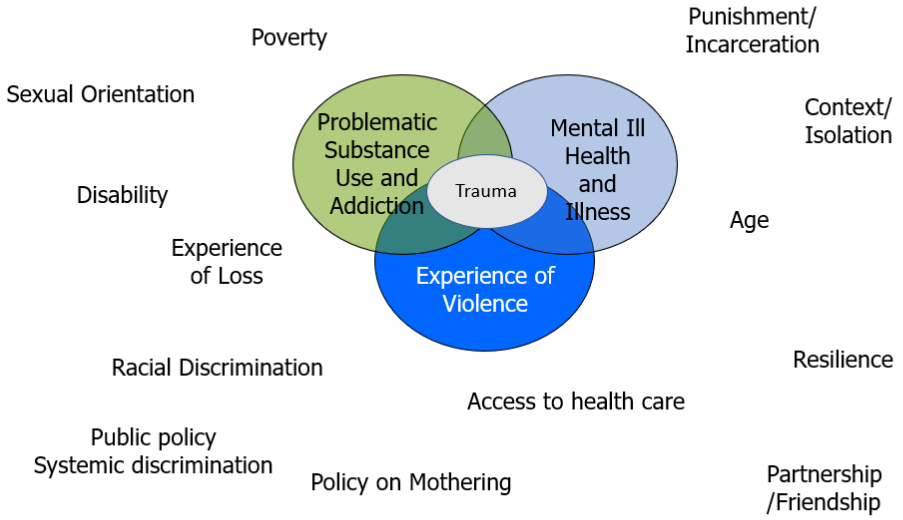
The diagram below from the Centre of Excellence for Women's Health in Canada demonstrates these connections.

[18] Delara, Mahin (2016) 'Social Determinants of Immigrant Women's Mental Health', Advances in Public Health, vol. 2016.

[19] Vaughan, Cathy et al. (2016). *Promoting community-led responses to violence against immigrant and refugee women in metropolitan and regional Australia: The ASPIRE Project: Research report*. ANROWS, Sydney.

Women's Mental Health Alliance

Interconnections and influences on women's experience of violence and substance use



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Some specific gender-specific considerations for mental health services include:

- The **types of trauma** experienced by women and the **age** or **circumstances** in which they experience it make it more difficult for women to present to mental health services. Women are more likely to have been sexually violated; they may have repressed memories or dissociative experiences which are difficult for most people, including family members to understand. Trauma that results from pre-migration experiences may not be understood or recognised after migration.
- Services need to address barriers to help seeking among women including:
    1. **shame, fear of stigma, and fear of not being believed**: "Victim blaming" has been reported as an issue for women who are seeking help for complex post-traumatic stress and anxiety
    2. **structural barriers** such as cost, lack of time or transport (especially difficult for women with disabilities and migrant women)
    3. **lack of knowledge** about mental health services available
    4. **unresponsive mental health services** that only offer English language therapies and do not use interpreters, practise cultural safety or employ bilingual staff

5. **fear of consequences** including fear disclosure will lead to further violence, and fear of the involvement of social services with children.

- Services also need to consider **day-to-day social, family and economic realities for women** e.g. women are more likely than men to live in poverty, be lone parents. In particular, women who have experienced intimate partner violence are often experiencing **other stress factors** including housing, employment stress etc and often lack access to the economic resources that men have access to. A Canadian study found that while women who had experienced trauma were more likely to have their basic needs met (housing stability, medication adherence) they may require more **social and practical support** to address recovery in the context of their roles as wives and mothers.[20]

- Women who have experienced IPV and other forms of trauma may also have chronic **physical health conditions**. Specialised services that integrate physical and mental health are needed.

- Support for and treatment of mental health concerns should be **integrated with support and treatment for substance use, violence and trauma**. Women and men take **different pathways** into services e.g. women with dual diagnosis with substance misuse are more likely to be seen initially in mental health or primary care services; men are more likely to present at drug/alcohol services

- Women have **different treatment needs and responses** e.g. women are more likely than men to actively seek 'talking therapies' and benefit from self-help.

- The **perspectives of family/carers** should be incorporated, to reflect the relational context within which – the evidence shows – recovery occurs.

A 2016 Canadian study examining gender differences in psychiatric hospitalisations found important differences suggesting that men and women may require different types of intervention to address their social determinants of health and clinical needs during hospital stays and post-discharge. Lifetime history of trauma was 1.5-3 times higher in women than men, women had higher depression and anxiety symptoms at discharge, and women were significantly more likely to self-harm post discharge.[21]

[20] Vigod, S (2016), Psychiatric Hospitalizations: A Comparison by Gender, Sociodemographics, Clinical Profile, and Postdischarge Outcomes Psychiatric Services, 67(12): 1376-1379. doi:10.1176/appi.ps.201500547
[21] Vigod, S (2016), Psychiatric Hospitalizations: A Comparison by Gender, Sociodemographics, Clinical Profile, and Postdischarge Outcomes Psychiatric Services, 67(12): 1376-1379. doi:10.1176/appi.ps.201500547

2.2.2 How do we improve the accessibility/experience of mental health services for women who have experienced trauma?

Evidence suggests that access to safety, appropriate and sympathetic services, and social support significantly enhance survivors' resilience.[22]

1. **Ensure safety.** Women who have experienced trauma and are experiencing PTSD or other kinds of distress just want to feel safe. We need a mental health service that helps women feel safe. This includes:

    - **Elimination of traumatic seclusion and restraint practices**. Seclusion and restraint resemble and replicate many women's experiences of past abuse and traumas, including sexual violence. Survivors of family violence report experiences of inpatient settings, which include being forced to take their clothes off, forcibly medicated, and at times restrained. These practices should be abolished, and other de-escalation techniques used instead. Sedatives should not be forced, but always offered with informed consent to give the person choice, control, and a sense of agency.

    - **Single sex wards:** Single sex wards and communal areas are essential to helping female inpatients feel safe from gender-based violence. Women also frequently request female only staff. Findings from VMIAC's consumer consultation workshops show that 87% of female participants want single gender acute wards, with potential for single-gender care and treatment.

2. **Provide a mix of treatments and supports, including social support.** There is a need for a mix of therapy, medication and social support for women who have experienced trauma. This should include:

    - Offering a **continuum of responses** from walking groups/peer support to brief interventions to counselling/therapy

    - Offering a range of trauma therapies and medication therapies (addressing biological brain changes due to trauma), targeting the **critical events and aftermath** – together with **current distress alleviation** (psychological treatment) and **future planning** (social support)

    - Clinicians need to take a **full story** and have the time and the skills to engage the woman in a range of **individualised treatments** – or to direct her to these.

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[22] Howell, K.H., et al., *Protective factors associated with resilience in women exposed to intimate partner violence.* Psychology of Violence, 2018. **8**(4): p. 438-447 and Anderson KM, Renner LM, and Danis FS, *Recovery: Resilience and Growth in the Aftermath of Domestic Violence.* Violence Against Women, 2012. **18**(11): p. 1279-1299.

- Women have been shown to benefit more from **psychotherapy** than men in the reduction of PTSD symptoms.[23] However, access to psychotherapy or counselling on inpatient units is often severely lacking or non-existent. Psychotherapy is not available in all languages and may not be accessible to many migrant women.

- Women seek more **social support**; lack of social support is the most consistent predictor of negative outcomes from trauma.[24]

- **Avoiding over-medicalisation** e.g.

    - avoiding an overemphasis on 'disorders' and focusing on resilience

    - recognising that women are often over-prescribed medications such as benzodiazepines, and ensuring that tapering from such medications is part of the services offered

- Provision of **physical healthcare** along with mental health care with a female focus, as modelled by the Monash Alfred Psychiatry research centre's Women's Mental Health Clinic.

3. **Introduce routine screening for trauma and abuse**. In the absence of direct questioning, survivors of domestic violence are reluctant to disclose abuse to health service providers.[25] However, research indicates that routine effective screening for experiences of violence by mental health professionals is infrequent. Despite the fact that mental health practitioners are used to asking individuals about their propensity to violence, asking about being a victim of violence was not part of their routine risk assessment. And when experiences of abuse are disclosed to mental health professionals it is unclear whether these disclosures are meaningfully incorporated into professional formulations and treatment plans.[26] The dominance of the biomedical model in mental health services, that is, managing symptoms not causation, ignores the trauma associated with gendered violence.[27]

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[23] Olff M. (2017). *Sex and gender differences in post-traumatic stress disorder: an update*. European Journal of Psychotraumatology, 8(sup4), 1351204. https://doi.org/10.1080/20008198.2017.1351204

[24] Olff M. (2017). *Sex and gender differences in post-traumatic stress disorder: an update*. European Journal of Psychotraumatology, 8(sup4), 1351204. https://doi.org/10.1080/20008198.2017.1351204

[25] Trevillion K, Hughes B, Feder G, Borschmann R, Oram S, Howard LM (2014) *Disclosure of domestic violence in mental health settings: A qualitative meta-synthesis.* International Review of Psychiatry. 26 (4):430-44. Available from: https://doi.org/10.3109/09540261.2014.924095 and Rose D, Trevillion K, Woodall A, Morgan C, Feder G, Howard L. (2011) *Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study.* Br J Psychiatry; 198(3):189-194. doi:10.1192/bjp.bp.109.072389

[26] Sellick, K., D. Rose, and L. Harms, *Hearing voices, sexual abuse and service system responses.* Psychosis, 2020. 12(1): p. 11-22.

[27] Trevillion K, Hughes B, Feder G, Borschmann R, Oram S, Howard LM (2014) *Disclosure of domestic violence in mental health settings: A qualitative meta-synthesis.* International Review of Psychiatry. 26 (4):430-44. Available from: https://doi.org/10.3109/09540261.2014.924095. And Rose D, Trevillion K, Woodall A, Morgan C, Feder G,

4. **Build workforce capacity to respond to women's experience of trauma.** An understanding that domestic and family violence, and other forms of trauma, underlie mental health issues for many women needs to be highlighted for the mental health workforce, and health and mental health services, particularly primary and community healthcare, need to be educated to ask about and respond appropriately to victim-survivors of gendered violence and their children. International evidence shows that mental health professionals have low levels of competence and confidence in addressing domestic violence and abuse issues with clients/patients.[28] Mental health practitioners also report feeling uncomfortable asking about domestic violence, being unsure if asking about it was part of their role, a lack of training, lack of time, lack of effective interventions and fear of offending the individual.[29] Workers would benefit from training on, for example: noticing trauma responses; not forcing disclosure; creating safety; building trust; supporting choice and control; and offering to teach self-regulation skills. Mental health workforces would also benefit from gendered cross-cultural awareness training.

The Alliance recommends the Royal Commission explore the resources available through the National Center on Domestic Violence, Trauma & Mental Health in the US, which addresses mental health, substance use and domestic violence in an integrated way. The Center recognises that the systems to which domestic violence and trauma survivors and their children turn are frequently unprepared to address the range of issues they face in trying to access safety and heal from the traumatic effects of abuse. The Center provides training, support, and consultation to advocates, mental health and substance abuse providers, legal professionals, and policymakers as they work to improve agency and systems-level responses to domestic violence survivors and their children.

Resources that may be of particular interest include:

- Coercion Related to Mental Health and Substance Use in the Context of Intimate Partner Violence: A Toolkit for Screening, Assessment, and Brief Counseling in Primary Care and Behavioral Health Settings
- A suite of resources for Mental Health and Substance Use Treatment and Recovery Support Providers

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Howard L. (2011) *Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study.* Br J Psychiatry. 198(3):189-194. doi:10.1192/bjp.bp.109.072389

[28] Ruijne, R.E., et al., *Mental health professionals' knowledge, skills and attitudes on domestic violence and abuse in the Netherlands: cross-sectional study.* BJPsych Open, 2019. **5**(2).; Rose, D., et al., *Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study.* The British Journal of Psychiatry, 2011. **198**(3): p. 189-194; Hegarty, K., *Domestic violence: the hidden epidemic associated with mental illness.* British Journal of Psychiatry, 2011. **198**(3): p. 169-170.

[29] Rose D, Trevillion K, Woodall A, Morgan C, Feder G, Howard L. (2011) *Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study.* Br J Psychiatry. 198(3):189-194. doi:10.1192/bjp.bp.109.072389

Theme 3: Gender and safety in the mental health system

As part of its inquiry into women's sexual safety in acute inpatient units, which resulted in the 2018 report *The Right to be Safe*, the Mental Health Complaints Commissioner commissioned a comprehensive evidence review on women's safety in the mental health system. The Alliance refers the Royal Commission to the literature and recommendations contained in that report.

Given the extensive evidence available to the Royal Commission, Women's Health Victoria asked Alliance members asked to identify their top three priorities for improving women's safety in the mental health system. Their responses largely reflected the key elements of a gender-responsive, trauma-informed service outlined in response to Question 2.2.2 above. In summary, Alliance members highlighted the need for:

1. **Transformation of mental health service models** away from patriarchal and heavy-handed psychiatric practice to models focused on healing. Cultural change is required at the system level, not just the organisational or individual level.

2. Separate wings – or even better – **separate wards for women** in inpatient units. While the implementation of single-gender units would not of itself prevent all sexual safety breaches, the Mental Health Complaints Commission (MHCC) found that data from complaints and relevant literature indicates that single-gender units would dramatically reduce the frequency and gravity of the nature of any breaches.[30] The MHCC noted the particular risk faced by women with disabilities, especially women with intellectual disabilities. Findings from VMIAC's consumer consultation workshops regarding the Royal Commission's recommendations show that 87% of female participants want the acute beds to be arranged by gender. Recognising that female consumers often request female staff, single sex areas need to be supported by good staff-to-patient ratios (with an appropriate gender mix, including gender-non-conforming staff) on the 'floor'.

3. **Training for staff on trauma-informed and gender-responsive mental healthcare.** Since the 1990s, the Department of Health & Human Services (and its predecessors) have produced a series of policies and guidelines relating to gender sensitivity and safety in mental health. However, these guidelines have failed to decrease violence against female inpatients, nor built the mental health workforce's capacity to respond effectively to women who have experienced family and sexual violence. Recent Australian research shows mental health staff feel 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, and often do not take disclosures seriously, minimise the experience or blame consumers. Some staff see providing gender-responsive care as the responsibility of others, and point out

[30] Mental Health Complaints Commission (2018), The Right to Be Safe: Ensuring sexual safety in acute mental health inpatient units: sexual safety project report, Victorian Government. Melbourne.

that there is not enough time to build the relationships with inpatients required for gender-responsive care.[31] The MHCC found that there were few examples of trauma-informed care being successfully implemented in a mental health inpatient environment,[32] and that existing research on implementing trauma-informed care generally tends to focus on reducing rates of restrictive interventions.[33]

4. **Routine screening for trauma and abuse**, supported by workforce training to ensure staff can ask about and respond appropriately to disclosures of violence and trauma.

5. **Elimination of traumatic seclusion and restraint practices**. Experiences of inpatient settings where survivors report being forced to take their clothes off, are forcibly medicated and at times restrained often replicate their experiences of abuse. These Other de-escalation techniques used instead. Sedatives should not be forced, but always offered with informed consent to give the person choice, control, and a sense of agency.

6. **Research into women's mental health**. A dedicated focus on and investment in sex- and gender-sensitive research is needed to address the current lack of understanding of how sex and gender impact on mental health and wellbeing. We have recommended to Mental Health Reform Victoria that the Collaborative Centre should include a dedicated research unit focusing on women's mental health, which would be a world first. Research into women's mental health should take a biopsychosocial and intersectional approach and investigate biomedical, psychosocial and psychoeducational approaches.

7. **Specialist women's mental health clinics**. While all mental health services should provide gender-responsive and trauma-informed care, there is still a need for more investment in specialist clinics – similar to the Women's Mental Health Clinic run by the Monash Alfred Psychiatry research centre – that specialise in addressing the combination of biological, social and environmental factors that influence women's mental health. During COVID-19, the Women's Mental Health Clinic has experienced an unprecedented spike in demand, demonstrating the need for this type of service.

8. **Funding for the Women's Mental Health Network Victoria**. WMHNV has a broad member base of health professionals and women with a lived experience of mental illness united to promote women's mental health across Victoria. It provides training, supports research and promotes systemic change to policy and service delivery. WMHNV has significant expertise and potential

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[31] O'Dwyer C, Tarzia L, Fernbacher S, et al. (2019) *Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units*, BMC Health Services Research. The Alliance's gender analysis of the Royal Commission's interim recommendations lists further skills and knowledge required by the mental health workforce.

[32] Muskett C (2014), *Trauma-informed care in inpatient mental health settings: a review of the literature*, International Journal of Mental Health Nursing, vol. 23, no. 1, pp. 51–59

[33] Mental Health Complaints Commission (2018), The Right to Be Safe: Ensuring sexual safety in acute mental health inpatient units: sexual safety project report, Victorian Government. Melbourne.

to drive innovation and change within the mental health system to better support women's mental health. However, as a currently unfunded, entirely volunteer-run organisation, its capacity is extremely limited.

Key **physical design elements** for gender-responsive and safe mental healthcare for women include:

- Separate wings – or even better – separate wards for women to provide safety and privacy. If a separate women's wing, it must be locked by the women at night
- Bedrooms to have single beds with attached ensuite plus capacity to lock from inside (and still have staff able to enter in emergencies)
- Separate lounge areas to allow women's children to visit
- Separate high dependency areas for women – if needed
- The whole design needs to be warm and friendly, but enable safety at all times
- Design must not have small 'nooks' - where people cannot be seen by staff
- Good lighting and lots of natural light
- Peaceful greenery and gardens
- Modern design with movable 'pods' to reconstruct and change from one configuration to another if required.

However, it is important to emphasise that physical design on its own is not sufficient to ensure women's safety. As discussed above, workforce training and the implementation of a trauma-informed healing model is also essential. It also appears to be the case that changes to the physical design to create women-only spaces can sometimes lead to complacency among staff. For example, many 'women-only' lounges or areas on mixed gender wards are not monitored sufficiently and can be flash points for gendered intimidation and endangerment, with staff under the false belief that the area is safe from gender-based violence.

The attached literature review on gender-responsive mental healthcare provides more detailed information.

Theme 4: Gender and mental health promotion

Addressing the social determinants of women's mental health

While the Royal Commission's areas of interest are largely focused on responding to mental ill-health among women, attention to social factors which contribute to poor mental health, especially inequality, is critical.[34] Any primary prevention strategy for mental health must address the gendered social determinants of poor mental health for women, men and gender diverse people.

At a population level, a gendered approach to prevention of mental ill-health means addressing the broader context of gender inequality that drives poor and unfair mental health outcomes for women and girls, as well as contributing to a host of other social and health inequalities including violence against women.

For example, factors associated with women's higher rates of depression and anxiety are clearly linked to gender-based inequalities and include: discrimination, poverty and socioeconomic disadvantage; insecure, low status employment; gendered expectations of high levels of unpaid domestic labour and caregiving; and differential exposure to physical and sexual violence.[35] As an example, evidence shows that violence experienced during pregnancy is associated with a near five-fold increase in antenatal or postnatal depression.[36] Despite this evidence, the dominant theme in contemporary literature is that women's mental health problems are biologically caused.[37]

It is important to distinguish primary prevention (population level interventions that seek to reduce modifiable risk factors and enhance protective factors for mental health) from secondary prevention (or early intervention, which targets individuals or cohorts at increased risk of mental ill-health). Without minimising the critical importance of early intervention, there has generally been less focus on primary prevention. Population level interventions to address the gendered determinants of mental health require focused attention.

Principles for a gendered approach to mental health promotion

There is currently a lack of research into how best to address the gendered drivers of poor mental health in order to promote mental health and wellbeing among women and girls, and this should be a priority for the new Collaborative Centre.

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[34] Shoukai Y (2018) *Uncovering the hidden aspects of inequality on mental health: a global study*. Translational Psychiatry 9(98):1-10. Available from: https://www.nature.com/articles/s41398-018-0148-0.pdf

[35] WHO. Department of Mental Health and Substance Dependence (2012) Gender disparities in mental health. World Health Organization. Geneva.

[36] Howard L.M., Oram S., Galley H., Trevillion K., Feder G. (2013) Domestic violence and perinatal mental disorders: a systematic review and meta-analysis. PLoS Med. 10:e1001452.

[37] Fisher, J (2017) Women and Mental Health in InPsych 39:1.

Given the current lack of evidence-based programs, the Royal Commission should be guided by evidence-based principles, including that mental health promotion strategies need to:

- **Counter the notion that women are intrinsically biologically vulnerable to mental health problems**. Women's experiences of interpersonal violence, gender-based restrictions on opportunities for social and economic participation and an unequal distribution of unpaid work have a disproportionate impact on their mental health.[38]
- **Directly address social risk factors, including gender**. As discussed below, the postnatal depression prevention program **What Were We Thinking** seeks to do this using gender-informed structured activities to enable couples to recognise and address stereotypes about the division of unpaid work and non-adversarial ways to address conflict. The program has been shown to be effective in reducing postnatal depression and anxiety in the medium and long term in a cRCT.
- **Train health workers to be aware of the gender norms and stereotypes** that influence what they say and do e.g. workers should ask a woman when she is starting work as a mother rather than when she is 'giving up' work; and ask how household tasks are shared rather than 'does he help you?'.[39]

We can also draw on existing health promotion approaches, including evidence and frameworks for preventing violence against women, to identify key elements of a gendered approach to mental health promotion. The approach taken to the primary prevention of family violence and all forms of violence against women in Victoria offers a useful example of the application of the public health approach to prevention. Its key features are:[40]

- A focus on addressing the 'drivers' of poor mental health (these include gendered violence, trauma, housing and financial insecurity, gendered roles and poor body image among others);
- An intersectional whole-of-population focus, supplemented by tailored approaches for specific population groups;
- Use of the socio-ecological model, which includes:
    - Addressing the structural, as well as individual, drivers of poor mental health
    - Mutually-reinforcing interventions across multiple settings where people live, work and play (such as schools, workplaces, sporting clubs etc)

[38] Fisher, J (2017) Women and Mental Health in InPsych 39:1.
[39] Fisher, J (2020) Gender competence and mental health promotion. World Psychiatry 19:1.
[40] For an example of the application of this model in the PVAW space, see Our Watch, ANROWS and VicHealth (2015) Change the story : a shared framework for the primary prevention of violence against women and their children in Australia.

In the case of violence against women in Victoria, this approach has been supported by a dedicated government strategy (*Free from Violence*) and accompanied by (limited) investment, with activity coordinated by a central body or bodies. The commencement of the new *Gender Equality Act 2020* (Vic) in March 2021 will provide further impetus for addressing gender equality as a determinant of mental health, although it is limited to public sector bodies.

Women's Health Victoria's *Gender equality in advertising* project, funded by the Victorian Government, is an example of an evidence-based approach to addressing the drivers of both poor mental health for women and gendered violence. Drawing on evidence demonstrating the harmful impacts of sexualised and stereotyped advertising on women's mental health,[41] the project takes a whole-of-system approach to industry, regulatory and community change to promote a gender transformative approach to advertising that will ultimately improve women's mental health and contribute to the prevention of violence against women.

Examples of gender responsive approaches to mental health promotion in Australia

While a comprehensive and systematic approach to addressing the social determinants of mental health for women and girls is missing, there is some research suggesting potential paths forward, as well as some promising practice that can be built on. For example, analysis of women's depressive symptoms by the Australian Longitudinal Study of Women's Health has suggested that a range of factors, including education and financial resources, promotion of positive social support systems, and encouragement of health promoting lifestyles, might serve to promote young women's mental health.[42]

What Were We Thinking

What Were We Thinking (WWWT) is an Australian gender-informed, psychoeducational program to promote respectful relationships and skilled management of unsettled infant behaviours and thereby reduce common postpartum mental disorders. It is a half-day psycho-educational program delivered to first time mothers and their partners. A 2010 Victorian evaluation of this program found that it reduced the onset of common postpartum mental disorders in mothers who had no history of psychiatric illness.[43] A 2018 evaluation that involved a 18-month follow-up of program participants found that WWWT had a significant sustained beneficial impact on postnatal generalised anxiety among first-time mothers compared with those in the control group who did not complete the program.[44] The program is

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[41] McKenzie M et al (2018), Advertising (in)equality: the impacts of sexist advertising on women's health and wellbeing. Women's Health Victoria, Melbourne.

[42] Holden L, Harris M, Hockey R, Ferrari A, Lee YY, Dobson AJ, et al. (2019) *Predictors of change in depressive symptoms over time: Results from the Australian Longitudinal Study on Women's Health*. Journal of Affective Disorders. 245:771-8.

[43] Fisher et al (2010) *Innovative psycho-educational program to prevent common postpartum mental disorders in primiparous women: a before and after controlled study*, BioMed Central.

[44] Fisher et el (2018) *Gender-informed psycho-educational programme to promote respectful relationships and reduce postpartum common mental disorders among primiparous women: long-term follow-up of participants in a community-based cluster randomised controlled trial*, Global Mental Health, doi:10.1017/gmh.2018.20.

gender-informed, in naming infant care and household tasks as work and making it explicit that failure to recognise the unpaid workload or to share it fairly contributes to occupational fatigue and interpersonal conflict. Rather than positioning partners and infants as victims of a new mother's mental state, the program treats intimate relationships as reciprocal and modifiable.[45]

WWWT is an evidence-based example of **how new ways of gender-informed thinking can make a major difference to the impact of mental health promotion strategies**. The program is currently being rolled out at scale in the Latrobe Valley and is being very well received by parents and primary care providers, who recommend that it is made available to all new parents.

The Alliance recommends that WWWT be rolled out across Victoria.

Happy Being Me

Happy Being Me is a three-session classroom prevention intervention for girls aged 11 to 14 years. This program was developed to reduce body dissatisfaction, desire to obtain the thin body type portrayed as ideal by the media, peer interactions that contribute to body dissatisfaction, and body comparison tendency. An evaluation of this program found significant improvements in body dissatisfaction and psychological risk factors post intervention and at six-month follow-up, compared to those who did not participate in the program.[46]

Girls on the Go!

Girls on the Go! is a 10-week out-of-school program designed to improve self-esteem, body image, and confidence, using an empowerment model that involves interactive and experiential learning approaches. An evaluation found a significant increase in self-esteem, self-efficacy and reduced dieting behaviours in secondary school participants. These gains were sustained at a 6-month follow-up. The study took place at a community health centre in a culturally diverse area of Melbourne and the authors concluded that Girls on the Go! is a successful way to improve self-esteem among girls from culturally diverse backgrounds.[47]

Gender competence in mental health promotion

Gender competence includes: the capacity to recognise gender-based discriminatory attitudes and behaviours; knowledge about gender-based discriminatory policies and initiatives; and actions to counter gender-based stereotypes in research, training and clinical practice.

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[45] Fisher et al (2010) *Innovative psycho-educational program to prevent common postpartum mental disorders in primiparous women: a before and after controlled study*, BioMed Central.
[46] Dunstan CJ, Paxton SJ, McLean SA (2017) *An evaluation of a body image intervention in adolescent girls delivered in single-sex versus co-educational classroom settings.* Eating Behaviors. 25:23-31.
[47] Tirlea L, Truby H, Haines TP (2016) *Pragmatic, randomized controlled trials of the girls on the go! Program to improve self-esteem in girls*. American Journal of Health Promotion. 30 (4):231-41.

Gender-informed approaches to mental health promotion require specific acknowledgement of gender-based risks, including experience of family violence, experiences of childhood abuse, and the burden of unpaid work and caregiving. Consideration of social and cultural contexts are critical. Gender competence therefore seeks to comprehend and address experiences of discrimination, interpersonal violence and being devalued, and to counter internalised beliefs about roles, rights and responsibilities.[48] Sex- and gender-responsive mental health promotion must also address reproductive and life stage elements of mental health and wellbeing. Applying an intersectional lens will ensure interventions are sensitive, appropriate and effective, and that they support equity among girls and women.

[48] Fisher, J (2020) Gender competence and mental health promotion. World Psychiatry 19:1.

Appendix: Gender responsive approaches to mental healthcare: A literature review

The state of the evidence

Although the need for gender sensitive mental health services is long established, there is a lack of evidence on what these services should look like (i.e. what services to deliver and how to deliver gendered services).[1]

A 2019 global study on the status of gender-sensitive mental health services reported that 'despite several recommendations regarding the need for gender-sensitive mental health services, the actual availability of these is not clear, both in high and low-income countries.'[2] A US study reported that while women with serious mental illness commonly seek mental health services, the specific needs and experiences of these women are often overlooked in treatment and research. This study could not find any evidence that interventions targeting women with severe mental illness had been developed, even though women differ from men in prevalence, symptoms, course and treatment response for serious mental illness (e.g.bi-polar disorder, severe depression, schizophrenia).[3]

A 2016 review by the Australian Health Policy Collaboration found that while there were pockets of good practice, there was little cohesion across various sectors that deal with women's mental distress and a lack of clearly identifiable specialist comprehensive mental health services for women that meet their mental health needs throughout the life course and that are culturally safe.[4] The report found that most services designed to address women's mental health take an individual pathology perspective, whereas the women who need these services consistently ask for a more holistic view of their lives.[5] To improve population mental health, it is crucial to move beyond an individualised approach and address the drivers of women's poor mental health, including gender inequality.

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[1] Abel, K and Newbigging, K (2018), Addressing unmet needs in women's mental health BMC (UK)

[2] Chandra, P et al (2019), The current status of gender-sensitive mental health services for women—findings from a global survey of experts, Archives of Women's Mental Health 2019. DOI: 10.1007/s00737-019-01001-2

[3] Mizock, L (2019), Development of a Gender-Sensitive and Recovery-Oriented Intervention for Women With Serious Mental Illness Psychiatric Rehabilitation Journal. DOI: 10.1037/prj0000313

[4] Duggan, M. (2016) Investing in Women's Mental Health. Strengthening the foundations for women, families and the Australian economy. Australian Health Policy Collaboration Issues paper No. 2016-02. Australian Health Policy Collaboration, Melbourne

[5] Duggan, M. (2016) Investing in Women's Mental Health. Strengthening the foundations for women, families and the Australian economy. Australian Health Policy Collaboration Issues paper No. 2016-02. Australian Health Policy Collaboration, Melbourne

Principles for gender-responsive mental healthcare

The most important aspects of gender-sensitive mental health care, rated by global experts in women's mental health in a 2019 survey include:[6]

- **most importantly**: training of mental health professionals in gender-sensitive care
- provision of mother-baby units and childcare
- accessibility of services (including transport, cost and disability access)
- separate wards in hospitals for women and safety mechanisms for preventing violence or abuse in inpatient settings
- respectful and sensitive provider-women interaction
- patient education regarding risks and safety
- having trained, sensitive and compassionate staff including female security personnel
- being able to choose the gender of the provider especially where the person has experienced sexual assault
- trauma-informed mental health care
- a life course approach in service planning and delivery
- focus on social determinants
- using feedback from women service users for service planning
- access to information
- grievance redressal and legal aid
- availability of sex-disaggregated data

Gender-responsive mental healthcare in the UK

Such is the poor state of the evidence that frameworks developed in the UK in the early 2000s remain the best examples of a gender-sensitive approach to mental health.

In 2002 and 2003, two landmark policies were developed for a gender-responsive approach to mental health in the UK: *Into the Mainstream* (2002), an evidence-based guide for service development and practice which remains relevant today, and Mainstreaming Gender and Women's Mental Health: Implementation Guide (2003).

The development of *Into the Mainstream* arose from practice development, feminist scholarship and activism, and the exposure of abuse by mental health professionals, including rape and abuse of women in inpatient settings. Unlike most psychiatric practice at the time, it asked mental health professionals and services to recognise elements of the feminist approach which **locates the origins of women's distress and mental illness both within social inequalities and the social construction of their difficulties. Therefore, the solutions to such distress were not simply better treatments but better solutions to that inequality and to the discrimination that women face.**

[6] Chandra, P et al (2019), The current status of gender-sensitive mental health services for women—findings from a global survey of experts, Archives of Women's Mental Health 2019. DOI: 10.1007/s00737-019-01001-2

Consultation with women for the development of *Into the Mainstream* enabled components of women-friendly services to be identified. These are summarised and updated as follows:[7]

- Prioritise understanding mental distress in the context of women's lives
- Are co-designed with women with lived experience
- Enable all dimensions of problems experienced to be addressed
- Address sexual abuse, domestic violence, body image concerns, reproductive and life stage elements of health and wellbeing
- Are sensitive to the diversity of women's needs, experiences and backgrounds including race, sexuality and disability
- Enable women to make choices about their care and treatment
- Provide women-only spaces, particularly in-patient settings, which enable women to feel secure, safe and respected
- Empower women to develop skills for addressing their difficulties
- Promote self-advocacy and advocacy for women who need support to voice their views
- Value women's strengths and potential for recovery

'Into the Mainstream' was accompanied by Mainstreaming Gender and Women's Mental Health: Implementation Guide (2003), a useful guide on how to implement and plan for gender-sensitive mental health provision. It outlined ways in which services could be modified and care delivered at no extra cost in a gender-sensitive and gender-specific way and models of good practice.

A pivotal element of the implementation plan was the appointment of **national and regional leads for gender equality and a women's mental health lead** by the National Institute for Mental Health in England (NIMHE). The implementation program also included:

- Improving access to perinatal mental health services
- Addressing violence and abuse through routine inquiry
- The roll out of single gender provision in acute inpatient settings
- Provision for women from black, Asian and minority ethnic communities.

Single sex wards in the UK

We have identified only one evaluation of single sex wards in the UK. While the study concluded that the move to same-sex wards proved to be successful,[8] there seem to have been flaws both in the model used (male and female patients were separated, but the single gender wards were not staffed by staff of the same gender) and the evaluation methodology (which appears to have only sought the views of staff and not patients/ consumers).

This study explored staff views before and after two mixed-sex inpatient wards were reorganised into two single-sex wards. Staff reported that the male wards had become calmer and the female wards more

[7] Abel, K and Newbigging, K (2018), Addressing unmet needs in women's mental health BMC (UK)
[8] Hawley CJ et al (2013) The effect of single-sex wards in mental health. Nursing Times; 109: 48, 20-22.

disruptive (while physical aggression was perceived to have decreased in the female wards, verbal aggression increased). The female staff in the female ward reported being more able to discuss 'female issues' and better able to manage instances of inappropriate attire or nakedness. Male staff felt 'under pressure' working on the female ward, believing the women patients were more likely to accuse them of abuse and inappropriate behaviour. Some female staff on the male ward feared violence from the male patients. Though the female ward had almost double the number of reported incidents (mostly attacks on staff), the researchers attributed this to 'case-mix rather than a sex attribute per se.'

Contemporary policy in the UK

Unfortunately, the era of gender-responsive mental health policy in the UK was short-lived and ended with the closure of NIMHE in 2010. Since then, UK mental health policy has not addressed the specific mental health needs of women and girls (apart from perinatal mental health), and the positive changes implemented in the early 2000s have not been retained. A 2016 survey of NHS mental health trusts by Agenda (an alliance of 70 organisations working with women with complex needs) found:

- only one had a strategy for providing gender-sensitive services for women
- the majority had no policy on 'routine inquiry' about abuse
- only 5 reported a policy on actively offering female practitioner.

Agenda concluded that: *'Some trusts may in fact offer women specific services, especially for pregnant women and new mothers or out in the community, but have no commitment to providing these services in their policies. Without such policies, there is a lack of a strategic approach and a risk that women's services may be lost in the future*.'

In 2017, a **Women's Mental Health Taskforce** was appointed in the UK to develop proposals to improve not only the mental health of women, but also their experience of mental health services. It was co-chaired by Jackie Doyle-Price, Parliamentary Under-Secretary for Mental Health, Inequalities & Suicide Prevention, and Katharine Sacks-Jones, then CEO of Agenda, the alliance for women and girls at risk.

The Taskforce conducted a series of focus groups of women who had been in the mental health system. They found that women needed service providers and practitioners to consider:

- **Voice and control** (treated with respect, not feeling like a burden, given meaningful choice, take back control over life)
- **Accessibility** (non-stigmatising, culturally appropriate, safe spaces, women-only spaces, practical and ongoing support)
- **Safety, respect and dignity** (holistic support, trust with providers, meet others with similar experiences)
- **Understanding trauma** (past and current, including bereavement, sexual and domestic abuse)
- **Children and caring responsibilities** (valued and supported in their role as mother/carer)

The Women's Mental Health Taskforce developed a set of gender and trauma-informed principles. (The Taskforce intended to publish a toolkit based on the findings of this report, which was due to be completed in 2019. The Alliance has not been able to locate this, but has reached out.)

Theme	Principle
Governance and leadership	There is a whole organisation approach and commitment to promoting women's mental health with effective governance and leadership in place to ensure this.
Equality of access	Services promote equality of access to good quality treatment and opportunity for all women, including LBTQ and BAME women
Recognise and respond to trauma	Services recognise and respond to the impact of violence, neglect, abuse and trauma.
Respectful	Relationships between health and care professionals and women using services are built on respect, compassion and trust.
Safe	Services provide and build safety for women, creating a safe environment that does not retraumatise. Services respond swiftly and appropriately to incidents that put women's safety at risk, including robust processes for reporting and investigating sexual abuse and assault.
Empowerment through co-production	Services engage with a diverse group of women who use mental health services to co-design and co-produce services. Services promote self-esteem, build on women's strengths and enable women to develop existing and new capacities and skills.
Holistic	Services prioritise understanding women's mental distress in the context of their lives and experiences, enabling a wide range of presenting issues to be explored and addressed, including with a focus on future prevention. Services support women in their role as mothers and carers
Effective	Services and treatments are effective in responding to the gendered nature of mental distress.

Gender-sensitive approaches in Australia

Alfred Hospital

In the Australian context, one study undertaken at the Alfred Hospital to assess the impact of creating a female-only area within a mixed-gender inpatient psychiatry service on female patient safety and experience of care found that there were significantly fewer incidents compromising females' safety on the ward containing a female-only area. Women staying on this ward rated their perceived safety and experience of care significantly more positively than women staying where no such gender segregation was available. Further, the female-only area was identified by the majority of surveyed staff to provide a safer environment for female patients.[9]

[9] Kulkarni et al (2014), Establishing female-only areas in psychiatry wards to improve safety and quality of care for women. Australasian Psychiatry, Vol 22(6): 551-556.

A description of the approach taken by the Women's Mental Health Clinic run by Monash Alfred Psychiatry research centre and feedback from women who have used the service is attached.

Springvale WPARC

A women's only Prevention and Recovery Centre (WPARC) was established in Springvale in 2014 and is the first of its kind in Victoria. It is run by Monash Health in conjunction with community organisation ERMHA. The centre caters for women from culturally diverse backgrounds, and a large focus is on providing treatment during the perinatal period. It has a full range of service treatment options including (areas) for babies and group rooms that are sensitive to women's needs. At least one woman staff member is rostered on every shift.

A small practitioner-led evaluation of the service based on consumer feedback from 115 participants reported that residents found it 'overwhelmingly positive' to participate in a women-only PARC program.[10]

- 91% of residents rated their satisfaction overall at 7/10 or above, with 56% rating their satisfaction at 10/10.
- 96% reported appreciating being in a female-only PARC
- 94% reported that their stay at WPARC better prepared them for managing their mental health
- 41% said they would not have wanted to come to a PARC service if it was not women-only.

The themes that consistently emerged from the survey were around feeling comfortable, safe and relaxed in a women-only environment. The women reported that this led to more honest and in-depth discussions around their needs and contributed to positive peer support experiences during recovery.

VMIAC also reports that consumers seem very happy with the WPARC.

Gender-sensitive approaches elsewhere

While we have found a smattering of other gender-sensitive mental health programs operating around the world (attached as an appendix), nowhere is a consistent, systemic approach taken to providing gender-responsive care and treatment.

[10] Dixon, K. J., Boase, A., Fossey, E. M., & Petrakis, M. (2018). Somewhere to be safe: women's experiences of a women-only Prevention and Recovery Care (PARC) service. *New Paradigm*, *2017/18* (Summer), 45-48.

Appendix

Examples of gender-responsive mental health care

The few gender-responsive programs that have been evaluated yield mixed results. Without a consistent definition of what constitutes a 'gender-responsive' program or in-depth analysis of the design of each program, it is difficult to draw conclusions about effectiveness from the existing research.

We have included some examples of gender-responsive or gender-specific mental health programs below. Key words that demonstrate distinctive elements that respond to women's needs and experiences are **bolded.**

Canada

Centre for Addiction and Mental Health

The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health teaching hospital. *womenmind* philanthropic is an initiative of CAMH working towards closing the gender gap in research on mental health on women and girls and aiming to support women become leaders in mental health research.

CAMH has:

- a women's inpatient unit (acute care for severe mental illness/mood and anxiety disorder/trauma/addiction);
- a Women's Addiction and Concurrent Disorder Service, which includes group therapy, specialty programming for eating disorders, addictions, first stage trauma and cognitive impairment groups;
- an observation and treatment unit/Women's Secure Unit for women found not criminally responsible due to mental illness. It provides assessment, treatment and rehabilitation in a secure setting.

The Roshni Project

The Roshni Project a multi-phase research project aimed at enhancing the mental well-being of young South Asian women, funded by the CAMH Foundation. It includes tip sheets for mental health service providers, family members, faith leaders and educators. The project began in 2017 and is ongoing.

Canadian Co-creating Evidence project

Canadian Co-creating Evidence project is an evaluation of 10 holistic programs that serve women who are at risk of having an infant with prenatal AOD exposure. They found the reason women sought help at these services was not only to get help for substance issues, but also to get information, support or assistance with child welfare, pregnancy, housing, healthcare and peer support opportunities. The evaluation concluded that pregnant and parenting women who are marginalised and use substances will seek help

when health and social care services **take into consideration their unique roles, responsibilities and realities**.[11]

Hear Me, See Me, Support Me

Hear Me, See Me, Support Me: What young women want you to know about depression is a 2006 resource developed by young women in Canada as part of the Validity project.

When asked for their ideas about depression, young women don't, for the most part, identify physical "symptoms" that can be treated with a prescription. They call attention instead to **factors outside of themselves** (e.g. cultural expectations, family dynamics, friendship, intimacy, peer pressure and fitting in, sizism, body image and media, racism, trauma (unspoken) and anger) that can prevent young women from slipping into clinical depression.

"I don't want to be treated. **I want to be heard**." One of the most helpful ways to deal with depression is to talk e.g. Girls Talk Program (an 8 week program for any girl aged 13-16) promotes understanding and awareness about depression. Since 2004, Girls Talk has been run over 65 times resulting in a 40-60% increase in knowledge of depression symptoms and causes.

Includes the following list of 'dos' and 'don'ts' from young women:

- **Don't:**
  - Tell us you know what we're going through
  - Do for us, but guide us
  - Just hand us a number to call. We need information about a referral and what will happen when we call
  - Ask yes/no questions. You need to hear about my world
  - Assume I want my family involved
  - Talk to me like I'm a child
  - Reject me because I am expressing anger – it has meaning
- **Do:**
  - Build a relationship with us before you start talking about depression
  - Educate us about depression
  - Give us information on other things besides medication that can help with depression
  - Empower us
  - Always check things out with us to make sure you understand what we mean

[11] Hubberstey, Carol et al. "Multi-Service Programs for Pregnant and Parenting Women with Substance Use Concerns: Women's Perspectives on Why They Seek Help and Their Significant Changes." International journal of environmental research and public health vol. 16,18 3299. 8 Sep. 2019, doi:10.3390/ijerph16183299

SNAP Girls

SNAP Girls is a family-focused, gender-specific early intervention program for girls ages 6-11 exhibiting early disruptive behaviour problems at home, school and in their community. The program components are similar to the SNAP Boys program, but there are important differences based on research and best practices for treating girl aggression. In SNAP Girls, for example, there is greater emphasis on **communication** and **relationship-building**.

When it launched in 1985, the original SNAP program was a co-ed program, but as the program grew and developed, it became apparent that girls were not gaining the same benefits from the program as their male counterparts. At the time, there was a significant gap in gender-specific research and programs focusing on girl aggression. As a result, Kathryn Levene, Clinical Director at the former Earlscourt Child and Family Centre, now Child Development Institute, began studying the unique factors influencing girl aggression and the treatment approaches to best meet the specific needs of girls.

In 1996, SNAP Girls Connection (now called SNAP Girls) launched as the first-ever sustained, gender-specific program for behaviourally troubled girls and their families. Developed using the SNAP model, the program incorporates a feminist lens to recognise gender differences. Along with the program's theoretical foundation of social learning, self-control and problem-solving, it offers a strong focus on relationship building and **positive mother-daughter attachment**.

Six key components:

- SNAP Girls Club – a structured group that meets weekly for 13 weeks and teaches girls the SNAP technique to achieve emotion-regulation, self-control, realistic thinking and problem-solving
- A concurrent SNAP Parenting (SNAPP) Group – teaches parents the SNAP technique in conjunction with effective child management strategies
- Girls Growing up Healthy – typically offered after SNAP groups are completed. The caregiver-daughter group aims to strengthen this essential relationship at the critical pre-teen stage, and to address issues related to physical development and healthy relationships
- Family counselling based on SNAPP (Stop Now and Plan Parenting)
- Individual counselling/mentoring for girls who require extra support
- School advocacy and teacher support to assist girls who are struggling behaviourally and/or not performing at their age-appropriate grade level at school

USA

Women's Empowerment and Recovery-Oriented Care (WE-ROC) group therapy intervention

- US pilot study of an 8-week group intervention, Women's Empowerment and Recovery-Oriented Care (WE-ROC), for 10 women with serious mental illness. This study did not have a control group, however future evaluation could include a waitlist control group.
- Participants recorded significant increase on recovery and empowerment scores
- High attendance rates, and feedback indicated participants found the group intervention valuable in terms of the provision of **peer support** and impact on **self-esteem**. However, participants were paid to attend and this may have influenced attendance rates and high rates of positive feedback.

The WE-ROC Intervention focused on **recovery and empowerment**. Learning and discussion sessions were conducted each week to increase awareness of the impact of gender on mental health and provide group support.

Topics such as family, dating, **relationships, stigma**, and double stigma (multiple forms of stigma i.e. sexism and mental illness stigma) were addressed based on the literature reflecting differences in women's needs in these areas. **Positive and negative experiences** in mental health care were explored as well as **strategies to advocate** for one's care. Experiences with **meaningful work** and **financial challenges** were also addressed based on the employment barriers and financial issues facing this group. **Women's strengths** pertaining to their gender and mental health identities were identified in order to boost self-esteem. Lastly, **community action** was a key focus, with activities developed to enhance **empowerment and agency** through working toward social change.[12]

PACE Center for Girls

This is a program in the US juvenile justice system that found:

- Participants told researchers that they wanted:
    - service providers to **listen to and use their opinions** about program content and delivery,
    - to have **caring staff** members
- Principles of gender-responsive care:
    - focus on **relationships**, physical and emotional **safety**;
    - attention to physical, mental and reproductive **health**;
    - **cultural appropriateness** and competence;
    - response to **sexism**;
    - **strengths-based**;
    - **holistic**;
    - **family** involvement, conflict resolution and development of positive family connections (where appropriate);
    - activities focus on acknowledging and responding to interpersonal trauma and abuse;
    - developing life **skills**, education and vocational opportunities.

Asian Women's Action for Resilience and Empowerment (AWARE)

Young Asian American women have high rates of depression and suicidality; however, few interventions address the urgent need for culturally informed care. **Asian Women's Action for Resilience and Empowerment** (AWARE) aims to be the first gender and culturally specific group psychotherapy intervention designed to improve mental and sexual health in Asian American women with trauma. Analysis revealed four cultural mechanisms that facilitated mental health improvements:

[12] Development of a Gender-Sensitive and Recovery-Oriented Intervention for Women With Serious Mental Illness Psychiatric Rehabilitation Journal, 2019

psychoeducation on disempowering parenting, the reduction of mental illness-related stigma, community and relational building, and a heightened sense of empowerment.[13]

United Kingdom

Solace Women's Aid's Hear2Change Project

Solace Women's Aid's Hear2Change Project is a prevention of violence against women (PVAW) program targeted towards young women and girls aged 11–19 from communities with the poorest access to provision that meets their needs. Feedback from young women indicates that many appreciate having a **gender-specific space** in which to **share experiences and develop solutions** to improve their lives. This has benefited their well-being as they feel their issues and ideas are finally **being listened to and heard**.[14]

Imkaan

Imkaan, a UK organisation dedicated to addressing violence against Black and minoritised women, points to the importance of ethno-cultural relevance. Service provision should recognise the implications and impact of patriarchy and colonisation and demonstrate an "understanding of the **impact of racism and discrimination** in the lives of women and girls within the context of violence."[15]

Women Side By Side

Women Side by Side is a new UK peer support program that aims to increase the provision of gender-responsive mental health peer support for women experiencing, and at risk of developing, mental health problems. The program will focus on women who are experiencing **multiple disadvantage**, including homelessness, drug and alcohol dependency and contact with the criminal justice system. The program evaluation hopes to increase understanding about the effect **peer support** can have on women experiencing multiple disadvantages that are rarely addressed in a gender-responsive way. The evaluation report is due to be published in June 2020.[16]

Australia

An ethnographic investigation among the Yolŋu people of north-east Arnhem Land remains the only in-depth investigation of **Indigenous Australian mental health and illness concepts** that was identified in this review. However, gender differences in experiences of mental health or illness were not reported on.[17]

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[13] Mechanisms of action in AWARE: A culturally informed intervention for 1.5- and 2nd-generation Asian American women. APA PsychNet 2019

[14] Gender-sensitive approaches to addressing children and young people's emotional and mental health and well-being Examples of promising practice National Children's Bureau [UK] 2017

[15] Imkaan, 2016. Imkaan safe minimum practice standards working with black and 'minority ethnic' women and girls. London.

[16] https://mcpin.org/womens-peer-support-programme-evaluation/

[17] "They have a story inside": madness and healing on Elcho Island, north-east Arnhem Land [Charles Darwin University PhD thesis] 2011 quoted in Acute mental health service delivery to Indigenous women: What is known? International Journal of Mental Health Nursing, 2015.