TOWARDS A GENDERED UNDERSTANDING OF WOMEN'S EXPERIENCES OF MENTAL HEALTH AND THE MENTAL HEALTH SYSTEM

ISSUES PAPER

Women's Health
VICTORIA

Abstract

This paper frames the structural, cultural, and service issues that inhibit good mental health and wellbeing and gender responsive mental health care for women and girls. Drawing on mostly Australian research, data and women's lived experience of mental ill-health and the mental health system, this paper discusses the determinants of women's mental health and illness and their experiences accessing care. With a focus on the Victorian mental health system, it highlights how the 'building blocks' of policy settings, funding, workforce, and research and data collection can both contribute to and reduce gender inequality.

Suggested citation:

ABOUT WOMEN'S HEALTH VICTORIA

Women's Health Victoria is a state-wide women's health promotion, policy, advocacy, and support service with a proud history of nearly 30 years. We are an independent, feminist, not-for-profit organisation. We advocate and build system capacity for a gendered approach to health that reduces inequalities and improves health outcomes for Victorian women. We collaborate with women, health professionals, researchers, policy makers, service providers and community organisations to influence and inform health policy and service delivery for women.

ACKNOWLEDGMENT OF COUNTRY

Women's Health Victoria acknowledges the Traditional Owners of the land we work on, the Wurundjeri people of the Kulin Nation. We pay our respects to their Elders past and present and acknowledge their continued custodianship of these lands and waters.

As a statewide organisation, we also acknowledge and pay our respects to the past and present Elders of Traditional Owners of the lands and waters across Victoria.

We recognise that sovereignty was never ceded and that we are the beneficiaries of stolen land and dispossession, which began over 230 years ago and continues today.

Contents

Executive Summary

Why a gendered approach to women's mental health is needed

- Gender disparities in mental health are significant, with women almost twice as likely as men to experience mental illness due to a mix of biological (sex), social (gender), and other intersecting forms of inequality. These factors also affect women's experiences in the mental health system. Yet most mental health services operate on a male-centric model that overlooks women's needs and experiences. Sex, gender, and inequality thus influence both the drivers of mental ill-health in women and their experience of accessing care.

- Gender and mental health research has, until recently, mostly focused on women, girls, men, and boys. While the paper cites research on LGBTQI+ mental health (including trans and gender diverse people) where possible, this evidence is limited but indicative of significant need. Mental health researchers are urged to consider and account for diversity of gender and sexuality in their work.

- The paper also adopts a range of terms for mental health and ill-health, often based on the source document under discussion. Mental health terminology is contested and evolving; it is acknowledged that certain terms may not be acceptable to some readers.

Biological and social determinants of mental health for women and girls

- Sex and gender influence women's mental health and illness in myriad, intersecting ways:

  - Biological factors mean some women experience specific mental health conditions linked to their hormonal systems and reproductive capacity.

  - Women, men, and trans and gender diverse people also experience different social determinants of mental ill-health, including gender. Gender inequities mean that women and trans and gender diverse people are more frequently subject to social risk factors that lead to mental illness and may also influence how health professionals and support services respond to them, potentially compounding distress and trauma.

  - Domestic, family and sexual violence (DFSV) is a significant social risk factor for mental ill-health among women, girls and trans and gender diverse people.

- Adding further complexity, the biological and social determinants of women's mental health and illness vary by age and life stage, from adolescence to young adulthood, through the perinatal period, to middle age, menopause, and older age.

- Gendered inequalities over the life course are magnified by intersectional inequalities. A significant increase in research and data collection is needed, but it is clear from the existing literature that mental health outcomes for First Nations and migrant and refugee women, women with disabilities,

and LGBTQI+ women and trans and gender diverse people reflect the compounding forms of marginalisation and discrimination faced by these communities.

The influence of gender on mental health diagnosis and treatment

- Through the interplay of norms, practices, and structures, gender shapes not only the drivers of mental ill-health in women, girls and trans and gender diverse people, but how their distress is understood, diagnosed and treated, and their experiences of care.

- The biomedical model, which remains dominant within Australia's mental health system and the research literature, emphasises biological causes of mental ill-health. In so doing, the model both ignores the social causes and contexts of women's distress and considers their responses to these stressors as psychologically abnormal. In particular, the complex relationship between gendered violence, trauma and mental ill-health is poorly understood and addressed.

- Gendered biases and assumptions intersect with and often compound the limited consideration mental health professionals give to the gendered drivers of poor mental health for women and girls; again, this is particularly the case with the impacts of DFSV and trauma.

  - This can lead to women's mental health concerns being overlooked, dismissed or misdiagnosed and/or the pathologisation of adaptive responses to traumatic experiences.

- Gendered expectations and stereotypes can also shape women's access to and experiences of mental and general health care, and of other services – particularly for women with other marginalised identities.

  - Impacts include health professionals perceiving women seeking mental health care as difficult to care for and failing to recognise the shame and stigma associated with disclosing

mental illness among specific groups including First Nations women, refugee and migrant women, and young women and girls. Women also report not seeking mental health care following experiences of violence for fear of not being believed, and experience mental health diagnoses being used against them in the legal and justice system.

- A key consequence of the biomedical approach to treatment of mental ill-health is heavy reliance on medication and hospitalisation, while largely ignoring the impacts of trauma. Evidence indicates that women may be overprescribed medication for mental health conditions, while attempts to treat trauma and distress using medication and coercive practices can cause further trauma.

- The historic exclusion of women from clinical trials also means that medications have largely only been studied on men, leading to limited understanding of appropriate dosage and tapering, and of side effects for women.

- Hospitalisation in mental health inpatient units may also be traumatising, due to restrictive practices such as seclusion and restraint and/or exposure to gendered and sexual violence in mixed gender wards from staff or other consumers.

Gender and the mental health system

- The 'building blocks' of the mental health system – sometimes described as system 'enablers' (or barriers) – also play a role in driving and reinforcing gender disparities in mental health. The paper takes the Victorian mental health system and 2021 mental health Royal Commission-driven reforms as examples to highlight how policy settings, funding, workforce, and research and data collection can both contribute to and reduce gender inequality.

- Policy settings across mental health, family violence and gender equality in both Victoria and nationally provide a historic opportunity to work towards a more gender

responsive mental health system. Of particular significance in Victoria are the Royal Commission into Victoria's Mental Health System (2021), Mental Health and Wellbeing Act (2022), Family Violence Royal Commission (2016), Gender Equality Act 2020 (Vic), the *Safe and Strong* gender equality strategy (Victoria DPC 2016), and gender-responsive budgeting. Federally, the new National Plan to End Violence Against Women and Children (2022-2030) and Respect at Work bill (2022) are promising developments in relation to family violence and gender equality.

• While more funding does not necessarily equate to improved outcomes in mental health, key areas where adequate resourcing has important impacts, particularly for women and girls, include better pay and conditions for the mental health workforce, and making the necessary investment into gender separated mental health inpatient units (currently underway in Victoria).

• The current mental health workforce is not equipped to deliver gender-responsive trauma- and violence-informed care to women experiencing mental ill-health and psychological distress, including victim-survivors of gendered violence. To address this, all mental health professionals must be trained in the dynamics of gendered violence and the delivery of intersectional, trauma- and violence-informed care. Workforce development must be accompanied by whole-of-organisation approaches to system and culture change driven by senior leaders. More women are needed in senior mental health leadership roles where they are currently underrepresented, and better pay and conditions and career progression opportunities are required for the lived experience workforce. While these are challenging problems in the context of workforce shortages, if they are not addressed women will continue to be poorly served by the mental health system.

• Finally, in not centring sex and gender considerations, mental health research and data collection have contributed to gendered inequalities in mental health experiences and outcomes, inadequate understanding of women's mental health needs, and ineffective interventions. Sex and gender-disaggregated data should be collected, publicly reported, and analysed, effective gender-sensitive approaches and interventions identified, and opportunities created to test new and promising approaches and build the evidence base for women and trans and gender diverse people's mental health.

Towards a gender responsive mental health system

• All women, girls, trans and gender diverse people are impacted by systemic and structural oppression and disempowerment, which is compounded for those impacted by gendered violence through choice and control being taken away. Accordingly, it is vital that mental health services provide opportunities to regain power, choice, and control.

• Unpacking the multiple, overlapping ways in which gender and gender inequality influence the mental health and wellbeing of women and girls makes it clear that the application of an intersectional, gender-responsive, trauma- and violence-informed, life course approach is essential across the whole mental health 'system'. Such an approach must encompass all components or 'building blocks' of the mental health system, particularly authorising policy settings, targeted and adequate resourcing, workforce capability-building, and gender sensitive research and data collection.
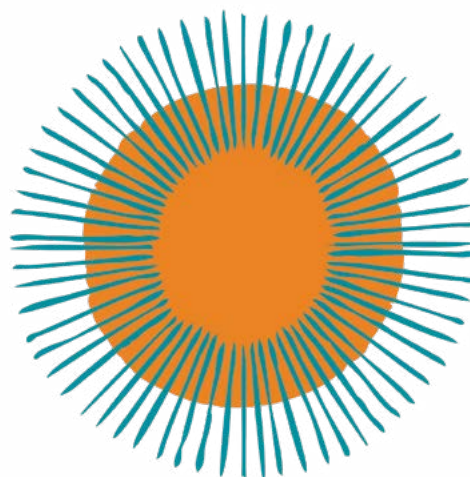
1. Why a gendered approach to women's mental health is needed

Globally, and in Australia, women are nearly twice as likely as men to suffer from a mental illness (Yu 2018, Women's Mental Health Alliance 2021a) (**See _Box 1_**). Poorer mental health and wellbeing among women and girls can be attributed to a combination of biological (sex), social (gender), and other factors including intersecting forms of inequality and marginalisation such as racism, colonisation, homophobia, transphobia, ableism, and ageism.

Yet women's mental health is not routinely considered as part of mainstream mental health policy or practice (Duggan 2016; Abel & Newbigging 2018). As a result, most mental health services are designed based on a male-centric model that does not recognise the specific needs and experiences of women and girls. Sex, gender, and gender inequality thus influence not only the drivers of mental ill-health in women, but also their experience of the mental health system.

> **Sex, gender, and gender inequality influence not only the drivers of mental ill-health in women, but also their experience of the mental health system.**

This paper draws on research, data, and the voices of Australian women with lived experience of mental ill-health and the mental health service system.[1] It discusses the biological and social determinants of mental health among women and girls, the types of diagnoses women are likely to receive, their ability to access safe and appropriate treatment and support, the attitudes they face, and how they are treated when they access mental health services.

It also highlights the ways in which gender inequality and gender bias have influenced aspects of the mental health 'system' - policy settings that enable or hinder gender inequality in mental health, investment in public mental health services, the capabilities, attitudes, leadership and composition of the mental health workforce, and gaps in the evidence base.

The prevention of mental ill-health and promotion of mental health and wellbeing, though important parts of the continuum of the mental health system, are not the focus of this paper. Nor is the paper intended to provide a comprehensive picture of women's mental ill-health, but rather to illustrate the range of ways in which gender and gender inequality impact women's mental health and experiences of the mental health system. By focusing on gendered and social factors, this paper is a counterpoint to the ongoing predominance of the biomedical model in mental health research, education, and clinical practice.

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1   Women's Health Victoria and the Women's Mental Health Alliance are based in Victoria and are closely involved in current Victorian mental health reforms. As such, much of the evidence, research and case studies discussed in this paper relate to the Victorian context.

Unpacking the multiple, overlapping ways in which gender and gender inequality influence the mental health and wellbeing of women and girls makes it clear that the application of an intersectional, gender-responsive, trauma-and-violence informed, life course approach is essential across the whole mental health system.

A system-wide approach to addressing gendered inequalities in mental health must encompass all components or 'building blocks' of the mental health system, including: leadership and governance, policy, funding, research, workforce education and training, and service delivery; and be applied across all 'points of intervention' from primary prevention and mental health promotion through to diagnosis, treatment and recovery.[2] Such an approach must address gendered 'norms' (such as negative and stereotyped beliefs and attitudes towards women experiencing mental ill-health), gendered 'practices' (such as uninformed and harmful responses to victim-survivors of domestic, family and sexual violence) and gendered structures (such as the under-representation of women in clinical and senior roles within the mental health workforce).

Finally, although this paper focuses on articulating the problem of gender inequality in mental health and its implications for women and girls, it locates these deficits within health and social systems, not individuals. An overview of the evidence on effective gender-responsive approaches in mental health – focusing on solutions – will be published as a companion piece to this paper. A separate paper on gender and mental health and wellbeing promotion and prevention of mental illness is also in development.

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2   The World Health Organisation (WHO) defines a 'health system' as comprising "all the organisations, institutions, resources and people whose primary purpose is to improve health. This includes efforts to influence determinants of health as well as more direct health-improvement activities. The health system delivers preventive, promotive, curative and rehabilitative interventions through a combination of public health actions and the pyramid of health care facilities that deliver personal health care - by both State and non-State actors." The WHO framework describes health systems in terms of six core components or "building blocks": (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership/governance (WHO 2010 p. vi).

> **A system-wide approach to addressing gendered inequalities in mental health must encompass all components or 'building blocks' of the mental health system … and be applied across all 'points of intervention' from primary prevention and mental health promotion through to diagnosis, treatment and recovery.**

A note on language

Throughout this paper, the terms 'women', 'girls', 'females', 'men', 'boys' and 'males' are predominantly used, reflecting the focus of and terminology used in most research on gender and mental health to date. Research on LGBTQI+ mental health is growing, albeit from a very limited base, and breaking down the specific experiences of transgender and gender diverse people isn't always straightforward. More research is urgently needed on how gender influences mental health overall, and for this research to be inclusive of and sensitive to the nuances of the experiences of people with different gender identities – cisgender women and girls as well as trans and gender diverse people. In the meantime, research on LGBTQI+ mental health (where available) is cited in this paper.

A variety of terms for mental health and ill-health are also used throughout the paper, including 'mental health', 'mental health and wellbeing', 'mental health outcomes', 'mental illness', 'mental ill-health', 'psychological distress', 'mental health condition', 'diagnosed psychiatric disorder', and a range of common mental health diagnostic labels. Often, the term used reflects that used in a particular source document being cited. Mental health terminology is contested and evolving, and the authors recognise that certain terms used in the paper may not be acceptable to some readers.

Box 1: Gender disparities in mental health in Australia: a snapshot

Unless otherwise indicated, sources for this data can be found in Snapshot of Australian women's mental health (Women's Mental Health Alliance 2021a).

Australian data show that relative to males, females are:

- almost twice as likely to experience mood disorders (such as depression),

- more likely to experience anxiety disorders,

- at higher risk of developing Post-Traumatic Stress Disorder (PTSD) (Olff 2017),

- hospitalised for intentional self-harm at almost twice the rate, and

- more likely to attempt suicide.

In addition:

- 95% of hospitalisations for an eating disorder are for females.

- At least one in five pregnant women and new mothers experience perinatal anxiety and/or depression

- Females represent the majority of people seeking mental health support/services in Australia and are significantly more likely to access Medicare-subsidised mental health services (AIHW 2022b).

Different groups of women and girls experience poorer mental health outcomes than the general population due to the intersections between gender inequality and other forms of inequality and discrimination. For example:

- Psychological distress, self-harm and suicide rates are significantly higher for **Aboriginal and Torres Strait Islander women** than for non-Indigenous women (AHRC 2020).

- **Young women** are twice as likely to report psychological distress as young men, and the prevalence of psychological distress is rising faster among young women than young men (Brennan et al. 2021).

- **Migrant and refugee women** experience higher rates of perinatal anxiety and/or depression than Australian-born women.

- A higher proportion of **women in rural and regional areas** have been diagnosed with anxiety or depression than women in metropolitan areas.

- **Women with disabilities** experience higher levels of isolation, discrimination, and violence than women without disabilities, and are more likely to experience employment, financial and housing insecurity than men with disabilities, all of which are key determinants of mental ill-health.

- **Women from the LGBTQI+ community** face higher risks of mental ill-health compared with heterosexual women and are almost four times as likely as their cis/heterosexual peers to have tried to self-harm or suicide (Suicide Prevention Australia 2016).

- **Carers** – around two-thirds of whom are female – have been shown to have the lowest collective wellbeing score of any group, with more than half of all carers found to have moderate depression as well as experiencing other stressors.

- Over 60% of **single mothers** (who make up 80% of single parent households) nominate managing their health or mental health as a key challenge.

- **Women in prison** are 1.7 times more likely to have a mental illness than men in prison.

2. Biological and social determinants of mental health for women and girls

Poorer mental health and wellbeing among women and girls can be attributed to a combination of biological (sex), social (gender), and other factors, as illustrated in Fig. 1.

Women and girls experience different mental health outcomes from men and boys for both biological and social reasons,[3] as well as gendered assumptions and biases that are embedded within the mental health system. These factors also shape the mental health outcomes of transgender and gender diverse people, with social drivers particularly influential due to the prevalence of transphobia and cisgenderism (A Gender Agenda 2022).

Biological determinants of mental health, such as hormonal fluctuations and genetics, can differ depending on a person's sex. Biological factors related to sex mean that women may experience specific mental health conditions linked to their hormonal systems and reproductive capacity throughout the life course, such as premenstrual dysphoric disorder and perinatal anxiety and depression (Kulkarni 2014).

Women, men, and trans and gender diverse people also experience very different **social** risk factors (sometimes called social determinants, causes or drivers) for mental ill-health and psychological distress. Gender-based expectations, practices, stereotypes, and discrimination play a key role in driving unequal mental health outcomes. Gender inequities mean that women are more frequently subject to social risk factors that lead to mental illness (Duggan 2016); the focus of this section of the paper. As discussed in Section 3, gender may also influence the response women receive from health professionals and support services, potentially further compounding distress and trauma.

Some of the most significant social risk factors for mental ill-health, including discrimination, domestic, family and sexual violence (DFSV) and associated trauma (**See Box 2**), and socioeconomic disadvantage (VMIAC 2020; Duggan 2016) impact women, girls, trans and gender diverse people at higher rates than men.

The biological and social determinants of mental health also intersect. For example, experiencing trauma can result in biological changes to hormonal systems and the brain structure (DeBellis et al. 2014), and neural response to stress also differs between females and males (Wang et al. 2007). Many mental health conditions affecting women arise from a combination of biological and social factors. Social factors contributing to perinatal mental illnesses, for example, include a lack of partner or social support, a history of mental health problems, previous trauma, and stressful life events (Biaggi et al. 2016; RCVMHS 2021b).

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3   There is increasing recognition of other determinants of health, including cultural, environmental and commercial determinants. See, for example the National Preventive Health Strategy 2021-2030 (Australia, Department of Health 2021).

Risk factors and symptoms that are sex-specific (like hormonal fluctuations) or gender-related (like gendered violence and unpaid care work) are either not recognised or pathologised

Exclusion of women from medical **research** has led to treatments that are not effective and/or have significant side effects for women

Women often feel and are **unsafe** when accessing mental health services, especially inpatient facilities

Gender norms and stereotypes can lead to women being **over-diagnosed** with stigmatised conditions like Borderline Personality Disorder and **under-diagnosed** with conditions like Post-Traumatic Stress Disorder and Attention Deficit Hyperactivity Disorder

Women's experiences of **gendered violence** (e.g., family and sexual violence) and **trauma** are not well understood by mental health workers who can perpetuate harmful practices

Influence of sex and gender on women's mental health

Women experience **gendered barriers to accessing mental health services** including cost, transport, care responsibilities, shame, fear and safety concerns. Some women (e.g., women with disabilities; migrant women) experience additional barriers (e.g., lack of interpreters)

Male-centric medical and mental health **education** means mental health workers aren't routinely taught about women's mental health or how sex and gender influence mental health

Gender bias and discrimination leads to a gender imbalance in the mental health **workforce**, with fewer women in clinical and senior roles and a devaluing of non-clinical and peer roles

Women experiencing mental ill-health and psychological distress face **stigma and discrimination** from health professionals based on gender bias and stereotypes

Mental health **treatment** tends to favour medication and hospitalisation over holistic, empowering, approaches and social supports, that reflect women's preferences

Mental health services are not **culturally safe and responsive** to the intersecting and compounding impacts of other forms of inequality and discrimination - such as racism, homophobia and ableism - on women's mental health and their interactions with mental health services

Box 2: Domestic, family and sexual violence (DFSV) as a leading determinant of mental ill-health for women and girls[4]

Violence against women is one of the most common causes of poor mental health among women and girls. The World Health Organisation considers violence to be '**the principal gender-related cause of mental health problems among women**' (cited in Fisher 2020, p. 34).

- Women who have experienced gendered violence (including domestic, family and/or sexual violence) are more likely to suffer from both short- and long-term mental health impacts, including trauma that can continue across the life course (ANROWS 2020b).

- The Royal Commission into Victoria's Mental Health System (Royal Commission) recognised that the trauma associated with family violence, sexual assault and childhood abuse can be especially harmful to mental health and wellbeing (RCVMHS 2021b). Women who have experienced gendered violence are at greater risk of a range of mental health conditions, including anxiety, depression, PTSD, self-harm, and suicide (Rees et al. 2011).

- While the relationship between gendered violence and mental health is complex and bi-directional, in a recent study of 658 Australian women with a self-reported history of intimate partner violence (IPV), around half reported receiving a diagnosis of mental illness. Of these women, only 13 percent reported having a diagnosis of mental illness prior to the IPV occurring – the remainder were diagnosed while IPV was being perpetrated or after leaving the relationship (ANROWS 2020b citing Moulding et al. 2020). This finding underlines the mental health impacts of IPV in women with no prior history of mental ill-health.

- In an Australian prospective study of 1507 first-time mothers, around one in four reported clinically significant mental health symptoms 10 years after having their baby. Of these women, 40% reported experiencing recent IPV, however two thirds had not disclosed this to a GP or mental health practitioner (Gartland et al. 2022). The extent of co-occurring IPV and mental health problems underlines the importance of prioritising family violence as a health and mental health issue, and the need for more coordinated efforts to strengthen health system responses.

Gendered violence and trauma also intersect with other forms of abuse and discrimination, compounding the impacts for different population groups.

- Existing research indicates that family violence is as prevalent within the LGBTQI+ community as within the general population, with some distinct characteristics (e.g., threats of being 'outed', higher rates of violence from family members due to transphobia and homophobia), and rates of sexual violence are comparable to those for heterosexual cisgender women (LGBTQI+ Health Australia 2021; Hill et al. 2020). Although research is limited, indications are that transgender and gender diverse people are particularly vulnerable. Transgender and non-binary people over 16 years of age are four times more likely to have experienced sexual coercion as the general population (LGBTQI+ Health Australia 2021). The most recent *Private Lives* survey found that sexual assault rates were highest among cisgender women, transgender men, and non-binary people, which the authors argue reflects 'the gendered nature of violence toward people socialised as women' (Hill et al. 2020).

- As noted in the Royal Commission report, Aboriginal and Torres Strait Islander people, refugees, people experiencing homelessness, children who have experienced violence, and people living with disability are more likely to experience trauma than others in the community (RCVMHS 2021b).

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4 More detail on other gendered social determinants of mental ill-health can be found in Women's Health Victoria's submission to the Royal Commission into Victoria's Mental Health System (2019).

2.1 HOW SEX AND GENDER INTERSECT WITH OTHER SOCIAL FACTORS TO INFLUENCE THE MENTAL HEALTH OF GIRLS AND WOMEN ACROSS THE LIFE COURSE

Women's mental health is impacted by the cumulative experiences of gender inequality, discrimination, and reproductive and life stage elements across the course of their lives. For many, gender inequality is compounded by other forms of oppression, discrimination, and abuse, including racism, colonialism, ableism, homophobia, and transphobia. As summarised in Fig. 2 and discussed at greater length in later sections of the paper, these intersecting forms of marginalisation and discrimination also affect women and trans and gender diverse people's experiences of mental health care, and both influence and are influenced by the design and delivery of the mental health system – its 'building blocks'.

Adolescence and young adulthood

Australian girls and boys enjoy comparable levels of mental health and self-confidence before puberty. However, during **adolescence**, young women's mental health outcomes worsen compared with young men's (Hankin et al. 2015). The rate of psychological distress among **young Australian women** is twice that of young men (Brennan et al. 2021), and young women aged 16 to 24 have been presenting with self-harm and suicidal behaviours at increasing rates over the last decade (Terhaag & Rioseco 2021). Although the reasons for this widening gender gap in mental health outcomes for young people are unclear, evidence suggests sex- and gender-based expectations and experiences are a contributing factor (Rowlands, Dobson & Mishra 2015; Brennan et al. 2021).

> **The rate of psychological distress among young Australian women is twice that of young men**
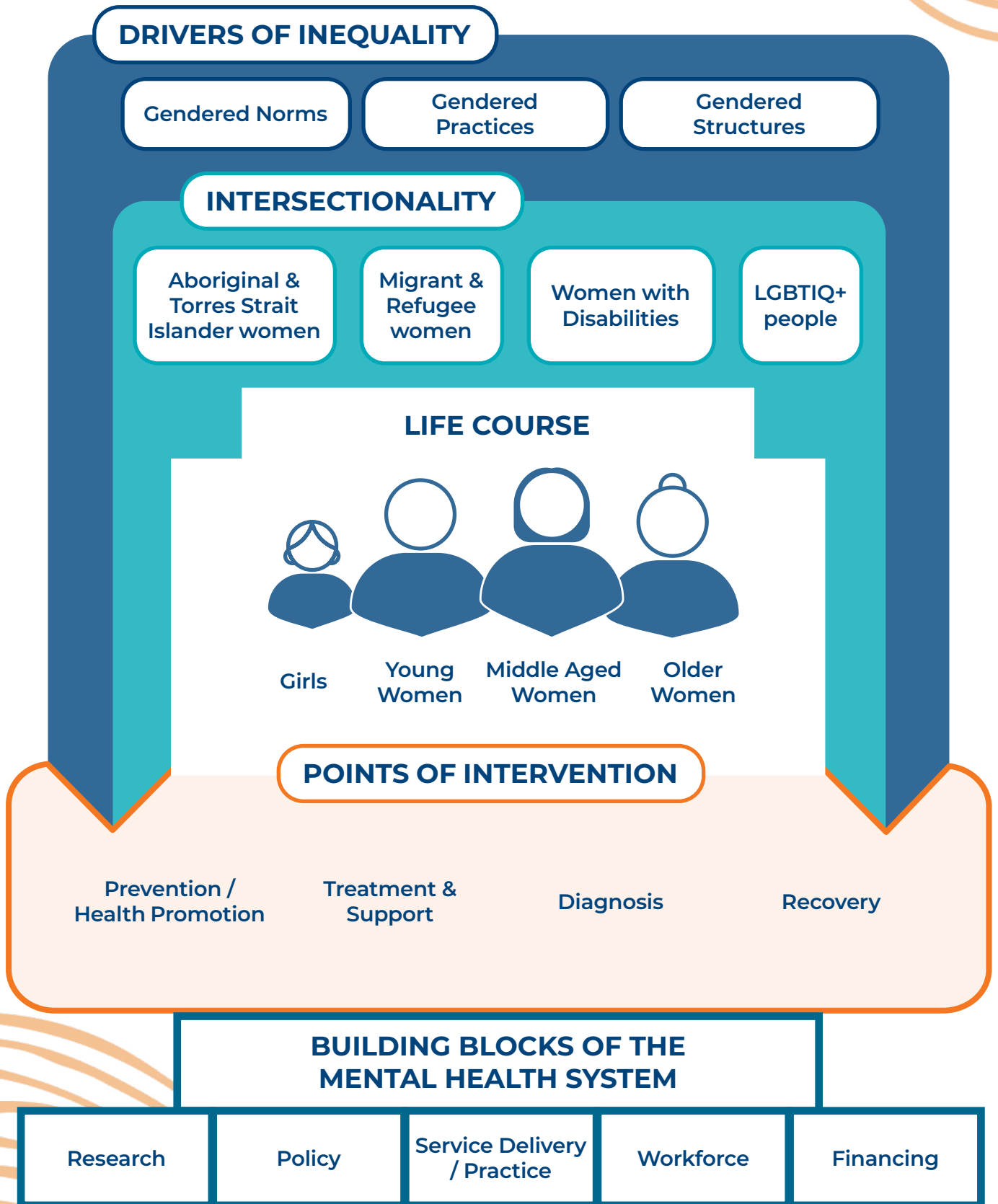
Sex and gender-based inequalities also intersect with other forms of inequality to influence the mental health of different groups of adolescent and young women. Young Aboriginal and Torres Strait Islander women report comparatively low levels of happiness and comparatively high levels of stress (Brennan et al. 2021), and suicide rates among Aboriginal and Torres Strait Islander women aged 15-19 are nearly six times higher than for non-Aboriginal young women (Suicide Prevention Australia 2016). This may reflect the compounding effects of a history of colonisation and dispossession, intergenerational trauma, removal from family and community, racism, and discrimination (Suicide Prevention Australia 2016). The most recent *Writing Themselves In* report found LGBTQI+ young people experience significantly higher rates of psychological distress, anxiety, depression, suicide ideation and attempts than the general population (Hill et al. 2020), and over 90% of transgender and gender diverse people aged 14 to 21 reported experiencing high or very high levels of psychological distress (LGBTQI+ Health Australia 2021). For young First Nations women and young members of the LGBTQI+ community, these figures are extraordinary and concerning.

Perinatal period and parenthood

The **perinatal period** is a high-risk period for women, with up to one in every five women experiencing symptoms of anxiety, depression, or both during pregnancy and/or following birth (PANDA 2022). For many women, distress can continue for years after having a baby, particularly if they are experiencing intimate partner violence (IPV). Moreover, as noted in Box 2, many women in these circumstances deal with both mental health problems and IPV without the support of a GP or mental health practitioner (Gartland et al. 2022).

Other social factors that intersect with gender during the perinatal period or early parenting years include socioeconomic and migrant or refugee status. Gartland et al. (2022) found that women experiencing socioeconomic disadvantage were more likely to be experiencing mental health issues and IPV. Rates of perinatal anxiety and depression are also

Fig. 2: How gendered inequalities and intersectionality impact the mental health and wellbeing of women and girls over the life course

DRIVERS OF INEQUALITY

Gendered Norms

Gendered Practices

Gendered Structures

INTERSECTIONALITY

Aboriginal & Torres Strait Islander women

Migrant & Refugee women

Women with Disabilities

LGBTIQ+ people

LIFE COURSE

Girls

Young Women

Middle Aged Women

Older Women

POINTS OF INTERVENTION

Prevention / Health Promotion

Treatment & Support

Diagnosis

Recovery

BUILDING BLOCKS OF THE MENTAL HEALTH SYSTEM

Research

Policy

Service Delivery / Practice

Workforce

Financing

higher for migrant and refugee women (Shafiei, Flood & Bee 2018), who, evidence suggests, generally experience poorer mental health outcomes during the perinatal period than Australian-born women, with race discrimination, gender inequality, violence against women, settlement stress and trauma all playing a role (Delara 2016; Sullivan 2020).

Middle and older age

Women in middle and older age confront social and biological determinants of mental health unique to their age and life stage. **Middle age** is a particularly challenging time. Rates of depression and anxiety are higher for women than men (ABS 2018), with 26.6% of women aged 45-64 years having a mental or behavioural condition (ABS 2018). The highest proportion of suicide deaths in women is in the 45-49 year age group (Kulkarni 2018), and between 2001 and 2018 rates of very high psychological distress more than doubled for women aged 55-64 years (3.5% to 7.2%), with women on lower incomes experiencing greater distress (Enticott et al. 2018). The Australian Longitudinal Study on Women's Health (ALSWH) has found that women with experience of interpersonal violence by age 45 years report poorer mental health and consistently higher levels of stress than those without (Mishra et al. 2022).

Relatively higher rates of mental distress in middle-aged women reflect the gendered complexity of their lives. Women aged 40 years and over are more likely be providing unpaid care to children, parents, and/or partners, while balancing paid employment. Evidence suggests that caregiving intensifies for those in their mid-50s to mid-60s, often related to a partner with a serious medical condition (Mishra et al. 2022). Caregivers in general report poorer mental health, in particular women who provide care for someone who lives with them, as indicated by higher levels of depression, anxiety, and stress. Low participation in paid work is also linked to poorer mental health in middle-aged women (Mishra et al. 2022).

A potential further complication is menopause, which occurs on average at age 51 years. Mental health impacts can result if women experience or are unable to effectively treat bothersome menopausal symptoms, while navigating the challenges of mid-life (Kirkman & Fisher 2021). Hormonal changes may also play a role (Kulkarni 2018).

ALSWH data suggest that younger generations of women appear to be suffering poorer mental health as they reach middle age. For example, though women born between 1946-51 reported improved mental health by the time they reached age 45-50, while women born between 1973-78 reported a rise in stress, anxiety, and depression in their 30s that had yet to improve in their 40s (Mishra et al. 2022). The COVID-19 pandemic and increasing frequency of extreme environmental effects may see a further rise in poor mental health (Mishra et al. 2022).

Relatively higher rates of mental distress in middle-aged women reflect the gendered complexity of their lives

The intersection between ageism and sexism across the life course can lead to **older women** being marginalised, rendered invisible, and experiencing high rates of depression. Illness and disability, economic insecurity, maltreatment, and loss and grief are among the main drivers of poor mental health among older women (Kirkman & Fisher 2021), again reflecting a combination of biological and social influences on mental health. On a positive note, many older women report improved mental health as they retire and cite feelings of relief associated with ceasing paid work reducing their stress levels. However, older women who experience changes in close relationships (including death, loneliness and a partner's health issues) and/ or financial insecurity experience poor mental health. Post-menopausal women (aged 60-75 years) have reported poor body image and disordered eating, citing internalised weight stigma and pressure to appear youthful as drivers (Carrard 2020).

As women move from middle to older age (50s -70s), they are more likely to drink alcohol at risky levels than younger women (Dare et al. 2020). Research on women's motivations for drinking is limited, but stress appears to play a critical role in initiating and maintaining alcohol use (Peltier et al. 2019).

Middle-aged and older women in the LGBTQI+ community along with trans and gender diverse people suffer poor mental health at higher rates than women in the general population. Recent research indicates that of LGBTQI+ women aged 45 to 59, 36.4% report having been diagnosed or treated for a mental health condition and almost one in five trans and gender diverse people over 50 years of age report having a major depressive syndrome (LGBTIQA+ Health Australia 2021). Beyond this data, intersectional research on older women's health, including on First Nations women, migrant and refugee women, women with disabilities, and LGBTIQ+ people is concerningly limited.

3. The influence of gender on mental health diagnosis and treatment

Gender inequality is expressed and maintained in society – and within the mental health system – through the interaction of gender(ed) norms, practices, and structures.

- **Gender norms** refer to values, attitudes and beliefs that construct masculinity, femininity, and binary gender difference.

- **Gendered practices** reflect the internalisation of gender norms by individuals, groups, and institutions.

- **Gendered structures** formalise gender inequality and the way power and resources are distributed in society and include legislation, policy, institutions, and funding.

- **Gendered norms, practices and structures** interact and overlap, and have a cumulative impact over time.

See *Box 3* for a more detailed explanation and examples relating to gender inequality in relation to mental health.

Gender norms, practices and structures not only influence the drivers of poor mental health and wellbeing in women, girls, trans and gender diverse people (as outlined in the previous section), but also shape how their mental distress is understood, diagnosed, and treated, and their experiences of care.

3.1 GENDER, THE BIOMEDICAL MODEL, AND WOMEN'S MENTAL HEALTH

Despite clear evidence of how gendered experiences influence women's mental health and wellbeing throughout the life course, the **biomedical model of mental health** remains dominant within Australia's mental health system and within the research literature (Fisher 2020) and continues to influence diagnosis and treatment models. In emphasising biological causes of mental ill-health, the biomedical model ignores the social causes and contexts of women's distress and pathologises women's responses to social problems and inequalities – that is, it treats women's responses to these stressors as psychologically abnormal (Archer, Lau & Sethi 2016)[5]. In particular, the complex relationship between gendered violence, trauma and mental ill-health is poorly understood and addressed by mental health professionals and the mental health system (O'Dwyer et al. 2019) (**See *Box 4***). The biomedical model pathologises what is a rational, adaptive response to trauma, violence and social inequality, and re-casts what is a systemic social problem as individual dysfunction (ANROWS 2020b, Tseris & Moulding 2021).

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5   By contrast, a **biopsychosocial model of mental health** considers not only the biological factors that influence mental health but also the social context of people's lives. It considers the intersections between biology, thoughts, emotions, behaviours, social factors (including structural inequalities) and the broader determinants of health. It recognises that, while biology plays a role, the causes of mental ill health are complex and the result of many forces (including gender) that occur and intersect in a person's life and have a cumulative effect (Vizzotto et al. 2013).

Box 3: How do gendered norms, practices and structures influence the mental health and wellbeing of women and girls?

Gender inequality is expressed and maintained in society – and within the mental health system – through the interaction of gender(ed) norms, practices, and structures.

Gender norms refer to values, attitudes and beliefs that construct masculinity, femininity, and binary gender difference. Deeply ingrained gender norms operate as informal rules or 'mental models' that construct certain traits, behaviours, and values as more feminine or masculine. People are provided with social and economic incentives to conform to traditional gender norms, and disincentives (including discrimination) if they fail to conform. Transgender and gender diverse people confront significant discrimination and prejudice because their existence challenges the widespread norm of binary gender difference.

Gender norms intersect with other social norms and stereotypes which shape the mental health and wellbeing of different groups of women and their experience of the mental health system. For example, public discourse suggesting people with disabilities be de-prioritised for healthcare during the COVID-19 pandemic reportedly had a psychological impact on women with disabilities, leading to them feeling de-valued (Women's Mental Health Alliance 2021c).

Examples of the ways in which gender norms shape women's mental health:

- **Risk factors or determinants of mental ill-health:** Rigid gender norms and stereotypes contribute to a range of risk factors for poor mental health among women and girls (Carbone 2020) including widespread experiences of gendered discrimination and violence (Our Watch 2021), the disproportionate burden of unpaid care work on women and girls (Women's Health Victoria 2018), and body dissatisfaction (Rumsey & Diedrichs 2018).

- **Treatment and support:** Some health professionals express stereotyped and harmful attitudes towards women experiencing mental ill-health and psychological distress – for example, women who present with self-harming or suicidal

behaviours may be dismissed as 'attention-seeking' and 'manipulative' (Suicide Prevention Australia 2016), and some victim-survivors of gendered violence and trauma report having their experiences minimised.

Gender norms are internalised by individuals, groups and institutions and become **gendered practices** - behaviours that reflect gendered norms and express and reinforce gender inequality and gendered power dynamics. Gendered practices play out in interpersonal relationships and within organisations and communities.

Gendered practices may also intersect with other forms of inequality, bias, and discrimination, resulting in practices that are not (culturally) safe for women from marginalised groups, such as Aboriginal and Torres Strait Islander women and transgender women.

Examples of the ways in which gendered practices shape women's mental health:

- **Diagnosis:** Screening practices for perinatal anxiety and depression may not be culturally safe for some populations of women. The Royal Commission into Victoria's Mental Health System found that commonly used screening instruments have known limitations, including in their validity and acceptability among Aboriginal and Torres Strait Islander communities and culturally diverse populations (RCVMHS 2021b).

- **Treatment and support:** Poor understanding of the nature and dynamics of DFSV among mental health professionals has led to practices that are harmful to victim-survivors, including denial or invalidation of their experiences, victim-blaming, misdiagnosis, use of retraumatising coercive practices like physical restraint, sharing information with perpetrators which compromises women's safety, and inability to see a female clinician (O'Dwyer et al. 2019; APS Women and Psychology Interest Group 2020; Choahan 2021).

Gendered structures formalise gender inequality and the way power and resources are distributed in society and include legislation, policy, institutions, and funding. Gendered structures or 'structural gender inequality' can

be direct (e.g., under-representation of women in leadership positions) or indirect (e.g., policy and programs that do not account for gender differences). Structural gender inequality is both informed by and perpetuates gendered norms and practices.

Intersecting forms of inequality and discrimination may compound gendered structural inequalities for different groups of women. For example, lack of access to health information in community languages and limited availability and use of qualified interpreters further marginalises people from migrant and refugee backgrounds (Plowman & Izzo 2021).

Examples of the ways in which gendered structures shape women's mental health:

- **Research:** The exclusion of women from clinical trials means that medications have largely only been studied on men and may have significant and unacceptable side effects for women. Similarly, despite the evidence for greater prevalence of depression among women, there is considerably less attention devoted to studying depression in females or sex differences in depression (LeGates et al. 2019).

- **Treatment and support:** Though the need for gender sensitive or specialist women's mental health services has long been established (Abel & Newbigging 2018), such services have not been publicly funded in Australia until 2021 (Victoria. Minister for Mental Health 2021). Their absence represents a structural barrier to women's access to effective mental health care.

Gendered norms, practices and structures interact and overlap, and have a cumulative impact over time.

Examples illustrating the intersection between gendered norms, practices, and structures in mental health:

- The lower status and remuneration associated with non-clinical and peer roles in the mental health workforce, which

are dominated by women (a **gendered structure**), reflect **gender norms** which deem care work to be 'women's work', and which devalue feminised work (Women's Heath Victoria 2018). These gendered norms and structures have in turn shaped treatment and service delivery models, which have historically overemphasised clinical treatments at the expense of more holistic supports which many women say they prefer (**gendered practice**) (Duggan 2016).

- There is a longstanding failure to protect women from sexual violence in mental health inpatient units (Victoria. Mental Health Complaints Commissioner 2018; VWMHN 2017). This **gendered practice** arises from gendered attitudes that do not prioritise women's safety and, in some cases, blame women and/or excuse men for sexual violence (**gender norms**). It also reflects **gendered structures** insofar as resources to promote women's safety (for example, to build or retrofit single gender units) have not been allocated. The failure to allocate resources for single sex units in turn reflects **gender norms** that deem it women's responsibility to manage male aggression and violence,[6] and which prioritise economic efficiency over women's safety.[7]

In 2021, the Victorian government accepted Recommendation 13 from the Royal Commission to address gender-based violence in mental health facilities and work to ensure new and existing mental health inpatient facilities enable gender-based separation is underway. However, physical spaces will not improve safety alone. The service model, operational policies and procedures and trained and resourced staff are key to improving safety in mental health inpatient facilities for women and other vulnerable/at risk cohorts.

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6   The Royal Commission into Victoria's Mental Health System noted that one of the reasons that 'meaningful change to keep women safe in inpatient units has not been achieved' is the false perception among staff that male-only areas would increase aggression (RCVMHS 2021a p. 633).

7   The scale of funding required to reconfigure existing units was cited by the Royal Commission into Victoria's Mental Health System as another reason why reforms to keep women safe in inpatient units have not been implemented (RCVMHS 2021a p. 633).

> " *I was made to feel like the way I functioned and was surviving was 'wrong' or a 'problem' rather than as an understandable response to what I have experienced."*

- Sandra, quoted in (RCVMHS 2019)

By failing to account for the political and social contexts in which gendered violence and discrimination occur, the biomedical approach can significantly exacerbate trauma and compound its cumulative effects on women, girls, trans and gender diverse people. Victim-survivors of gendered violence may also be subjected to retraumatising experiences within the mental health system, including sexual abuse and coercive interventions (Maker 2022).

In pathologising rational, adaptive responses to trauma, violence and social inequality, the biomedical model of mental health and re-casts systemic social problems as individual dysfunction

Diagnostic approaches and treatment models based on a narrow biomedical understanding of mental health also fail to recognise the complexity of women's lives (United Kingdom. Department of Health 2002), and to identify and respond to the gendered drivers of distress and trauma (VMIAC 2020; Tseris 2016).

> " *[The counsellor] kept asking me if I had been to the police and got a restraining order on my ex-partner because that was one of the reasons that I'd gone into hospital in the first place - I'd just gone through a relationship breakdown. I had child support issues, a child support hearing going on, and I lost my job and it was Christmas time."*

- Barb, quoted in (RCVMHS 2021d)

3.2 HOW GENDER BIAS AND STEREOTYPES INFLUENCE MENTAL HEALTH DIAGNOSIS

Gendered biases and assumptions are a key contributing factor to a range of concerns surrounding the diagnosis of mental health conditions in women and girls. Such biases and stereotypes intersect with and often compound the limited consideration mental health professionals give to the gendered drivers of poor mental health for women, in particular the impacts of gendered violence and trauma as discussed above. As a result, women's mental health problems may be dismissed, overlooked, or misdiagnosed – including overdiagnosis of some conditions and underdiagnosis of others (American Psychological Association 2007) (**See Box 3**). Alternatively, understandable responses to traumatic experiences may be pathologised.

Diagnostic labels such as Borderline Personality Disorder (BPD) can appear to blame women, or be framed as the cause of why they have been vulnerable to violence, neglecting the gendered and social nature of violence and its effects (Grealy 2008). Research has found that, when describing the impacts of complex trauma arising from experiences of gendered violence, victim-survivors focus on the physical and psychosocial implications. In contrast, health professionals often view responses through a psychological or biomedical lens (ANROWS 2020a) or downplay women's distress and misattribute it to flawed personalities and dysfunction within the self (Salter et al. 2020). Women are frequently perceived as attention-seeking, difficult and unworthy, which often leads to re-traumatisation when receiving mental health services (Salter et al. 2020).

The current mental health system thus pathologises the very behaviours that have allowed women victims to survive (Burstow 2005). As Brown (2018, p. 47) explains, 'often people have experienced extreme violations of body, mind, thought, feeling, spirit, culture, or some combination of all of these, and have protected themselves by developing strategies of passivity; dissociation from body, affect, or memory; or self-inflicted violence'. These

Box 4: The experience of victim-survivors of gendered violence within the mental health system

"Women who experience mental anguish after violence are not "irrational".
Their mental distress is an understandable response to overwhelming events."
(Tseris & Moulding 2021)

Violence against women and girls is one of the most common causes of poor mental health and can have long-term psychological impacts (ANROWS 2020b; **also see** *Box 2*). The links between gendered violence and trauma are now well established. However, common coping strategies for survivors continue to be misdiagnosed due to misunderstandings of the causes of symptoms such as dissociation, amnesia, hallucinations, self-harm, and substance use (Quadara 2015).

Despite the high prevalence of histories of domestic, family and sexual violence among women seeking mental health treatment,[8] recent Australian research (O'Dwyer et al. 2019), together with complaints made to the Victorian Mental Health Complaints Commissioner,[9] paint a troubling picture of the failings of the current mental health system in responding appropriately to victim-survivors of gendered violence. Inadequacies of the current system highlighted in research and consumer complaints include:

- Mental health staff **do not routinely ask about DFSV** (either historical or experienced within mental health settings) and **lack the confidence and skills** to respond to disclosures and work with victim-survivors of gendered violence. Some **do not see this as part of their job** (O'Dwyer et al. 2019).

- **Negative responses**, such as victim-blaming, doubting the veracity of a story, minimising the seriousness of the violence or denying assistance, are not uncommon from health professionals, particularly men. For example, sexual violence is often overlooked as secondary to a diagnosed psychiatric disorder, dismissed as a symptom

of psychosis, or minimised as historical, therefore not relevant to the consumer's current presentation (O'Dwyer et al. 2019).

- Women experiencing family violence report being **misdiagnosed** – in particular, they feel they are underdiagnosed with PTSD and the seriousness of their experience of family violence is not understood (Toko 2021).

- Victim-survivors have reported dissatisfaction with being **unable to see a female clinician** (Toko 2021).[10]

- Practitioners are not trained or enabled to provide trauma- and violence-informed **care**.

"The biomedical model trains health professionals to focus on diagnosis, treatment, and prescription of medication, rather than how to respond to the impacts of trauma, with trauma symptoms seen as pathological rather than adaptive."
(O'Dwyer et al. 2019)

- The lack of adequate training on sensitive inquiry and response to disclosure of sexual violence can lead to use of **re-traumatising practices** such as restraint and seclusion, body searches and round-the-clock observations (O'Dwyer et al. 2019).

" *Being restrained reminded me of being raped."*

- Elizabeth (pseudonym), quoted in (RCVMHS 2021e)

There is also evidence that women's boundaries in relation to information-sharing with family and carers are not respected. In some cases, information is shared with the perpetrator of violence, practitioners may collude with perpetrators in discrediting the victim-survivor's experience of violence, and victim-survivors may even be returned to the 'care' of the perpetrator, putting them at risk of further harm (Toko 2021; Choahan 2021).

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8 A systematic review (Krug et al. 2002) estimated that one in three women presenting at inpatient or outpatient mental health services has previously experienced **family or domestic violence**, including sexual violence. The estimated prevalence of **sexual violence** reported at time of admission to a psychiatric inpatient unit varies between 5% and 45% (Krug et al. 2002). A small study conducted by the Victorian Mental Illness Awareness Council (VMIAC 2013) noted that almost half (45%) of women reported historic sexual assault and 67% reported sexual or other harassment while accessing a psychiatric inpatient unit in Victoria.

9 In 2020-21, the Victorian Mental Health Complaints Commissioner received 36 complaints from victim-survivors of family violence about poor experiences within public mental health services (Choahan 2021); Comments from Assistant Commissioner Maggie Toko (Toko 2021).

10 Note that other research has found that the gender of the clinician is irrelevant when they provide a supportive response to a disclosure of violence (Tan, O'Doherty & Hegarty 2012).

strategies are evidence of a person's struggle to obtain power in the face of patriarchy, rather than evidence of deficit, pathology or problematic symptoms that must be addressed (Brown 2018). Moreover, research on PTSD has been predominantly conducted with white male participants, and thus misses the unique threats experienced by women and the gender-specific ways they may respond to trauma to survive (Wilkin & Hillock 2014).

Gender stereotypes and gender role socialisation further contribute to mental health professionals' inappropriate use and overuse of certain mental health diagnoses among women and girls, such as histrionic and borderline personality disorders, depression, dissociative disorders and somatisation disorder (American Psychological Association 2007, Eriksen and Kress 2008). The World Health Organisation has reported that doctors are more likely to diagnose depression in women than in men, 'even when they have similar scores on standardised measures of depression or present with identical symptoms' (WHO 2011).

Women are overrepresented in the most stigmatised mental health diagnoses, particularly BPD, with which they are three times more likely to be diagnosed than men. Despite the high prevalence of experiences of trauma and sexual violence among those diagnosed with BPD, negative attitudes towards people with this diagnosis remain pervasive (Henderson et al. 2014 cited in O'Dwyer et al. 2019), resulting in less empathy for and re-traumatisation of survivors (Hockett et al. 2016 cited in O'Dwyer et al. 2019). On the other hand, reliance on prototypes can lead to a reluctance to diagnose BPD where there is no history of trauma.

> " *This system has tried to tear my life apart for the crime of having [Borderline Personality Disorder] with no history of trauma in my life. Many practitioners have suggested that I am faking my illness. To have it suggested that you are faking something that is as horrific as [borderline personality disorder] because you weren't abused or assaulted as a child just eats away at the part of my brain that has been told many times over, you're not sick, you just want attention."*
>
> - Georgina, quoted in (RCVMHS 2021g)

Gender norms, stereotypes and gendered understandings of mental illness can also lead to underdiagnosis of certain mental health conditions among women, including PTSD or complex trauma among victim-survivors of family violence (Trevillion 2014; ANROWS 2020a).

An important part of the backdrop to mental health professionals' tendency to diagnose women with certain psychiatric labels and not others is the long history within psychiatry of treating the expression of 'femaleness' as a disorder. First described by the Ancient Greeks, the diagnosis of 'hysteria' was only removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1980 (VMIAC 2020). While conceptions of hysteria have changed over time, the underlying message has remained the same – women who do not conform to accepted gender norms may be considered 'mentally ill' (Ussher 2013). Historically these labels have been used to control women, inflict violence on them, and/or to discredit and dismiss their experiences of violence and trauma (Ussher 2018).

3.3 GENDER AND WOMEN'S ACCESS TO AND EXPERIENCES OF MENTAL HEALTH CARE

Dismissing the concerns of women experiencing mental illness and/or stigmatising their psychological distress affects not only the diagnostic labels they are given, but their access to and experiences of mental and general health care – particularly for women with other marginalised identities. Stigma also impacts women's experiences in other settings such as the justice system and can affect family members and carers.

As noted above, there is evidence that women who self-harm or attempt suicide can be perceived or described by health practitioners as 'attention-seeking' and manipulative. Research has shown that after hospitalisation for self-harm, women report feeling dissatisfied with emergency and psychiatric services due to negative attitudes directed towards them (Suicide Prevention Australia 2016).

❝ *I felt high, my thoughts were racing, and I was distressed. They both said I was fine and dismissed my concerns."*

- Elizabeth, (pseudonym) quoted in (RCVMHS 2021e)

❝ *I first reached out for help with my mental health when I was 13, when I became actively suicidal. Despite another few attempts at getting some support (and again feeling misunderstood, patronised, and dismissed), my depression continued to go untreated and undiagnosed until I was 16."*

- Sandra, quoted in (RCVMHS 2019)

In inpatient units in Victoria, recent research shows some staff perceive female consumers as more difficult to care for, and express negative attitudes towards the women in their care (O'Dwyer et al. 2019).

❝ *People with borderline, everyone sort of just runs away because they're so difficult to manage."*

- Anonymous medical registrar, quoted in (O'Dwyer et al. 2019)

As noted in Box 4, there is also evidence to suggest that negative perceptions of female consumers result in some mental health workers dismissing or denying disclosures of sexual assault (O'Dwyer et al. 2019).

Shame, fear of stigma and fear of not being believed can also be a barrier to help-seeking among women who have experienced violence: 'victim-blaming' has been reported as an issue for women who are seeking help for complex post-traumatic stress and anxiety (Women's Mental Health Alliance 2020).

"Behaviours that can be associated with complex trauma, from self-harm to suicidality to problematic substance abuse, are stigmatised in service settings and can attract punitive and dehumanising responses from professionals." (ANROWS 2020a, p. 7)

Gendered expectations and stereotypes can also influence staff decisions about using restrictive interventions – for example, expectations about appropriate emotional expression and behaviour for women, and about the motivations behind women's behaviour (Maker 2021). For women experiencing eating disorders, lack of understanding of this phenomenon among general health workers (who may be the first point of contact in the hospital system because presentations often relate to physical health issues such as nutrition deficiencies) can result in stigmatising responses, heightening distress and prolonging patient journeys (Women's Mental Health Alliance 2021b).

The stigma associated with women's experiences of mental illness also extends beyond the mental health system. In the legal

system, mental health diagnoses are used against women in family law and sexual assault matters. As Australia's National Research Organisation for Women's Safety (ANROWS) has highlighted, raising mental health in Family Court matters is gendered; mental health is cited as the 'reason limiting child contact' with mothers in 30 percent of these cases, but only in 2 percent of cases limiting contact with fathers, which does not reflect the relative prevalence of mental ill-health among women and men (ANROWS 2020b).

Family members and carers of those with mental illness, who are predominantly women, also experience the impacts of stigma and discrimination through contact with mental health services, including having their concerns dismissed.

> " I was literally begging them saying, 'He's not right, I'm really concerned about him'. And I'll never ever forget this, she turned around and said to me, 'He says he is fine. I'm worried about you."
>
> - Julie Rickard, quoted in (RCVMHS 2021h).

There are also persistent and harmful stereotypes such as 'the schizophrenogenic mother', which place guilt and blame on the mother or 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 (van der Sanden et al. 2015; Scheyett 1990; Johnston 2013).

Stigma and shame associated with disclosure of mental health issues can be heightened for specific groups including First Nations women, refugee and migrant women, and young women and girls, which mental health services may fail to recognise (ANROWS 2020a; Hall et al. 2019). For Aboriginal and Torres Strait Islander and migrant and refugee communities, cultural beliefs and community stigma about mental health can create barriers to accessing support and treatment. These barriers are exacerbated

by a lack of cultural competence in the mental health workforce leading to discriminatory assessment and misdiagnosis of cultural beliefs as mental illness (AHRC 2020).

> "…. the Western way of treating mental illness is overshadowing cultural beliefs. If someone says they see their ancestors, they're deemed as delusional and possibly locked up."
> (AHRC 2020 p. 657)

Discrimination, stigma, and a failure to acknowledge gender and sexual diversity also creates an unsafe and hostile mental health service system for the LGBTIQ+ community (Carman et al. 2020).

3.4   COMMON TREATMENTS DO NOT EFFECTIVELY ADDRESS WOMEN'S MENTAL HEALTH CONCERNS AND MAY EXACERBATE THEM

The biomedical approach to treatment of mental ill-health and psychological distress is overly reliant on medication and hospitalisation, and largely ignores the impacts of trauma. There is evidence that women may be overprescribed medication for mental health conditions, while attempts to treat trauma and distress using medication and coercive practices may cause further trauma.

More women than men receive medication for a mental health condition – not only for conditions where there is higher prevalence among women, such as depression, but also for conditions that are more likely to be diagnosed in men, such as psychotic disorders (Progress In Mind 2020). However, the exclusion of women from clinical trials means that medications have largely only been studied on men. As a result, there is limited understanding of appropriate dosage and tapering, and medications often have significant and unacceptable side effects for women (Kulkarni 2010).

Women show more severe side effects from psychotropic medication, including greater weight gain, cardiovascular and metabolic side effects per dose of medication than men but mental health clinicians are largely unaware that side effects are gendered.
(Abel & Newbigging 2018, p. 6)

For example, treatment for BPD often includes non-targeted psychotropics, which do not effectively treat the symptoms and have significant side effects (Wasylyshen & Williams 2016; Moeller et al. 2016). This means women with BPD end up with additional health issues such as obesity, diabetes and infertility related to the medications used (Frankenburg & Zanarini 2006), yet their symptoms are not effectively treated and the underlying trauma is not addressed.

The exclusion of women from clinical trials means that medications have largely only been studied on men

Hospitalisation in mental health inpatient units may also be traumatising, due to restrictive practices such as seclusion and restraint and/ or exposure to gendered and sexual violence in mixed gender wards from staff or other consumers (**See *Box 5***). The Royal Commission into Victoria's Mental Health System noted that 'people who have been exposed to childhood trauma, and some other forms of trauma, are likely to spend longer in seclusion, have longer and more frequent admissions, and receive more medication' (RCVMHS 2021b). Yet medication cannot address underlying trauma, and the ongoing use of seclusion and restraint in mental health treatment or experiences of gendered violence while in hospital risks retraumatising women, girls and trans and gender diverse people and compromising their recovery. Restrictive practices are incompatible with women's safety, recovery, and human rights (Maker 2022).

" *When I went back to hospital, they made me take medication, and most of the time this absolutely slammed me."*

- Barb, quoted in (RCVMHS 2021d)

" *The default response was to lock me in a cell, drug me and allow me to scream myself hoarse for over an hour until I eventually fell asleep."*

- Sandra, quoted in (RCVMHS 2019)

Women experiencing problematic alcohol or other drug (AOD) use are more likely to have a history of trauma, including because of gendered violence (SAMHSA 2021). However, gender norms associating women with parenting and as responsible for upholding social and moral values lead to women facing greater social disapproval than men for AOD use, hindering help-seeking, particularly for women with children (NADA 2021). Rather than AOD use being considered as a potential consequence of women's lived experience of discrimination, abuse and trauma and requiring trauma- and violence-informed, gender responsive treatment, it may be seen as a behavioural issue instead, or treated via 'gender neutral', one-size-fits-all programs (Salter & Breckenridge 2014).

Women who have experienced violence and trauma may also experience physical health conditions. Trauma can affect the endocrine system, with resultant impacts on physical health, behaviour, and cognition. For example, autoimmune diseases, infertility, and obesity are all more common in traumatised girls and women (Thomas, Gurvich & Kulkarni 2019). Women who have experienced intimate partner violence also often experience chronic physical health conditions (Dillon et al. 2013). However, the dominance of the biomedical model in mental health, combined with the siloing of mental, physical, and reproductive health, does not enable the kind of integrated, holistic and multidisciplinary health response that women ask for (Duggan 2016).

Box 5: Women's safety in mental health units

Women routinely report feeling unsafe when accessing mental health services and continue to experience unacceptably high rates of gendered and sexual violence within mental health facilities – both from other patients/ consumers and from staff (MHCC 2018; Clarke 2007; Kulkarni et al. 2014a).

> " I had a male patient try to come into my room and he was pulled back by staff members. It triggered nightmares and flashbacks of sexual assault. I have a history of rape, and that is largely a trigger of my psychosis, and a lot of my delusions are around rape".

- Elizabeth (pseudonym), quoted in (RCVMHS 2021e)

The 2018 report from the Victorian Mental Health Complaints Commissioner, *The right to be safe*, found high rates of sexual assault and sexual harassment within acute mental health inpatient units in Victoria – which are predominantly mixed gender – with women making up about 80% of those raising concerns about sexual safety (Victoria MHCC 2018). Women also report that their experiences of gender-based violence (before and/or during treatment) are often dismissed and not taken seriously (O'Dwyer et al. 2019). In addition, the continued use of seclusion and restraint is often retraumatising for women with a history of trauma, especially where male staff are involved.

> " I don't feel comfortable with men. However, sometimes when I have been in compulsory treatment in medical wards, I have [been] given one-on-one care with a male nurse … It means every time I need to go to the bathroom, he's in the bathroom with me. It's a terrifying experience."

- Lucy Barker, quoted in (RCVMHS 2021i)

There is a long history of advocacy by women with lived experience and their supporters to improve women's safety in mental health inpatient units, including through gender-separated units and training in gender-responsive and trauma- and violence-informed practice (VWMHN 2007; Women's Mental Health Network Victoria 2017; VMIAC 2013).

Work underway to upgrade new and existing mental health facilities to enable gender separation in Victoria following the recommendation of the Royal Commission into Victoria's Mental Health System (RCVMHS 2021c) is welcome though long overdue; similar recommendations made in the past were never implemented. Suggested reasons include normalisation of gender-based violence and resistance to change, false perceptions that mixed gender wards reduce male aggression, and funding and bed availability pressures leading to women-only areas either not being considered feasible or ultimately being used for male consumers (RCVMHS 2021a).

While the Victorian Government appears to be making progress on women's safety in mental health units (having committed to implement all the Royal Commission's recommendations), sexual violence in mental health facilities remains a significant problem in other jurisdictions around Australia, requiring a national response (ANROWS 2020c; Kulkarni 2017).

Just as the failure to protect women from sexual violence in mental health facilities reflects the interplay between gendered norms, practices and structures that cumulatively devalue women's safety (**See *Box 3***), ensuring women are safe when they access mental health services will require more than capital infrastructure investment. Simultaneous targeting and transformation of gender unequal norms, practices and structures to prioritise women's health and safety across the mental health system will be required, through organisational leadership, workforce capability-building and system-wide culture change.

4. Gender and the mental health system

Much of this paper is focused on understanding the gendered drivers of poor mental health among women and girls, and the ways in which mental health practice is both underpinned by and perpetuates gender bias and inequality. However, it is also important to recognise the role of 'building blocks' of the mental health system – sometimes described as 'system enablers' (or barriers) – in driving and reinforcing gender disparities in mental health. Taking the Victorian mental health system and Royal Commission-driven reforms as an example, this section focuses on the building blocks of policy settings, funding, workforce, and research and data collection to illustrate how different system elements can both contribute to and reduce gender inequality.

The 2021 Royal Commission into Victoria's Mental Health System emphasised the need for gender safe, culturally responsive and trauma- and violence-informed mental health services
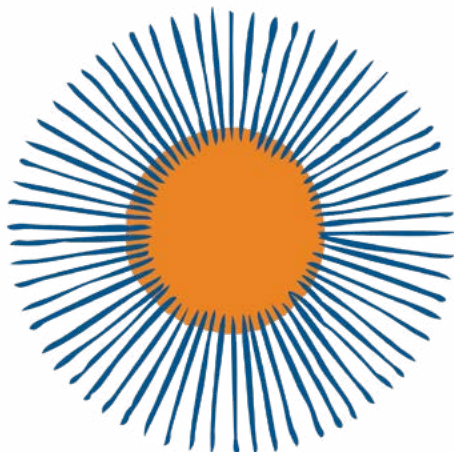
4.1   POLICY SETTINGS

Policy settings are a foundational enabler of or barrier to gender equality in the mental health system. They create the authorising environment for prioritising gender equality and include policy settings in mental health as well as other areas of government.

A mental health reform agenda in Victoria

There has never been a more important or opportune time for a stronger focus on women's mental health in Victoria. In handing down its final report in 2021, the Royal Commission into Victoria's Mental Health System emphasised the need for gender safe, culturally responsive and trauma- and violence-informed mental health services – informed by women with lived experience – as part of a fundamental system re-design. Overlapping with the Royal Commission, the COVID-19 pandemic starkly illuminated gendered disparities in mental health and led to a surge in demand for mental health services, especially from women. Victoria also introduced new mental health legislation in 2022.

Two of the Royal Commission's 65 recommendations (RCVMHS 2021c) directly address women's needs and experiences:

- Recommendation **13**: Addressing gender-based violence in mental health facilities

- Recommendation **18**: Supporting the mental health and wellbeing of prospective and new parents

In addition, Recommendation **13.4** recognises the importance of system and workforce

capability-building to support mental health and wellbeing services to eliminate sexual and gender-based violence in their facilities. Other important recommendations include **23**, which recommends establishing a statewide trauma service, and **34**, which highlights the importance of actively engaging Victoria's 'diverse communities' in planning, implementing, and managing the reformed mental health and wellbeing system.

Although not explicit in the Royal Commission's recommendations, acknowledgement of the need for a gender lens on the reforms is further evident in the early stages of implementation including the new 35-bed dedicated women's mental health service. The Royal Commission also emphasised the central role of lived experience in systems change, underscoring the importance of ensuring the voices of women with lived experience as consumers and carers are centred in policy and service design and supported to participate in co-production.

From a gender perspective, three features of the new *Mental Health and Wellbeing Act 2022 (Vic)* are noteworthy. First, the inclusion of gender and cultural safety principles (Part 1.5) means mental health and wellbeing services are now required to consider gender safety needs, and ensure access to services that:

- are safe for people of all genders, and culturally safe and responsive to people of all racial, ethnic, faith-based and cultural backgrounds;

- are responsive to any current or past experience of family violence and trauma;

- recognise and respond to the ways gender dynamics may affect service delivery, treatment and recovery;

- recognise and respond to the ways in which gender intersects with other types of discrimination and disadvantage;

- provide treatment and care consistent with the cultural and spiritual beliefs and practices of a person living with mental illness or psychological distress, account for the views of the person's family and significant members of the person's community where possible, and give

consideration to Aboriginal and Torres Strait Islander people's unique culture and identity, including connections to family and kinship, community, Country and waters; and

- ensure treatment and care for Aboriginal and Torres Strait Islander peoples is, where possible and as appropriate, to be decided and having given regard to the views of elders, traditional healers and Aboriginal and Torres Strait Islander mental health workers.

Although the inclusion of these principles is important to set expectations for gender- and culturally-responsive approaches to mental health care, this will need to be supported by workforce- and system capability-building. Additionally, the gender safety principle would be strengthened by removing the emphasis on safety to reflect that fact that women and girls have a broad range of gender-related needs and experiences beyond safety to which the mental health system needs to be responsive. Finally, while the reference to 'family violence' is welcome, it does not reflect the high rates at which women, girls and LGBTQI+ people experience a range of different forms of gendered violence, including sexual violence (Our Watch 2021), and the associated impacts on their mental health and interactions with the mental health service system (ANROWS 2020b).

Second, Part 1.6 of the Act (on the application of mental health and wellbeing principles), includes an information sharing limitation on mental health professionals if there may be a risk of family violence or other serious harm. This is also welcome, however, there is no mention of the need for services to be aligned with the Multi-Agency Risk Assessment Matrix (MARAM), Family Violence Information Sharing Scheme (FVISS) or Child Information Sharing Scheme (CISS) as required by Part 11 of the *Family Violence Protection Act 2008 (Vic)* and discussed below.

Finally, the objectives of the Act (Part 1.3) include enabling 'a reduction in the use of seclusion and restraint with the aim of eliminating its use within 10 years'. From both a human rights and trauma recovery perspective, this is a vitally important goal to achieve, but in electing not to legislate it (as has occurred in other jurisdictions internationally), the Victorian Government has attracted criticism (Maylea 2022).

Family violence reforms

Driven by growing community concern about persistent or increasing rates of gendered violence, the family violence reform agenda has gathered pace over the last decade. At the national level, the first National Plan to Reduce Violence Against Women and Their Children commenced in 2010, accompanied by the establishment of a key pieces of the national family violence architecture including Our Watch and Australia's National Research Organisation for Women's Safety (ANROWS). The second National Plan to End Violence against Women and Children 2022-2032 (Australia DSS 2022) has just been launched. Meanwhile in Victoria, a new family violence strategy, legislative amendments, and investments in the service system have followed the 2016 Royal Commission into Family Violence (RCFV 2016).

Recent family violence reforms matter to the work of addressing gender disparities in mental health because of the close links between gendered violence, trauma and mental distress.

These developments matter to the work of addressing gender disparities in mental health because of the close links between gendered violence, trauma and mental distress referenced throughout this paper. The need for greater cross-sector collaboration between the mental health, sexual assault response and family violence sectors to better support victim-survivors' recovery was first recognised by the Victorian Government in 2006 (Victoria. DHS 2006). Yet a lack of support for program implementation and monitoring meant that little work was done to strengthen these connections, leading the recent Royal Commission into Family Violence to again highlight the need for these sectors to work more closely together.

The Royal Commission recommended increased collaboration between mental health, drug and alcohol and family violence services

(recommendation 99), and the development of a family violence learning agenda for medical practitioners (recommendation 102). Legislation and requirements following the Royal Commission also oblige public mental health services to bring their organisational policies and practices into line with the MARAM framework, which includes identifying and responding to family violence. However, there has been low take-up of MARAM training in public mental health services to date, and MARAM alignment is not required for private mental health services, even though they see an estimated third of consumers (RCVMHS 2021a). Notably, some private clinics have opted to train their staff in the MARAM framework in acknowledgement of the importance of building workforce capability in this area.

While support for recovery from family violence and trauma counselling are mentioned in *Ending Family Violence: Victoria's Plan for Change* (Victoria DPC 2016), no targets or actions specifically addressing this are outlined in the ten-year plan, nor is there evidence of a systemic approach to ensuring victim-survivors are supported to recover from violence-related trauma. Neither of the first two Rolling Action Plans (2017-2020 and 2020-2023) accompanying *Ending Family Violence* have focused on addressing the mental health impacts of family violence and trauma recovery; the forthcoming three-year renewal cycle presents an opportunity to advocate for this in the next Action Plan (Victoria DFFH 2017; Victoria DFFH 2020). Promisingly, the second National Plan (Australia DSS 2022) includes a new and welcome commitment to address recovery from violence. This may open opportunities for federal funding or state-federal collaboration.

Adequately supporting women, girls and trans and gender diverse people's trauma recovery via an appropriately skilled and resourced mental health system working in concert with the family violence and sexual assault response service systems is an important step towards reducing gendered inequalities in mental health reflected in women's higher prevalence of PTSD, BPD, and other mental health diagnoses relative to men.

Gender equality reforms

A final area of policy that significantly and positively influences some of the social determinants of women's mental health is gender equality. Federally, the *Anti-Discrimination and Human Rights Legislation Amendment (Respect at Work) Bill 2022* represents important progress towards ensuring workplaces are safe and free of sexual harassment. In Victoria, the state Government has introduced a suite of reforms aimed at addressing inequality between men and women, including the State's first Gender Equality Act 2020 (Vic), the *Safe and Strong* gender equality strategy (Victoria DPC 2016), and gender-responsive budgeting (GRB).

> **Policy reforms aimed at addressing gender inequality significantly and positively influence some of the social determinants of women's mental health and wellbeing.**

Under the new gender equality legislation, public sector organisations in Victoria – including health services – are obliged to ensure their workplaces and services are gender equitable via the implementation of Gender Equality Action Plans (including workplace gender audits and reporting), and Gender Impact Assessments of public-facing programs and services. Gender-responsive budgeting (GRB) has been re-introduced as a founding reform in *Safe and Strong* (Victoria DPC 2016; Victoria Parliament PAEC 2022).
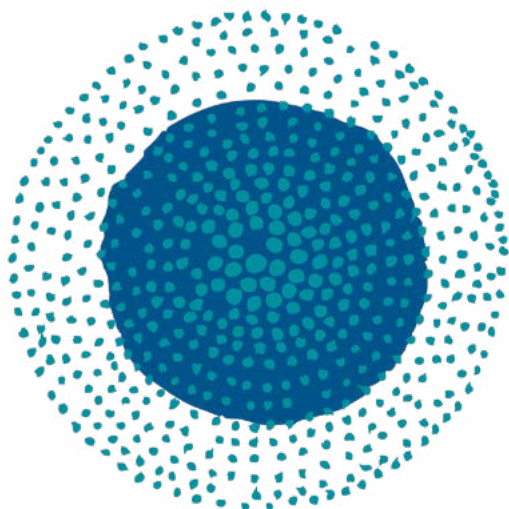
Safe and Strong explicitly commits the Victorian Government to applying a gender perspective to policies, budgets and economic planning. It defines GRB as a process that *'reviews and adapts budgetary processes and policies so that expenditures and revenues reflect gender differences and gender inequalities in income, assets, decision-making power, service needs and responsibilities for caring'*. The strategy also commits the Victorian Government to *'progressively introduce gender impact analysis in policy, budgets and service delivery'* and acknowledges that intersecting forms of discrimination and marginalisation (e.g., racism, ableism, homophobia, transphobia, ageism) shape the experience of gender inequality for different groups of women, girls and trans and gender diverse people.

These reforms have the potential to drive improvements in intersectional gender equality in the public mental health workforce and service system – improvements that are long overdue. For example, despite the significant deterioration in women's mental health during the COVID-19 pandemic – exacerbating existing gendered discrepancies in mental health (Women's Mental Health Alliance 2021a) – investment targeted to women's mental health represented just 0.68% of the Victorian Government's total investment of $3.8 billion in the 2021-22 State Budget.[11] In future, expenditure must benefit people of all genders and address the fact that the mental health system has, to date, been built around men's needs despite women experiencing mental illness at around twice the rate of men (Shoukai 2018). Supported by the emerging gender equality policy architecture described above, a gender-transformative approach, targeting investment in research, workforce development and the redesign of mainstream services, can ensure all mental health services better meet women's needs.

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11   This includes $6.9 million for expansion and reform of community perinatal mental health services and the reannouncement of $18.9 million for the establishment of a 35 bed specialist women's mental health service from the 2020-21 State Budget.

4.2   FUNDING

A long-standing gap exists between the disease burden of mental ill-health and its share of health expenditure.[12] However, more resources don't necessarily improve outcomes (Jorm 2017). Rather, what is needed is better targeted resources and a focus on quality improvement. Nonetheless, there are some key areas in mental health where adequate resourcing does have important impacts and particularly for women and girls. These include pay and conditions for the mental health workforce, and necessary investment in making mental health services safer for women and girls.

Workforce supply and retention, discussed below, cannot be addressed without attending to the under-resourcing of the mental health sector. Under-resourcing is reflected in workforce shortages and workers on low-paid, short-term contracts (ASU 2019). This leads to burn-out, which in turn leads to people taking time off, creating a vicious cycle of additional pressure on remaining staff.

Under-resourcing also contributes to much of the stigmatisation and poor human rights outcomes for mental health consumers that arise through interactions with mental health workers. For example, to avoid use of traumatising and coercive interventions such as compulsory treatment and restrictive interventions, workers need time, resources, and training to work through alternatives. At the same time, funding is needed to expand the range of services available so that people can access appropriate services before they become acutely unwell.

> **To avoid using traumatising and coercive interventions such as compulsory treatment and restrictive interventions, mental health workers need resources (e.g., time, training) to work through alternative approaches.**

Low pay and conditions for workers

Critical to attracting and retaining an adequate supply of skilled mental health workers is improving the poor pay and conditions (including insecure work) in the public mental health sector (ASU 2019). This is important for workers, consumers, and mental health services alike.

Poor pay and/or conditions contribute to high rates of burn-out and staff turnover, which in turn adversely impact workers' own mental health. This is also a gendered and lived experience issue – a workforce survey conducted by ORIMA Research in 2020 found 77% of Victorian mental health workers identify as female, and 43% had personal lived experience of mental health conditions (RCVMHS 2021f). Poor remuneration and conditions therefore exacerbate gender inequality by contributing to financial insecurity and disadvantage for female mental health workers, for example by making it difficult to secure a mortgage.

For consumers, the quality of mental health service provision deteriorates when services are short-staffed or staff are burnt out. Poor pay and conditions in the public mental health sector also drive workers to the private sector to secure better salaries and conditions and, often, obtain more opportunities to specialise and make better use of their skills and qualifications. This further depletes the public sector workforce, placing additional pressure on public mental health services and increasing barriers to care through private mental health services only being available to those who can afford them.

Improving pay and conditions also involves replacing short-term funding with ongoing funding to enable employers to offer ongoing employment and will assist in addressing the stigma and negative perceptions associated with working in mental health by making it a more attractive field.

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12   In 2018 the national disease burden of mental health conditions was estimated at around 13% (AIHW 2021) while in the 2019-20 financial year, government health expenditure on mental health-related services was an estimated 7.6% (AIHW 2022c).

Failure to fund gender separated units

Despite consistent calls for women-only inpatient wards and growing international evidence that suggests this is critical for improving women's sexual safety in inpatient facilities (Hawley 2013), these are not routinely provided in intensive care areas of inpatient units in Victoria. For example, the final report of the Mental Health Complaints Commission's investigation on this issue is titled *The right to be safe*. The report's chief recommendation is to ensure that unit planning, design, and maintenance support sexual safety (Victoria MHCC 2018). In the wake of the Royal Commission into Victoria's Mental Health System, long overdue action on gender separated spaces in mental health facilities is finally taking place. However, as noted in Box 5, gender separated physical spaces will not improve safety alone. The service model, operational policies and procedures and properly trained and resourced staff are key to improving safety in acute inpatient units for women and other vulnerable/ at risk cohorts.

4.3   WORKFORCE

There is clear evidence that the mental health system and workforce are not currently equipped to deliver gender-responsive trauma- and violence-informed care to women experiencing mental ill-health and psychological distress, including victim-survivors of family and sexual violence. Key gaps include capabilities, staff attitudes and behaviours, system and cultural change, leadership, and lived experience workforce.

Capabilities

As highlighted in Section 3, mental health workforces often lack an understanding of the dynamics of gendered violence and demonstrate harmful attitudes and practices towards women (see for example, O'Dwyer et al. 2019).

> *I think a lot of staff here try hard to do their best. A lot of staff openly say they don't quite know what to do. I've had doctors say to me they don't know how to ask."*

- Research participant Elise (Allied Health), quoted in (O'Dwyer et al. 2019).

There is a significant need for cross-sector capability-building between the mental health and family and sexual violence response sectors. Family and sexual violence response workers require an understanding of the mental health impacts of family and sexual violence to be able to provide a supportive response to victim-survivors, make appropriate referrals where specialist mental health support is required, and support recovery. The broader mental health workforce also requires substantial capability-building to understand and respond to victim-survivors of family and sexual violence; skills that mental health workers say they lack.

> *We were never taught it [to screen for and respond to disclosures of sexual violence] in Med[ical] School, even in orientation."*

- Research participant Camilla (medical staff), quoted in (O'Dwyer et al. 2019).

All staff delivering mental health services must be adequately trained in delivering intersectional, trauma- and violence-informed care to equip them to respond to issues of intersectional disadvantage and compounded mental health issues, the impacts of family and sexual violence and the consequences of structural and systemic discrimination in the lives of women, girls, trans and gender diverse people.

Staff attitudes and behaviours

As discussed (**See *Box 4* and *Section 3***), many women seeking or receiving mental health care encounter negative stigmatising attitudes and behaviours from mental health workers. Women report being made to feel that they are difficult to care for (O'Dwyer et al. 2019), victim-blamed when seeking help for complex post-traumatic stress and anxiety (Women's Mental Health Alliance 2020), or misdiagnosed. These attitudes impact the quality of mental health care women receive and act as a barrier to help-seeking, particularly for women who have experienced violence.

System and cultural change

On their own, workforce training and capability-building are insufficient to embed new ways of working, address entrenched attitudes and behaviours and dismantle harmful and discriminatory practices and structures (PwC Australia 2015). Workforce development must be accompanied by whole-of-organisation approaches to system and culture change, driven by senior leaders and adequately resourced to provide staff with the space and time required to learn and adapt to new ways of thinking and working.

Research shows that some mental health staff see providing gender-responsive care as the responsibility of others and claim that building the relationships with patients required for gender-responsive care takes time they don't have (O'Dwyer et al. 2019). This highlights the importance of whole-of-organisation capacity-building and a commitment from leadership, prioritised and consistent across the sector. It is

essential that senior staff are engaged and buy into the change process, prioritise the issue, and role-model attitudes and behaviours, to both support change and help manage resistance.

Mechanisms for accountability and transparency (for example, requirements for all sexual safety incidents in mental health services to be reported to the CEO) are also important to drive engagement and prioritisation at the leadership and middle management levels but, again, must be accompanied by values-driven change management. Structural gender equity interventions (for example, quotas to increase the number of women in leadership positions) that are not supported by efforts to change attitudes are more likely to result in resistance or 'backlash' (Salter, Carmody & Presterudstuen 2015), and to be ineffective. For example, gender sensitivity policy guidelines for mental health units introduced in Victoria over a decade ago (Victoria DOH 2011) failed to keep women safe because they were not accompanied by workforce development to build capability in gender-responsive practice and address negative and stereotyped attitudes towards women experiencing mental ill-health (Women's Mental Health Alliance 2020).

> **The mental health system – and its workforce – must reflect on structural barriers and entrenched biases ...a shift in focus from the 'marginalised' to the 'marginaliser'**

This means that complementary interventions that address gendered norms, practices and structures must be introduced to achieve optimal mental health outcomes for women, girls and trans and gender diverse people. So rather than individualised approaches that aim to 'fix' or 'empower' the individual to access a system that marginalises their needs and experiences or sees their needs through the lens of 'other', the mental health system – and its workforce – must reflect on structural barriers and entrenched biases; that is, there needs to be a shift in focus from the 'marginalised' to the 'marginaliser'.

Leadership

Leadership within the mental health workforce is a gendered issue. While the mental health workforce is female-dominated, the most powerful roles – that is, senior clinical roles – remain male-dominated (RCVMHS 2019). The Royal Commission-led mental health reforms must not only work to increase the representation of women and lived experience workers (see below) in senior positions, but also actively challenge and subvert traditional power hierarchies that deem lived experience and non-clinical workforces to have less value and legitimacy. To achieve this, the perspectives of these workforces must be centred and historically powerful professions and positions/roles must step back. Addressing power and hierarchy within the mental health workforce must occur both at a structural level (e.g., equal remuneration for work of equal value) and at an organisational/interpersonal level (e.g., within multidisciplinary teams/practice).

While there are more male psychiatrists than female psychiatrists, the number of female psychiatrists is increasing at a greater rate (Newton et al. 2019). However, the growing number of women choosing to become psychiatrists has not led to an increase in the number of women in leadership positions. For example, the Royal Australian and New Zealand College of Psychiatrists report that 45% of their members are female and 55% are male, yet only 21.5% of Clinical Director positions are held by women and only 20% of senior academic positions are held by women (RANZCP 2021).

In a qualitative study of 30 medical practitioners in medical leadership roles in Australia (Bismark et al. 2015), the majority stated that preventable gender-related barriers were impeding women's ability to achieve and thrive in medical leadership roles. A related reason for psychiatrists leaving the public sector is the frequent insistence that they must work full-time (Newton et al. 2019). This lack of flexibility – given a significant proportion of women are likely to be juggling multiple roles in addition to their work, for example as mothers and carers – highlights the need for gender equitable workplace conditions such as flexible work.

Lived experience workforce

Lived experience workforces are undervalued. Roles tend to be short-term, part-time and offer limited opportunities for career progression. Once again, this is a gendered issue as most of the lived experience workforce is female. Other barriers include access to only basic training, lack of access to lived experience supervision and the fact that the impact of a peer worker's lived experience is often not accommodated in the workplace.

Some services see peer workers as a 'cheap' workforce; they are not treated as an essential and valued role (Women's Mental Health Alliance 2021b). The expertise of lived experience workforces needs to be recognised, and, as noted above, power imbalances between lived experience and other workforces addressed.

4.4 RESEARCH AND DATA COLLECTION

The final mental health system 'building block' this paper considers is research and data collection. From prevention to recovery, investment in mental health should be guided by existing evidence. To support a better understanding of the mental health needs, experiences and outcomes of women, girls, and trans and gender diverse people, data disaggregated by sex and gender should be collected, publicly reported, and analysed. Examples of effective approaches and interventions also need to be identified, as well as opportunities to test new and promising approaches and build the evidence base. In contrast, failure to centre consideration of sex and gender in mental health research contributes to gendered inequalities in mental health experiences and outcomes, inadequate understanding of women's mental health needs, and ineffective interventions (see Section 3 for more detail).

Despite widespread acceptance of sex and gender as a key determinant of mental health, readily available sex-disaggregated data about the prevalence of mental health conditions is limited. Such data is either not published (e.g., sex-disaggregated mental health data

routinely collected by many health services), not collected (e.g., the three-yearly Victorian Population Health Survey was unable to report on mental health conditions by sex and local government area in 2020 because of the COVID-19 pandemic), or exists as raw data only, yet to be analysed. Examples include the 2020-21 National Study of Mental Health and Wellbeing (ABS 2022a) and data from the 2021 Australian Census, both published in 2022. Last updated in 2007, the National Study of Mental Health and Wellbeing provides Australia-wide summary statistics on key mental health issues including the prevalence of mental disorders and service use, reported by sex and age groups, while a new feature of the 2021 Census is self-reported prevalence of any diagnosed mental health condition (ABS 2022b). Both offer an excellent starting point for further analysis of mental health data by sex and a range of other indicators; it is hoped this work will be undertaken as a matter of priority to update the evidence base on women's mental health in Australia. Similarly, it is recommended that sex-disaggregated mental health data routinely collected by health services be made publicly available (without compromising patient confidentiality) to inform service planning, health promotion, and policy development.

Finally, there is also limited evidence about effective gender-sensitive interventions for women and girls. This highlights the need for significant investment in building the evidence base for gender-sensitive approaches and is the focus of a forthcoming companion paper.
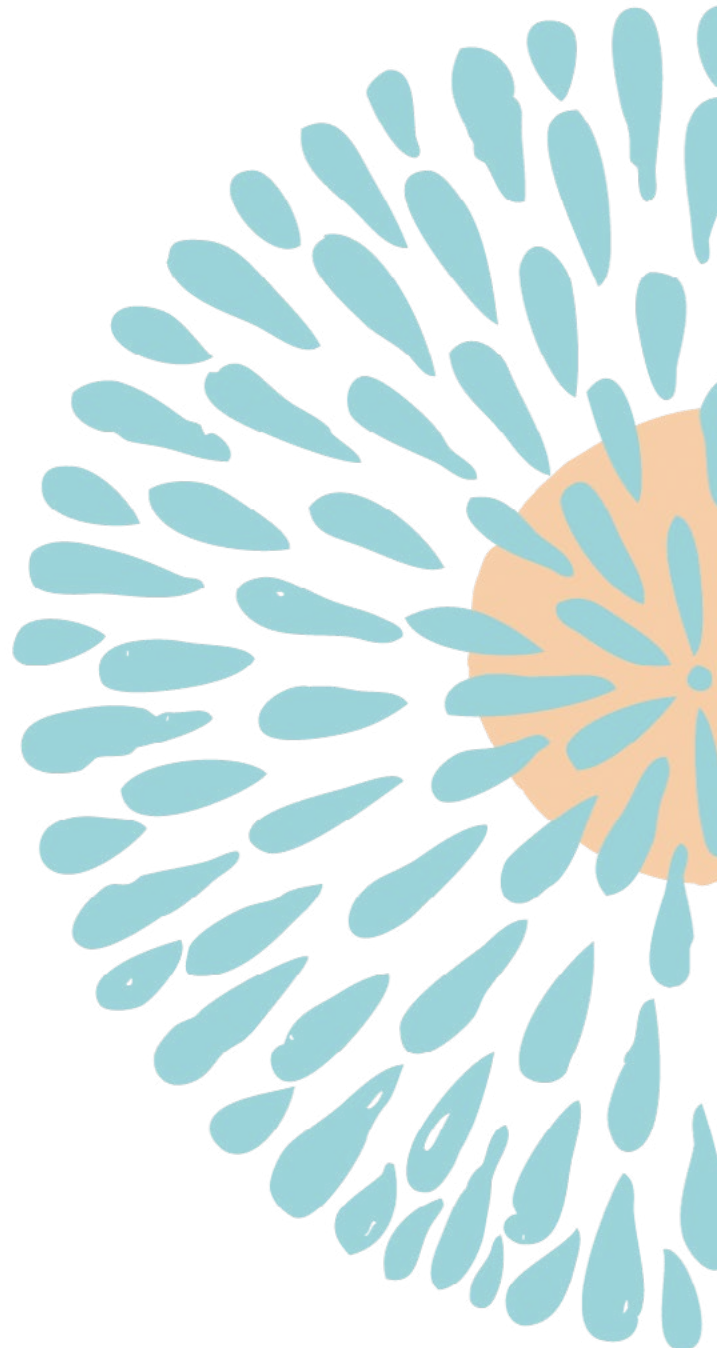
5. Conclusion: Towards a gender responsive mental health system

All women, girls, trans and gender diverse people are impacted by systemic and structural oppression and disempowerment. Women impacted by gendered violence have this disempowerment compounded through choice and control being taken away (Burmester 2019). Accordingly, it is vital that disempowering environments are not replicated within mental health services, and rather opportunities to regain power, choice, and control form part of the service receipt for women (Burmester 2019).

Unpacking the multiple, overlapping ways in which gender and other forms of inequality influence women and girls' mental health and wellbeing and experiences of mental health care (summarised in Fig. 2) makes it clear that the application of an intersectional, gender-responsive, trauma- and violence-informed, life course approach is essential across the whole mental health 'system'.

A system-wide approach to addressing gendered inequalities in mental health must encompass all components or 'building blocks' of the mental health system, including leadership and governance, policy, financing, research, workforce education and training, and service delivery; and be applied across all 'points of intervention' from primary prevention and mental health promotion through to diagnosis, treatment, and recovery (WHO, 2011).

Such an approach must address gendered 'norms' (such as negative and stereotyped beliefs and attitudes towards women experiencing mental ill-health), gendered 'practices' (such as uninformed and harmful responses to victim-survivors of domestic, family and sexual violence) and gendered structures (such as the under-representation of women in clinical and senior roles within the mental health workforce).

All staff delivering mental health services must be adequately trained in delivering intersectional, gender, trauma- and violence-informed responses. This training will mean professionals can respond to intersectional disadvantage and compounded mental health issues, the impacts of gendered violence and the consequences of structural and systemic discrimination in the lives of women, girls, trans and gender diverse people.

Increased resources must be dedicated to ensure this system-wide approach is established and sustained, otherwise the gendered mental health needs of Victorian women, girls, trans and gender diverse people will continue to be unmet, perpetuating cycles of violence, abuse and mental ill-health.

This paper has framed the structural, cultural, and service issues that inhibit good mental health and wellbeing and gender responsive mental health care for women and girls. But what would women's mental health and mental health care look like in the absence of these barriers? Read our forthcoming papers on gender-responsive mental health care and gender-responsive mental health and wellbeing promotion and primary prevention to find out.

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EXPERIENCES OF MENTAL HEALTH & THE MENTAL HEALTH SYSTEM

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Towards a gendered understanding of women's experiences of mental health and the mental health system

Women's Health Victoria. Issues Paper No. 17