Women's Mental Health Alliance

Parliamentary Inquiry into Mental Health & Suicide Prevention

Submission from the Women's Mental Health Alliance

August 2021

Women's Health VICTORIA

Introduction

The Women's Mental Health Alliance (the Alliance) thanks the Committee for the opportunity to make a late submission to the Inquiry into Mental Health and Suicide Prevention. This submission has been drafted by Women's Health Victoria with input from members of the Alliance. At the Committee's request, we have kept this submission short. We are happy to elaborate further on our submission or provide additional information upon request.

About the Women's Mental Health Alliance

The Alliance was established by Women's Health Victoria in 2019. It is made up of over thirty organisations and individuals who provide expert advice to policy makers and health services on the mental health of women and girls, and undertake advocacy to ensure all women have access to evidence-based, gender-sensitive and trauma-informed mental health support. The Alliance works to ensure the voices of women with lived experience are centred in policy, advocacy and service delivery. The Alliance brings together consumer and carer advocates, service providers, clinicians, women's health organisations, human rights bodies and researchers.

The need for a gender-responsive approach in mental health

It is widely recognised that gender is a key social determinant of mental health.[1] Women are approximately twice as likely as men to suffer from a mental illness. This includes both more common conditions such as anxiety and depression, as well as more serious conditions such as post-traumatic stress disorder, intentional self-harm and suicidal behaviours.[2] Females also make up the majority of people seeking mental health support/services.[3]

Despite this, gender and women's mental health are not routinely considered as part of mainstream mental health policy or practice,[4] meaning 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.

This submission focuses on the importance of workforce development and addressing the stigma and discrimination associated with mental ill-health among women as central elements within the Inquiry's Terms of Reference that are required for a more gender-responsive approach to women's mental health.

Summary of recommendations

Workforce development

Recommendation 1:

Implement a gendered approach to building the mental health workforce which incorporates:

a. Development of a mental health capabilities framework that embeds intersectional gender competence/responsiveness as a priority capability to enable workers to address the specific mental health needs and experiences of women, girls and gender diverse people, including:
    a. Capability to respond to gendered violence, including family and sexual violence
    b. Capability in gender-responsive trauma-and violence-informed practice
    c. Capability to prevent and respond to gendered violence in mental health facilities
    d. Capability in gender-informed mental health promotion/primary prevention
b. Development of well-defined and practical frameworks for intersectional, gender-responsive trauma-informed mental healthcare and mental health promotion
c. Training for all existing mental health practitioners and mental health promotion workers in intersectional, gender-responsive, trauma-informed approaches
d. Pre-service curricula and training for prospective mental health practitioners and mental health promotion workers in intersectional, gender-responsive, trauma-informed approaches
e. Adequate resourcing to enable mental health workers to be able to invest the time needed to build relationships with consumers/clients/patients, implement gender-responsive and trauma-informed approaches, and avoid coercive and traumatising practices
f. Measures to address negative gendered attitudes towards women with lived experience of mental health and psychological distress within the mental health workforce and workforces in related sectors, such as the legal and justice systems
g. Measures to drive the development and/or expansion of workforce and/or practice models that incorporate a strong emphasis on:
    a. integration of consumer and carer lived experience workforces
    b. holistic and multidisciplinary approaches
    c. integrated and collaborative approaches across sectors, including strong collaboration with the family violence response sector
h. A gender-sensitive approach to supporting the health and wellbeing of the mental health workforce, especially in the context of an increasing focus on expanding and embedding the role of peer/lived experience workforces, which are female-dominated

i. Measures to increase the representation of women in senior roles within the clinical and non-clinical workforces, including women with lived experience, and to address power imbalances between the clinical, non-clinical and peer workforces

j. Ongoing collection and analysis of intersectional workforce data

Recommendation 2:

Ensure the implementation of gender-responsive workforce development measures and practice models is accompanied by whole-of-organisation approaches to system- and culture change, driven by senior leaders.

Reducing stigma and discrimination

Recommendation 3:

Ensure any strategy or initiatives to reduce stigma take a gendered approach and consider:

a. Stigma and discrimination both as a cause or driver of poor mental health among women and as a barrier to service access and recovery

b. Stigma and discrimination against women with a mental illness that is experienced both within the community (interpersonal stigma), and in interactions with the mental health system and other service systems (systemic stigma)

c. Stigma related to negative attitudes towards women and girls who have experienced gendered violence (which is a significant cause of poor mental health among women and girls), including victim-blaming and dismissive and attitudes

d. Intersectional experiences of stigma and discrimination, where gendered attitudes intersect with other forms of discrimination such as racism and homophobia

e. Stigma experienced by families and carers of those with mental health conditions, especially mothers.

Recommendation 4:

Ensure any strategy or initiatives to reduce stigma go beyond addressing 'attitudes' to addressing discriminatory practices and structural inequalities that impact women experiencing mental illness or psychological distress.

Recommendation 5:

Ensure any anti-stigma messaging or campaigns do not inadvertently reinforce inaccurate and unhelpful ideas about mental ill-health and/or access to mental health services.

Workforce development

Capabilities required by mental health practitioners

A national capabilities framework or frameworks for both clinical and non-clinical mental health workforces is required. This framework or frameworks must include the following elements:

1. **Intersectional gender competence**,[5] that is, an understanding of the ways in which gender and other social factors influence women's mental health and the capability to respond to women's needs and experiences, including:
    - Understanding the role of gender as a social determinant of mental health and the importance of a biopsychosocial model;
    - Capacity to recognise and address gender-based discriminatory attitudes and behaviours;
    - Implementing actions to counter gender bias and gendered attitudes, stereotypes and inequalities in research, training and clinical practice;
    - Gendered cross-cultural awareness

2. **Capability to respond to gendered violence, including family and sexual violence**
    - Violence against women and girls is one of the most common causes of poor mental health. Women who have experienced violence are more likely to suffer from a range of mental health conditions, many of which have long-term impacts.[6]
    - However, recent Australian research shows mental health staff feel unprepared to work with patients/consumers with histories of family violence and sexual abuse. For example, they frequently do not ask about sexual violence, whether historical or experienced on the ward, and often do not take disclosures seriously, minimise the experience or blame consumers.[7]
    - Initiatives implemented following the Victorian Royal Commission into Family Violence – such as the Strengthening Hospital Responses to Family Violence project and the Specialist Family Violence Advisor Capacity Building Program in mental health and alcohol and other drug services – have played an important role in building the capability of Victorian mental health practitioners to identify family violence, manage risk and make appropriate referrals. These initiatives warrant further investment and rollout beyond Victoria. However, they stop short of integrating an understanding of the impacts of gendered violence into mental health *practice*.
    - Any national mental health workforce strategy must include a focus on building capability to identify and respond to women who have experienced gendered violence, as well as integrating an understanding of the impacts of gendered violence into mental health practice. This should:
        - Include routine screening for trauma and abuse and meaningful incorporation of disclosures into treatment plans: Evidence suggests that victim-survivors of family violence are reluctant to disclose abuse in the absence of direct questioning;[8]

- Draw on the CATCH model, which identifies Commitment, Advocacy, Trust, Collaboration, and Health system support as vital in building readiness and confidence to provide sensitive care for survivors of family violence;[9]
- Align with principles underpinning trauma-informed practice (explored below).

3. Capability in gender-responsive trauma-and violence-informed practice

- An organisational and practice model that is grounded in understanding and responding to trauma is important in any service that supports women, due to the links between poor mental health and experiences of gendered violence, including family and sexual violence.[10]
- An effective gender-responsive and intersectional trauma-informed approach must:[11]
  - Be empowering, strengths-based and promote autonomy;
  - Ensure the physical and emotional safety of consumers/survivors;
  - Incorporate analysis of gendered power relations, drawing links between women's individual experiences and systemic issues of gender inequality and violence, as well as other forms of systemic oppression such as racism, homophobia and poverty;[12]
  - Being responsive to the lived, social and cultural contexts (e.g. recognising gender, race, culture, ethnicity) of consumers, which shape both their needs as well as recovery and healing pathways;
  - De-centre therapeutic expertise and emphasise collaboration;
  - Recognise the potential for coercive practices within mental health settings to be retraumatising and avoid their perpetuation through training and resources for staff to implement gender-informed alternatives to coercion;[13]
  - Extend beyond individual practice to the whole organisation 'from the environment to the reception staff';[14] and
  - Integrate care across services, recognising women's complex needs (mental health problems, family and sexual violence, child abuse, war- and migration-related trauma, alcohol and drug issues).[15]

4. Capability to prevent and respond to gendered violence in mental health facilities

- Women continue to experience unacceptably high rates of gendered and sexual violence within mental health facilities.[16] Recognising this, the Royal Commission into Victoria's Mental Health System has recently recommended that all new and existing mental health facilities be upgraded to enable gender separation.
- However, to be effective, changes to the physical environment must be accompanied by workforce training in preventing and responding to gendered violence. Experience in Victoria has shown that the publication of guidelines on gender/sexual safety is insufficient without workforce training.[17]

5. Capability in gender-informed mental health promotion/primary prevention

- In addition to building the gender competence of mental health practitioners, it is essential that any national workforce strategy and capability framework(s) incorporate a strong focus

on building capability within the health promotion workforce to deliver gender-informed mental health promotion/primary prevention programs.

- Gender competence in mental health promotion requires specific acknowledgement of gender-based risks (or social determinants), including experiences of gender discrimination, gendered violence, income inequality, gender norms and stereotypes, and gendered roles including unpaid care work.

Workforce/practice models

In addition to a focus on building capability in intersectional, gender-responsive and trauma-informed practice across the mental health and related workforces, any national workforce strategy must also incorporate measures to drive the development and/or expansion of workforce and/or practice models that incorporate a strong emphasis on:

- Integration of **consumer and carer lived experience workforces**: For example, the Victorian Mental Illness Awareness Council recommends setting targets/quotas for consumer workforces and the full integration of these positions into services and clinical teams.[18]
- **Holistic and multidisciplinary approaches**: Women consistently ask for a more holistic approach that addresses mental health within the broader context of their lives.[19] A biopsychosocial approach to mental ill-health means moving away from a biomedical model to a broader view of women's mental distress that recognises and addresses social harms and inequities. This opens up practice opportunities that extend beyond treating 'dysfunction' and 'symptoms'.[20] A holistic approach must also include practice models that address physical and mental health together, as seen for example at the Women's Mental Health Clinic run by Monash Alfred Psychiatry research centre (MAPrc).
- **Integrated and collaborative approaches across sectors**, including strong collaboration and warm referrals with the family violence response, housing and homelessness, and alcohol and other drug sectors.
- **Place-based, collective impact approaches to mental health promotion:** There are opportunities to draw on promising practice from the prevention of violence against women sector to develop locally-relevant, gender-informed approaches to the primary prevention of mental ill-health.[21]

Workforce attitudes and behaviours

Any national workforce strategy must address negative gendered attitudes (stigma and discrimination) towards women with lived experience of mental health and psychological distress within the mental health workforce and workforces in related sectors, such as the legal and justice systems.

Further detail is included in the section of this submission on 'Reducing stigma and discrimination'.

System and cultural change

Workforce training and capability-building is insufficient to address entrenched attitudes and behaviours and dismantle harmful and discriminatory practices and structures. Workforce

development must be accompanied by whole-of-organisation approaches to system- and culture change, driven by senior leaders.

For example, research shows that some mental health staff see providing gender-responsive care as the responsibility of others, and point out that there is not enough time to build the relationships with inpatients required for gender-responsive care.[22] This highlights the importance of whole-of-organisation capacity-building and a commitment from leadership. It is essential that senior staff are engaged and buy into the change process, prioritise the issue, and role-model attitudes and behaviours. This will also help to manage resistance.

Mechanisms for accountability and transparency (for example, requirements for all sexual safety incidents to be reported to the CEO) are also important to drive engagement and prioritisation at the leadership and middle management levels, but must be accompanied by values-driven change management.

Supporting the health & wellbeing of the mental health workforce

A national workforce strategy must include a focus on supporting the health and wellbeing of the mental health workforce. This is especially important in the context of an increasing focus on expanding and embedding the role of peer/lived experience workforces.

A gender-sensitive approach to supporting the health and wellbeing of the mental health workforce is essential, recognising that:

- The mental health workforce is highly feminised. For example, the ORIMA workforce survey found 77% of Victorian mental health workers identify as female.[23] This means the majority of the mental health workforce are likely to be juggling multiple roles in addition to their work – for example as mothers and carers – highlighting the need for gender equitable workplace conditions such as flexible work options;
- Many of the life experiences of female service users (e.g. experiences of gendered violence, anxiety and depression) are common and therefore likely to be shared by a significant number of staff. The ORIMA workforce survey found 43% of mental health workers had personal lived experience of mental health conditions.[24] If these issues are unresolved, they can cause stress for the practitioner, have a negative impact on staff ability to develop therapeutic relationships or, at worst, have a detrimental effect on service users' potential for recovery. Availability of work-related counselling is therefore an essential element of staff support e.g. out-of-hours crisis support, confidential counselling services.[25]

Gender composition of the mental health workforce

It is also essential that a national workforce strategy consider the gender composition of the mental health workforce and identify mechanisms or approaches for:

- Increasing the representation of women in senior roles, including women with lived experience – for example, the interim report of the Royal Commission into Victoria's Mental Health System found that there is a disproportionately low number of women in leadership positions in psychiatry;[26]
- Addressing power imbalances between the clinical, non-clinical and peer workforces, recognising the overlay of gendered power dynamics, where the peer and non-clinical

workforces are female-dominated and senior clinical and governance roles are dominated by men.

Regular workforce data collection is also essential, and should include collection of data on workers' gender and culture/ethnicity, including at a regional level, to support workforce planning (for example, to ensure that all Victorian populations have adequate numbers of bicultural and bilingual community mental health and support workers).

Reducing stigma and discrimination

Stigma associated with mental illness is gendered. Any strategy or initiatives to reduce stigma and discrimination must consider:

- Stigma and discrimination both as a cause or driver of poor mental health among women and as a barrier to service access and recovery
- Stigma and discrimination against women with a mental illness that is experienced both within the community (interpersonal stigma), and in interactions with the mental health system and other service systems (systemic stigma)
- Stigma related to negative attitudes towards women and girls who have experienced gendered violence (which is a significant cause of poor mental health among women and girls), including victim-blaming and dismissive and attitudes
- Intersectional experiences of stigma and discrimination, where gendered attitudes intersect with other forms of discrimination such as racism and homophobia
- Stigma experienced by families and carers of those with mental health conditions, especially mothers.

Initiatives to address stigma must also go beyond addressing 'attitudes' to addressing discriminatory practices and structural inequalities. As Dr Emma Tseris argues, 'it is important that the potential benefits of attempting to reframe public attitudes about mental illness, as well as service user's self-perceptions, are not overstated. An attempt to shift societal *attitudes* about mental illness, in and of itself, is unlikely to achieve a goal of transforming mental health service users' position in society in terms of their vastly unequal opportunities and access to material resources, including housing and employment, nor can it alleviate the unfavourable treatment that they often receive, within both community and professional treatment contexts.'[27]

It is also important to ensure any anti-stigma messaging or campaigns do not inadvertently reinforce inaccurate and unhelpful ideas about mental ill-health and/or access to mental health services, for example, messages which individualise dysfunction and conceal social drivers of mental ill-health, and messages that direct people to services that may not be safe, appropriate or accessible. Dr Emma Tseris provides a useful critique of prominent anti-stigma messages that we commend to the Inquiry: *Accepting My Illness? Problematising the Claims of Mental Health Anti-Stigma Efforts* (2019).[28]

Stigma and discrimination as a driver of poor mental health

The role of gender discrimination (e.g. income inequality, sexual harassment), gendered attitudes (e.g. rigid gender stereotypes, sexualisation of women and girls) and gendered roles (for example, women undertaking a disproportionate share of unpaid care work) as drivers (or social determinants) of poor mental health among women and girls is well-established.[29]

This highlights the critical importance of ensuring that any strategy or approach to reducing stigma and discrimination incorporates a focus on addressing harmful gendered norms, practices and structures that give rise to poor mental health outcomes for women and girls.

Stigma and discrimination against women within the mental health and other service systems

There is clear evidence that women who are experiencing mental ill-health or psychological distress, are diagnosed with a mental health condition, or have experienced gendered violence are subjected to stigma and discrimination in their interactions with mental health practitioners and services.

As Dr Emma Tseris argues, 'the assumption that professional workers are immune from stigmatising beliefs about mental illness has created a significant reflexive blind spot to the sometimes violent practices that occur within contemporary mental health services, as well as the symbolic violence contained within mental health labelling practices themselves.'[30]

For example, there is evidence that women who self-harm or attempt suicide can be perceived or described by health practitioners as 'attention-seeking' and manipulative.[31] For example, 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.[32] 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.[33] There is also evidence to suggest that negative perceptions of female consumers result in some mental health workers dismissing or denying sexual assault disclosures.[34]

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.[35]

Women are also over-represented among those with the most stigmatised diagnoses. For example, 75% of people diagnosed with Borderline Personality Disorder (BPD) are women. BPD is one of the most stigmatised/stigmatising diagnoses. People with BPD are often stereotyped as manipulative, attention-seeking and self-destructive. The name of the disorder implies that the person's personality is dysfunctional or defective and suggests that personality features associated with BPD simply arise on their own, often resulting in harsh judgments about people with this diagnosis. What is missing is recognition of the prevalence of early life trauma and childhood sexual abuse amongst those diagnosed with BPD: 85% of women with BPD have experienced significant early life trauma.[36] There is significant work to be done to de-stigmatise gendered diagnoses like BPD.

Diagnoses of mental illness and coercive mental health practices have long been utilised as a form of abuse and violence against women and to control women who do not conform to social expectations about women's behaviour.[37]

Anti-stigma initiatives must also be targeted beyond the mental health sector and general community, with a particular focus on the legal and justice sector. The stigma associated with female mental illness in the legal system allows mental health diagnoses to be used against women in family law/custody matters and in 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, with it given as the 'reason limiting child contact' with mothers in 30 percent of such cases, but only in 2 percent of cases limiting fathers, which does not reflect the prevalence of mental ill-health.[38]

Stigma experienced by family members and carers

Family members, friends and carers of those with mental illness, who are predominantly women, also experience the impacts of stigma and discrimination – both externally through contact with clinical services and a lack of community awareness, as well as internalised stigma, often linked to a lack of understanding of the diagnosis and what it does or does not mean for the person they care for and support.

There are also persistent and harmful stereotypes such as 'the schizophrenogenic mother' that remain today, which place guilt and blame on the mother/ female caregiver. These harmful and unfounded stereotypes problematise the individual and their experience of mental distress, whilst simultaneously framing the female caregiver as a problem or causal factor. [39] While it is true that some family members are harmful, it is not the experience of all consumers and should not be an assumption upon which services operate.

Any anti-stigma initiatives must include support and education for family, friends and carers in challenging experienced and internalised stigma.

An intersectional approach to reducing stigma and discrimination

An intersectional approach that recognises the ways in which intersecting forms of inequality and discrimination, including harmful attitudes, compound gendered experiences of stigma is essential.

Not only are racism, homophobia, transphobia and other forms of discrimination drivers of poor mental health, but higher levels of stigma associated with mental illness in different communities can be a barrier to help-seeking, for example in some migrant communities.[40]

Whenever possible, bilingual and bicultural education around mental illness and stigma should be available for consumers, families and carers, communities and services.

Endnotes

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