



Draft National Stigma and Discrimination Reduction Strategy

Submission by Women's
Health Victoria

February 2023



WHV acknowledges the support of the Victorian Government.

Introduction

Women's Health Victoria (WHV) welcomes the opportunity to comment on the draft National Stigma and Discrimination Reduction Strategy. Our submission focuses on the 'what's missing' consultation question – *Are there any critical issues or actions to address stigma and discrimination that are not referenced or sufficiently prioritised in the Draft Strategy?* Women's Health Victoria argues that gender bias and stereotypes faced by women in the mental health system are critical issues that are not adequately addressed in the draft Strategy. Given how poorly women have been treated within the mental health system, WHV believe that sexism and gender discrimination must be specifically named and addressed in the Strategy, including in specific actions aimed at educating and training mental health and other professionals.

About Women's Health Victoria

[Women's Health Victoria](#) (WHV) 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. We have convened the [Women's Mental Health Alliance](#) since 2019. The Alliance is made up of nearly 45 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.

Overview

WHV commends the National Mental Health Commission (NMHC) for developing the Draft National Stigma and Discrimination Reduction Strategy, the first national, government-led strategy of its nature. We particularly welcome the Strategy's definition of stigma as including structural stigma, its focus on bringing about behavioural change, and its recognition of key issues such as discrimination beyond the mental health sector, and the multiple and compounding forms of stigma and discrimination experienced by particular groups. We also welcome the focus on human rights, as reflected in the first guiding principle of the Strategy – to uphold the dignity and human rights of people experiencing mental ill-health, trauma, and distress.

WHV further commends the Commission for highlighting new mothers as a particular group which experiences multiple and compounding experiences of stigma and discrimination. However, we encourage the NMHC to take a gendered approach throughout the Strategy more broadly, to address the ways in which stigma and discrimination in the form of gendered expectations and stereotypes can shape women and trans and gender diverse people's access to and experiences of mental health care, and of other services – particularly for women with other marginalised identities.

An important part of the backdrop of the stigma and discrimination that women face in the mental health system 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 1980.¹ 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'.² Historically these labels have been used to control women, inflict violence on them, and/or to discredit and dismiss their experiences of violence and trauma³, practices which persist through to today.

Gender-based stigma can manifest in health professionals perceiving women seeking mental health care as difficult to care for, and/or failing to recognise the shame and stigma associated with disclosing mental illness among specific groups of women including First Nations women, refugee and migrant women, and young women and girls – an illustration of multiple and compounding forms of discrimination. Women and girls report having their concerns about their mental health dismissed, being victim-blamed, and being labelled attention-seeking and manipulative after self-harming or suicide attempts. Stigma and discrimination are also a barrier to help-seeking. Women report not seeking mental health care following experiences of violence, for example, for fear of not being believed. Accounts of experiences of mental health diagnoses being used against women in the legal and justice system are also common, and rates of mental health diagnoses such as depression and anxiety are particularly high among trans and gender diverse people.

Stigma and discrimination must be addressed not only as issues facing those experiencing mental ill-health, but also as *drivers* of mental ill-health. Strategies to address stigma and discrimination should consider the role of gendered norms and attitudes, as well as gender discrimination in contributing to mental ill-health. Gendered violence and its psychological impacts is a stark example of the role of unequal gender norms, practices and structures in driving mental ill-health.

WHV agrees that education and training are critical to reducing stigma and discrimination among the mental health and related workforces, and the general public. We recommend that anti-stigma and discrimination training and education covers the sex and gender-based discrimination and gender-stereotypes that confront women, girls, trans and gender diverse people when accessing mental health support.

Summary of recommendations

1. Ensure that anti-stigma training in key sectors (mental health and justice sectors) includes specific efforts to address harmful gender biases, stereotypes, and discrimination in the mental health system and among the general public.
2. Use the biopsychosocial model of mental health in anti-stigma initiatives to challenge the dominance of the biomedical model
3. Ensure the mental health workforce is properly resourced through pay and has adequate patient-to-staff ratios.

¹ VMIAC (2020) [Gender discrimination and inequality](#). Victorian Mental Illness Awareness Council. Melbourne. – (VMIAC Policy Position Paper, 4)

² Ussher JM (2013). [Diagnosing difficult women and pathologising femininity: Gender bias in psychiatric nosology](#). *Feminism and Psychology*. 23(1): 63-69.

³ Ussher JM (2018) [A critical feminist analysis of madness: pathologising femininity through psychiatric discourse](#) In: Cohen BMZ (ed.) *Routledge international handbook of critical mental health*. Routledge, London. pp. 72-78.

Recommendations

Recommendation 1: Ensure that anti-stigma education and training in key sectors (including mental health and justice sectors) includes specific efforts to address harmful gender biases, stereotypes and discrimination in the mental health system and among the general public.

Consistent with Priority 1.4: *Educate and train key cohorts and workforces*, anti-stigma and education and training approaches must address gendered mental health stigma and discrimination via (but not limited to) the following actions across the mental health and other workforces:

Priority	Action
2.2: Ensure equity of access to quality healthcare	2.2k: Develop and deliver, in collaboration with the Lived Experience workforce, ongoing professional development training for healthcare professionals.
2.5: Support people to receive equitable treatment by legal systems	2.5b: Review justice system rules and protections around the use of Mental Health Care and Protection Orders, including in family law matters, child protection and custody cases, to prevent discrimination and to encourage people to seek help.
2.7 Improve mental health capabilities and supports in education and training settings	2.7b: Conduct mental health education programs for students that embed lived experience stories to challenge stereotypes around mental health.
	2.7g: Initiate steps to incorporate mental health literacy, with an explicit anti-stigma focus, into pre-career standards, qualifications and ongoing professional development.
3.1 Build a social movement to catalyse community action to reduce stigma and discrimination	3.1b Design and implement appropriately tailored and culturally-safe hybrid educational and contact-based training initiatives (with a rights-based framing) for people in frequent contact with people with personal lived experience, including: <ul style="list-style-type: none"> • mental health workers (including NDIS administrators, service providers and other employees) • health workers • social services workers • child protection workers • teachers and early childhood educators • police • people working in legal and financial systems • Managers, supervisors and people in HR roles.

	As part of this, embed informal and formal Lived Experience roles in leadership and support roles throughout organisations.
	3.1d Specify that professional mental health education and training (pre-service and ongoing professional development) must include content about rights-based approaches to mental health care, valuing lived experience and the impact of stigma and discrimination (including diverse and compounding experiences of stigma and discrimination) in their curricula.

Rationale

Gender bias contributes to misdiagnosis of mental health concerns in women

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 a result, women’s mental health problems may be dismissed, overlooked, or misdiagnosed – including overdiagnosis of some conditions and underdiagnosis of others.⁴ Alternatively, understandable responses to traumatic experiences may be pathologised.

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.⁵ Women are overrepresented in the most stigmatised mental health diagnoses, particularly Borderline Personality Disorder (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,⁶ resulting in less empathy for and re-traumatisation of survivors.⁷

Women experience negative stigmatising attitudes and behaviours from mental health professionals

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. This must be addressed as a workforce issue.

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

⁴ American Psychological Association (2007) [Guidelines for psychological practice with girls and women](#). *American Psychologist*. 62(9): 949-979. [Note this is not the most up-to-date version of the guidelines]

⁵ American Psychological Association (2007) [Guidelines for psychological practice with girls and women](#). *American Psychologist*. 62(9): 949-979; and Eriksen, K, and Kress, V. (2008) [Gender and diagnosis: struggles and suggestions for counselors](#). *Journal of Counseling and Development*. 86(2): 152–162.

⁶ Henderson C, Noblett J, Parke H, Clement S, Caffrey A, Gale-Grant O, et al. (2014) [Mental health-related stigma in health care and mental health-care settings](#). *Lancet Psychiatry*. 1(6):467-82

⁷ Hockett J, Smith S, Klausning C, Saucier D (2016) [Rape myth consistency and gender differences in perceiving rape victims: a meta-analysis](#). *Violence Against Women*. 22(2): 139-67

to care for,⁸ victim-blamed when seeking help for complex post-traumatic stress and anxiety,⁹ or, as noted, 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.

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.¹⁰ 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.¹¹ 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.¹² 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.¹³ 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.¹⁴

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.¹⁵

The intersection of gendered norms, practices and structures has led to the failure to protect women from sexual violence in mental health inpatient units

Gender inequality is expressed and maintained in society – and within the mental health system – through the interaction of gender(ed) norms, practices, and structures, as the longstanding failure to protect women from sexual violence in mental health inpatient units illustrates.¹⁶ 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

⁸ O’Dwyer C, Tarzia L, Ferbacher S, Hegarty K (2019) [Health professionals’ experiences of providing care for women survivors of sexual violence in psychiatric inpatient units](#). *BMC Health Services Research*. 19: 839.

⁹ Women’s Mental Health Alliance (2020) [Additional evidence on gender and mental health for the Royal Commission into Victoria’s Mental Health System](#). Women’s Health Victoria. Melbourne

¹⁰ Suicide Prevention Australia (2016). [Suicide and suicidal behaviour in women: issues and prevention. a discussion paper](#). Suicide Prevention Australia. Sydney.

¹¹ Suicide Prevention Australia (2016). [Suicide and suicidal behaviour in women: issues and prevention. a discussion paper](#). Suicide Prevention Australia. Sydney.

¹² O’Dwyer C et al (2019) [Health professionals’ experiences of providing care for women survivors of sexual violence in psychiatric inpatient units](#) *BMC Health Services Research* 19:839.

¹³ O’Dwyer C et al (2019) [Health professionals’ experiences of providing care for women survivors of sexual violence in psychiatric inpatient units](#) *BMC Health Services Research* 19:839.

¹⁴ Women’s Mental Health Alliance (2021b) [Victorian Mental Health and Wellbeing Workforce Strategy Forum summary report: response from the Women’s Mental Health Alliance](#). Women’s Health Victoria. Melbourne, p. 40.

¹⁵ Maker Y (2021) [Beyond restraint: gender-sensitive regulation of the control of women’s behaviour in Australian mental health and disability services](#). In: McSherry B, Maker Y (eds). *Restrictive practices in health care and disability settings: legal, policy and practical responses*. Routledge, London. pp. 91, 93-95

¹⁶ Victoria. Mental Health Complaints Commissioner (2018) [The right to be safe: Sexual Safety Project report](#). MHCC. Melbourne; and VWMHN (2007) [Nowhere to be safe: women’s experiences of mixed-sex psychiatric wards](#). Victorian Women and Mental Health Network. [Melbourne](#)

reflects **gender norms** that deem it women's responsibility to manage male aggression and violence,¹⁷ and which prioritise economic efficiency over women's safety.¹⁸

While the Victorian Government is 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.¹⁹

To ensure women are safe when they access mental health inpatient units and mental health services requires not just capital infrastructure investment, but the simultaneous targeting and transformation of gender unequal norms, practices and structures to prioritise women's health and safety across the mental health system, through organisational leadership, workforce capability-building and system-wide culture change.

Stigma impacts women's experiences in other settings such as the justice system and can affect family members and carers

The negative and stigmatising attitudes associated with women's experiences of mental illness also extends beyond the mental health system, in particular to 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 a gendered practice. Mental health is given as the 'reason limiting child contact' with mothers in 30 percent of such cases, but only in 2 percent of cases limiting contact with fathers, which does not reflect the prevalence of mental ill-health by gender.²⁰

Family members, friends 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. There are persistent and harmful stereotypes such as 'the schizophrenogenic mother', 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.²¹ While it is true that some family members can cause harm, it is not the experience of all consumers and these attitudes must be dispelled within mental health workforces.

¹⁷ 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).

¹⁸ 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).

¹⁹ ANROWS (2020c) [Preventing gender-based violence in mental health inpatient units](#). Australia's National Research Organisation for Women's Safety, Sydney – (Research Report, Issue 1); and Kulkarni J, Galletly C. (2017) [Improving safety for women in psychiatry wards](#). *Australian and New Zealand Journal of Psychiatry*. 51(2):192-4.

²⁰ ANROWS (2020). [Violence against women and mental health](#). Australia's National Research Organisation for Women's Safety. Sydney. pp 7-8. (*ANROWS Insights*, 04/2020).

²¹ Van der Sanden R et al (2015) [Stigma by association among family members of people with a mental illness: a qualitative analysis](#). *Community and Applied Social Psychology*. 25(5): 400-417; Scheyett A (1990) [The oppression of caring: women caregivers of relatives with mental illness](#). *Affilia*. 5(1), 32-48; Johnston J (2013) [The ghost of the schizophrenogenic-mother](#). *AMA Journal of Ethics - Virtual Mentor*. 15(9), 801-805.

Recommendation 2: Use the biopsychosocial model of mental health in anti-stigma initiatives to challenge the dominance of the biomedical model

WHV commends the draft Strategy for adopting a nuanced understanding of stigma as comprising structural, public and self-stigma, for acknowledging different conceptualisations of mental health among different groups within the population (p. 9), and for including psychological distress, trauma, suicidality, suicide attempts and alcohol and other drug issues alongside mental ill-health as the stigmatised experiences within the scope of the Strategy. This recommendation – that the understanding of mental health throughout the strategy is based on a biopsychosocial model – is focused on how mental health and illness are understood and framed within anti-stigma initiatives. It is further recommended that this understanding is clarified in the Strategy, either in the ‘Language Matters’ section or the addition of a new section titled ‘Understanding mental health and ill-health’.

Rationale

A biopsychosocial model of mental health considers not only the biological factors that influence mental health but also the social context of people’s lives²². 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.²³

In contrast, the biomedical model of mental health – dominant within Australia’s mental health system and within the research literature – stigmatises women. 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 what are rational, adaptive responses to trauma, violence and social inequality, and re-casts systemic social problems as individual dysfunction.²⁴

Mental health anti-stigma campaigns also sometime assert that mental illnesses emerge regardless of social circumstances and background – that ‘mental illness does not discriminate’. This framing ignores the importance of material and social resources in emotional wellbeing, as well as the strong correlations between experiences of poverty, violence, racism and homophobia in the development of mental distress.²⁵ Evidence suggests that effective mental health strategies should counter the notion that women are intrinsically biologically vulnerable to mental health problems.²⁶

²² WHV notes that the draft Strategy defines the medical model as a biopsychosocial approach (p.33), however we consider the biopsychosocial and biomedical models as distinct approaches.

²³ Vizzotto A, de Oliveira A, Elkis H, Cordeiro Q, Buchain P (2013) [Psychosocial characteristics](#). In: Gellman M, Turner J (eds.) Encyclopedia of behavioral medicine. Springer, New York.

²⁴ ANROWS (2020b). [Violence against women and mental health](#). Australia’s National Research Organisation for Women’s Safety, Sydney. (ANROWS Insights, 04/2020); and Tseris E, Moulding N (2021) [Evidence shows mental illness isn’t a reason to doubt women survivors](#). *The Conversation*. (Mar 9): 1 webpage.

²⁵ Tseris E (2016) [Thinking critically about ‘mental health issues’ affecting women during/after violence](#). In *Social Alternatives*. 35(4): 35- 42.

²⁶ Fisher, J (2017) [Women and Mental Health](#) in *InPsych* 39:1.

Recommendation 3: Ensure the mental health workforce is properly resourced, remunerated, and respected.

Actions to address the resourcing and remuneration of the mental health workforce are consistent with Priority 1 of the Strategy: Implement foundational actions to address stigma and discrimination.

Rationale

A well-resourced, remunerated and respected mental health workforce is best placed to implement gender- and -culturally responsive, trauma- and violence-informed care. Under-resourcing means that there are workforce shortages and workers are on low-paid, short-term, casualised contracts. This leads to burn-out, which leads to people taking time off, which creates a vicious cycle of additional pressure on remaining staff.

The Women's Mental Health Alliance has noted²⁷ that much of the stigmatisation and poor human rights outcomes for consumers that arise through interactions with mental health workers stem from under-resourcing. For example, in order 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, resourcing is needed to expand the range of services available so that people can access appropriate services before they become acutely unwell. Improving pay and conditions will also assist in addressing the stigma and negative perceptions associated with working in mental health by making it a more attractive field to work in.

Further reading

For more detailed information about the ways in which gender inequality, including sex and gender-based stigma and discrimination impact women and girls in the mental health system, please see WHV's latest paper, [Towards a gendered understanding of women's experiences of mental health and the mental health system](#) (2023).

Towards a gendered understanding 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, the 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.

²⁷ Women's Mental Health Alliance (2021) [Response to the Victorian Mental Health and Wellbeing Workforce Forum Summary Report](#). Women's Health Victoria. Melbourne.