



Women's Mental Health Alliance response to the Department of Health consultation on the recommendations from the Productivity Commission's Report on Mental Health

Introduction

The [Women's Mental Health Alliance](#) welcomes the Productivity Commission's Inquiry Report on Mental Health and the opportunity to comment on the implementation of the final recommendations within this report. We particularly welcome the focus on creating a person-centred mental health system and prevention and early intervention within the recommendations. However, we are disappointed that – despite the clear gendered discrepancies in mental health outcomes – the report only addresses the specific mental health needs and experiences of women and girls in a very limited way. The implementation phase presents an opportunity to apply an intersectional gender lens across all recommendations to ensure they are gender-responsive and effectively address the mental health needs of all women, girls, men, boys and non-binary people.

The Women's Mental Health Alliance (the Alliance) was established by Women's Health Victoria (WHV) in 2019. The Alliance is made up of 33 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. For more information about the Alliance, including a full list of members, please visit our [webpage](#).

The Alliance has identified a number of evidence-based principles and actions for the Department of Health to consider in order to effectively address the mental health and wellbeing needs of women and girls. This submission outlines how these can be applied during the implementation of recommendations within the Productivity Commission's Inquiry Report on Mental Health.

Summary of recommendations for inclusion during implementation

1. Apply an intersectional gender lens to the implementation of the Productivity Commission's recommendations to ensure a gender-sensitive approach is taken to mental health – from prevention and early intervention through to treatment and recovery
2. Prioritise recommendations relating to women's safety in inpatient units for immediate implementation
3. Address the drivers of poor mental health – including gender inequality – in all prevention initiatives to ensure an effective, evidence-based approach to primary prevention
4. Ensure mental health systems and services are trauma-informed
5. Ensure the mental health workforce is trained to effectively support the diverse needs of women, girls and gender non-binary people
6. Collect gender-disaggregated data, undertake a gender analysis and centre the consumer as part of monitoring and evaluation of implementation outcomes.

Analysis of Productivity Commission's approach to gender and women's mental health

Overall, the recommendations and actions do not reflect the importance of addressing gendered issues in mental health. Although the report acknowledges some differences in the experience of mental health between males and females, this evidence is not reflected in the recommendations. The Alliance reiterates the importance of applying an intersectional gender lens to the implementation of all recommendations to ensure a gender-sensitive approach is taken to mental health – from primary prevention through to treatment and recovery. This includes ensuring that: adequate funding is provided to address key mental health issues that impact women and girls; the specific mental health needs of women and girls are considered within mainstream programs and services; and the gendered impacts of any mental health reforms are considered and accounted for.

Specifically, the recommendations do not address the drivers (or social determinants) of poor mental health, including gender inequality, poverty, racism and unemployment.¹ The report recognises that environmental, community and family risk factors - including family violence - impact on mental health, but no recommendations are made to address these risk factors. While the report includes welcome recommendations to promote children's mental wellbeing, its failure to address the underlying causes of poor mental health means that it will not be effective in preventing mental ill-health.

The report references WHV's submission as emphasising the importance of ensuring that 'women and girls with lived experience and those who are carers' and 'gender diverse consumers and carers' were not overlooked in the co-design of mental health services and programs. However, the report goes on to say: *Obviously, it is not practicable to have every population subgroup involved in every design, implementation, delivery and evaluation process. But it is reasonable to have consumer and carer representatives from particular population subgroups where they are the policy target.* However, it is critical to ensure that universal mental health services – not just targeted programs – effectively respond to the diverse needs and experiences of consumers, including being gender-responsive, culturally safe and trauma-informed. While it may be challenging to ensure all sub-populations are represented in co-design processes for mainstream services, there is little chance of this being achieved if it is dismissed from the outset; a representative co-design process must be the goal, even if it is sometimes imperfectly achieved.

We commend the Commission for recognising the gender differences in some mental health conditions in Parts 1 and 2 of the report. However, this recognition is inconsistent and does not translate into recommended actions. For example, there is recognition that eating disorders, self-harm and suicidal ideation are more common in young women (p135), but no recognition that personality disorders are gendered. Additionally, the report recognises the inadequate funding for the prevention of eating disorders, as well as a lack of specialist services and insufficient data on prevalence and consumer pathways. However, no recommendations are made to address these issues.

While the Productivity Commission recognises that domestic and family violence has mental health impacts, it makes no recommendations to address this and demonstrates no understanding of the gendered nature of domestic and family violence. Effective coordination is needed between the mental health and family violence sectors to ensure an integrated response to women who have experienced

¹ Cohealth [2020], [Productivity Commission recommendations welcome, but fail to address the 'big picture' social determinants of mental health \[Media Release\]](#), Victoria.



violence and trauma. Capacity-building for the mental health workforce is also vital, as evidence shows this workforce is ill-equipped to respond effectively to women who have experienced gendered violence.²

While we commend the Commission's call for trauma-informed care for Aboriginal and Torres Strait Islander women who are incarcerated, we are disappointed that trauma-informed mental health care is not recommended more widely, especially in light of the report's recognition that trauma can have lifetime effects on a person's mental health. A trauma-informed approach is essential to respond effectively to women's mental health needs and experiences. Evidence shows that women are twice as likely as men to experience Post-Traumatic Stress Disorder and that both sex and gender play an important role in the response to trauma.³

We support a life-course approach to mental health and wellbeing. However, the only gendered life stage mentioned in the report is in relation to perinatal depression and anxiety, with the recommendation to *put in place strategies to reach universal screening for mental ill-health of new parents*. This recommendation is made in the context of improving children's mental health, not improving mothers' and parents' mental health in their own right. This is concerning given the high rates of perinatal depression and anxiety,⁴ and the implications of this for women's mental wellbeing and social and economic inclusion, and the fact that suicide was the leading cause of all maternal deaths in Victoria from 2017-2019. The main contributors to maternal suicide are consistently poor mental health, substance use and difficulty accessing services.⁵

Priorities for implementation of the Productivity Commission report

The Women's Mental Health Alliance have identified evidence-based principles and actions for the Department of Health to consider in order to effectively address the mental health and wellbeing needs of women and girls during implementation of the Productivity Commission's recommendations.

1. Apply an intersectional gender-lens on the implementation of the Productivity Commission's recommendations to ensure a gender-sensitive approach is taken to mental health – from prevention and early intervention through to treatment and recovery

Consider during implementation of all recommendations from 1-24.

Applying an intersectional gender lens to the implementation of the Productivity Commission's recommendations is critical to ensure that the mental health needs and experiences of people of all genders are addressed – from prevention and early intervention through to treatment and recovery. In contrast to a one-size-fits-all approach, an intersectional gender-sensitive approach will ensure that programs and services are more effective in improving mental health outcomes for all people.

An intersectional gender-sensitive approach to mental health includes:

- Understanding the mental health needs of all genders and the impacts of mental health initiatives on all genders, especially women and non-binary people whose needs have been historically neglected. This includes understanding not only how gender influences women's mental health

² O'Dwyer C, Tarzia L, Fernbacher S, et al. (2019) Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units, BMC Health Services Research

³ Olf M. (2017). [Sex and gender differences in post-traumatic stress disorder: an update](#). European Journal of Psychotraumatology, 8(sup4), 1351204.

⁴ Anderson R, Webster A, Barr M (2018) [Great expectations: how gendered expectations shape early mothering experiences](#). Women's Health Victoria. Melbourne. - (Women's Health Issues Paper; 13)

⁵ Safer Care Victoria 2021, [Victoria's mothers, babies and children 2019 \[Report\]](#) Safer Care Victoria, Melbourne.

needs and experiences, but also being responsive to the diversity of women's needs, experiences and backgrounds – including race, sexuality and disability – and acknowledging and addressing the compounding impacts of other forms of discrimination and inequality – such as racism, ableism, ageism and homophobia – on women's mental health.⁶ This means ensuring services are culturally safe and accessible for all users – for example, providing services and therapies in community languages delivered by bilingual and bicultural staff.

- Prioritising understanding mental distress in the context of women's lives, for example, any caring responsibilities and social and economic stressors such as poverty, intimate partner violence, housing and employment stress.
- Co-designing initiatives and programs with women and girls with lived experience of mental ill-health, and enabling and empowering them to make choices about their mental health care and treatment.
- Addressing reproductive and life stage elements of mental health and wellbeing. For example, women are at risk of experiencing poor mental health at times of significant change, such as the perinatal period and menopause. Pregnancy and the first year post-partum are times that women are at increased risk of developing poor mental health, with suicide being the leading cause of maternal deaths in Victoria from 2017-2019.⁷ The highest rate of suicide for women is in middle age, which is a time of heightened responsibility and pressure, as women juggle paid employment with childcare and caring for ageing parents.
- Addressing the mental health impacts of gendered experiences including sexual abuse, family violence and poor body image.⁸

Further considerations relating to a gendered approach to primary prevention of mental ill-health and promotion of mental health and wellbeing is explored under Principle 3.

2. Prioritise recommendations relating to women's safety in inpatient units for immediate implementation

This relates to Action 13.2, part of recommendation 13

The report highlights that no one should have to face concerns about their safety during their stay in a mental health inpatient unit. However, the Alliance is concerned that the report does not recommend that women's safety in inpatient units be addressed as an immediate priority. Rather, *Recommendation 13* suggests considering gender-separated wards in future design of acute inpatient wards.

Single sex wards and communal areas are essential for female inpatients to feel and be safe from gender-based violence. Women also frequently request female staff. Findings from the Victorian Mental Illness Awareness Council's consumer consultation workshops show that 87% of female participants want single gender acute wards, with potential for single-gender care and treatment.

Women-only inpatient units should be a 'start now' priority as women's safety is continually compromised in current settings.

⁶ Delara, M (2016) 'Social Determinants of Immigrant Women's Mental Health', *Advances in Public Health*, vol. 2016.

⁷ Safer Care Victoria 2021, [Victoria's mothers, babies and children 2019 \[Report\]](#) Safer Care Victoria, Melbourne.

⁸ This list has been adapted from the principles provided by: British Medical Association (2018) *Addressing unmet needs in women's mental health*. BMA. London. Available from: https://www.cancerresearchuk.org/sites/default/files/womens-health-full-report-aug2018_0.pdf

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

3. Address the drivers of poor mental health – including gender inequality – in all prevention initiatives to ensure an effective, evidence-based approach to primary prevention

This applies to prevention-based recommendations including recommendations 5, 6, 8 and 9.

Attention to social factors which contribute to poor mental health, especially inequality, is critical.⁹ The Productivity Commission's report steps out a number of actions aimed at prevention of and early intervention in mental health issues. These are, however, largely aimed at young people in education settings and do not address the drivers of poor mental health, which include gendered violence, racism, trauma, housing and financial insecurity, inequality, and poor body image.

A gendered approach to prevention of mental ill-health means addressing the gendered social determinants of poor mental health for women, men and gender diverse people at all life stages. At a population level, this involves tackling the broader context of gender inequality that drives poor and unfair mental health outcomes for women and girls, as well as contributing to a host of other social and health inequalities including violence against women.

We welcome the recommendation for a national stigma reduction strategy. This strategy should address stigma and discrimination not only as an issue facing those experiencing mental ill-health, but also as a driver of mental ill-health, and should consider the role of gendered norms and attitudes, as well as gender discrimination.

To effectively prevent mental health issues across the whole population, the Alliance recommend approaching this task using the socio-ecological model, which includes:

- Addressing the structural, as well as individual, drivers of poor mental health, including gendered violence and gender inequality
- Implementing mutually-reinforcing interventions addressing these drivers across multiple settings where people live, work and play (such as schools, workplaces, sporting clubs etc).

Mental health promotion strategies must:

- **Counter the notion that women are intrinsically biologically vulnerable to mental health problems.** Women's experiences of interpersonal violence, gender-based restrictions on opportunities for social and economic participation and an unequal distribution of unpaid work have a disproportionate impact on their mental health.¹⁰
- **Directly address social risk factors, including gender inequality.** For example, the postnatal depression prevention program **What Were We Thinking** seeks to do this using structured, gender-

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

¹⁰ Fisher, J (2017) [Women and Mental Health](#) in *InPsych* 39:1.

informed activities that enable couples to recognise and address stereotypes about the division of unpaid work and understand non-adversarial ways to address conflict. The program has been shown to be effective in reducing postnatal depression and anxiety in the medium and long term.¹¹

- **Ensure health workers are aware of the gender norms and stereotypes** that influence what they say and do. For example, workers should ask a woman when she is starting work as a mother rather than when she is 'giving up' work, and ask how household tasks are shared rather than 'does he help you?'.¹²

It is also possible to draw on existing health promotion approaches, including evidence and frameworks for preventing violence against women, to identify key elements of a gendered approach to mental health promotion. The approach taken to the primary prevention of family violence and all forms of violence against women in Victoria offers a useful example of the application of the public health approach to prevention, including taking an intersectional whole-of-population focus, supplemented by tailored approaches for specific population groups.

Whenever possible, bilingual education around mental illness and stigma should be available for migrant communities from non-English speaking backgrounds. Education should be delivered by trained bilingual educators and community leaders who are supported, remunerated and recognised for their work. Similarly, campaigns or public information about mental illness, mental health and mental health services should be developed in consultation with relevant communities, to ensure that both English content and translated content are widely accessible, appropriate and that content remains meaningful for all communities.

4. Ensure mental health systems and services are trauma-informed

This needs to be considered specifically for recommendations 12, 13, 14 and 16.

A trauma-informed approach needs to be applied across all mental health services and systems in line with evidence-based practice. Research is increasingly demonstrating strong links between traumatic experiences and a range of mental health diagnoses, including 'borderline personality disorder' and Post-Traumatic Stress Disorder. Being trauma-informed is increasingly being recognised both in Australia and internationally as a leading principle of care. Implementation of the Productivity Commission's recommendations is a key opportunity to embed trauma-informed practice across systems and services. Trauma-informed practice is not just a workforce issue, but a whole-of-organisation issue.

It is important to ensure that trauma-informed practice is also gender-responsive, recognising gender differences in the experience and impact of trauma. Overall, women have a two to three times higher risk of developing PTSD compared to men. This difference is believed to be attributable to both psychosocial factors (women are more likely to be exposed to prolonged and high impact trauma and at a younger age) and biological factors (sex differences in how the brain responds to trauma).¹³

A gender-sensitive, trauma-informed approach to mental health reform should include:

¹¹ Fisher et al (2018) *Gender-informed psycho-educational programme to promote respectful relationships and reduce postpartum common mental disorders among primiparous women: long-term follow-up of participants in a community-based cluster randomised controlled trial*, Global Mental Health, doi:10.1017/gmh.2018.20.

¹² Fisher, J (2020) [Gender competence and mental health promotion](#). World Psychiatry 19:1.

¹³ Olf M. (2017). [Sex and gender differences in post-traumatic stress disorder: an update](#). European Journal of Psychotraumatology, 8(sup4), 1351204.

- Women-only areas with specific groups/treatment approaches tailored for women
- Provision of physical healthcare along with mental health care with a female focus
- Ensuring trauma therapy is available for women with early life and later life traumas
- Integrating support for and treatment of mental health concerns with support and treatment for substance use, violence and trauma
- Ensuring inclusion of a continuum of treatments/responses – from walking groups/peer support to brief interventions to counselling/therapy and medication
- Understanding day-to-day social, family and economic realities including: caring responsibilities (ensuring women feel valued and supported in their role as mother/carer) and social and economic stressors e.g. poverty, intimate partner violence, housing and employment stress
- Addressing barriers women face in accessing treatment such as: shame, stigma, fear of not being believed or fear of losing their children; and structural barriers such as cost, lack of time or transport, or childcare concerns.¹⁴

5. Ensure the mental health workforce is trained to effectively support the diverse needs of women, girls and gender non-binary people

This should be considered during the implementation of recommendation 16.

The Productivity Commission report recognises that building and strengthening the mental health workforce is a core foundation for ensuring access to a range of services and supports.

The report recommends a number of actions [16.1- 16.7] aimed at aligning the workforce to better meet the needs of consumers. While the Alliance agrees that workforce development is key to improving services and creating a person-centred mental health system, we also highlight the importance of addressing organisational structures and culture - rather than simply 'training' for individual staff. For example, despite sexual safety guidelines being in place in state-run facilities, their failure to improve women's safety suggests they have never been implemented effectively. This raises a question about what training, capacity-building and organisational culture change has been implemented to embed these guidelines in mental health practice.

In addition to the actions recommended by the Productivity Commission, the Alliance recommends the following to build the capacity of the mental health workforce to better respond to women's mental health needs:

- **Ensure the mental health workforce is gender competent.** This means having the capacity to recognise gender-based discriminatory attitudes and behaviours; knowing about gender-based anti-discriminatory policies and initiatives; and implementing actions to counter gender-based stereotypes in research, training and clinical practice. Gender competence seeks to comprehend and address gendered experiences of discrimination, interpersonal violence and being devalued, and to counter internalised beliefs about roles, rights and responsibilities.¹⁵ Gender competence should also incorporate cross-cultural awareness. Some staff see providing gender-responsive care

¹⁴ NADA (2016) Working with women engaged in alcohol and other drug treatment – 2nd ed. - Network of Alcohol and other Drugs Agencies (NADA). Sydney

¹⁵ Fisher, J (2020) [Gender competence and mental health promotion](#). World Psychiatry 19:1.

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,¹⁶ highlighting the importance of whole-of-organisation capacity-building and a commitment from leadership.

- **Introduce routine screening for trauma and abuse.** In the absence of direct questioning, survivors of domestic violence are reluctant to disclose abuse to health service providers.¹⁷ However, research indicates that effective routine screening for experiences of violence by mental health professionals is infrequent. When experiences of abuse are disclosed to mental health professionals, it is unclear whether these disclosures are meaningfully incorporated into professional formulations and treatment plans.¹⁸
- **Build workforce capacity to respond to women's experience of trauma.** An understanding that domestic and family violence, and other forms of trauma, underlie mental health issues for many women should underpin workforce and service responses. International evidence shows that mental health professionals have low levels of competence and confidence in addressing domestic violence and abuse issues with clients/patients.^{19,20} Workers would benefit from training on, for example: noticing trauma responses; not forcing disclosure; creating safety; building trust; supporting choice and control; and offering to teach self-regulation skills. Women's experiences of coercion and restrictive practices must also be treated as potential sources of trauma themselves. Recognising these experiences and avoiding their perpetuation through, for instance, training and resources for staff to implement alternatives to coercion, is a necessary element of staff training and workforce capability building.²¹
- **Bilingual and bicultural workforce:** In order to deliver culturally appropriate services for people from migrant and refugee communities, mental health services and organisations must employ bilingual and bicultural staff. Whenever possible, bilingual education around mental illness and stigma should be available. High quality and culturally appropriate service delivery is facilitated by:
 - comprehensive, ongoing, in-person support and case management to migrant and refugee families accessing the service

¹⁶ O'Dwyer C, Tarzia L, Fernbacher S, et al. (2019) Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units, BMC Health Services Research

¹⁷ Trevillion K, Hughes B, Feder G, Borschmann R, Oram S, Howard LM (2014) *Disclosure of domestic violence in mental health settings: A qualitative meta-synthesis*. International Review of Psychiatry. 26 (4):430-44. Available from: <https://doi.org/10.3109/09540261.2014.924095> and Rose D, Trevillion K, Woodall A, Morgan C, Feder G, Howard L. (2011) *Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study*. Br J Psychiatry; 198(3):189-194. doi:10.1192/bjp.bp.109.072389

¹⁸ Sellick, K., D. Rose, and L. Harms, *Hearing voices, sexual abuse and service system responses*. Psychosis, 2020. 12(1): p. 11-22.

¹⁹ Ruijne, R.E., et al., *Mental health professionals' knowledge, skills and attitudes on domestic violence and abuse in the Netherlands: cross-sectional study*. BJPsych Open, 2019. 5(2).; Rose, D., et al., *Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study*. The British Journal of Psychiatry, 2011. 198(3): p. 189-194; Hegarty, K., *Domestic violence: the hidden epidemic associated with mental illness*. British Journal of Psychiatry, 2011. 198(3): p. 169-170.

²⁰ Rose D, Trevillion K, Woodall A, Morgan C, Feder G, Howard L. (2011) *Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study*. Br J Psychiatry. 198(3):189-194. doi:10.1192/bjp.bp.109.072389

²¹ Kezelman, C. and Stavropoulos, P. (2012) *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery – Blue Knot Foundation*. And Mental Health Coordinating Council (MHCC) (2013) *Trauma Informed Care and Practice: Towards a Cultural Shift in Policy Reform across Mental Health and Human Services in Australia – A National Strategic Direction*. And Williams, J., Scott, S. and Waterhouse, S. (2001) 'Mental Health Services for "Difficult" Women: Reflections on Some Recent Developments', *Feminist Review*, 68(1): 89–104

- recognising that many technology-based modes of service delivery exclude some users of non-English speaking backgrounds from accessing timely early intervention services
- ensuring that migrant and refugee clients do not pay for interpreting or translating
- training mental health services staff and the interpreting workforce in gendered cross-cultural awareness

While training is fundamental, ultimately what is needed is capability-building, which requires a whole of organisation approach - addressing organisational structures and culture - rather than simply 'training' for individual staff.

System and cultural change is needed to address entrenched attitudes and behaviours - and fundamentally shift the values and approach embedded in current mental health practice, which are based on a male model or standard. Therefore, it is essential that:

- Senior staff are engaged and buy into the change process, prioritise the issue of gender equality, 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/Board), which are important to drive engagement and prioritisation at the leadership and middle management levels, are accompanied by values-driven change management.
- The representation of women in senior roles is increased; for example, in psychiatry there is a disproportionately low number of women in leadership positions.

We also need to take a **gender-sensitive approach to supporting the mental health workforce** (particularly given the increased focus on peer workers). A gender-sensitive approach to workforce recognises that:

- The majority of the mental health workforce are women and potentially juggling multiple roles including their work
- Many of the life experiences of women service users are common and therefore likely to be shared by a significant number of staff e.g. violence/abuse, bereavement
- Aspects of mental ill health experienced by women service users e.g. depression, anxiety, substance misuse and eating disorders will also be/have been experienced by a significant number of staff
- 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 an essential element of staff support e.g. out-of-hours crisis support, confidential counselling services.²²

²² Mainstreaming Gender and Women's Mental Health Implementation Guidance, Department of Health, Mental Health, Health & Social Care Standards & Quality Group, 2003, UK.

6. Collect gender-disaggregated data, undertake a gender analysis and centre the consumer as part of monitoring and evaluation of implementation outcomes

This needs to be considered during the implementation of all recommendations 1-24.

As part of the implementation of these recommendations, it is imperative that each action is fully evaluated to consider the impacts on people using mental health services.

Gender-disaggregated data should be collected, analysed and reported on to ascertain whether interventions are successful for people of all genders. Where possible, data should also be disaggregated by other demographic characteristics. Consumers must be centred in evaluating programs that affect them; too often evaluations privilege the perspectives of clinicians and service providers.

As an example, the UK Women's Mental Health Taskforce (2018) recommended a research and data commissioner be established to improve the evidence base around women's mental health. It proposed the following principles for ensuring sex and gender are considered in research and data:

- **Study Design:** To improve consideration of sex and gender, research should be informed by involving women and considering gender from the outset.
- **Collect Data:** More should be done by researchers to collect data on topics that are relevant to women and their health, such as violence and abuse, poverty, physical health and the impact of different medications on women of different ages.
- **Data Access:** To make progress in women's mental health research and to understand women's lives and use of services, it is important to be able to access timely, affordable, research-quality data.
- **Data Analysis:** Research gaps must be identified and addressed that currently limit understanding of women's mental health and their service needs.
- **Publish Data:** Statistics and routinely collected data, disaggregated by sex and other characteristics, must be published in meaningful and accessible formats.

Conclusion

The implementation phase of the Productivity Commission's final inquiry report on Mental Health's presents an opportunity for the Department of Health to apply an intersectional gender lens across all recommendations to ensure they are gender-responsive and effectively address the mental health needs of all women, girls, men, boys and non-binary people. Applying an intersectional gender lens to the implementation of the Productivity Commission's recommendations is critical to ensure that the mental health needs and experiences of people of all genders are addressed – from prevention and early intervention through to treatment and recovery.

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