The Royal Commission and women's mental health: Challenges and opportunities

Responses to questions raised in the webinar

How do we support women's mental health if they can't access services/support due to complex situations in their lives (e.g. family violence)?

WHV: During the pandemic, many family violence response services have recognised that public health restrictions are constraining women's ability to access services and have shifted to delivering more support online and after hours. Additional online support is also available from mental health services like Beyond Blue, Head to Help, Butterfly Foundation and Lifeline. Increased access to support via online and after-hours services is something we hope can be retained after restrictions ease – including via new Local Mental Health & Wellbeing Services – since we know many women will continue to face barriers to access.

We also need to build cross-disciplinary capability so that services can provide a more holistic response and women receive appropriate support no matter which 'door' they enter. This means building capability within both the family violence response and mental health sectors to understand and respond to the mental health impacts of family violence and support recovery.

Many women are conditioned to prioritise caring for others above themselves. How can we debunk this conditioning so women can be supported in whatever circumstance they find themselves?

WHV: We still have a long way to go in shifting gendered attitudes that contribute to poor mental health for people of all genders. Recent research from colleagues at the University of Melbourne has found that, for both men and women, egalitarian gender attitudes were associated with better mental health.[1]

This is long-term work, but some ideas for how we can address this include:

- Continuing to address gender stereotypes, norms and attitudes that create expectations about the role and value of women in society;
- Continuing to address gendered social and economic inequalities that mean women are more likely to take on unpaid care responsibilities;
- Providing additional support for carers to support their mental health and wellbeing.

[1] T. King et al (2021). Traditionalism vs egalitarianism: Is there an association between gender attitudes and mental health? *Australian & New Zealand Journal of Psychiatry*. doi:10.1177/00048674211031488

How do we best support women who have a dual diagnosis (substance use and mental health)?

WHV: The Royal Commission recommended that all mental health and wellbeing services, across all age-based systems, including crisis services, community-based services and bed-based services, should provide integrated treatment, care and support to people living with mental illness and substance use or addiction (Recommendation 35).

International evidence suggests integrated mental health and substance use services are an effective model for women with a dual diagnosis. Many women experience a constellation of issues (mental health concerns, together with violence, unstable housing and poverty) and benefit from a more comprehensive response across a wider range of services/locations.

A gender and trauma lens on substance use is important. Along with many sex-specific factors that affect both women's substance use and its effects, there are also many gendered influences that determine the course of prevention, use, treatment or recovery. The majority of women and men with substance use problems report having experienced some form of trauma, and most have experienced multiple traumas.

Canadian scholars Nancy Poole and Lorraine Greaves have done extensive work on the intersections between gender, trauma, substance use and mental health. Their research indicates that often women reveal the full extent of their substance use, only when they feel safe, accepted, not stigmatised, and when their program/service is meeting their practical needs.[2] As part of the roll-out of Royal Commission Recommendation 13, there is an opportunity to explore whether gender-separated/gender-safe spaces in substance use services would be beneficial.

What do the speakers think about naming the specific forms of oppression we are trying to change, such are ableism, racism, sexism etc. in the work?

WHV: Any approach to recognising and responding to the diverse needs of service users needs to be underpinned by an understanding of the impacts of inequality and discrimination on mental health. In addition to ensuring services are responsive to people's needs and experiences, we must also address the structural and systemic inequalities, assumptions and biases – arising from racism, sexism, ableism, homophobia etc – that influence individuals' mental health and access to and experiences of the mental health system.

We should focus on addressing inequality at a structural level within the mental health system, 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'.

[2] L. Greaves (2021). 'Chapter 1: Missing in Action: Sex and Gender in Substance Use Research' in L. Greaves (ed) (2021). Sex, Gender and Substance Use, *International Journal of Environmental Research and Public Health*. Some other publications from Poole and Greaves that may be of interest include: L. Greaves, N. Poole, E. Boyle (eds) (2015). Transforming Addiction: Gender, Trauma, Transdisciplinarity, Routledge; L. Greaves and N. Poole N (eds) (2008). Highs and Lows: Canadian Perspectives on Women and Substance Use.

In all your years advocating what would you see as the most important changes that have happened in women's mental health?

Maggie Toko: I feel that women's issues are on the agenda finally. The promotion of family violence has enabled women to speak out and make choices which are in the public sphere. Women's rights are front and foremost and our human rights and equality are number 1 issues today. This would not have happened had women not campaigned for years to be heard. I remember speaking at Reclaim the Night in 1997 asking for women's rights to be recognised, for First Nations women to be recognised for the strong women they are – it has taken 24 years for that shift to happen, thank goodness.

Will there be specific funding dedicated to new gender-separated units?

WHV: Dedicated funding has been allocated for the new specialist women's mental health service (35-bed public-private partnership). However, the new women's mental health service is funded at one-eighth of the cost per bed as the 120 'mainstream' mental health beds funded in the November 2020 State Budget.

The Alliance is not aware of specific funding for upgrading existing mental health units to enable gender separation nor for new gender separated units within mainstream services. However, we understand gender separation has been included as a specification for all new beds/units and are seeking further information from the Department of Health about how this is being rolled out.

What does the panel think of the timeline for eliminating seclusion and restraint and the impact of this timeline on women's experience of the mental health system?

WHV: In our submission to the consultation on the new Mental Health & Wellbeing Act, the Alliance advocated for this timeline to be shortened to a maximum of five years, down from ten years.

You can also read our gender analysis of the recommendations related to the elimination of seclusion and restraint here.

Complex trauma is behind many mental health diagnoses. How can hospital admissions be more respectful to all women who are admitted?

WHV: 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. Unfortunately, as discussed in the webinar, 'trauma-informed' care or practice is a commonly used term, but not often meaningfully applied in practice.

Trauma-informed care needs to extend beyond individual practice to the whole organisation 'from the environment to the reception staff'.[3] Services need to recognise the potential for coercive

[3] K. Hegarty et al (2017), Women's Input into a Trauma-informed systems model of care in Health settings: The WITH study – Final report (ANROWS), p 3-5.

practices within health settings to be retraumatising and avoid their perpetuation through training and resources for staff to implement gender- and trauma-informed alternatives to coercion.

The Alliance has recommended that trauma-informed practice be included as an additional stand-alone principle in the new Mental Health & Wellbeing Act to create a standard/expectation for all staff across all health and mental health services.

What do we want the public at large to think/say/do on the issue of gender-based violence in mental health facilities?

WHV: Despite multiple inquiries and reports, the prevalence of gender-based violence in mental health facilities remains an under-recognised issue – within the mental health service system, among policy-makers and across the broader public. Thankfully we are seeing this issue finally getting some traction in Victoria, but it remains an unaddressed issue in many other jurisdictions.

The first step is raising awareness of the issue. The voices of women with lived experience – those who are feel safe and able to speak out about their experiences, recognising this can be very retraumatising – are important here. We know what the solutions are – gender separated services and a gender sensitive workforce – so we need advocates and the public to keep pushing for this and not accept any excuses for why this can't be done.