

VMIAC Policy Position Paper #4: Gender Discrimination and Inequality

Purpose

To eliminate and prevent discrimination and inequality against consumers on the basis of gender and gender identity.

A note on language: VMIAC supports every person's right to determine how their gender is described. For the purposes of this paper, references to 'women' refer to any person who identifies as such, and references to 'men' refer to anyone who identifies as being a man. The term 'gender diverse' will be used to refer to trans individuals who do not identify as being a man or a woman, as well as gender fluid and non-binary individuals.¹

The Issue

Women and gender diverse people experience many inequalities in society. Women are over a third more likely than men to be diagnosed with 'mental illness'² and gender diverse people experience mental health issues at more than twice the rate of the general population.³ Both women and gender diverse individuals are more likely to have experienced trauma in their lifetime than men.⁴ Issues experienced by these groups include:

- **Gender inequality as a driver of mental and emotional distress** – despite supposed equal rights under international and domestic law,⁵ women and gender diverse people experience inequality, discrimination, increased risk of abuse and gendered violence,⁶ poverty and homelessness at a rate far higher than men.⁷ These inequalities, combined with rigid gender roles and increased exposure to trauma contribute to the increased risk of mental and emotional distress experienced by many women and gender diverse individuals. These issues must be addressed in order to ensure equality in mental health for these groups.⁸
- **Discrimination in psychiatry** – Psychiatry has a long history of discrimination against women and gender diverse individuals. Diagnoses such as Borderline Personality Disorder ('BPD'), Histrionic Personality Disorder ('HPD') and Gender Dysphoria are based on outdated, stigmatizing and restrictive attitudes about gender and gender roles.⁹ Psychiatric treatments also reflect discrimination, with women historically being excluded from clinical trials for medication. Recent research demonstrates that women have differing responses to medications than men,¹⁰ in spite of the fact that women are more likely to be prescribed these medications.¹¹
- **The medical model fails to address trauma and distress** – trauma and distress cannot be adequately addressed by the medical model and in many cases attempts to do so cause further traumatising.¹² The medical model fails to identify and respond to the gendered drivers of distress and trauma and reinforces restrictive gender norms by relying on a risk averse, 'paternalistic' approach to mental health care.¹³ In many cases, what are seen as symptoms of 'mental illness' are actually adaptive responses to overwhelming situations.¹⁴ The medical model pathologizes distress in order to make it tangible, and accordingly, treatable.¹⁵

¹ VMIAC notes that the use of the term 'Culturally and Linguistically Diverse' ('CALD') can be considered problematic. We use 'CALD' in this paper in order to acknowledge that amongst different cultures, there are often very different norms and expectations with respect to gender and gender roles and that this can impact equality.

² Australian Bureau of Statistics, Mental and Behavioural Issues 2017 – 2018 (December 2018) ABS < <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/mental-health/latest-release>>; Jill Astbury, 'Gender disparities in mental health' (WHO, 2001) 2.

³ National LGBTI Alliance, 'Snapshot of Mental Health and Suicide Prevention Statistics for LGBTI People', (National LGBTI Alliance, February 2020), 3; Ruth McNair & Rachel Bush, 'Mental health help seeking patterns and associations among Australian same sex attracted women, trans and gender diverse people: a survey-based study' (2016) BMC Psychiatry, 7; Ada Cheung et al, 'Non-Binary and Binary Gender Identity in Australian Trans and Gender Diverse Individuals' (2020) 49 Archives of Sexual Behaviour 2673, 2676 – 2677.

⁴ Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing: Summary of Results (October 2008) ABS < <https://www.abs.gov.au/statistics/health/mental-health/national-survey-mental-health-and-wellbeing-summary-results/latest-release>>; The Mental Health Complaints Commissioner, 'The Right to Be Safe – Ensuring Sexual Safety in Acute Mental Health Inpatient Units: Sexual Safety Project Report' (State of Victoria, March 2018) 45.

⁵ For example, see: Convention on the Rights of People with Disabilities, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 16 August 2008) art 16; Sex Discrimination Act 1984 (Cth) s 4(b); Equal Opportunity Act 2010 (Vic) s 6.

⁶ Australian Human Rights Commission, National Inquiry into Sexual Harassment in Australian Workplaces, Report (2020) 138 – 143.

⁷ Astbury, above n 2, 3; Women's Mental Health Network Victoria, Submission to the Royal Commission into Victoria's Mental Health System, Royal Commission into Victoria's Mental Health System, July 2019, 20.

⁸ Fiona Judd, Sue Armstrong & Jayashri Kulkarni, 'Gender-sensitive Mental Health Care' (2009) 17(2) Australasian Psychiatry 105, 107; National LGBTI Alliance, above n 2, 3; Carol O'Dwyer et al, 'Health Professionals' Experiences of Providing Trauma-Informed Care in Acute Psychiatric Inpatient Settings: A Scoping Review' (February 2020) 2; Astbury, above n 2, 2; McNair & Bush, above n 3, 7.

⁹ Jane M Ussher, 'Diagnosing difficult women and pathologising femininity: Gender bias in psychiatric nosology' (2013) 23(1) Feminism & Psychology 63, 65.

¹⁰ It could be extrapolated from this that gender diverse consumers would likely have a different response again: Nikolaos Kokras, Christina Dalla & Zeta Papadopoulou-Daifoti, 'Sex differences in pharmacokinetics of antidepressants' (2011) 7(2) Expert Opinion on Drug Metabolism & Toxicology 213, 214 – 216; Kristen L Bigos et al, 'Sex Differences in the Pharmacokinetics and Pharmacodynamics of Antidepressants: An Updated Review' (2009) 6(4) Gender Medicine 523, 523 – 535; Judd, Armstrong & Kulkarni, above n 8, 107.

¹¹ Londa Schiebinger, 'Women's Health and Clinical Trials' (2003) 112(7) The Journal of Clinical Investigation 973, 974. Of note, Valium was never tested in randomised, controlled clinical trials with women, in spite of the fact that it has historically been overprescribed in women.

¹² Australia's National Research Organisation for Women's Safety ('ANROWS'), 'Violence Against Women and Mental Health' (ANROWS Insights, April 2020), 4 – 5.

¹³ O'Dwyer et al, above n 8, 7 – 8; The Mental Health Complaints Commissioner, above n 4, 77.

¹⁴ ANROWS, above n 12, 4 – 5.

¹⁵ Ussher, above n 9, 63, 64.

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- **Underrepresentation of women and gender diverse individuals in leadership roles** – This is particularly important in relation to the representation of women and gender diverse consumers with lived experience of mental and emotional distress. As the late US Supreme Court Justice Ruth Bader Ginsberg said, "Women belong in all places where decisions are being made. It shouldn't be that women are the exception." In Victoria, four out of the 21 Clinical Directors of the Area Mental Health Services are women.¹⁶ The underrepresentation of women and gender diverse people in leadership roles is yet another example of the inequalities experienced by these groups. The system cannot be effective if more than half of the people it is designed to help are not represented in its governance.

Our Position

- **Women and gender diverse individuals must have equal access to human rights** – human rights do not currently apply equally to women and gender diverse people. Equality in human rights will improve the mental health of these groups by reducing the social drivers of distress, such as violence, discrimination, unequal pay and workforce participation and gender norms. Equality in human rights will also improve access to gender appropriate services, through recognition of the fact that women and gender diverse consumers often have different needs than men.
- **The medical model perpetuates gender inequality** – the medical model pathologizes and discriminates against people who fail to conform to accepted gender norms and in doing so, reinforces harmful stereotypes and inequality. It is not equipped to address the prevalence and impact of trauma, especially as it relates to women and gender diverse individuals.¹⁷ We must acknowledge the limiting nature and negative impact of the medical model on women and gender diverse people in order to address inequality.
- **Equality requires trauma-informed and gender-sensitive care** – trauma-informed and gender sensitive care are critical to addressing the gendered inequality experienced by women and gender diverse consumers in relation to mental health.¹⁸ Trauma informed care works from the assumption that our distress is caused by our life experiences, and asks what *happened* to us rather than what is *wrong* with us.¹⁹ Gender sensitive care involves acknowledgement of the role that gender plays in determining mental health outcomes and responding to this so as to treat the person in a holistic way, and preventing further trauma. This includes consideration of differences in cultural gender norms, socio-economic status, trauma history and biology and the impact that these factors have on mental health outcomes for women and gender diverse consumers.²⁰ Successful implementation of these practices across all sectors will prevent re-traumatisation of vulnerable people and will be a crucial step in ensuring the attainment of equal rights for women and gender diverse consumers.

Our recommendations

VMIAC calls upon the Victorian government to take immediate steps to prevent discrimination and guarantee the equal rights and of women and gender diverse individuals when accessing inpatient mental health treatment. Specifically, VMIAC recommends:

1. **That the Victorian Government take immediate steps to address gender discrimination, hate and violence.** Provision of funding for research into gender-based drivers of poor mental health and treatments that are appropriate and effective for women and gender diverse consumers is critical to address discrimination.²¹ The Victorian government must also undertake law and policy reform to prevent and eliminate all forms of gendered discrimination, hate and violence. This includes reforms to the vilification and equal opportunity laws to better protect women by enabling equal protection by the law and effective enforcement by regulators, including the Victorian Equal Opportunity and Human Rights Commission.²²
2. **That the Victorian government immediately fund the implementation of gender-sensitive, trauma informed training and practice across all sectors.** This is of crucial importance if we are to address the issues of trauma and gendered violence. It is not enough for health services alone to implement these

¹⁶ Richard Newton et al, 'The challenges facing the public mental health sector: implications of the Victorian Psychiatry workforce project' (2019) 27(6) *Australasian Psychiatry* 618, 620.

¹⁷ Australia's National Research Organisation for Women's Safety, 'Preventing Gender based violence in Mental Health Units' (ANROWS, July 2020), 14.

¹⁸ Australia's National Research Organisation for Women's Safety, 'Horizons Report: Women's Input into a Trauma-informed Systems Model of Care' (ANROWS, May 2017), 46 – 47.

¹⁹ The Mental Health Complaints Commissioner, above n 4, 47 – 53.

²⁰ Judd, Armstrong & Kulkarni, above n 8, 105 – 107.

²¹ Women's Mental Health Alliance, 'Statement from the Women's Mental Health Alliance' (Women's Health Vic, November 2019) 1 – 2.

²² We support the expansion of Victorian Equal Opportunity and Human Rights Commission's powers under the Equal Opportunity Act 2010 (Vic) and the Racial and Religious Tolerance Act 2001 (Vic): Victorian Equal Opportunity and Human Rights Commission, Submission to the Parliament of Victoria, Inquiry into Anti-Vilification Protections, 31 January 2020.

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practices. We are currently required to have contact with many and varied services in order to receive adequate treatment, including sexual health services, mental health services, the justice system, family violence services and child protective services. We need a push for education and training in trauma informed and gender sensitive care across the board in order to address gendered inequality in mental health.

3. **That health services prioritise the implementation of gender sensitive, trauma-informed and holistic care.** Training should be provided on an ongoing basis, and these practices should be utilised holistically when treating every individual, instead of relying only on the medical model. We urgently need to eliminate restrictive practices and compulsory treatment in order to prevent the re-traumatisation of consumers. Services must also take steps to ensure the substantive equality of women and gender diverse individuals. These steps could include separate spaces for women and gender diverse individuals who do not feel comfortable in mixed gender units.²³
4. **That the Victorian Government immediately fund research into co-produced, co-designed services that include the voices of women and gender diverse consumers.** Lived experience must be at the forefront of this research. Research should include a gender-lens to examine current practices and drivers of poor mental health for women and gender diverse consumers.²⁴ We urgently need a more integrated system that includes cross communication and referral between services (for example, strengthening the relationship between trauma specialist services and mental health services)²⁵ and comprehensive trauma-focused services that are located outside of the clinical mental health system. Reform of the current system must ensure that women and gender diverse consumers are represented in leadership roles in order to address the inequalities experienced by these groups with respect to mental health.

Background

- Throughout history women have been pathologized for being ‘female.’²⁶ This is evident in the historical diagnosis of ‘hysteria’, which was first described by the Ancient Greeks and was only removed from the DSM in 1980. While conceptions of hysteria changed over time, the underlying message remained the same – women who do not conform to accepted gender norms are ‘mentally ill.’²⁷
- Diagnoses such as BPD and HPD are derived from the now outdated diagnosis of ‘hysteria.’ These diagnoses are discriminatory and known to be strongly correlated with trauma, and yet many individuals who receive these diagnoses are stigmatised and often re-traumatised as a result.²⁸
- Discrimination is also evident in psychiatric treatments - up until the late 1980s, women of childbearing age were prevented from being included in clinical trials for medications, which means that most of the psychiatric medications on the market today were originally tested in men.²⁹
- Current processes for assessing vulnerability and risk have been identified as being inadequate and constitute harm minimisation strategies at best.³⁰ Trauma histories are often not taken by staff, and where they are, they are simply tick boxes, with no further inquiry made in relation to what would help the individual to feel safe.³¹ Consumers have identified that they do not feel comfortable disclosing trauma histories to staff and that where they do, they are often met with invalidating and dismissive responses. While there is widespread consensus on the need for trauma-informed and gender sensitive care, most services have yet to fully implement this.
- The introduction of the *Mental Health Act* in 2014 purported to promote a human rights-based approach, however it explicitly allows for restrictive practices such as seclusion and restraint, which are incompatible with human rights, re-traumatising for consumers and often experienced as gendered violence.

²³ Current rights legislation allows for special measures to be taken in order to achieve substantive equality: Sex Discrimination Act 1984 (Cth), s 7C; Equal Opportunity Act 2010 (Vic), s 15.

²⁴ Women’s Mental Health Alliance, above n 21, 1 – 2.

²⁵ The Victorian Mental Illness Awareness Council, ‘Zero Tolerance for Sexual Assault: A Safe Admission for Women’ (VMIAC, 2013), 14 – 25; ANROWS, above n 12, 11.

²⁶ Ussher, above n 9, 63 – 65.

²⁷ Ibid.

²⁸ ANROWS, above n 12, 5.

²⁹ Schiebinger, above n 11, 974.

³⁰ ANROWS, above n 17, 55.

³¹ The Mental Health Complaints Commissioner, above n 4, 70; VMIAC, above n 25 27.