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POLICY SERIES

Mainstreaming Women's Mental Health

BUILDING A CANADIAN STRATEGY

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Building a Canadian Strategy

A National Women's Mental Health Strategy

Evidence shows that certain mental illnesses are more prevalent in women, that women utilize mental health services more frequently than men do, and that women would like a wider range of treatment and support options than is currently available.[14,15,10,11,12] Collectively, this evidence suggests that the mental health needs of women are significantly different from those of men and warrant particular attention.[1,2] To date, this evidence has not been translated into policy and practice in the mental health system, contributing to treatment inadequacies and less-than-optimal mental health outcomes for women.

Mental health care services have been described as the "orphan children" of Medicare.[3:178] This reflects both the fact that mental health services have historically received a relatively small portion of federal and provincial health budgets and that only certain kinds of mental health services (i.e., primarily psychiatric) are covered by Medicare. The result is a two-tiered system in which people with financial resources and/or private health coverage can access a wider range of mental health service options than those without such coverage who must rely on the public system. Women's concentration in lower wage sectors and in part-time employment makes them more likely to be ineligible for employee assistance programs and extended health coverage. In addition, health reform and restructuring are shifting the ways in which mental health services are delivered through the involvement of more home- and community-based providers.

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The Canadian Alliance on Mental Illness and Mental Health[4] recently called for a national policy framework and an organized mental health research agenda. The last national report and strategy pertaining specifically to women's mental health dates back to 1993[2] and no longer reflects the current health reform context.

As governments make key decisions about health care funding and delivery it is imperative that they utilize the evidence base and strategies necessary to improve the mental health system's responsiveness to women and their unique mental health needs. A national women's mental health strategy would provide this by:

- Making recommendations about the kinds of mental health services that should be covered under Medicare and the kinds of funds needed to provide these.

- Recommending that the federal government mandate provincial/territorial resource allocation for services and supports for women with mental illness that take into account current reforms (e.g., the shift of care from institutions to the community).
- Making recommendations for support and treatment models for women that take into account the intersections between mental illness, addictions, poverty, homelessness, and past and present experiences of physical and sexual violence.
- Making recommendations about utilizing and expanding the evidence base with respect to the mental health needs of diverse groups of women.
- Providing the tools to assist policy-makers, health planners and researchers in applying a gender-based analysis to their work and developing women-centred mental health care models.
- Suggesting consumer involvement models that would actively engage women in decision-making processes.

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1. Sex, Gender, and Women's Mental Health

Differing rates and diagnoses of mental illness between men and women are the result of an interaction between biological (sex) and social (gender) factors. The following section briefly reviews the evidence with respect to sex and gender differences in mental health as they pertain to women.

Prevalence

Sex differences exist in the rates of specific mental health problems.[1,5] For example, women are almost twice as likely as men to experience depression[6] and anxiety.[7] This is also a problem among Canada's young female population – the incidence of depression is significantly higher among young women than among young men.[8] Women are more likely than men to be diagnosed with seasonal affective disorder, eating disorders, panic disorders, and phobias, and they make more suicide attempts.[9] These differences have implications for the treatment and ongoing support of women with mental illness.

Pharmacological differences

As yet, little is known about how sex and gender differences over the life course affect the metabolism, overall efficacy, and side effects of many medications, including tricyclic antidepressants, selective serotonin reuptake inhibitors (SSRIs), neuroleptics, sedatives, and benzodiazepines.[10,11] Sex differences, such as variations in lean body mass, hormonal concentrations, and gastric absorption, have been shown to affect the absorption, distribution, metabolism, and elimination of drugs and the biochemical and physiologic effects of drugs.[10,11] More research is needed to better understand women's reactions to psychotropic drugs

in order to minimize adverse side effects and optimize the benefits of drug therapies.

Patterns of access and utilization of mental health services

Women access the mental health system more frequently, receive treatment more often, and have higher rates of hospitalization for psychiatric problems than men do.[12,13,14] Moreover, women cope with stress and life events in different ways and vary from men in how they signal their distress.[15] These differences may have implications for the diagnoses and treatments women receive. For example, some psychological assessment methods do not consider women's past or present experiences of violence or how their mothering responsibilities might be relevant to their situation.[16]

Social inequality, violence, and addictions

There is an established association between poverty and mental illness.[17] Women, especially elderly women, Aboriginal women, and single mothers, are disproportionately poorer than men.[18] For women with mental illness, poverty is often associated with increased risk of violence and abuse.[19] When these inequities and vulnerabilities are not addressed in treatment, program development, and policy, women's illness may be exacerbated and their safety may be compromised. Research has also shown a strong connection between violence, mental illness, and addictions and some treatment models have begun to successfully address these interconnections.[20,21]

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Diversity

Women are not a homogenous group. Sex and gender intersect in numerous ways with age, class, ethnicity, sexual orientation, physical and mental ability, gender identity, and life experience and result in different mental health outcomes among women. For example:

- Research has described how the process of resettlement and pre-immigration experiences affect women's mental health, sometimes resulting in increased anxiety and depression.[2,22,23]
- The legacies of colonization and residential schooling have resulted in cultural discontinuity and oppression in many Aboriginal communities that have been tied to high rates of depression, alcoholism, suicide, and violence against Aboriginal women.[24] Between 1989 and 1993 Aboriginal women in Canada were more than three times as likely to commit suicide as were non-Aboriginal women.[25]
- Socioeconomic status, race, and gender have been found to intersect and influence the presence of depression.[26] Aboriginal youth have been found to have one of the highest rates of depression because they live in the lowest

socioeconomic conditions compared to other groups.[27] Overall, the highest prevalence of depression is found among Aboriginal women due in part to their often impoverished living conditions.
- Lesbians and bisexuals have higher rates of suicide than the general population,[12] often experience discrimination because of their sexual orientation, and are more frequently the victims of hate crimes.
- Although little research has been done on the mental health needs of transgendered women, it is clear that gender identity issues are an important component of women's mental health.

Mental health across the life course

Women's mental health needs differ across the life course. During their childbearing years women may require mental health supports related to pregnancy and post-partum depression, especially if they have serious mental illnesses.[28,29] Women of all ages may struggle with body image and eating disorders, although eating disorders are more prevalent among younger women.[30] Older women also have particular mental health needs related to diseases like Alzheimer's and dementia. The likelihood of dementia increases with age and women, in part because of their greater longevity, are twice as likely as men to develop dementia.[31,32]

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Although a solid evidence base exists upon which to begin building a national women's mental health strategy, research in a number of areas would complement the available knowledge.

2. Expanding the Evidence Base

In June 2002 a national meeting of mental health researchers, policy-makers, practitioners, and women who have utilized mental health services convened at the British Columbia Centre of Excellence for Women's Health to develop a national women and mental health research agenda with funding from the Institutes of Gender and Health and of Neurosciences, Mental Health and Addictions of the Canadian Institutes of Health Research. The resulting document, *Women and Mental Health across the Life Span: Creating a National Cross-Disciplinary Research Agenda and Strategy*, outlines a range of cross-disciplinary research questions (i.e., bio-medical, clinical science, health systems, and services, socio-cultural factors which affect the health of populations and policy) related to women's mental health. One of the unique features of this meeting was that it actively engaged women who have been diagnosed with mental illness and who have had experiences with psychiatry and the mental health system.

The participants identified key components that are needed for the development of women-centred research models, including the development and use of gen-

der-based analytic tools and models that foster interdisciplinarity. Additionally, participants identified the need for cross-sectoral research. That is, research that utilizes the understanding that is gained through personal experience of mental illness and through the work of service providers and advocates as well as researchers.

Meeting participants pointed out that the mental health system still emphasizes bio-medical aspects of illness over social factors. They argued that this approach is inadequate for responding to women with mental illness, especially with respect to women's past and present experiences of physical and sexual violence, women with addictions, the concerns of mothers with mental illness, and the need for women to have adequate financial resources and safe, affordable, and supportive housing.

Although some provincial mental health policies have also begun to recognize that the mental health needs of women and men differ (e.g., Ontario, British Columbia) current practice and policy in the mental health system does not fully take into account the existing evidence related to women and mental illness.[33,34] Participants at this meeting discussed the kinds of research needed to expand our understanding of women's mental health. For example, there are gaps in our knowledge about the differing treatment needs of women and men[35] with mental illness and with respect to understanding the effects of psychotropic medications and their side effects on women.[10,11]

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Likewise, although there is some literature examining women's differing social experiences (e.g., of racism, poverty, homophobia) and how this might impact on mental health, much more research is needed to understand which of these differences are most salient and how differing needs might be met through policy, service delivery, and programming.

Peer support and self-help have long been recognized as key components of recovery and of maintaining wellness for people with mental illness.[37,38] Additionally, consumer leadership of projects is now recognized as an important component of healing and maintaining wellness.[38] Despite this, very few studies have examined the role that peer support and consumer leadership might play specifically for women, or how programs might need to be modified to better meet the needs of women.

Some women request access to alternative and complementary therapies other than counselling (e.g., massage, naturopathy, homeopathy) and report that these kinds of supports assist in ameliorating their symptoms.[39] However, there have been few studies that systematically evaluate the efficacy of these therapies, or how they might interact with more traditional forms of treatment. Additionally, some Aboriginal women suggest that spirituality and traditional healers play a

role in recovery. Again, however, little research has been done to examine these claims.[33]

Finally, participants discussed the ways in which the links between mental illness and addictions have been under-theorized and suggested that research that would result in service provision models for this population would be useful.

3. Gender-Based Analysis and Women-Centred Mental Health Care

Although some provincial policy statements acknowledge the particular needs of women, there is still a paucity of women-specific supports in the mental health system.[39,40] For example, some women report that they feel more comfortable and gain more benefits from women-specific peer support groups[33] but few such supports are available, especially for women with mental illness who have had experiences of physical or sexual violence.[21,40] These kinds of supports are critical for recovery. We know that adequate income, access to safe and affordable housing, and access to social support are key factors in attaining and maintaining mental health, and yet many women with mental illness do not have access to these kinds of supports.[21] Care that combines social support, safe, affordable housing, and adequate income with women-specific psychological care is likely to lead to better outcomes for women with mental illness.

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The development of women-centred mental health care can be facilitated through the application of gender-based analysis to policy and program analysis in order to better understand what kinds of issues women with mental illness face. A number of important gender-based analytic tools have been developed that could assist in this work, including, for example, Health Canada's *Exploring Concepts of Gender and Health* (2003), the British Columbia Ministry of Women's Equality's *Gender Lens: A Guide to Gender-inclusive Policy and Program Development* (1997), and Status of Women Canada's *Gender-based Analysis: A Guide for Policy-making* (1996).

4. Models for the Participation of Women with Mental Illness in Decision–Making

Public participation is an important goal of health promotion [41,42] and most provinces and territories in Canada now have mechanisms to involve mental health consumers in the policy-making process.[43,44] It can be argued that public participation is critical for its ability to both ground policy-making and program development in the actual experiences of the individuals it will affect, and also to give people a sense of control over their own mental health, support, and treatment choices.[45]

Mechanisms for soliciting and maintaining public participation vary with respect to the degree of decision-making power granted to people using the system and have often not included the requisite support and training required for effective and meaningful participation.[45,46] This is especially the case in the area of mental health, where participants may have spent many years in institutions, often have gaps in their work and educational histories, and are marginalized and discriminated against because of their psychiatric conditions.

The barriers to the participation of consumers has meant that in the mental health arena, public participation rarely moves beyond the token presence of individuals on advisory boards or committees. Further, these mechanisms have rarely sought to involve women with a range of personal experience in the mental health system and with a diversity of views on mental health treatment.[33] Ontario has begun to move beyond traditional notions of public participation in policy-making to the establishment of consumer-controlled and -operated businesses.[47,48] Fostering the capacity of women mental health consumers to actively participate in policy decision-making and in designing programs that address their specific needs should be a critical goal of all mental health systems in Canada.

The development of women-centred mental health care can be facilitated through the application of gender-based analysis to policy and program analysis.

5. Mental Health Reform and Restructuring

Health reform and restructuring over the last several decades has resulted in several key changes in mental health:

- The recognition that people with mental illness are better supported in home- and community-based services, with hospitals being used only in times of crisis and for short stays.
- The recognition that mental health consumers and their families should be actively involved in mental health decision-making processes.
- The promotion of self-help models.
- Increased recognition of the effects of stigma and discrimination on the lives of people with mental illness.
- The move towards a regionalized mental health delivery system in the majority of provinces and in the territories.

Despite the fact that these critical developments parallel some of the changes taking place in the health system more generally (e.g., reducing hospital use) national reports on health reform have paid very little attention to mental health services and have ignored women's mental health needs altogether.[e.g., 3,49]

One hopeful sign is that the recently released report from the Commission on the Future of Health Care in Canada (the Romanow Report) recognizes this disparity and recommends that mental health home care services be included as medically

necessary services under the *Canada Health Act*.[3] As the Commission has suggested, it is time to "bring mental health into the mainstream of public health care." [3:178] The Romanow report and the current debates on health care provide a space for opening up discussions about what kinds of mental health services should be covered under Medicare. That is, aside from home care services are there other forms of support and treatment that should be covered (e.g., counselling for child sexual abuse survivors, complementary, and/or alternative medicines)?

Provinces and territories could also use this opportunity to allocate further health resources to mental health–related services. For example, despite active plans in some provinces to move people with mental illness into the community, cutbacks in some jurisdictions are constraining the ability of community-based resources to adequately respond. In the case of women moving from psychiatric hospitals to the community, women-specific services like women's centres, transition houses, and women's addiction treatment programs are key supports that must have resources allocated to them.

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Although mental health resource allocation is under provincial jurisdiction and mental health services are delivered through a regionalized structure in most provinces and in the territories, the federal government has an important role to play in terms of providing a national strategy and framework to guide resource allocation, policy-making, and mental health service delivery.

The Canadian Alliance on Mental Illness and Mental Health's (CAMIMH) *A Call for Action: Building Consensus for a National Action Plan on Mental Illness and Mental Health* is a useful building block in this process with its focus on health promotion and prevention issues. Further, the *Citizens for Mental Health Project,* funded by Health Canada, seeks to expand on CAMIMH activities by enhancing partnerships and bolstering the capacity of the voluntary sector to contribute to mental health policy. This initiative could usefully engage women and women-serving organizations in their consultation process, which is meant to inform a national strategy. Building on these initiatives and other key federal government reports (i.e., The 1993 Federal/Provincial/Territorial Report on women's mental health and Health Canada's 1999 *Women's Health Strategy*) will be important in the development of a national women and mental health strategy.

Recommendations:

A national women's mental health strategy

- The federal government should strike a working group that would include representation from Health Canada, the Women's Health Bureau, Mental Health Promotion, the Canadian Alliance for Mental Illness and Mental Health, and women's mental health advocates and consumers in each province and territory to oversee the development of a women's mental health strategy.
- The working group on women and mental health would investigate models for mental health resource allocation that will best address women's mental health needs and discuss and make recommendations to the federal government about what services should be covered under Medicare.

Utilize and expand the evidence base

- Expand the national evidence base by gathering sex-disaggregated data on mental illness.
- The Institutes of Gender and Health and of Neurosciences, Mental Health and Addictions of the Canadian Institutes of Health Research should utilize the report, *Women and Mental Health Across the Life Span: Creating a National Cross-Disciplinary Research Agenda and Strategy*, to inform their research agendas.
- Utilize existing evidence about women's mental health and the mental health needs of diverse groups of women in the development of research, programming, and policy in all jurisdictions.

Apply gender-based analysis (GBA) to evaluation and policy and program development

- Apply GBA to research, policy, planning, program development, and evaluation in mental health at all levels – federal, provincial, territorial, and regional.
- The federal government should support the creation of independent mental health advocate positions in each province and territory whose task it would be to monitor and evaluate the strengths and weaknesses of the mental health system with specific attention to how the system is working for women.

It is time to "...bring mental health into the mainstream of public health care." 3:178

Develop women-centred mental health care

- All mental health services should develop specific treatment/support protocols for women with present and past experiences of physical and/or sexual violence.
- All jurisdictions should support and develop interdisciplinary mental health teams with strong connections to community supports for women, especially those organizations working on issues related to violence, mental health, and addictions.
- All jurisdictions should develop models for women-specific supports and services that incorporate current evidence about sex and gender differences and the mental health needs of ethnically diverse groups of women.

Develop mechanisms for women consumer involvement

- All jurisdictions should support capacity building of women consumer/survivors to provide leadership in peer support, programming and policy development.
- The federal government should ensure that any national strategy on women's mental health has the active and meaningful participation of a wide range of women consumer/survivors.

It is time for a women's mental health strategy in Canada.

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