Improving Conditions: Integrating Sex and Gender into Federal Mental Health and Addictions Policy

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Executive Summary

This report addresses mental health/ illness and substance use/ addictions for both women and men in Canada. These critical health issues are broad and pervasive, and have historically been under attended to in social and health care systems in Canada. The premise of this review is that sex and gender in its intersections with other forms of social difference (e.g., race, ethnicity, socioeconomic status, sexual orientation, and ability) ought to be key considerations in responses to mental health and addictions, from research to action on programs and policy. This paper highlights key examples and selected upstream factors across the lifespan which underscore how and why an examination of sex differences and gender influences must be a crucial component to any policy work in mental health/ illness and substance use/ addictions.

The application of sex and gender analyses would refine federal responses in Canada regarding the upstream factors/ determinants of health that contribute to mental health/ illness and substance use/ addictions among women and men, the provision of accessible, comprehensive, gender-specific care for mental illnesses and addictions, the prevention of mental illness and addictions, and mental health promotion. The gendered expressions and consequences of mental health/ illness and substance use/ addictions are important considerations for health service providers and policy makers. In the context of the merging of mental health and addictions fields, these considerations will also improve continuity of care, integration of systems of response and provide a space for the inclusion of important gendered issues, such as those connected to trauma and violence, into research and action.

Our overview of the literature on these broad topics offers selected examples underscoring sex and gender issues in mental health and substance use/addictions. These include gendered considerations such as poverty, housing, caregiving, stress/coping, trauma, pregnancy, and issues of specific concern to populations under federal jurisdiction such as military personnel, incarcerated women, and Aboriginal peoples. The report highlights how and why an examination of these differences is a crucial component of any policy work on mental health/illness and addictions. The synthesis, analysis, and recommendations focus on five broad areas: a) upstream factors/ determinants of health (with an emphasis on social determinants); b) service responses; c) assessment/diagnosis; d) treatment and related health services; and e) mental health promotion/ illness prevention.

The components of this paper are:

- ✓ A broad scan of recent nationally-based evidence (within the last 5 years) on the impacts of sex and gender in mental health/illness and addictions to provide a synthesis of current evidence and established best practice.

- ✓ Examples of key sex differences and gender influences in mental health/ illness and addictions, and the implications of these for the development of federal policy, programs, and research

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- ✓ Analysis of considerations and identification of recommendations on integrating sex and gender in mental health and addictions policy development in the federal health portfolio. This will also include discussions of explicit and implicit sex and gender specific implications for relevant policy arenas

This report concludes with recommendations which emphasize opportunities for integrating sex and gender in mental health and addictions policy development in the federal health portfolio, including a) the federal role in providing leadership; b) knowledge development, synthesis, and translation; c) public awareness, health literacy, and anti-stigma initiatives; d) working with the provinces and territories; and e) populations under federal jurisdiction.

Introduction

This report addresses mental health/ illness and substance use/ addictions for both women and men in Canada. These critical health issues are broad and pervasive, and have historically been under attended to in social and health care systems in Canada. In this discussion the importance of sex and gender analysis in assessing, defining and responding to these issues is fore grounded, so that all parts of the Canadian population can benefit from and enjoy improved health. This report utilizes a gender-based analysis to frame the discussion of implications for incorporating sex and gender in federal policy development on mental health and addictions. The premise of this review is that sex and gender in its intersections with other forms of social difference (e.g., race, ethnicity, socioeconomic status, sexual orientation, and ability) ought to be key considerations in responses to mental health and addictions, from research to action on programs and policy. This paper is not meant to provide an exhaustive or comprehensive analysis of all evidence accumulated to date on this topic. Rather, we highlight key examples and selected upstream factors across the lifespan which underscore how and why an examination of sex differences and gender influences must be a crucial component to any policy work in mental health/ illness and substance use/ addictions.

The application of sex and gender analyses would refine federal responses in Canada regarding treatment protocols, accessibility to care, quality of programming and prevention and mental health promotion for all Canadians. Mental health/ illness and substance use/ addictions issues often, but not always, co-occur at the levels of individual lived experience, clinical practice, and, more recently, health policy development and implementation. The gendered expressions and consequences of mental health/ illness and substance use/ addictions are important considerations for health service providers and policy makers as separate (though not mutually-exclusive) health issues. In the context of the merged mental health and addictions fields, these considerations will also improve continuity of care, integration of systems of response and provide a space for the inclusion of important gendered issues, such as those connected to trauma and violence, into research and action.

Key policy considerations and recommendations on integrating sex differences and gender influences in mental health/ illness and addictions are identified to inform and enhance current federal policy work. An overview of the literature on these broad topics highlights selected examples of how sex and gender issues in mental health and substance use/addictions and provides some recommendations for future policy development. The report highlights how and why an examination of these differences is a crucial component to any policy work on mental health/illness and addictions. The synthesis, analysis, and recommendations focus on five broad areas: : a) upstream factors/ determinants of health (with an

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Both mental health/ mental illness and substance use/ addiction exist on a continuum in terms of their clinical implications and impacts on one's health and well-being. In this report we refer to a continuum of substance use that includes *substance use* (which typically occurs at minimal levels and with little impact on health), *problematic substance use* (in which one's substance use contributes to compromised health or well-being) and *substance use disorders* or *addiction* (which are specific diagnostic terms, with criteria outlined in clinical texts such as the DSM-IV). Similarly, we use the term *mental health* in its positive valence (indicating conditions of optimal mental and emotional well-being), and distinguish between *mental health problems* (in which a person is experiencing compromised mental health, but may not necessarily receive a clinical diagnosis) and *mental illnesses* (which we use to refer to mental health conditions which have been diagnosed according to clinical criteria).

Gender Based Analysis

When it comes to health, it matters whether you are a woman or a man. Research shows that both sex (biologically based differences) and gender (the socially constructed roles ascribed to men and women) have a profound impact on determining health status. Gender is relational and refers not only to women or men, but to the relationship between them. Some health related issues or health conditions are unique to one sex or the other (usually related to biological factors)

while others are more prevalent, pose more risk, are more serious, or less understood (usually as a result of both sex and gender issues). “Gender can determine different exposures to certain risks, different treatment seeking patterns, or differential impacts of social and economic determinants of health.”[1]. This report utilizes a gender-based analysis to frame the discussion of implications for incorporating sex and gender in federal policy development on mental health and addictions.

Gender-based analysis is a tool that provides a framework “for analysing and developing policies, programs and legislation, and for conducting research and data collection--- a framework that recognizes that recognizes that women and men are not all the same”[2] and assists in identifying and clarifying the differences between women and men, the nature of their social relationships, and their different social realities, life expectations and economic circumstances. Historically, patriarchal forces have created conditions where women are disadvantaged in relation to men with respect to accessing resources such as money, information, power, and influence. “Gender-based analysis in health seeks to understand how gender and gender biases in society and in the health care system affect the health of women and men”. In addition, androcentric approaches to research, policy and programming have produced many options that implicitly benefit men, but may be presented as “gender-neutral”[3-5].

Recognizing that past inequities and gender biases have resulted in women’s health issues being neglected, under-funded, and misunderstood, Health Canada has implemented a “gender-based analysis policy” (GBA). Further, a diversity analysis is always overlaid on a GBA in order to identify different issues among women and among men. Hence, GBA strengthens federal policy and program development in mental health and addictions by bringing forth and clarifying the differences among diverse groups of women and men, the nature of their different social realities, and the ways these interact to inform mental health/ illness and problematic substance use/ addictions. “(GBA) challenges the assumption that everyone is affected in the same way by policies, programs and legislation, or that health issues such as causes, effects and service delivery are unaffected by gender.” [2].

Accordingly, GBA is integral to the development of federal policy in mental health and addictions which seeks to promote good health, strengthen health care delivery, and provide relevant health information for women and men[2] . The current Canadian policy context provides key opportunities to apply GBA. The recent establishment of the Canadian Mental Health Commission and the Inter-departmental Task Force on Mental Health and Mental Illness , coupled with the releases of the reports of the Standing Senate Committee on Social Affairs, Science and Technology and the *National Framework for Actions to Reduce the Harms Associated with Alcohol and other Drugs and Substances in Canada,* provide occasion for GBA to clarify the potential for differential impacts of policy,

research, programs on women and men and propose options that will reduce disadvantages and health disparities among those living with mental illness or addictions.

Sex, Gender and Determinants of Mental Health

Overview

The Canadian Institute for Health Information (CIHI) estimates that about 20% of Canadians will experience a mental illness in their lifetime [6]. Recent data suggests that the overall prevalence rates for mental health problems for Canadian women and men are similar– 11% of women and 10% of men [6]. However, it has been well established that certain mental illnesses are more prevalent in women than men, 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.

Numerous studies have shown that women are more likely than men to experience depression and anxiety[7, 8]. Most recent Canadian data shows that 5.5% of women and 3.5 % of men reported a major depression and that that 6% of women and 4% of men reported feelings and symptoms consistent with panic disorder, agoraphobia or social phobia [9] . Women are also more likely than men to be diagnosed with seasonal affective disorder, eating disorders, panic disorders, and phobias[10]. The mortality rate for men by suicide is four times the rate of women but women are hospitalized for attempted suicide at 1.5 times the rate of men [6].

With respect to health care utilization, a recent analysis of data collected in Cycle 1.2 of the Canadian Community Health Survey shows that overall, women are 2.9 times more likely than men to use primary health care services for mental health complaints.[11] Yet, slightly more women than men in the same survey reported unmet mental health care needs (i.e., over 22% reported they needed help for their emotions, mental health or use of alcohol or drugs but did not receive it, while fewer than 20% of men reported a similar problem). Men predominate in institutional psychiatric care but women are hospitalized more frequently for mental illness [12, 13]. For example, Canadian data shows that hospital rates for anxiety disorders in general hospitals are twice as high for women as for men [6]. Hospital rates for some disorders are increasing; since 1997 the rates of hospitalization for young women (under age 15) with eating disorders has increased by 34% and by 29% for women 15-24 [6].

Sex differences, such as variations in lean body mass, hormonal concentrations, gastric absorption, and nutritional requirements have been shown to affect the

distribution, metabolism and elimination of drugs, the biochemical and physiologic effects of drugs, suggesting that the metabolism, overall efficacy, and adverse effects of many medications, including tricyclic antidepressants, selective serotonin reuptake inhibitors (SSRIs), neuroleptics, sedatives, and benzodiazepines may be different for women and men [14, 15].

The expression of symptoms of some mental illnesses (such as schizophrenia) also differ according to sex (i.e., men tend to develop schizophrenia earlier in life than women) suggesting a possible biological component to the illness[16] . However, reliable studies analyzed using sex disaggregated data, documenting incidence, prevalence, disease trajectories, and health outcomes for individuals with mental illness are scarce, resulting in challenges for sex-sensitive policy development based on national surveillance data.

Selected Upstream Factors

Stigma, Marginalization, and Discrimination

As has been highlighted in the recent Canadian Mental Health Commission's "Proposal to Establish a Canadian Mental Health Commission, "to eliminate the stigma and discrimination faced by Canadians living with a mental illness and their families"" is a key priority area for federal action (pg. 3). Stigma involves the applications of misperceptions or labels, often based on stereotypes, about these conditions to the people or groups who have them. Discrimination is the actions that reinforce stigma and marginalization. Homophobia, poverty, and racism in particular are forms of marginalization which have a documented relationship to alienation, low self-esteem, poorer physical health, and symptoms of psychological distress[17-23]. Experiences of discrimination are more strongly correlated to mental ill health among women than among men. US studies have shown that experiences of social exclusion are more strongly correlated with mental health problems among African Americans and those with low socioeconomic status than among whites and those with higher incomes[10] . Few systematic Canadian studies have been done on race and discrimination in mental health but it has been observed that people of colour and Aboriginal people experience particular barriers to care based on experiences of racism[24]. While low-income young women are at much higher risk for developing psychiatric disorders, this population is also more likely to report that stigma associated with a mental illness diagnosis (and with taking psychiatric medications) is a significant barrier to accessing treatment [25].

Stigma, social exclusion and marginalization of women and men living with mental illness and addictions can exacerbate health disparities. The impact of mental illness on the lives of women and men can be found not only in the symptoms of

disease, but also in disadvantages experienced by individuals diagnosed with mental illnesses. Indeed, concerns about the reactions of others to a diagnosis of mental illness and the stigma associated with mental illness is one of the main reasons individuals report choosing not to access mental health services[26] Stigmatizing attitudes about mental illness, such as those evident in many media representations, are generally negative and reinforce social distance between people who are and are not assumed to be “mentally ill”[27].

Stigma and discrimination directed toward people living with substance use problems is also highly gendered. Accordingly, Roberts and Ogborne have concluded that women experience “[a] greater stigma… attached to [their] substance use problem” than do men[28]. Research has also demonstrated that women experience “greater resistance on the part of family and friends; [and]… more negative consequences associated with treatment entry [28] . The stigma associated with women’s substance use influences women’s abilities to report their substance use patterns and concerns, the rates at which women are screened for substance use problems, and access to addictions treatment. Although past and present experiences of social exclusion can result in negative health outcomes for women and men in society, policy responses to mental illness and addictions have often failed to attend to these interrelationships for diverse groups of women and men.

Eliminating stigma and discrimination means not just taking measures to ensure “equality” within the delivery of health care, but involves many measures that go well beyond the delivery of health care. This requires a determined and sustained approach which embraces fundamentally the requirement to identify long term structural inequalities that continue to contribute to the marginalization of women and men who are “consumers” of mental health and addictions services, as well as those whose access to (or lack of access to) and experiences of those services have resulted in even greater disparities in health, social, economic, and political status. These also intersect with multiple forms of stigma and discrimination, including those associated with living with HIV, visible disabilities, involvement in criminal-legal systems (including incarceration) etc. Indeed, these multiple intersecting forms of discrimination and experiences of stigma have fundamentally frustrated efforts undertaken by community-based advocates, service providers, and users of mental health and addictions services to significantly involve care recipients in their own treatment and support.

In order to be full members of the general community, there is a need for ensuring that basic needs of housing, employment, and meaningful participation in community life are met. Policy makers, working in collaboration with the full spectrum of services and peer-support organizations, need to actively promote efforts to make services welcoming, accessible, relevant and safe for women with substance use and mental health problems.

Central to action on problematic substance use and mental illness among girls and women is addressing the misinformation and discrimination directed at girls and women with substance use problems. This is essential in helping to reduce the guilt and shame that prevent women from learning more about the risks of substance use, recognizing symptoms of declining mental health, and identifying if/where they may need help.

Advocacy organizations like the Canadian Mental Health Association have spearheaded anti-stigma, anti-discrimination campaigns in the area of mental health primarily through public education. There is space for much of this work to be more directly translated into policy articulations to guide mental health service provision. However, when these campaigns are targeted against a generalized concept of stigma, there can be a screening effect that conceals the multiple forms of stigma and discrimination experienced by the majority of people judged to have mental illness or substance use problems. Future public education campaigns in this area should include sustained focus on these issues, rather than reinforcing the idea that a single "stigma" applies equally to all people with substance use or mental health problems. Stigma can also be counteracted by addictions treatment, and can also be addressed specifically in treatment practices. It can also be addressed in policy, and through health promotion and social marketing campaigns[29, 30]. There are multiple audiences for such efforts, all or which can be supported by enhanced policy.

Poverty & Housing

The links between mental illness and poverty are clear with the literature showing that poverty both exacerbates mental illness and can lead to poor mental health. Studies have also illuminated the deleterious effects on mental health that occur when people have difficulty getting their basic material needs met[31, 32] . Specifically, research on the relationship between poverty, inadequate housing and mental health outcomes suggest that substandard housing and/or homelessness can have serious effects on mental well-being[33-35] The National Council of Welfare[36] reports that total welfare incomes everywhere in Canada were well below the poverty line in 2004 and that the value of provincial and territorial welfare and related benefits have continued to decline to their lowest levels since the 1980s after adjusting for inflation.

Although poverty numbers in Canada are not disaggregated to accurately reflect poverty rates amongst people with mental illness, we know that women, especially elderly women, Aboriginal women, and single mothers are disproportionately poorer than men [37]. Because primary responsibility for caregiving continues to fall on women, women's poverty is directly linked to child poverty. Enduring financial insecurity increases the risk of violence towards women, especially

women with mental illness who are vulnerable because of the conditions of their illness.

Poverty also has a demonstrated negative impact on access to mental health services, there by exacerbating mental health disparities experienced by those living in poverty. Disruptions in education and training coupled with stigma and discrimination experienced by people with mental health problems frequently leads to difficulties in securing and maintaining employment (as well as ghettoization in marginal occupations). People who become ill while in the workplace are often poorly supported and are sometimes actively stigmatized and discriminated against[38] [11] [39] [40, 41]. As such, women can experience increased difficulties in maintaining both economic security and mental health.

The health implications of homelessness have been well documented. Although it is difficult to determine the prevalence of mental illness and substance use among homeless people, Canadian and US rates suggest that the numbers of people with a diagnosed mental illness range depending on the type of diagnosis. For example only about 6% of the homeless population in Toronto has a diagnosis of schizophrenia whereas the numbers of homeless with affective disorders range from 20-40% Substance use rates are higher especially among homeless men whereas homeless women are more likely to have just a mental illness [42, 43] Dual diagnoses (mental illness and substance use problems) among homeless people are not uncommon . Homelessness among the mentally ill population is not always visible. People at risk may be sleeping on couches at friends' houses or live in substandard or temporary housing.

A number of factors contribute to people with mental illness being homeless or inadequately housed. Although a variety of forms of specialized supported housing for people with mental illness exists in most large urban centres in Canada these housing options are often over-subscribed and have long wait lists. Available subsidized housing has diminished across Canada and the rising costs of market housing and rents (especially in cities like Toronto, Calgary and Vancouver) make it prohibitive for most working people to afford let alone people suffering from mental illness.

Other factors that contribute to the instable housing situation among people with a mental illness are the following: their generally low income; the weakness of their social support networks (many lose contact with their families of origin); the cyclical nature of some illnesses – clients may be hospitalized, and lose their housing as a result or they may be evicted because they have a concurrent drug addiction, and the landlord considers them to be a danger to his/her property or the other tenants; and the general stigma attached to mental illness (and drug addiction) that makes it difficult to find safe and decent housing at affordable prices. The symptoms of illness can also make women more vulnerable to

exploitation by others, which makes the need for safe and affordable housing at affordable prices (including subsidized housing) all the more important for women living with mental health and addictions issues.

Homelessness is a barrier to finding a job, and often prevents people from accessing mental health services or applying for disability benefits. People can get trapped between episodic hospitalization and life on the street[44, 45]. Life on the street often triggers the development of a mental illness or contributes to worsening the symptoms of an already existing mental illness.

Ideally, a range of housing options would be available to people with mental illness and specialized housing for women would be available to support individual needs. Most adults with a mental illness prefer independent living in a self-contained unit (but with access to the support services they need) over group settings. Housing should be located in a variety of neighborhoods (not only poor neighborhoods).

Caregiving

Women bear a disproportionate share of caregiving responsibilities, both with respect to the care of children and the care of elderly parents and/or ill family members. It has been widely recognized that the burden of care results in increased stress for women and has implications for women's mental health [46, 47].

Prior to the mental health reforms of the 1960s and 70s, the long-term institutionalization of people with serious mental illness coupled with pervasive beliefs about the inability of women with mental illness to care for their children, meant that women diagnosed with mental illness who had children were not encouraged to mother them and usually had them apprehended by the state and placed in foster care. With the advent of de-institutionalization and the recognition that many people with serious mental illness can live fulfilling lives in the community, increasing numbers of women have the opportunity to have and raise children. Indeed, the birth rate for women diagnosed with mental illness is either the same or higher than for the rest of the population [48, 49]. What this means is that increasingly clinicians and mental health professionals are recognizing the multiple roles that women with mental illness play with respect to caregiving and how this might effect their treatment and recovery.

There are a variety of challenges women with mental illness face during pregnancy and in their roles as parents. While some women with mental illness experience remission of symptoms during pregnancy, this is not the case for all women. Many of the psychotropic medications that help keep women's symptoms under control are believed to pose a risk to the fetus, and once women learn they

are pregnant they are strongly encouraged to modify their treatment regimens [48]. As a result, some women may experience exacerbation of symptoms during which time they may be unable to care for themselves or their children. They may even require periodic hospitalization. Women with mental illness tend to have more anxiety about their pregnancy and delivery, some are reported to become actively psychotic during childbirth [48]. Whether this is due to their illness, to social pressures (e.g., the fears of child apprehension), or related to past sexual trauma is rarely examined.

In contrast, some research suggests that women with mental illness place a high value on parenting and a woman's ability to maintain a relationship with her children is often critical to her recovery [48, 50-53]. Mothering in this context is often seen as a rehabilitative tool. Experts in the field suggest that assisting mentally ill mothers in maintaining contact with their children increases their self-esteem, provides them with a sense of normalcy, and promotes personal growth [51, 52].

The gendered impact of caregiving expectations and responsibilities on poor mental health among men is gaining increasing attention, particularly in relation to masculine role expectations as "bread-winner". Among men, unemployment, employment in hazardous occupations (emergency services, construction, mining, forestry, etc.), homelessness [however, no data has been collected to date which demonstrates homelessness to be more prevalent among women or men], separation and divorce (leading to higher suicide risk, particularly when access to children is limited following marital breakdown) have been found to lead to compromised mental health and increased diagnoses of mental illness (particularly depression). The most salient depressing experience for men after relationship breakdown is the loss access to their children[54].

Key Examples

Depression

***Depression in Women*:** Depression has been identified as a single leading cause of disability in women between the ages of 18 and 44 years of age, the age group in which depression rates are highest[55]. The rate of depression in boys and girls are almost equal until puberty, after which adolescent girls' rate of depression doubles when compared to the boys. Women are twice as likely as men to be diagnosed with depression and anxiety. [14,15]. Women are also more likely than men to be prescribed an SSRI medication for a diagnosis of depression. Recent Pharmanet data from BC show that 19% of women (nearly 1 in 5) over the age of 30 received at least 1 SSRI prescription between August 1, 2002- July 30, 2003[56]. Women accounted for 66% of physician office visits for depression in Canada in 2004, and 81% of such visits for depression resulted in a prescription for an antidepressant medication[56].

Research has described how the many social, cultural, political, and economic processes interact to inform experiences of depression. To illustrate, process of resettlement and pre-immigration experiences resulting in increased anxiety and depression for immigrant and refugee women [3, 16-18[31]]. These studies have shown how gendered dimensions of migration, specifically those which enforce dependency and restrict access to services, can create vulnerabilities to depression. For example**,** although 80% of the world's refugees are women and children, adult men are more likely to be granted political asylum and refugee status in Canada and in other countries [57]. This is because current criteria for acquiring legal refugee status in Canada (which are based on those found in the UN Convention relating to the Status of Refugees) are more likely to recognize forms of persecution more common to men as grounds for granting refugee status. As a result, most female refugees enter the country via the sponsorship of a male relative or husband who has "official" refugee status, which can in turn compromise their autonomy and access to resources [57] [58-61].

10-16 percent of women in Canada suffer from Postpartum Depression (PPD), as defined by established clinical guidelines[62, 63]. However, 50-80 percent of women experience depressive symptoms during the postpartum, an experience often referred to as "the blues"[64]. Research has demonstrated that sex-specific, biological factors interact at multiple levels with socio-cultural, economic and psychological factors to amplify the risk for developing PPD in women. Some of these significant risk factors have been identified as: a history of mental illness (such as a past history of PPD, other depressions or psychiatric illnesses, and a family history of affective disorders); individual hormonal sensitivity (such as

history of premenstrual dysphoric disorder (PMDD) and mood symptoms during the third trimester of pregnancy); financial strain; and obstetrical and gynecological problems[64-67]. Fear of the actual process, lack of sleep, fear of performing the role of mother and other concerns about parenting, physical discomfort, and other physical symptoms are also responsible for depression in new mothers[65, 68].

Numerous studies have documented how the highly gendered experience of becoming a mother involves a shift in one's identity at multiple levels[64, 69]. These experiences have been shown to increase stress for women and create vulnerabilities for depression, including PPD. Multiple roles in the family, societal expectations of the role of mothers, fear of their own performance as new mothers, weight gain, loss of former slimmer self etc induce PPD or the blues in new mothers[65, 70].While more information about experiences and incidence of postpartum depression in diverse ethnocultural communities is greatly needed, a recently completed study of PPD among immigrant Punjabi and Chinese women indicates that cultural expectations such as the desire for baby boys and interference from in-laws also aggravated experiential symptoms associated with PPD[65, 71]. These interact with other dimensions of immigration and re-settlement , including lack of social support, de-skilling, financial difficulties, isolation, which can render women more vulnerable to PPD[72].

***Depression in Men*:** Some recent studies of depression among men (including studies of postpartum depression in men) have argued that symptomology, classification, and interventions for depression (including mental health literacy efforts designed to encourage help-seeking for depression) have been predicated on a standardized "feminine" form of depression, thus leading to the under-diagnosis and under-treatment of depression in men and potential over-diagnosis and treatment of depression among women.

For example until recently, postpartum depression has been seen as sex-specific mental illness, because theories about the influence of hormonal differences have dominated explanations of this form of depression. Studies of social and cultural determinants of postpartum depression have demonstrated that biological mechanisms (i.e.: hormonal changes) are not the sole factors mediating this form of depression. While PPD research in women shows a dynamic interaction between biological and social factors in developing this condition, there is a growing body of evidence supporting the idea that men also experience postpartum depression. Depending on the definition of depression used, various studies and surveys show depressive symptoms in new fathers ranging from 2% to 9%, to 49% [73].

While still a new phenomena of study, these emerging findings suggests that changing patterns of social interaction during pregnancy and following childbirth, including concerns about the responsibilities of fatherhood, the health of the mother and the child, changes in the relationship with one's partner, and a

heightened awareness of mortality following childbirth, may also affect the mental health of new fathers. It has been asserted that PPD in men may well have been overlooked or under-estimated, because of the common assumption that PPD by definition only affects women.

The strong correlation of paternal postpartum depression with maternal postpartum depression has important implications for family health and well-being. If PPD in males becomes well established, research will be needed to explicate the gender differences and dimensions of PPD, to describe more fully the male- and female-specific experiences attached to this condition. In addition, research will be needed to determine incidence, prevalence, and mitigating factors of PPD in fathers as well as mothers, and consideration of co-occurrence of depression in couples.

Gender, Trauma, and PTSD in Military Personnel

Current approaches to assessment, diagnosis, and treatment of Post Traumatic Stress Disorder (PTSD) among North American veterans are predicated on the assumption that the events or experiences that lead to PTSD arise from participating in armed combat or witnessing war-related atrocities during peacekeeping[74-76]. The House of Commons Standing Committee on National Defence and Veteran Affairs' 1998 Report, "Moving Forward: A Strategic Plan for Quality of Life Improvements in the Canadian Forces," emphasized "the importance of programs to assist individuals dealing with the effects of post-traumatic stress disorder and other types of stress."[77] Increased attention to issues of PTSD and other psychological harms experienced by military personnel have prompted concerns that some veterans, such as reservists participating in peacekeeping operations, may have less access to mental health services [78]. While no Canadian studies have attended specifically to gendered dimensions of mental health problems among veterans, US research examining military-related PTSD from a gender perspective has shown that the mental health needs of female veterans may be among the most neglected. For female soldiers, the experiences that lead most often to diagnoses of PTSD differ from those of their male counterparts. Nowhere is this more apparent than in evidence of the impact of sexual assault on the mental health of female military personnel.

The issue of sexual assault of female military personnel has been the subject of increasing international attention[79]. These studies have shown that female soldiers are frequently victims of sexual violence during their period of military service. Multiple studies of risks and vulnerabilities associated with military sexual assault indicate that the most reliable factor in vulnerability to sexual assault is gender. Female military personnel are sexually assaulted at rates much higher than males[79, 80]. In two separate studies of sexual assault of female personnel, over 98% of offenders were male[81, 82]. Studies to determine factors that

distinguish sexually aggressive men have found that men who are repeat assaulters have more hostile gender-role beliefs (particularly hostile masculinity) and more callous attitudes toward women than did non-aggressive men[79, 83, 84]. In a study of incidence and prevalence of sexual harassment among female military personnel, 52% of women who experienced attempted or completed rape reported that the incident took place at work and during duty hours [85]. 35% percent of these women noted that they were raped or experienced attempted rape on a frequent basis [82, 85]

Military-related sexual assault is the most salient contributor to PTSD among female veterans. In a study of the impact of duty-related stress and sexual violence on the development of PTSD among treatment-seeking female veterans, 63% reported experiences of physical sexual harassment during military service, and 43% reported rape or attempted rape [86]. Although both duty-related stress (including experiences of working shifts of 24 hours or longer, seeing continual casualties, being under enemy fire, or assisting someone in dying) and sexual stress (defined by the study team as experiences of physical sexual harassment, abuse, rape, or attempted rape) were found to contribute independently and significantly to the development of PTSD in female veterans, sexual stress was found to be 4 times more influential in the development of PTSD than was duty-related stress. Moreover, while experiences of sexual violence in all stages of life are correlated with PTSD in civilian female populations [87], this study found no statistically significant relationship among female veterans between post-military "sexual stress" and the development of PTSD "above and beyond the contribution of military sexual stress" [86]. The authors of this study conclude that "sexual stress is the more toxic factor by far" and "special clinical attention should be paid to exposure to sexual stress in determining accurate diagnoses and in focusing treatment on the most relevant problems" [86].

Although experiences of sexual assault during military service are correlated with diagnoses of PTSD in male and female veterans, rates of sexual assault are much higher among women. For example, a cross-sectional study of US military veterans seeking VA Disability Benefits found that 6.5% of male and 69% of female combat veterans reported in-service or post-service sexual assault. Among non-combat veterans, 16.5% of male veterans and 87% of female veterans reported in-service or post-service sexual assault[88]. This study concluded that sexual assault prevalence for females serving in the armed forces is 3-10 times higher than found in the general female population. In other studies, rates of in-service sexual assault among American female soldiers deployed in Operations Desert Storm and Desert Shield were shown to be 10 times higher than those found in civilian female populations[89, 90]. Suris et al have found that female veterans who were sexually assaulted while in the military are 9 times more likely to be diagnosed with PTSD than those who were not assaulted[87].

US studies have shown that women who survive sexual violence during military service report multiple and pervasive health and social consequences attributable to trauma. Sadler et al found that women veterans who endured multiple military-related sexual assaults had significantly more out-patient physician visits, poorer self-rated health status, and more post-military experiences of violence than did their non-traumatized peers[82]. Rates of current depression and problem alcohol use are two and three times higher (respectively) for women veterans who were sexually assaulted while in the military [91]. Female veterans who were sexually assaulted while in the military are less likely to complete college, and more likely to use prescription medication for emotional problems and to report annual incomes below $25,000[92].

Social support from family and friends appears to play a major role in averting the development of PTSD in female veterans, while psychological isolation is the strongest predictor of PTSD among veterans of both genders. However, female veterans who were sexually assaulted during military service frequently report that their complaints are belittled or ignored by senior officers. Indeed, a survey of female veterans found that ¾ of women who were raped did not report the incident to a ranking officer, 1/5 said they didn't know how to report the incident, and 1/5 stated that they believed rape was to be expected in the military [82] . Moreover, like civilian women, female soldiers are subjected to shame, guilt, disbelief, and stigma when they report experiences of sexual assault upon returning home from deployment[91].

The US Department of Veterans Affairs has established specialized women's stress disorder treatment teams. The introduction of these teams has facilitated increased opportunities for evaluating and treating problems of women veterans, notably the impact of experiences of sexual harassment and trauma on PTSD [86]. A Task Force was established in February 2004 by the same department to "undertake a 90-day review of all sexual assault policies and programs among the Services and DoD," in order to "recommend changes necessary to increase prevention, promote reporting, enhance the quality and support provided to victims, especially within combat theaters, and improve accountability for offender actions" [5]. Following the recommendation in the April 2004 report for a single point of accountability for sexual assault policy, a permanent office was established in October 2005 to continue the work initiated by the Task Force: the US Department of Defense Sexual Assault Prevention and Response Office. It is likely that similar initiatives in Canada are urgently needed.

Mental Health Issues of Federally-Sentenced Women

World wide, women represent the fastest growing constituents of prison populations[93]. Between 1997 and 2002, the number of female offenders serving sentences of more than two years in the Correctional Service of Canada (CSC)

has increased by approximately 12.3 percent, while the number of male inmates in federal institutions has regressed by 9 percent[94, 95]. Moreover, 51.6% of incarcerated women and 40% or federally-sentenced women on conditional release in the community are between the ages of 18-34 only. This presents increasingly urgent issues for the development of gender-sensitive mental health services and policies.

There are significant gender differences evident in the mental health issues of incarcerated populations. For example, incarcerated women are 3 times more likely than non-incarcerated men to be diagnosed with depression (non-incarcerated women are twice as likely). Incarcerated women are more likely to be assessed with symptoms of schizophrenia, but are less likely than incarcerated men to exhibit symptoms of antisocial personality disorder (29% women versus 57% men). Incarcerated women and men are equally likely to have histories of substance use problems, but women inmates are more likely than men to have used “hard” drugs (such as cocaine and heroin) and are more likely to have injected drugs[94] . Incarcerated women also have much higher lifetime prevalence than women in community samples of many psychiatric disorders, including major depression (19% vs. 8.1%) and schizophrenia (7% vs. 1.1%), and have higher rates of alcohol problems (as designated by DSM III-R criteria for substance use disorder, 36% vs. 4.3%), drug problems (26% vs. 3.8%), and much higher rates of intimate partner violence (69% vs. 27%)[94]. In addition, a 1995 study of federally-sentenced women found that incarcerated women are 3 times more likely than incarcerated men to have received treatment for mental illness in the community prior to their sentence[94] .

Since the establishment in 1934 of the (now closed) Prison for Women in Kingston, Ontario, numerous Task Forces and Commissions have observed that federally-sentenced women experience disadvantages within the prison system relative to male inmates[94]. More recent attempts by the CSC to address these inequities include the release and acceptance of the report of the Task Force on Federally-Sentenced Women, *Creating Choices*. Among the recommendations of this report that have been acted on to date are the closure of the Prison for Women in Kingston, the creation of four new regional facilities for women offenders (in Nova Scotia, Quebec, Ontario, and Alberta), the creation of Akimaw Ohci Healing Lodge for Aboriginal Women offenders, and the expansion of community-based services for women offenders. The Regional Psychiatric Centre-Prairies provides a 12-bed women's unit for Anglophone women, while CSC has contracted Institute Phillipe- Pinel in Quebec to provide inpatient psychiatric service for Francophone women. However, despite these changes, federally-sentenced women still have inadequate access to beds in women-only facilities, and experience significant barriers to effectively addressing mental health problems while in prison.

The CSC 2002 Mental Health Strategy for Women Offenders emphasizes the importance of empowerment-based approaches to mental health programming that acknowledge the social contexts that mediate mental heath/ illness among incarcerated women [94]. Accordingly one of the key principles of mental health service delivery for women offenders is the delivery of women-centered care, in which gender-specific programming for women are delivered by personnel sensitive to women's unique needs and experiences [94]. One example of this type of programming currently offered to incarcerated women include the inclusion of a survivors of abuse and trauma group in CSC's Core Programs for women offenders, and the current focus on Psychosocial Rehabilitation, which "has its conceptual roots in a response to the failure of the mental health system to assist individuals in coping with the psycho-educational devastation brought on by severe mental or emotional illness, severe behavioral problems, and traditional treatment methods (i.e. institutionalization and medication)" [94].

Despite CSC commitments to empowerment-based and women-centred mental health supports for women, women prisoners' advocacy groups have expressed concern that certain CSC practices exacerbate gender inequalities for incarcerated women. One CSC practice which has received criticism from women prisoners' advocates is the imposing of "behavior contracts" on women in maximum security facilities who refuse to participate in compulsory "therapeutic" programs. This has a coercive practice that for many women triggers similar reactions to those they have experienced related to trauma, violence, and multiple forms of abuses. This report also emphasizes that employing "male-oriented classification tools" for assessing the mental health needs of federally sentenced women" often results in the misclassification of the needs of women and the level of risk which incarcerated women pose to society.

As is noted in the 2005 *CSC Action Plan in Response to the Report of the Canadian Human Rights Commission*, women prisoners whose mental health problems compromise their ability to cope with daily living in maximum security pods or community-living houses often become "long-term segregation cases" (p. 17). Repeated and prolonged forced segregation of female prisoners with mental health issues has proven to be therapeutically detrimental and further traumatizes and restricts women from accessing available services and resources[96]. The smaller number of female prisoners has meant that few resources are allocated to female prisoners. To illustrate, in 2005, men had access to "over 30 minimum security prisons across the country, whereas… [women had access to] one minimum security prison [housing] 10 beds"[96]. If CSC efforts are primarily centred on the needs of male prisoners, women will not be able to access appropriate rehabilitation services and programs.

The need for gender-sensitive services is also evident in that fact that women accessing therapeutic programs often object working with male therapist[96]

because of violence and abuse committed by men. This intensifies barriers to care and can be therapeutically detrimental for women.

Sex, Gender and Determinants of Substance Use and Addictions

Overview

"Gender neutral" policy and program responses to problematic substance use have often obscured the differences in the causes, types, and consequences of substance use that are evident between males and females, as well as differences among diverse groups of women and men. Historically men have had higher rates of use for alcohol, tobacco and illicit drugs, and have accessed treatment services two to three times more frequently than women [97]. Accordingly, in the recent Canadian Addictions Survey of 2004 more women (74.2%) than men (53.4%) reported drinking no more than one or two standard drinks on a single occasion in the past year[98]. There is also a marked gap in heavy drinking (>4 standard drinks per occasion for women, and >5 standard drinks for men). Almost twice as many men (33%) than women (17%) reported heavy drinking on a monthly basis [98]. However, the high rates of use of other licit substances with addictive potential, which women have historically used more than men, are commonly overlooked and the negative health impacts minimized. For example, since the 1970s the licit use of addictive prescription drugs, such as benzodiazepines, has consistently been twice as high for women[99]. And new evidence suggests that women's use of alcohol, tobacco and illicit substances may converging with that of men, particularly amongst some subpopulations[97].

Although heavy substance use is more common among men, women are more susceptible to adverse the health effects of all substances, including tobacco (Kirkland, Greaves, and Devichand 2003), alcohol, and other drugs [97, 100]. For example, women develop alcohol-related liver disease earlier than men and after shorter periods of use[101]. Other health risks that are higher for women who drink heavily include hypertension, osteoporosis, neurological impairment, breast cancer, and gastric ulcers [102]. In addition, certain health problems related to tobacco use are unique to women, including cervical cancer and some lung cancers[97], and smoking –related deaths among women are increasing[103]. The health effects of some illicit drugs can also be different for males and females. For example, women appear to experience more long-term mental health problems related to ecstasy (MDMA) use, including depression, mood swings, paranoia, and anxiety[104].

While research clearly demonstrates gender differences in rates and consequences of problematic substance use, little is known about the pathways to substance use and addictions that may be unique to women and girls. However, recently- released findings from a landmark study undertaken by the National Centre on Addiction and Substance Abuse at Columbia University have shed light on key risk factors for developing addictions as well as health consequences of use that may be more serious for girls and women[105]. These include: greater vulnerability to the physical effects of alcohol, tobacco, and other drugs (which make girls and women more vulnerable to developing problems associated with use); tendencies to use substances to improve mood, increase confidence, reduce tension, or cope with problems (which can promote destructive cycles of use in the absence of other supports); and strong correlations between sexual and physical abuse and earlier, more frequent, and larger quantities of substance use[105]. Emerging findings from other international studies support CASA's representation of these gendered pathways, calling attention to an immediate need for more understanding of the relationship for women between lack of social supports, trauma, and other upstream factors in mediating problematic substance use across the life course[106]. In addition, all the emerging literature on gender, substance and addictions places high priority on the need to examine and address key, gendered barriers to treatment for girls and women.

Selected Upstream Factors

Housing

In many Canadian cities there is a paucity of housing for women, especially for mothers with mental health and/or substance use problems. The role of housing in supporting women's mental health and reducing impacts of problematic substance use is also gaining increasing attention [107] from policy makers and program providers alike. While homelessness and inadequate housing is associated with problematic substance use in both men and women, housing as a determinant of health presents unique issues for women, particularly pregnant women and mothers. For example, the most common reason for homelessness cited by pregnant women with substance use problems is the need to escape from male violence or predation[108]. Other common causes of homelessness among addicted pregnant women include unsafe living conditions or condemned housing, unaffordable rents or eviction, fire, and divorce or separation from a spouse or partner [109]. In a study by Tuten, Jones, and Dace[110] homeless pregnant women who used substances had the most severe drug, medical, social/family, and psychiatric challenges and the poorest treatment outcomes when compared to domiciled women. A recent study of mortality rates of female injection drug users in Vancouver's Downtown Eastside found that unstable housing was one of the top three factors statistically linked to early death among women who inject drugs[111].

The conditions accompanying residence in homeless shelters, including loss of privacy, freedom, parental authority and respect from others, has been shown to negatively impact homeless mothers' substance use problems[109]. Nyamathi, Leake and Gelberg[112] have documented that unsheltered women are less likely to utilize available services to them compared to sheltered women. Among young homeless women, additional barriers to accessing services include lack of awareness of these services, fear of being turned away, worry about confidentiality issues, and fear of the involvement of police or social services[113]. However, homeless pregnant women who do enter treatment tend to fare much better than domiciled women. For example, homeless pregnant women who enter women-only addictions treatment facilities are more than twice as likely to complete treatment compared to women in mixed-gender programs, [114].

Stress, Coping, and Benzodiazepine Use

Canadian women and men report numerous sources of stress in their daily lives, including stresses related to schooling, work, and finances. Research on how these stresses shape and differentiate women's and men's experiences throughout the life course has uncovered significant gender differences in how stress may influence the development of problematic substance use and addictions. For example, Canadian women between the ages of 15-80 are more likely than men to self-rate their mental health and their ability to handle unexpected problems as "fair" or "poor"[9]. Both men and women between the ages of 15-64 report that work and finances are major sources of stress. However, more women than men report that time pressure, family or personal relationships, finances, family health, and their own physical health are sources of stress. Women's reporting of poor mental and physical health is often related to pressures from juggling multiple roles[9].

In this context, women often use substances to self-medicate to cope with the impact of multiple stresses on their health and well-being[115]. Significantly these sources of stress, coupled with gendered help-seeking behaviours, make women more likely than men to visit a physician for mental health problems of all kinds, including those related to stress, depression, and anxiety[99, 116]. When women visit a doctor for stress, anxiety, insomnia, and related complaints, they are twice as likely to be prescribed a benzodiazepine than males.[117-121] Cormier et al. suggest that "it is becoming clear that women are over prescribed benzodiazepines to cope with difficult life circumstances rather than to relieve severe clinical symptoms"[116]. While recent large-scale Canadian studies (including the Canadian Community Health Survey and the 2004 Canadian Addictions Survey) have provided insight into the extent to which women and men use alcohol, tobacco, and illicit drugs to cope with life stresses, both studies have missed opportunities to ask people of both sexes about problems associated with tranquilizer and other prescription drug use[9, 122]. Problem prescription drug use,

and benzodiazepine addiction in particular, is a highly gendered phenomenon that is often overlooked in Canadian health promotion, illness prevention, and addictions treatment.

Although gendered coping patterns make women more likely to represent to physicians for stress-related problems, it is physician prescribing patterns which render women more vulnerable to developing benzodiazepine addictions. Ashton asserts that doctors are more likely to perceive illness in women as having a psychological rather than a physical basis, and this makes them more likely to respond by prescribing psychotropic drugs[123]. In either case, benzodiazepine use and prescription is gendered, manifest either in the physical and psychological toll that gendered day to day stresses take on women, or gendered perceptions of women as weak, vulnerable, and emotional[99].

Although the gender differences in benzodiazepine use and addiction holds for all age groups, the highest prevalence rates of problem use and addiction are found among elderly women.[99, 124] The Therapeutics Initiative[124] recently studied benzodiazepine use among the senior population in British Columbia. They reported that more females than males received at least one benzodiazepine prescription in 2002. Older women are also more frequently prescribed questionable combinations of psychotropic drugs, benzodiazepines for longer than 30 days, and long-acting benzodiazepines that are contraindicated in the elderly. In Howard et al's study of Potentially Inappropriate Medication (PIM) use among seniors (including benzodiazepine use), no variable other than gender, including those related to use (age, education, self-rated health, number of health conditions, and number of prescriptions) or with prescribing, (physician gender, family medicine certification status, and time since graduation) was significantly associated with PIM use[125]. Szwabo has described this problem in very explicit terms: "older women are at greater risk for prescription drug abuse by a physician or physicians" [99].

Women and older adults, the two groups most likely to be prescribed benzodiazepines[124, 126] are also the most vulnerable to adverse effects.[124] Even at normal prescribed levels, benzodiazepines can impair a wide range of skills, such as memory, cognition, and balance,[99] required for day to day functioning.[124] Excessive dosage, interactions with other drugs and especially long-term use (i.e. more than one month in duration) have been associated with a myriad of other problems such as over sedation; memory and learning impairment; depression (increasing risk of suicide); emotional blunting and paradoxical aggression, and the development of tolerance, dependence, and addiction in a very short period of time. [127] The lengthy withdrawal process and need for tapering support and management requires trained professionals and dedicated out-patient benzodiazepine clinics which are largely unavailable in Canada.[127]

Key Examples

Pregnancy and Alcohol

Pregnant women who use alcohol (other drugs) come under considerable scrutiny in Canadian society. Public discourse regarding pregnant women who drink been fundamentally judgmental, blaming, and unsympathetic[27, 128]. Public policy and research related to women who use substances has tended not to focus on the health and welfare of women themselves, but on "the dangers that drug-using women pose to their children and families, and to civil society more generally"[129]. In this context, it has been challenging to create health policies, systems, and responsive to women, enhance women's health literacy in relation to substance use and addiction, and provide women with supportive options for treatment.

Among women, certain groups have constructed as particularly prone to problematic substance use, and thus requiring increased attention from health, social service, and criminal-legal systems. This heightened attention has led to disparities in screening for problem alcohol and drug use among pregnant women. For example, poor women and women of colour are more frequently screened for substance use when accessing perinatal care than are middle class and Caucasian women [130-133] .Canadian studies of women's alcohol use during pregnancy, particularly in discussions of Fetal Alcohol Spectrum Disorders, have focused disproportionately on Aboriginal mothers [134, 135]. Although there are no Canadian epidemiological data confirming that Aboriginal women are at higher risk for having children with FASD than other groups, Aboriginal women's mothering practices and substance use have been highly scrutinized, surveilled, and pathologized in both historical and contemporary contexts[135, 136]. These stereotypes and discriminatory practices can also discourage Aboriginal women from accessing addictions treatment[132, 134]

The extraordinary level of public scrutiny paid to alcohol and other drug use by pregnant women in Canada has not been balanced by extraordinary levels of public support for mothers to access addictions treatment or other forms of support to address the root causes of their problematic substance use. Although pregnant women are considered priority clients for entry into detox and treatment programs in many jurisdictions, few facilities are prepared to meet pregnant women's unique needs. For example, Canada currently has only two hospital-based perinatal programs for pregnant women with addictions that provide integrated access to obstetrical care and medically-supervised detox, withdrawal, and social stabilization support (BC Women's Hospital in Vancouver and St. Joseph's Hospital in Toronto). Canadian mothers wishing to enter residential addictions treatment consistently report that inability to bring their children with them is a significant barrier to care[137]. Although research has shown that mothers who

bring their children with them to treatment are more likely to complete treatment and have better treatment outcomes[138-140], few treatment facilities in Canada are equipped to enable this type of support. The result of the tensions evident in public responses to alcohol use in pregnancy have been to further marginalize pregnant women who drink, smoke, or use drugs, decrease the likelihood that mothers will disclose substance use problems, and frustrate women's efforts to identify and access supports they need[27, 131, 132, 137].

Gendered Dimensions of Tobacco Use

Canada has been successful in reducing the use of tobacco across the populations by approximately 50% in the past forty years [2][3]. However, these reductions have usually taken place first among men and among the economically and socially advantaged [4].

Applying a gender-based analysis to these patterns highlights specific subpopulations where smoking is still of great concern. Smokers in Canada are now a minority of the population, and are often disadvantaged or marginalized. These groups may be living on low income, of particular minority groups, Aboriginal, young, and/or experiencing violence, mental illness and other substance use. Gender is a key determinant of health and acts in concert with these elements of disadvantage or identity.

For example, people living on low income are more likely to initiate and maintain tobacco use. In 1996-97, at the lowest income level, smoking prevalence among women was approximately 35%, and 41% among men. In contrast, smoking prevalence at the highest income level was 18% for women and 22% for men [39]. The experience of smoking and living on low income is gendered, with women often coping with compromised family nutrition on tight budgets and trying to maintain smoke-free spaces for children.

A second example of gender interacting with vulnerability to influence tobacco use occurs among Aboriginal youth. Rates of smoking among adolescents have historically been characterized by distinct gender differences in rates of uptake and regular use. For example, amongst non-Aboriginal youth 6% report they are current smokers compared to 12% of Aboriginal youth [85]. However, patterns of tobacco use among Aboriginal adolescents are unique in that the prevalence of smoking among girls is higher than that among boys: in BC, levels of tobacco use among Aboriginal adolescent females are the highest among any ethnocultural-gender group in the province, including Aboriginal adolescent boys. Of Aboriginal youth 15% of females are current smokers versus 9% of males [85]. In addition to individual and social risk factors [10, 12] that may influence tobacco use among Aboriginal youth, recently attention has focused on structural factors. An Indigenous stress-coping model, developed in reference to American Indian

women [3], proposes that discrimination, traumatic life events, and historical trauma influence health behaviors and outcomes, including substance use and dependence. Colonial processes affected the gender roles of Aboriginal peoples and may in some way contribute to smoking and other substance use. Further, current structural inequalities (also gendered) may also play a role.

Evidence from the United States indicates that among immigrant and second generation youth, the prevalence and predictors of smoking are highly variable from one ethnocultural community to the next. [86-88]. In many cases, the pattern of tobacco use differs by gender within the same ethnocultural community[89] [90, 91]. However, Canadian studies that examine smoking prevalence among our diverse ethnocultural communities are unfortunately very sparse. Similarly, a recent nation-wide study in the U.S. has found that girls who identified themselves as being lesbian or bisexual were 10 times more likely to have smoked at least weekly in the past year compared to their heterosexual counterparts [52]. This strong relationship was not observed among homosexual or bisexual boys [52]. Again, little Canadian research has addressed this topic.

As these patterns and trends demonstrate, it is critically important to better understand both the realities of disadvantage among girls and women as well as the effects of comprehensive tobacco policies, in order to lower the rate of smoking below 15-20% of the population in Canada. Lack of access to health services, health information and material resources contribute to smoking initiation and cessation during both adolescence and adulthood. Applying a gender-based analysis to existing data on tobacco use, and integrating this approach to future tobacco policy development, will be imperative in reducing smoking among vulnerable populations of women and men.

Aboriginal Women and HIV

The legacy of colonization in Canada includes well-documented disparities in health among Aboriginal women[141]. The combined effects of poverty, racism, and cultural losses profoundly affect First Nations peoples and contribute to high rates of interpersonal violence, depression, suicide, and problem substance use[141]. Aboriginal women's' health researchers have emphasized the compelling need to examine how multiple forms of marginalization interact with experiences of poverty, trauma, and problematic substance to increase health disparities for Aboriginal women [142-145]. For example, the vulnerabilities associated with marginalization in Canada present multiple, interrelated risk factors for HIV among many Aboriginal women[141] [146].

Public policy responses to reducing HIV transmission are increasingly focusing on reducing transmission of blood borne pathogens via injection drug use (IDU). Indeed, incidence of new HIV and AIDS cases are increasing most rapidly among

Aboriginal women, and are closely associated with IDU. Aboriginal women represent 50% of all HIV-positive test results among Aboriginal people. In contrast, non-Aboriginal women represent only 16% of new HIV infections in non-Aboriginal populations[147]. Aboriginal women account for 25% of reported AIDS cases among Aboriginal people, while non-Aboriginal women account for 8.2% of non-Aboriginal AIDS cases[147]. IDU is cited as the main mode of HIV transmission in 64.9% of reported AIDS cases among Aboriginal women, followed by 30.9% citing heterosexual contact[148].

The effects of poverty, trauma, marginalization, ill health, and problem substance among Aboriginal women are also evident in their disproportionate representation among survival sex trade workers, which places women at further risk for HIV infection. In a number of communities across Canada, Aboriginal women and youth comprise up to 90% of the visible sex trade [149]. In Vancouver's Downtown Eastside, Aboriginal women account for nearly 80% of survival sex trade workers [145] . A recent study by Farley et al[141] linking intergenerational effects of colonization and trauma to systemic poverty and health disparities shows the devastating impact of injection drug use and survival sex work on the health of Aboriginal women, particularly in relation to risk factors for HIV. To illustrate, 90% of Aboriginal sex-trade workers reported being raped by their clients, and 72% reported that they have had clients refuse to wear condoms. There experiences alone place Aboriginal sex-trade workers at high risk for HIV infection.

Many Aboriginal sex-trade workers experience high levels of trauma in their daily lives, which are often linked to previous life experiences such as childhood abuse, death of a friend or family member and serious illness. For many women engaging in sex trade work, trauma becomes an everyday part of their lived reality. The physical and emotional violence inherent in survival sex trade work has been shown to lead to somatic dissociation, which is also associated with chronic health problems. The link between problematic substance use and addictions and trauma is well documented, as women who have experienced past or current trauma may turn to substance use in an effort to cope with the physical and emotional effects of trauma. However, federal policies and program initiatives in the areas of Aboriginal health, addictions, harm reduction, and HIV prevention have traditionally failed to address these issues.

Service Responses

The tendency evident among all levels of government to assume "gender neutral" policy stances in addressing mental illness and harms associated with problematic substance use has sometimes obscured the integral role of sex and gender in mental illness and substance use. Such policies have in turn supported the delivery of "gender-neutral" care for individuals living with mental illness and addictions. The result has been to entrench inequalities for women and men

experiencing symptoms of compromised mental health and/or problematic substance use and to construct barriers to effective and compassionate care.

Health Promotion and Prevention

The federal government has a role in bringing holistic approaches to health promotion that highlight the interconnecting factors that impact individual, family, and community well-being to the attention of communities, in providing funding for community based action that affects gender inequities and the other determinants of health, and in translating the knowledge gained on best practices back to communities. Attention to gender and other determinants of health could be built in to existing federal prevention program strategies such as the Drug Strategy Community Initiatives Fund

The field of mental health promotion has been heavily influenced by developments within the larger field of health promotion worldwide [150, 151]; [152, 153] [154] [151, 155-159]. In Canada, mental health promotion has been defined as

> A process of enabling individuals and communities to express consciously constructed identities and aspirations through access to capacities such as land, language, housing, economic resources and decision-making institutions[160].

This definition embraces the determinants of health and their role in shaping mental health by recognizing their contribution to people's sense of self and identity and their expression. However, as with the determinants of health in general, access to the determinants of mental health is typically unequal in a given society.

> Access to various mental health determinants or capacities such as income, housing and healthcare for different groups is unequal, particularly for those at the economic and cultural margins of society. The same groups are also often stereotyped in ways that negatively influence self-perception. Ample evidence demonstrates that these groups experience mental health disparities[161].

One such approach to mental health promotion and addictions prevention which is compatible with a gender-sensitive and determinants of health framework can be drawn from the "The Circle of Health," developed in 1995 by in partnership with the Community Service System and the Prince Edward Island's (PEI) Health Promotion Framework [162]. Grounded in the principles articulated in the Ottawa Charter, The Circle of Health offers a holistic approach to health promotion that highlights the interconnecting factors that impact individual, family, and community well-being and health promotion [162]. The Circle of Health illustrates the broad

scope of key factors that may be overlooked in strategic planning and health promotion, including gender and other determinants of health.

The Circle of Health is readily adaptable for a wide variety of health concerns, including mental health issues, and provides a practical framework for implementing health policy and practice. This model illustrates the various levels of interactive personal, social, cultural, political, and economic factors and that must be considered in developing health promotion strategies. Thus, the Circle of Health model provides a "visual representation… [that] can be used by health care professionals and clients to identify disease reduction strategies or a health improvement program" [163]. [164] emphasizes that "health must work in [partnerships with] economic, education, environmental, employment and social service sectors" to form authentic partnerships with mental health consumers, the general public, health workers and the federal government should work together to reach the common goal of healthy individuals and communities.

In some provinces, both the addictions and mental health fields are moving towards defining and applying the advances in health promotion, disease prevention, primary health care and chronic disease management, which have been successfully applied to a variety of chronic illnesses such as heart disease, asthma and depression. At federal provincial tables, there is opportunity to support and advance such efforts, so for example, the primary health care system becomes systematically more engaged in discussing substance use and depression with women of child bearing years, to prevent chronic substance use and mental illness in women, as well as conditions in their children such as Fetal Alcohol Syndrome. Pregnancy Outreach Programs such as those funded by the Canada Prenatal Nutrition Program (CPNP) and the Community Action Program for Children (CAPC) are excellent examples of how to develop consistent proactive prevention programs that take gender and other health determinants into account.

Diagnosis and Assessment

Accessible, integrated, and transdisciplinary assessment models are needed that are able to assess gender-specific dimensions of mental ill health and problematic substance use. As been highlighted earlier in this report, experiences of trauma, housing and nutrition needs, income support needs, parenting and caregiving responsibilities and other upstream factors can support or compromise women's and men's well-being. However, current assessment tools rarely capture the impact of these upstream factors on an individual's mental health or substance use.

Women are at greater risk for interpersonal victimization, including childhood abuse, sexual abuse, and intimate partner violence [165, 166]. For women, the long term effects of trauma can include: a wide range of somatic complaints, difficulty with interpersonal relations, feelings of powerlessness, dissociative symptoms, depression, anxiety, post-traumatic stress response, self blame and poor self-image, substance use problems, eating disorders, self inflicted injury, and vulnerability to further abuse [See review in 167]. The challenges inherent in multifaceted and gendered diagnostic and assessment approaches is evidenced by barriers in integrating trauma to the assessment of co-occurring mental ill health and substance use. Trauma can be related to social processes, such as social exclusion, voluntary and involuntary migrations, displacements due to war, hunger, poverty, homelessness, hate crimes, homophobia, violence in families and communities, and colonization. Lack of attention to effects of trauma and their connection to both alcohol and drug use and mental health problems can lead to misdiagnosis, extended suffering and even re-traumatization [168-172] (see also [173]). The cost of this is significant for individuals, for service systems and for governments.

Substance use and mental health problems frequently co-occur among women who are survivors of violence, trauma, and abuse, often in complex, indirect, mutually reinforcing ways [169, 174-177]. The overlap is not restricted to a small group of women. As many as 2/3 of women with substance use problems report a concurrent mental health problem such as PTSD, anxiety, depression[178]. Women with substance use problems also commonly report surviving physical and sexual abuse either as children or adults [169, 176, 178]. A Washington DC study showed that over 70 % of women diagnosed with mental disorders have co-occurring substance use problem and virtually all with co-occurring disorders have a history of trauma [170]. The overlap in the experience of these problems in women is also significant among diverse populations of women and men. Aboriginal women are three times more likely than non-Aboriginal women to die as a result of violence, and are over represented among women admitted to hospital for violence-related injuries[179].

When the underlying issue of trauma is not addressed, people with trauma histories are likely to access emergency rooms, mental health inpatient units, and/or end up in the criminal justice system as they seek to cope with symptoms. A participant in a recent evaluation of an integrated trauma/mental health/substance use program in Victoria estimated that she spent over 20 years unsuccessfully seeking help within the mental health system before coming to the realization that her mental health symptoms were trauma sequelae that needed to be addressed in trauma specific way [172]. Thus, with the awareness of the co-prevalence, impact and interaction of trauma, mental health and substance use problems, increasing priority is being placed on the need for integrated approaches to assessment, treatment and support.

Treatment and Related Health Services

Visible, accessible service system(s)

Often, we refer to addictions and mental health "systems", when in fact, for many Canadians, there may be no visible or coherent system that they can access, or the system may be only partially developed. For many, there is a two- or multi-tier 'system' available to them, depending upon their insurance coverage, social class, income level or ability to pay. While the public health care system in Canada attempts to be comprehensive in its coverage and accessibility, there are many Canadians with substance use issues, addictions and mental health issues who seek and receive treatment in the private sector. Counselors, therapists, psychologists, private treatment programs, some pharmaceuticals and a range of other alternative approaches are routinely accessed in private with either individual or third party payers. We do not yet have a clear idea of how the various response systems can interact, merge, or overlap, as we are still so often struggling with filling gaps in research, prevention, treatment or policy.

In short, the challenge is to not only merge addictions and mental health systems, but at the same time to improve them by making them more accessible, comprehensive, integrated and continuous. These goals relate to improvements in primary and emergency and acute care and may require shared care models. These goals will be reached more quickly if gender and diversity analyses are a key component of design, evaluation and research, and when sex differences and similarities are taken into account in designing research and treatment options.

Gender-specificity in service provision and health promotion

One of the most salient better practices demonstrated consistently in treatment for problematic substance use and addictions is the provision of gender specific services[180]. In Canada, women-only treatment centres have demonstrated considerable success in addressing experiences of trauma as they impact women's substance use, particularly trauma's associated with relationship violence and childhood sexual abuse. While fear of child apprehension and separation from one's children is consistently reported to be a barrier to treatment for women, gender specific programs for women have also shown how the integration of on-site childcare in residential and day programs can be effective in engaging and retaining women in addictions treatment[140, 180]. However, such facilities are appallingly unavailable for women in most communities across Canada.

Specific services and programs for women with mental illness are not as common, however, there are several programs that have shown success with respect to

addressing the particular needs of women. for example stable long-term housing for women with mental illness and their children, attention to reproductive health issues, attention to co-occurring trauma and mental illness, integration of culturally competent programming for lesbians and African Canadian women, etc. Other mental health programs for women have been able to promote more research in the area of women's mental health, education for psychiatry residents on women's mental health, other professional training, education and broad public educational forums. Systematic evaluation of women-specific programming is necessary to determine best practices in women's mental health.

Specific services for men are emerging that explore bio-psycho-socio-spiritual understandings of "manhood" and masculinity across the lifespan, and the extent to which these gendered life experiences inform problematic substance use among men. [181]. Increased attention to the ways in which ideologies and lived experiences of masculinity can mediate risk for and experiences of problematic substance use and addiction is needed to ensure effective responses to this issue in policy, program, and service provision.

Integrated Services

In 1998, the groundwork for a large cross site study entitled the Women, Co-Occurring Disorders and Violence Study was laid by the US Substance Abuse and Mental Health Services Administration. The goal of this initiative was the generation and application of empirical knowledge about the development of an integrated service approach for women with co-occurring substance use problems and their children. With this initiative SAMHSA through its three constituent Centres (The Center for Substance Abuse Treatment, The Center for Mental Health Services and the Center for Substance Abuse Prevention) was able to support and fund pioneering service development and implementation for women and their children whose lives had been impacted by violence/trauma and co-occurring mental illness and substance use problems.

For a five year period between 1992 and 1997 9 sites across the US were studied as they developed and tested integrated service models that were integrated, comprehensive, trauma-informed, gender specific and involved consumers of these services in meaningful ways. The results of this large study involving over 2000 women, in the 9 sites showed that women with these complex co-existing problems were able to reduce these problems when integrated models that were trauma informed and financial accessible were provided; that these integrated counseling in a trauma informed policy and service context was more effectives than services as usual; and that complex collaborations including consumers, providers and system planners in all aspects of the policy design, implementation and evaluation of services improve the quality of the work [182].

In Canada, some collaborations between health service systems and community based women-serving agencies have built on the SAMHSA study findings to develop and refine programs for women. Women-serving organizations that address violence/trauma issues have developed integrated programming that provides concurrent support for women on trauma related, mental health and substance use problems. Support for further development of such programs, integration into mental health and substance use and related systems, as well as systematic evaluation is crucial to ensure a robust evidence base specific to the current Canadian context. The Canadian federal government has a role in funding such demonstration projects that lead to improved outcomes for women by influencing systems and policy that have long created barriers to integrated care.

Integrated, gender-specific programs are also being developed for men experiencing trauma, mental health, and substance use problems. For example, the Annual Men's Wellness Gathering in the Fraser Valley, sponsored by Stó:lo Nation Health, has been designed to address the needs of Aboriginal men, including those who are survivors of the Indian Residential School system. While noting that lack of culturally-specific assessment tools has made it difficult to screen Aboriginal men for conditions such as depression and anxiety, a recent article describing the Gathering observes, "When Aboriginal men discuss addiction, substance misuse and mental health issues, the conversation always moves to the sources of these problems: identity issues, lack of purpose, little sense of belonging and difficulty communicating emotions." A regular participant at the Gathering further described, "Listening and sharing are the keys. For many men, it is the first time they have been able to share or talk about the 'real' life story beyond just surface stuff--jobs, money, hunting, fishing, cars, trucks and other things."[183]. However, like the programs for women noted above, these initiatives have also not been the subject of comprehensive evaluation.

Comprehensive care

The use of a comprehensive women-centred care framework to guide community based and acute care service delivery has been shown to be particularly effective in programs for pregnant women with substance use problems and related health and social problems. In its application to problematic substance use and addictions, women-centred models of care recognize the unique experiences of women who use substances, including the context in which women use substances, and the importance of empowering women to become active agents making choices about their options for support, treatment, and recovery[137, 145]. Evaluations of these programs demonstrate significant benefits in engagement in care as well as a wide range of improvements in health outcomes for women and children[184, 185].

Consumer and peer led initiatives

Peer support and self-help has long been recognized as a key component of recovery and of maintaining wellness for people with mental illness[32, 186-188] [189] [190],[191],. Indeed, throughout Canada peer-support is now recognized as an integral component of the mental health system (e.g., as articulated in most provincial mental health plans)[30] [192], [193]and a key resource for people with addictions who are in need of abstinence -oriented support (such as is provided by organizations such as Alcoholics Anonymous and Narcotics Anonymous) . The success of peer-support appears to be the breaking of isolation through the sharing of similar experiences and the learning of self-advocacy skills[194]. Such initiatives are critical components of comprehensive, community-based health promotion, illness prevention, and early support. The CMHA policy initiative, *Building a Framework of Support*, was the first attempt in Canada to put into policy a consultative framework that would bring consumer/psychiatric survivors together with policy makers and providers [195]. Consumer leadership of projects are now recognized as an important component of healing and maintaining wellness[191, 195]

Marginalized groups such as sex trade workers, who experience significant barriers to mental health care and addictions treatment have taken effective leadership in defining integrated multifaceted models of response [196] and developing consumer led initiatives that address to women's mental health, substance use and related health and social needs. An example is the Prostitutes Empowerment Education and Resources Society based in Victoria BC (See http://www.peers.bc.ca) who have engaged sex trade workers who are birth mothers of children with fetal alcohol syndrome in designing FASD prevention materials, providing peer education groups and developing innovative outreach models to sex trade workers with alcohol and related health and social problems (insert Poole evaluation report.

The CSC 2002 Mental Health Strategy for Women Offenders supports the inclusion of peer support visits from other inmates "during critical periods when the women may require a great deal of support"[94]. The Strategy also notes that "offenders could reasonably and effectively be trained to facilitate [mental health programs for women] which could positively affect their self-esteem"[94]. For federally-sentenced Aboriginal women, the Strategy underscores that "Mental health programs for Aboriginal women should be developed and delivered by Aboriginal Organizations or individuals with demonstrated awareness of their concerns and needs while incarcerated"[94].

Recommendations

This section identifies key recommendations for policy, research, and programs which stem from our analysis of recent literature, as well as opportunities presented by recent federal initiatives. These recommendations emphasize opportunities for federal involvement in mental health care from the perspective of gender in the following areas:

- providing leadership and facilitating inter-sectoral collaboration;
- knowledge development, synthesis, and translation,
- increasing public awareness, health literacy and anti-stigma initiatives;
- health promotion;
- working with the provinces and territories; and
- populations under federal jurisdiction.

Providing leadership and facilitating inter-sectoral collaboration

- ✓ Establish a National Mental Health and Addictions strategy that will account for issues of gender and other salient determinants of health which inform incidence and experiences mental health / illness. This could be closely linked to related policy frameworks, such as the *National Framework for Actions to Reduce the Harms Associated with Alcohol and other Drugs and Substances in Canada* and recommendations evolving from the Kirby Commission.

- ✓ Apply Gender-Based Analysis in the development, implementation, and evaluation of mental health and substance use/addictions policy and programs at the federal level, and encourage this practice by providing training and relevant case studies for federal staff who are working at the federal and regional offices.

- ✓ Support gender mainstreaming in current policy initiatives in the area of mental health/ illness and problematic substance use/addictions through the Women's Health Contribution Program and the Bureau of Women's Health and Gender Analysis at Health Canada. The recent release of the *National Framework for Actions to Reduce the Harms Associated with Alcohol and other Drugs and Substances in Canada* provides a key opportunity to provide leadership and enhance inter-sectoral collaboration from a gendered perspective in relation to problematic substance use.

- ✓ Provide leadership and funding for community-based health promotion initiatives that incorporate gender and embrace a social determinants of health perspective.

- ✓ Provide intersectoral leadership (in conjunction with the Canada Mortgage and Housing Corporation and other relevant federal and provincial bodies) to expand the range of housing options available to people living with mental illnesses and/ or addictions. This could include specialized housing for women, and prioritize independent living options in self-contained units. Such housing should be located in a variety of neighbourhoods (i.e. not only socioeconomically disadvantaged or inner city neighbourhoods). Housing for women with children should also be prioritized.

Knowledge Development, Synthesis, and Translation

- ✓ Utilize and expand the current evidence base by collecting and reporting sex-disaggregated data, particularly groups for whom this data is not currently collected or sex-disaggregated. This includes, for example, data collected by FNIHB pertaining to NIHB claims, and data collected by CIHI pertaining to physician visits and prescription practices for mental health issues.

- ✓ Fund research that enhances understanding of sex and gender specific dimensions of mental health/illness and addictions. Research is urgently needed regarding dynamic interactions between sex and gender and other determinants of health which inform the etiology, diagnosis, trajectory, treatment, and consequences (including treatment-related consequences) of mental health/illness and/or addictions for women and men.

- ✓ Accumulate and coordinate data documenting expenditures on mental health services and addictions treatments in both public and private facilities. These data should be collected and analysed by sex, age, ethnicity, and income and reported in this disaggregated form.

- ✓ Build on the CIHR STIHR training initiative to prioritize transdisciplinary research in mental health and addictions from a perspective of gender and other related determinants of health.

- ✓ Privilege the funding of research through both Health Canada and CIHR into non-pharmacologic ways of treating mental health concerns and ensure that the results of these trials are made publicly known.

- ✓ Establish policies at Health Canada that require clinical trials of psychiatric medications to include meaningful outcome measures for all groups for whom the drug will be used including women and men, those aged 65+ (55+ for Aboriginal populations).

- ✓ Establish policies at Health Canada that require clinical trials for psychiatric medications (including SSRIs) to include testing of dependency by extending trials to include a withdrawal phase, and extending over periods of time reflecting the periods women and men typically consume them. These data should be collected and reported publicly in sex and age-disaggregated forms.

- ✓ Collect and publish data on the relative use of services and costs of mental illness and addictions within the public health system. These data should be collected and analysed by sex, age, ethnicity, and income and reported in this disaggregated form by Health Canada.

- ✓ Ensure that the Canadian Community Health Survey (CCHS) is enlarged to collect a wider array of mental health information than is currently collected and that the questions and analysis are reviewed for their gender-appropriateness.

- ✓ Fund gender-sensitive demonstration projects through both Health Canada and the CIHR to build an evidence base and highlight opportunities for policy and program development in mental health and addictions, such as demonstration projects in trauma-informed mental health and addictions services for women and men.

- ✓ Provide funding and infrastructure through Health Canada with CHSRF, CIHR and relevant NGOs to support evaluation of mental health and/or addictions initiatives undertaken by community-based organizations that are gender-specific and/or gender-sensitive. For example, evaluations are urgently needed of integrated services for women and men that address trauma, mental health, and substance use issues concurrently.

- ✓ Work with Statistics Canada to apply GBA to federally sponsored research instruments such as surveys, in order to sensitize and change data collection relevant to mental health and addictions, including tobacco use.

Public Awareness, Health Literacy, and Anti-Stigma Initiatives

- ✓ Expand and enhance access to health literacy about mental health and substance use to better support individuals in identifying and accessing supports in their communities. Such health literacy initiatives must be informed by diverse perspectives, experiences, and understandings of mental health/illness and substance use issues, and reflect gender influences that mediate health outcomes.

- ✓ Develop national mental health literacy and “anti-stigma” campaigns predicated on principles of empowerment and social justice, and reflecting the primacy of determinants of health (particularly social determinants) in mediating experiences of mental health and illness for women and men. Provide support to ensure that psychiatric consumer/ survivor, women’s health, and other stakeholder groups are actively involved in the design and dissemination of mental health literacy and “anti-stigma” campaign materials.

- ✓ Work with all affiliates of the Canadian Health Network to integrate a gender mainstreaming approach to information collection and dissemination generally and specifically with respect to mental health and addictions.

- ✓ Support health literacy initiatives undertaken by communities who are confronted with substantial barriers to accessing the mental health and substance use supports they desire via federal policy and program development

- ✓ Issue safety warnings to consumers of psychiatric medications (through Health Canada). These warnings should include a message to consumers to report any adverse drug reactions directly to Health Canada (with instructions on how to do so)

- ✓ Provide funding through Health Canada for client/consumer/survivor-directed services which build and enhance capacity for leadership and self-determination in the identification of opportunities for involvement in federal policy making in mental health and addictions. Such funding could support peer-based and consumer groups to provide information about mental health and substance use issues and options for treatment.

- ✓ Fund professional development and training opportunities for Canadians on the impact of discrimination against people with addictions and mental illnesses (particularly women) by health care providers (and in clinical settings generally) that result in barriers to accessing treatment.

- ✓ Integrate gender-specific mental health and addictions information into public education and public health campaigns in other areas, such as violence prevention, Healthy Living Agenda, workplace safety and occupational health, perinatal nutrition, and other work of the Public Health Agency of Canada.

Working with the provinces and territories

- ✓ Work with the provinces and territories to develop a comprehensive gender and diversity sensitive National Mental Health and Addictions Framework that incorporates a Women-Centred approach. Such a Framework should enable increased access to community-based services not currently supported by provincial and territorial health plans (i.e.: counseling, trauma services, social supports for individuals and families experiencing crisis/ distress, peer supports, supportive housing, etc.). Fundamental to these efforts must be a national commitment to increasing access to a spectrum of services and programs to enhance the mental health of Canadian women and men.

- ✓ To support the federal interministerial mechanisms , re-establish the F/P/T Advisory Network on Mental Health as the F/P/T Advisory Network on Mental Health and Addictions , with the federal representative working to ensure that gender considerations are integrated throughout the work of this group in line with federal commitments to gender equity and gender-based analysis.

- ✓ Integrate gender considerations into the deliberations on funding transfers between levels of government and in the development of legislative frameworks such as a Canada Mental Health Act by explicitly identifying issues of gender equity as a goal.

- ✓ Integrate mental health promotion into the work of the Public Health Agency of Canada, particularly its framework and activities on the determinants of health, to address the gender-specific dimensions of mental ill health and problematic substance use, including experiences of trauma, housing and nutrition needs, income support needs, parenting and caregiving responsibilities and other upstream factors which support or compromise women's and men's well-being.

- ✓ Inventory and map the range of programs, services, and health literacy initiatives available in the provinces and territories and provide to researchers and the general public with respect to gendered dimensions of mental health/ illness and substance use/ addictions.

- ✓ Assess the comparative indicator reporting process at CIHI for opportunities to include sex and gender-specific reporting on mental health and addictions related indicators.

- ✓ Support the development and evaluation of dedicated benzodiazepine tapering and withdrawal clinics for women and men through pilot or demonstration project funding in consultation with the provinces and territories.

- ✓ Support the development and evaluation of dedicated benzodiazepine tapering and withdrawal clinics for women and men through pilot or demonstration project funding in consultation with the provinces and territories.

Populations under federal jurisdiction

First Nations and Inuit Populations:

- ✓ Make funding available to support gender-specific, culturally responsive care for mental health and substance use problems, including the need for trauma-informed and trauma-specific care. Such programming should be predicated on antiracist principles and contribute to larger decolonization and self-determination efforts.

- ✓ Develop pilots and demonstration projects for providing harm reduction services specifically designed for Aboriginal mothers and Aboriginal women involved in the survival sex trade.

- ✓ Provide funding from FNIHB and Health Canada to support urban and rural Aboriginal communities (on and off reserve) to develop community-specific, culturally-responsive, and gender-sensitive harm reduction initiatives

- ✓ Ensure that these initiatives are accompanied by adequate funding for evaluation.

- ✓ Develop an extended framework for developing and evaluating tailored policies and programs for tobacco reduction in collaboration with FNIHB and communities

Corrections:

- ✓ Ensure the ongoing implementation and review of Canadian Human Rights Commission recommendations for Correctional Service of Canada reforms to better meet the mental health and addictions-related needs of federally-sentenced women, as contained in the reports *Protecting their Rights- A Systematic Review of Human Rights in Corrections Services for Federally*

Sentenced Women and *CSC Action Plan in Response to the Report of the Canadian Human Rights Commission.*

- ✓ Develop and implement programming which will better support federally-sentenced women in their role as mothers

- ✓ Ensure the implementation and regular review of CSC practices which may compromise the identification and treatment of mental health problems among federally-sentenced women, as outlined in the August 2004 *Program Strategy for Women Offenders*. This includes, but is not limited to, the imposition of behaviour contracts, the use of repeated and prolonged segregation, and the use of classification tools designed for males when assessing female prisoners

Military Personnel and Veterans:

- ✓ Provide leadership through Health Canada, Veterans Affairs Canada, and the Department of National Defense to in address gender-specific traumas which compromise the health of female veterans (including reservists and peacekeepers).

- ✓ Improve and enhance existing PTSD prevention, education, and treatment initiatives for veterans to account for the role of gender in the development of mental health and substance use problems among male and female military personnel

- ✓ Undertake gender-sensitive and trauma-informed initiatives through Veterans Affairs Canada and the Department of National Defense to encourage military personnel to report all incidences of sexual harassment and violence (including attempted and completed sexual assaults and rapes). Such efforts should be accompanied by research and record-keeping practices that enable the collection of data documenting the current incidence and prevalence of military-related sexual harassment and assault in Canada. Such data must be disaggregated by sex, age, and ethnicity.

- ✓ Incorporate gender-sensitive approaches, including principles of women-centred care, into mental health and addictions treatment for veterans and their partners.

- ✓ Create policies and programs which support spouses and families of veterans who incurred psychological injuries (such as depression, anxiety, PTSD) during deployment.

- ✓ Create policies and programs to prevent sexual harassment and assault of female military personnel.

- ✓ Create policies and programs that provide health services, counseling, and support with PTSD and addictions issues for women who are sexually harassed and/ or assaulted during military service.

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