Women, Mental Health and Mental Illness and Addiction in Canada: An Overview

By the Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions

May 8, 2006

The Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions was informally and spontaneously convened by the Canadian Women's Health Network (CWHN) and the Centres of Excellence for Women's Health (CEWH) in anticipation of the Standing Senate Committee on Social Affairs, Science and Technology's Final Report on Mental Health, Mental Illness and Addiction in Canada, chaired by Senator Kirby.

This document was prepared prior to the tabling of the Committee's Final Report on May 9, 2006, and responds to interim reports tabled in 2005. It provides information about issues in women's mental health, illness and addictions and makes recommendations for the next steps.

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Members of the Ad Hoc Committee include:

Madeline Boscoe	Canadian Women's Health Network
Anu Bose	National Organization of Immigrant and Visible Minority Women of Canada
Paula Caplan	Brown University, Washington College of Law
Jill Cory	BC Women's Hospital
Linda Day	Aboriginal Women's Health and Healing Research Group
Janet deGroot	University of Calgary
Elina Farmanova-Haynes	National Organization of Immigrant and Visible Minority Women of Canada
Linda Furlini	McGill University, Canadian Women's Health Network
Lorraine Greaves	British Columbia Centre of Excellence for Women's Health
Joanne Havelock	Prairie Women's Health Centre of Excellence
Kathy Hegadoren	University of Alberta
Abby Lippman	Canadian Women's Health Network, McGill University
Laila Malik	Canadian Women's Health Network
Marina Morrow	Faculty of Health Sciences, Simon Fraser University
Kim Parry	Canadian Women's Health Network
Ann Pederson	British Columbia Centre of Excellence for Women's Health
Nancy Poole	British Columbia Centre of Excellence for Women's Health
Valerie Regehr	Women's Health Clinic
Anne Rochon Ford	Women and Health Protection
Amy Salmon	British Columbia Centre of Excellence for Women's Health
Donna Stewart, MD	University of Toronto, University Health Network
Janet Stoppard	University of New Brunswick
Cara Tannenbaum	University of Montreal
Kathleen Thompson	PhD candidate, University of Calgary
Bilkis Vissandjée	University of Montreal
Jayne Whyte	Prairie Women's Health Centre of Excellence

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1. Women, Mental Health and the Kirby Report: Establishing the Context

A lack of gender analysis in research, programs, and policies in women's mental health and illness has been a central focus of feminist critique for the past century. This critique has included a discussion of the ways in which women have been pathologized and over-medicated as well as the ways in which the specific mental health concerns of women have been under-recognized resulting in a lack of access to appropriate services. Nineteenth century diagnoses of "hysteria" assumed that a uterus and ovaries somehow placed women at risk for "nervous" disorders. On this basis, it was argued that women were unfit to vote, be educated or otherwise participate equally in society[1]. Decades of lobbying have for the most part established such blatant sexism as flawed science. In many more subtle ways, however, mainstream mental health research, promotion and treatment has continued to neglect women's experiences of mental health and mental health care, despite the fact that certain mental illnesses are more prevalent in women, that women utilize mental health services more frequently than men and that women seek a wider range of treatment and support options than is currently available[2].

On a broader scale, the Romanow Commission's Final Report on the Future of Health Care in Canada described mental health as the "orphan child" of health care in Canada, and recommended that it be brought into the mainstream of public health care. Leading organizations and experts across the country have echoed the concern that mental health and addictions have been marginalized in health care despite the fact they directly affect one in five Canadians and have severe social, employment and economic implications[3]. It is estimated that mental health problems/illnesses cost approximately $14 billion annually. Mental illnesses and disorders are the seventh highest among all diseases in terms of the overall cost of illness. The World Health Organization (WHO) predicts that by the year 2010 depression (over-represented in women) will be second only to ischemic heart disease in terms of global burden of illness. In addition, mental illness is the second leading cause of hospital use among those aged 20 to 44, a period of life normally associated with high productivity[4].

The Standing Senate Committee on Social Affairs, Science and Technology Report on Mental Health, Mental Illness and Addictions has taken important strides toward shedding light on the current state of mental health and addictions services, as well as providing some key information that can be used for policy development and reform of service delivery systems in Canadian jurisdictions. In particular, its references to the role of the social determinants of mental health (a population health approach), the effects of stigma and discrimination on mental health care recipients and the need to more significantly involve care recipients in their own treatment and support (a 'patient-centred' approach) mark a significant move forward in understanding and developing mental health and addictions policy and programming.

However, one dimension in which this study is critically under-informed is the multifaceted and embedded ways in which sex and gender mediate individual and collective experiences of mental health, mental illness and addiction. The following document is not intended to replace a systematic gender-based review of mental health, mental illness and addiction in Canada. Rather, its goal is to

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[1] Ehrenreich, Barbara and English, Deirdre (1978). *For Her Own Good; 150 Years of Experts Advice to Women*, Anchor Press/Doubleday.

[2] Morrow, M. (2003). *Mainstreaming Women's Mental Health: Building a Canadian Strategy*, BCCEWH.

[3] Canadian Association of Mental Health (November 25, 2005). *Organizations laud Kirby Committee's proposed new Canadian Mental Health Commission,* Press Release.

[4] Canada. Parliament. Senate. Standing Committee on Social Affairs, Science and Technology (January 2002). *The Health of Canadians – The Federal Role* (Interim Report), Volume Two: Current Trends and Future Challenges.

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illuminate the urgent need for such a review, and for concrete action to address the gender gap in mental health, mental illness and addiction service delivery.

2. Why sex and gender matter in mental health and addictions

Canada's Commitments[*]

Canada has made explicit commitments to gender equity and to using Gender-Based Analysis (GBA) as a means of improving policy and program development and enhancing gender equity. Gender equality is guaranteed under Sections 15(1) and 28 of the Canadian Charter of Rights and Freedoms and by many international human rights instruments to which Canada is signatory. Canada's international commitments to gender equity include ratification in 1981 of the UN Convention on Elimination of All Forms of Discrimination (CEDAW) and adoption of the UN Platform for Action, the concluding document of the UN World Conference on Women in Beijing in 1995.

At the Beijing Conference, the Government of Canada presented its own Federal Plan for Gender Equality (1995-2000), which stated that all subsequent legislation and policies would include, where appropriate, an analysis of the potential for differential effects on men and women. The Federal Plan also made a commitment to government-wide implementation of gender-based analysis in the development of policies, programs and legislation. In 2000, the federal government approved the Agenda for Gender Equality, an initiative which included engendering current and new policies and programs and accelerating implementation of gender-based analysis commitments. Several federal government departments have issued formal gender-based analysis guidelines, including the Canadian International Development Agency, Human Resources Development Canada, the Department of Justice Canada, Status of Women Canada, and Health Canada. Health Canada's commitment is expressed in the Women's Health Strategy (Health Canada 1999) and Gender-Based Analysis Policy (Health Canada 2000).

Provincial and territorial governments have agreed on "the importance of having gender-based analysis undertaken as an integral part of the process of government" (statement by Federal, Provincial and Territorial Ministers Responsible for the Status of Women, 14th Annual Meeting, May 1995), and have also supported the implementation of CEDAW. They have done this through the establishment of Status of Women Ministers and women's directorates and/or advisory councils with the provincial/territorial structure. Many provinces and territories have also undertaken GBA training of policy analysts and prepared supporting materials. These provincial and territorial commitments apply to departments of health, many of which have or have had gender-related focal points (e.g., offices of women's health) and undertaken specific training for their staff.

Given these commitments, government at all levels is responsible for ensuring gender analysis and gender equity and for developing mechanisms to do so.

What is GBA?

GBA is a process of interrogating research, programs or policies about what they tell us about, or how they might affect, women and men. It is not a prescribed set of techniques but rather the process of questioning whether, how and why something might be different for women or men, girls or boys. It is a form of analysis that recognizes that people and populations are always influenced by gender and that the contexts of men's and women's lives matter. Its primary aim is to understand the nature of men's and women's lives; the secondary aim is to understand the similarities and differences between women and men. GBA also includes trying to understand the experiences of sub-groups of women

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[*] *Parts of this section have been drawn from* Gender-based Analysis and Wait Times: New Questions, New Knowledge, *written by Beth E. Jackson, Ann Pederson, and Madeline Boscoe for the National Coordinating Group on Health Care Reform and Women (NCGHRW)(2006).*

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and of men, recognizing that neither women nor men as a group are all the same but rather that people differ in important ways according to income, education, ethnicity, race, age, geographic location, sexual orientation and so on.

Most guides to GBA distinguish between the key concepts of "sex" and "gender." Health Canada identifies both sex ('biological and genetic endowment') and gender as determinants of health (Health Canada 2003). "Sex" is generally understood to refer to biological characteristics. These include the reproductive organs and their functions, as well as sex-specific hormonal activity, cellular functioning and developmental patterns (Wizemann and Pardue 2001). "Gender" on the other hand, generally refers to "the array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influences that society ascribes to the two sexes on a differential basis" (Health Canada 2003, p. 8). These distinctions between sex and gender are useful for helping us to recognize that *both* material and social phenomena affect women's and men's health. But the relationship between sex and gender is complex – they are not entirely separate. Biological matter (e.g. chromosomes, cells, bodies) does not exist outside of social structures and cultures, and gender relations occur in the physical world. So – even though it may be tempting to do so – we can't simply extract sex from its social meaning and context, nor can we understand gender apart from its relation to physical bodies. Not surprisingly, because the relationship between sex and gender is complicated, these constructs are often conflated and confused in research and policy statements. An adequate understanding of women's and men's health requires an examination of the complex interactions of both sex and gender.

GBA is better science – it produces more valid and reliable evidence – and the evidence produced by GBA can lead to better recommendations, better strategic interventions, and better outcomes for individuals, households, communities and economies. It can help to produce evidence that will support the development of initiatives that ameliorate the conditions that produce gender inequities and accommodate sex and gender differences. It may also reduce system costs in the long run by identifying the problems and solutions more appropriately. Recently, the Health Evidence Network of the WHO Regional Office for Europe (2005) has begun to look specifically for evidence about the effects of health care reforms on gender equity in the health field. After searching for and reviewing evidence of the gender-related effects of decentralization, financing, privatization and priority setting, they concluded that "(e)merging evidence shows that health care reforms can affect men and women differently, as a consequence of their different positions as users and producers of health care" (p. 4). Data are also beginning to be collected that demonstrate that gender-sensitive programming has positive outcomes. An assessment of program evaluations conducted on a wide range of reproductive health programs worldwide, for example, has demonstrated that integrating gender considerations into reproductive health programs can improve both health *and* gender outcomes (that is, the status of women) (Interagency Gender Working Group 2004) that benefit not only women but the society as a whole[5].

How does gender mediate experiences of mental health, mental illness, substance use and addiction?

Societies are organized along what Hanna Papanek (1984) has called the "fault lines" of sex and gender, which means that women and men are thought of, treated and live their lives as different kinds of people with different types of bodies and different roles, responsibilities and opportunities. This can result in women and men having different access to life choices and chances – including economic activity, educational attainment, health and care.

Women's and men's health and health needs are distinct both because of differences in their bodies and because of differences in how women and men live, work, and play, as well as how they were raised as children. For example, overall women have less financial security, and are more likely to be

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[5] Jackson, Beth E., Pederson, Ann and Boscoe, Madeline (2006). *Gender-based Analysis and Wait Times: New Questions, New Knowledge,* National Coordinating Group on Health Care Reform and Women.

part-time workers with less access to extended benefit plans. Women are also the overwhelming majority of paid and unpaid care providers,[6] and therefore have a unique interest in the way in which mental health services are provided, or the reforms that may be coming. Too often, health care reform has meant offloading care to unpaid care providers through early discharge.

Women are also at greater risk for interpersonal victimization, including childhood abuse, sexual abuse, and intimate partner violence. 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. Further, women interact with the health care system more frequently than men, in part because of their roles in reproduction and in overseeing the care of other family members.

3. Women, Mental Health and Addictions – an ongoing concern

Since the groundbreaking publication of *Women Look at Psychiatry: I'm Not Mad, I'm Angry* in 1975, the women's health movement in Canada has revolutionized how women's mental health issues are conceptualized and contextualized within a climate of systemic social inequity, as well as developing new models of appropriate care. In 1987, a Canadian Mental Health Association (CMHA) report entitled *Women and Mental Health in Canada: Strategies for Change* took this analysis several steps further, detailing a range of key mental health issues and concerns facing women in Canada and investigating some of their causes, such as the feminization of poverty and violence against women. It outlined 25 recommendations for improving women's mental health in Canada , including the development of affordable, high quality child care services, the establishment of pay equity policies, recognition of unpaid caregiving, and the creation of a national clearinghouse of research and programs on women's mental health.

Since then, a number of studies and papers have been undertaken in the field, echoing, reinforcing and developing on the findings of the CMHA report. For example, researchers have suggested that up to one-third of the prevalence rate difference in depression in women is accounted for by increased rates of childhood sexual abuse. Other research reveals that women who experience social adversity have a poorer response to antidepressants than other women[7]. *Hearing Women's Voices* (Morrow & Chappell, 1999) argues that women's mental health cannot be understood in isolation from the social conditions of women's lives, characterized by social inequities (e.g., sexism, racism, ageism, heterosexism, ableism) which influence the type of mental health problems women develop and impact on how those problems are understood and treated by health professionals and by society.

On an international level, organizations like the World Psychiatric Association (WPA) have officially recognized the critical importance of the gendered aspect of mental health, launching the *International Women's Mental Health Consensus Statement*, signed in the fall of 2005 by 140 of its member associations. The consensus statement stresses that mental health must be considered within the context of women's lives, including women's unique roles in reproduction, the family and society, and their often lower socioeconomic status. According to the statement, women's mental health cannot be achieved without equal access to basic human rights: autonomy of the person, education, safety, economic security, property and legal rights, employment, physical health, including sexual and reproductive rights, access to health care, and adequate food, water, and shelter. Further, the statement underscores that women's mental health requires the elimination of violence and discrimination based on sex, age, income, race, ethnic background, sexual orientation or religious beliefs[8].

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[6] "Overall, about 80% of health care professionals in Canada in 2000 were female." (Canadian Institute for Health Information 2002, p. 40) According to Statistics Canada, as of 1996 most unpaid caregivers were women (Canadian Institute for Health Information 2002, p. 12).
[7] Hamilton, J.A., & Jensvold, M.F. (1995). "Sex and gender as critical variables in feminist psychopharmacology research and pharmacology" *Women & Therapy, 16,* 9-30.
[8] See Appendix B for Consensus Statement recommendations, p.44.

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Unfortunately, this ever-expanding Canadian and international inventory of authoritative resources on women and mental health has resulted in very little action. The 1987 CMHA report recommendations were never implemented by the various levels of government, by clinicians' training programs, or by the CMHA itself. Landmark federal studies like the Romanow and Kirby Reports have remained gender-blind in their analysis.

The Senate Committee's first three volumes on Mental Health, Mental Illness and Addiction continue this trend. They do not systematically and comprehensively address mental health issues as they pertain to women, or consult widely with experts in the women's health and mental health fields. This omission warrants serious consideration, given the well-documented evidence indicating significant gender differences in the prevalence and manifestation of certain mental illnesses, in how women and men use mental health services, and in the specific needs and concerns of women with substance use problems or co-occurring disorders.

Clearly, there is a dire need for a systematic gender analysis of mental health, substance use and addiction in Canada. Such a review is far beyond the scope of this document. Post-partum depression, attempted suicide, women in the prison system, sexual orientation and gender identity, sexual abuse, schizophrenia, and mental health service provision are only a few of the complex issues we have not broached here.

Nonetheless, examples are useful in illuminating the breadth and depth of the ground to be covered. Appendix A of this document highlights a sampling of the mental health, substance use and addiction issues facing women in Canada today. It includes a look at:

- *Women and Mental Health Promotion* p.12
- *Women-Centred Care for Mental Health and Addictions* p.14
- *Women and Trauma* p.16
- *Women and Psychiatric Diagnosis* p.18
- *Women and Depression* p.20
- *Women and Psychotropic Drugs* p.23
- *Women and Addictions* p.27
- *Women and Dementia* p.29
- *Women and Eating Disorders* p.33
- *Aboriginal Women and Mental Health* p.37
- *Impact of Immigration And Settlement on Women's Mental Health, Mental Illness, Substance Use and Addiction* p.39
- *Rural, Remote and Northern Women* p.43

These snapshots span a variety of topic areas, as well as a spectrum of perspectives from experts recognized in their fields. The positions expressed in individual pieces are not necessarily shared by all authors in this collection. The diversity of views found here reflects the depth and range of work in progress, as well as the magnitude of what remains to be achieved.

4. Recommendations

As stated in previous briefs on women and mental health in Canada, to improve women's mental health we must recognize the particularities of all women's lives and improve women's social and economic status. Accordingly, any interventions (policies as well as practices) in the domain of women's mental health must be informed by the following general principles:

- *A commitment to decrease social and economic inequities among between men and women and among women;*
- *The direct and active involvement of women in general, and mental health service consumers in particular in the development of mental health, substance use and addictions policy and programming at all stages in the development of policies, programs and service;*

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- *The commitment to analyzing the impact of sex and gender on mental health and addictions across the lifespan in program and policy development;*
- *The integration of a gender and diversity analysis in the development of policies, programs and service.*

With these principles in mind, we put forth the following recommendations:

1. Healthy gender-sensitive public policy

Addressing gender as a determinant of mental health is an essential first step to laying the ground for improving women's mental health in Canada. Healthy gender-sensitive public policy includes, but is not limited to:

- *increasing affordable and safe social housing for women;*
- *reducing unpaid care giving by expanding publicly-funded home care (including care for the elderly) and day care;*
- *legislating pay equity;*
- *ensuring food security;*
- *increasing funding for women's anti-violence work and education campaigns;*
- *developing initiatives to combat isolation of rural and remote women;*
- *instituting broad-based policies to reduce the hypersexualization of girls and young women;*
- *instituting media literacy programs for young women and regulate the portrayal of female bodies in advertising;*
- *improving pension arrangements that account for women's particular work experiences;*
- *reducing income inequities and addressing issues of unstable incomes due to fluctuations in primary industries (such as farm economies);*
- *reducing social exclusion of people with mental health conditions;*
- *eliminating direct-to-consumer advertising of prescription drugs.*

2. Surveillance and monitoring (investigating indicators of health, not just illness)

All mental health data (whether these relate to measures of disease and disability, to treatments, or other markers) must be sex-disaggregated. Further, data collection must go beyond the narrow confines of diagnostic and drug-use data, to measure the determinants women's mental health. Women's income trends, stress levels in the workplace, time constraints, access to affordable, long-term housing, and work and family balance are all examples of indicators that must be measured and factored into analyses, promotion and treatment of women's mental health. Wherever possible data should be collected and desegregated by geographic location, cultural and racial identities, and concurrent health conditions.

3. Diagnostic Categories

Existing surveillance data is premised on the assumption that diagnostic categories accurately reflect the realities of women's mental health and their experiences. However, these categories can distort or obscure women's lived experiences, which can contribute to women being both under and over-diagnosed and under- and over-treated. Such diagnostic categories should be re-visited with a gender and diversity analysis, with a view to re-conceptualizing women's mental health experiences to reflect women's realities more accurately. Wherever appropriate and valid, diagnostic labels should be removed from everyday life experiences and reactions to them.

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4. Health Services and Beyond: Reforming and improving access to effective and appropriate women-centred care

A comprehensive approach to addressing women's mental health, mental illness and addictions must range from continued efforts to achieve equality between men and women and among women, to mental health promotion, illness prevention, community-based care and tertiary care, when necessary. While the Commission and its proposed activities may perform an important role as a national focal point for anti-stigma campaigning and information dissemination, **there is an urgent need for new and separate funding for mental health promotion and care <u>now</u>.**

The current service delivery system must be restructured and expanded to accommodate women's diverse and socially embedded mental health needs. To this end, the following measures should be taken:

- Increased support and funding for consumer initiatives led by women consumers;
- Women with mental health and addiction concerns must be included in the development, management and evaluation of health services that are provided to them;
- Restoration and development of mechanisms for meaningful consumer participation in policy and program decision making in mental health;
- Increase funding for multi-disciplinary, comprehensive community based mental health services that include, for example, accredited mental health workers, social workers, nurses, health educators, occupational therapists, physiotherapists, etc;
- Revise existing fee schedules for physicians so that time spent counselling and listening to patients is adequately compensated;
- Improved development of and access to alternative models of care, such as feminist therapies and other effective interventions;
- Increased training on gender-sensitive and women-centred mental health care for health care providers and managers;
- In Volume 3 of the interim report, a question was raised about merging mental health and addictions and substance use services. There are some sound arguments and appropriate contexts for the aggregation of mental health, mental illness and addictions in analysis and intervention. However, given a legacy of the criminalization of addictions, and of the over-medicalization of women's distress, for example, such aggregation must be undertaken with extreme caution and vigilance.
- The Federal Government should create a Mental Health Service Innovation Fund, modeled on the Health Transition Fund, to stimulate the development of new, innovative and alternative community-based services for treatment and promotion of mental health, substance use and addictions that could be accessed by community groups.

5. Increase research on women and mental health which includes prevention, health promotion, and innovation in care

- 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.
- Create mechanisms and organizational support through which research results can be accessed by women and mental health consumers to enhance their input into policy and decision-making.
- Support 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.

- 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 analyzed by sex, age, ethnicity, and income and reported in this disaggregated form.

6. The Canadian Mental Health Commission

While a commission is a worthy mechanism to help build an action plan and accountability mechanisms for improving care, this should not be used to avoid taking action now.
The proposed Canadian Mental Health Commission should adopt a commitment to GBA from its inception. In order to represent and respond to its constituency, at least half of the Commission's seats should be reserved for women, including women's health advocates from diverse backgrounds. The proposed Knowledge Exchange Centre (KEC) should establish a centre on women immediately and work in close collaboration with existing researchers, organizations and programs in the field.

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Appendix A

Information sheets

The following documents span a variety of topic areas, as well as a spectrum of perspectives from experts recognized in their fields. The positions expressed in individual pieces are not necessarily shared by all authors in this collection. The diversity of views found here reflects the depth and range of work in progress, as well as the magnitude of what remains to be achieved.

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Women and Mental Health Promotion*

AUTHORED BY: British Columbia Centre of Excellence for Women's Health, www.bccewh.bc.ca

*The positions expressed in this document are the author's own, and do not necessarily reflect the views of the Ad Hoc Committee at large.

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AT ISSUE:

Current mental health promotion initiatives typically ignore the contribution of gender to mental health and mental illness and addiction. Mental health promotion efforts need to incorporate sex and gender and to recognize the need for tailored programs and policies, in addition to population-wide initiatives.

ANALYSIS:

Mental health promotion is receiving increasing attention from researchers, practitioners and policy makers [1]. This reflects the growing understanding that there "is no health without mental health," that is, the inseparability of physical and mental health, and the continuing shift away from a focus on disease and illness to health. However, to date, mental health promotion programs often fail to address gender-related determinants of mental health such as poverty, lack of education, housing, and discrimination. While there is growing recognition of the role of violence and abuse on the mental health of women and children, more work remains to be done on the gender-related aspects of the determinants of health.

Mental health promotion is concerned with enhancing mental health in general through actions that strengthen individual resilience, foster equitable and safe communities and reduce structural barriers to health such as income, employment and educational inequalities. "Improving mental health requires policies and programmes in government and business sectors including education, labour, justice, transport, environment, housing and welfare, as well as specific activities in the health field relating to the prevention and treatment of ill-health" [1 p. XIX]. In some jurisdictions, mental health promotion has also been concerned with reducing the stigma associated with mental illness through education and awareness-raising about mental illness. Campaigns in the United Kingdom, for example, have sought to clarify mental illness and to shift public attitudes toward people with mental illness through the schools, work place, in the community and through health services (see www.mentality.org.uk). Canada has been a leader in defining mental health promotion and in developing health promotion responses to mental illness, though not yet from the perspective of gender. Research further suggests that few interventions directed at mental health promotion reach ethno-racial/cultural communities [2].

Stigma is also a feature of addiction; there is research to suggest that women experience greater stigma attached to their addiction than do men, greater resistance from family and friends when they want to access addictions treatment, and more negative consequences associated with treatment entry [3]. Experiences of stigma and discrimination undermine women's abilities to report their substance use patterns and concerns, influence the rates at which some women are screened for substance use problems, and access to addictions treatment. Public discourse regarding pregnant women who drink has been fundamentally judgmental, blaming, and unsympathetic [4, 5].

RECOMMENDATIONS:

Adopt a comprehensive response to mental health and addictions that incorporates mental health promotion that recognizes that gender is a determinant of mental health.

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Appendix A: <u>Information sheets</u>

Develop community-based health promotion initiatives that incorporate women's experiences (including those stemming from multiple roles as workers, mothers, caregivers, partners, and community members) and embrace a social determinants of health perspective. These campaigns would include health literacy and anti-stigma campaigns addressing the lack of specific information for women and girls about how substance use affects them and the impact of discrimination in creating barriers to care.

Incorporate an intersectoral action into the work of the proposed Canadian Mental Health Commission to promote the mental health of girls and women.

Conduct program evaluations to ensure that mental health promotion programs are reaching their intended audiences, including ethno-racial/cultural communities.

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Women-Centred Care for Mental Health and Addictions*

AUTHORED BY: British Columbia Centre of Excellence for Women's Health, www.bccewh.bc.ca

*The positions expressed in this document are the author's own, and do not necessarily reflect the views of the Ad Hoc Committee at large.

AT ISSUE:

"Gender neutral" approaches to health policy and health service delivery have fundamentally neglected the unique treatment needs of women living with addictions and mental health problems.

ANALYSIS:

Health policy makers, planners, and service providers across Canada are adopting women-centred care models as frameworks for delivering health and social services to women with substance use and mental health problems[1-5]. Women's health advocates and providers have also developed women-centred frameworks to address the social, political, economic, and health inequalities experienced by women in the context of their practice. The most common elements of women-centred care are:

Participatory
- Involves women and their health care providers in an interactive process defined by mutual respect and collaboration
- Recognizes that women have authority on their own lives

Empowering
- Involves the empowerment of women, to be informed participants in their own health care, with the right to control their own bodies
- Supports women learning from, and with, each other

Respectful of Diversity
Recognizes the impact of :
- age, sexual orientation, culture, language, disability
- geography, financial and informational constraints
- social, economic, environmental and other living conditions of women's lives

Social Justice
- Encourages full participation by women in health service and program planning, implementation, evaluation, policy and research
- supports the involvement of service providers and all women in advocating for women's achievement of political, cultural, social and economic equality

Women centered care

Safe
- Establishes emotionally, spiritually, culturally and physically safe environments
- Incorporates approaches that actively take into consideration the likelihood of women's experience of

Individualize
- Takes into consideration health concerns unique to each woman and her personal experiences including her experience of violence, her role(s) as homemaker, worker, and caregiver and other aspects of her life, as well as her choices about the type and extent of change she wishes to make

Comprehensive
- Supports increased collaboration and partnering across health sectors, disciplines and professions
- Supports use of alternative and complementary therapies
- Involves comprehensive care, including health promotion, education prevention, treatments and rehabilitation

Holistic
- Applies knowledge of bio-psycho-social-spiritual factors in provision of comprehensive care,
- Avoids unnecessary medicalization of natural life changes related to reproduction, menopause and child birth

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Women-centred care models are unique from other models because they underscore the importance of contextualizing health service delivery in relation to the social and economic situation of women and girls as they receive care. They also recognize unique issues such as women's likelihood of

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experiencing violence and women's roles as caregivers as well as patients. In highlighting the importance of sex (biological differences) and gender (social influences) on health, women-centred models also recognize that women and men often differ in the determinants that impact on their health, in their patterns and experiences of illness, disease and mortality, in how they interact with the health system, and in which programs and treatments ensure the best health outcomes for them[6].

RECOMMENDATIONS:

There are compelling reasons for bringing women-centred care to policy, program, and treatment responses for women living with addictions and mental health problems, and for incorporating a gender-based analysis to all such efforts.

Women-Centred Addictions Care: Comprehensive women-centred care frameworks have successfully guided community-based and acute care policy and programming for women with substance use problems[7, 8]. Evaluations of women-centred addictions programs demonstrate significant benefits in engagement in treatment as well as a wide range of improvements in health for women and their children[9, 10]. **Women-centred models recognize the unique experiences of women who use substances, including:**

- **the context in which women use tobacco, alcohol, and other drugs**
- **the likelihood of co-existing violence/ trauma connected to women's substance use ; and**
- **the importance of empowering women to make choices about their options for support.**

Women-Centred Mental Health Care: Differences in prevalence, pathways, and expressions of mental illness in males and females t warrants gender-specific mental health program planning and treatment. Studies of women-centred care models for women with mental illness suggest that they are especially useful when they incorporate peer-initiated and led models[6]. **Women-centred peer support programs can:**

- **provide important kinds of information and social support to women with mental illness**
- **assist women in understanding their mental illness and navigating the mental health system**
- **increase the likelihood that women will receive the care they need; and**
- **help women to avoid relapses and, in some cases, hospitalization.**

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Bringing Women's Experience of Trauma and Violence into Canadian Mental Illness and Addictions Policies and Programs*

AUTHORED BY: British Columbia Centre of Excellence for Women's Health, www.bccewh.bc.ca

*The positions expressed in this document are the author's own, and do not necessarily reflect the views of the Ad Hoc Committee at large.

AT ISSUE:

The experience of trauma and violence is common in the lives of women and girls, particularly those who also live with substance use and mental health problems. Lack of attention in health policies and service delivery to the ways experiences of trauma are connected to both alcohol and drug use and mental health problems can be can have serious health and social consequences for girls and women.

ANALYSIS:

Violence and trauma including childhood abuse, sexual abuse, and intimate partner violence are common in women. The Canadian Research Institute for the Advancement of Women reports that half of Canadian women have survived at least one incident of sexual or physical violence and that four out of five victims of family-related sexual assaults (79%) are girls [1]. 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 [2]. 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 problems, often related their experiences of surviving physical and sexual abuse as children or adults [3-5]. Aboriginal women are more severely impacted by violence and trauma [6, 7], including intergenerational effects of trauma, often connected to the impact of residential schooling on their parents/grandparents [8].

Lack of recognition in health policies and service delivery to the ways experiences of trauma are connected to both alcohol and drug use and mental health problems can be devastating for girls and women. Women who have sought help for trauma and mental health issues report misdiagnosis, extended suffering, overprescription of anti-anxiety and anti-depressant medication, and even retraumatization through their encounters with health care providers who are not sensitive to their needs [9-11]. The cost can also be significant for service systems when the underlying issue of trauma is not addressed. Women with trauma histories are likely to over-utilize emergency rooms, mental health inpatient units, and/or end up in the criminal justice system as they to cope with symptoms in a context of unresponsive health and social policies and programs.

There exist evidence-based models for the delivery of integrated support for women on substance use, mental health and trauma related issues. For example, in the Women, Co-Occurring Disorders and Violence Study funded by the US Substance Abuse and Mental Health Services Administration found that women with trauma, substance use, and mental health problems were able to reduce these problems when integrated models that were trauma informed and financially accessible were provided; that integrated counselling in a trauma informed policy and service context was more effective than services as usual; and that collaborative approaches involving consumers, providers and system planners in all aspects of the policy design, implementation and evaluation of services are foundational to the effectiveness of this work [11, 12].

In Canada, some community-based addictions services and women-serving agencies have built on the SAMHSA study findings to develop and refine integrated programs for women. 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 [13, 14]. The Canadian 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.

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Appendix A: <u>Information sheets</u>

Currently in Canada, addictions and mental health systems are being merged, with the medicalized approach of the mental health system dominating, at the expense of multifaceted, comprehensive and women-centred addictions and trauma informed approaches. The challenge in merging addictions and mental health systems is to at the same time improve them by making them more accessible, comprehensive, integrated and continuous.

Attention to trauma needs to be a key component in the design of treatment options as well as in research that can guide this practice.

Given the impact and interaction of trauma, mental health and substance use problems in the lives of Canadian girls and women, developing policies and programs that support integrated approaches to treatment, harm reduction and prevention must be made a national priority in federal mental health and addictions policy.

RECOMMENDATIONS:

Expand and enhance public and professional access to information on the interconnections among trauma, mental health and substance use.

Collect and publish data on the use of services and costs of trauma/violence, mental illness and addictions within the public health system.

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.

Build supports for problematic substance use/addictions issues around a framework of Women-centred care. This includes the need for more women-only facilities as well as gender-specific supports for women and men around trauma issues.

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Women and Psychiatric Diagnosis*

AUTHORED BY: Paula J. Caplan, MD

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AT ISSUE:

Psychiatric diagnosis is not an empirical science. However, most patients are not fully informed of the limitations of the diagnostic labels that are usually the basis for therapists' treatment recommendations, and it is extremely rare that they are informed of any of the negative legal, economic, social, employment, emotional, or other negative consequences that can result from simply receiving any psychiatric label. For women, such diagnoses can also obfuscate the effects of larger, chronic social inequities like poverty and violence, instead mistakenly identifying women's bodies as the problem. Pharmaceutical drugs are the physiologically based treatment prescribed far more often than any other, and they are extremely likely to be prescribed when formal diagnoses are given. In many cases, however, patients are not made aware of the side effects of such medication, nor are they offered alternative treatment options which are often less invasive and more effective.

ANALYSIS:

Virtually none of the standard diagnostic categories has been empirically validated. This absence of science in psychiatric diagnosis creates an opening for biases and distortions, including racism, sexism, ageism, classism, and homophobia to operate when diagnoses are created and then when they are applied to individuals. Such biases are all the more cause for concern, given that receiving any psychiatric label can result in the loss of a patient's right to make decisions about legal and medical affairs, loss of health insurance or sky-high premiums, loss of child custody, and plummeting of self-confidence. To complicate things further, both government insurance programs and private insurance companies only pay for treatment of emotional suffering if the patient's condition is given a psychiatric label. As a result, clinicians who believe people need supportive or other treatment when they are suffering emotional pain are driven to use such labels.

Although drugs can be helpful for some people, it is important for the public and their therapists to know that they are often prescribed to treat diagnostic "entities" that may not even exist. Patients have a right to try anything that might help them, including medication, but it is essential that they do so after being fully informed of the limitations of the diagnostic labels that are usually the basis for therapists' treatment recommendations.

RECOMMENDATIONS:

- The federal government via Health Canada should fund a comprehensive public education program to teach consumers (1)that psychiatric diagnosis is not a scientific enterprise and (2) the benefits and the economic, personal, health, and legal risks of simply receiving any psychiatric label at all;
- Introduce legislation that would ensure that the discipline bodies for psychiatrist, psychologists, social workers, and other psychotherapists will take responsibility for being fully informed about psychiatric diagnosis and for fully informing their patients. Clinicians should also fully inform patients: (1) that they have to give them a diagnosis, (2) the reason that they have to do this (most often because required by their place of work and/or required for reimbursement by insurance companies and because diagnoses are used in treatment planning), (3) that there are potentially negative consequences of receiving a diagnosis and

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what these can be, and (4) what the clinician is doing—or will do in the future, if relevant—to try to protect the patient as much as possible from those consequences;
- Fund more research concerning the frequency, forms and operations of bias in the creation and application of psychiatric diagnostic categories.

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Women and Depression*

AUTHORED BY: Kim Parry, Madeline Boscoe, Lissa Donner, Kathy Hegadoren, Abby Lippman, Donna Stewart, Janet Stoppard, Cara Tannenbaum. For further information contact the Canadian Women's Health Network. www.cwhn.ca

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AT ISSUE:

Adolescent girls and women are at higher risk of depression than are adolescent boys and men, with a ratio of 2:1 (2, 15, 11, 8, 6, 13, 9). Depression is described as being both under and over diagnosed and under, inappropriately and over treated. Women are more likely to be hospitalized for depression and less likely to gain full remission from single therapy with antidepressants. Waiting lists for traditional mental health care services are long and for many women, access to complementary services is unavailable or financially inaccessible. It is imperative that there is increased acknowledgement of social, psychosocial, cultural, economic and biological factors influencing women and girls' lives that result in mental health issues such as depression.

ANALYSIS:

Gender analysis demonstrates women and girls' higher risk of depression. It is critically important that women's and girl's experiences with depression be taken into account in developing health services and health policy. Intersecting with the physical, social and economic experiences and exposures that are inherent with being a woman in this society are a number of other determinants that contribute to depression. Systemic discrimination based on gender, race, social class, sexuality, disability, age, culture and language work to determine vulnerability to depression, accessibility of mental health services and treatment response. Within the health care system, women are both under diagnosed and over diagnosed with depression and there is an over-reliance on monotherapies with pharmaceuticals as treatments. Depression in women and girls is associated with other health and social risks, both as cause and as an outcome. Relationships between women and girls and their care providers and social structures, values and policies can either contribute to women's vulnerability to depression or can be used to develop highly targeted gender-sensitive interventions for depression.

Health service utilization data from Manitoba (3) and Quebec (15) shows that substantially more women than men received a diagnosis of a mental health problem and of an anxiety/ depressive disorder and that more women than men received a psychotropic or an anti-anxiety drug or antidepressant[1].

At the same time, Stewart et al. (11) have noted that "although the number of women who seek and obtain treatment for depression is greater than that for men, this still represents only a small proportion of depressed women. Data from the 1994–1995 cycle of the NPHS revealed that although depression is amenable to treatment, only 43% of those who met the criteria for major depressive episode in the

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[1] During the five year period from April 1, 1997 to March 31, 2002, 29% of Manitoba women and girls ten years and over were treated for mental health conditions* compared to 19% of men and boys. (Mental health conditions included are with one or more of depression, anxiety disorders, substance abuse, personality disorders and schizophrenia. Not included is dementia.). RAMQ 2003 data shows that among those consulting a physician, more women than men received a diagnosis of any mental health problem (22% vs. 15%) and of anxiety/ depressive disorders (8% vs 5%) and among those being covered by the RAMQ drug plan, more women than men received a psychotropic drug (35% vs 26%) or an anti-anxiety drug/ antidepressant (22% vs 14%).

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previous year reported talking to a health professional about their emotional problems" (11). About 75% of individuals in the 1994-1995 NPHS cycle who suffered form a major depressive episode were below the minimum four visits deemed necessary for acute treatment (11).

Similar data were reported from Manitoba (6). During the five-year period from 1997/98 to 2001/02, 12.6% of Manitoba males and 23.6% of females aged 10 years of age or older received treatment for depression. While those most likely to self-report depression were girls and young women aged 15 to 19 years, those most likely to receive treatment for depression were women aged 40 to 50, of whom 28% received treatment (6). **The implications of these reports are that depression is even more common than has been reported by most of the major surveys, and that the health care system faces a large unmet need.**

The survey data underscore that depression in women and girls is a serious public health problem. Attention needs to be paid to risk factors and risk conditions specific to girls and women at all stages of their lives. The complex relationships among psychosocial and biological factors change across women's lifespan and thus would necessitate differences in interventions and required supports.

There continues to be a disconnect between the kind of care women with depression seek and that which is available. The peer reviewed literature (10) is now reporting what community based service providers working with women have known for a generation: that counselling, information, support, protection from violence and help with access to housing, training, and income supports are what women seek – and yet these fundamental services are rarely available or have long wait lists. Publicly funded services remain under-funded. A commitment to expanding services within Medicare is critical for women, since they are more likely to be part-time workers with less access to extended benefit plans. Community based services for women are infrequent with significant waiting lists. Comprehensive programs that include attention to life style issues like exercise, good nutrition, self help groups and other social supports remain rare.

Risks for depression for women [besides being female] include being poor, of an ethnic minority, having had major negative life experiences including sexual and physical violence, unpaid care giving responsibilities, "blue collar" work, and "time stress". Other risk factors include "low sense of mastery and feeling overwhelmed, lack of social support, greater severity of pain, other chronic physical or mental health or conditions, high Body Mass Index, smoking, previous experiences of depression (11). Social disadvantage and social adversity are associated with the increased prevalence of depression in women, as well as poorer response to antidepressant treatment (4, 13).

It is critically important that these social risks are addressed if there is to be an impact on prevalence rates of depression in women.

RECOMMENDATIONS:

Rates of depression in Canadian women and girls are unacceptably high and urgent action is required to assist those suffering from depression and to actively address psychosocial and structural conditions that are known to be associated with the development of depression. A comprehensive action plan is needed within and outside of health care services.

Put in place explicit strategies to reduce and prevent depression in women and girls
It is essential that the social determinants of health become more fully integrated into public policy and that gender analysis and health impact assessments are institutionalized. Therefore, the existing commitments to gender equality need to supported and enhanced, specifically in terms of income inequities, the need for supportive and low income housing, programs for home care and child care and the prevention and management of violence.

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Appendix A: <u>Information sheets</u>

Involving Women
Women who have experienced depression must be included in the development, management and evaluation of health services that are put in place.

Improving Care
- Increase access to publicly funded gender sensitive and where necessary, gender-specific services that recognize the contexts of women's lives.
- Implement training programs for providers that will increase their capacity to provide gender sensitive care, using a lifespan approach to women's mental health.
- Develop and expand access to publicly fund community based care with a variety of health care providers including services provided by social workers, psychologists, accredited counselors, community workers, physio- and occupational therapists and nursing professionals.
- Increase counselling fees and interpersonal psychotherapy fees for fee-for-service physicians.
- Include, and ensure, public funding for, exercise, healthy eating, self-help and mutual aid programs, social support, light therapy, and psychotherapy in the treatment of depression rather than relying solely on antidepressants.
- Provide resources that are flexible and appropriate for important sub-populations of women: refugee and immigrant women, women of colour, Aboriginal women, women with disabilities, lesbian and bisexual women, transsexual and transgendered women.

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Women and Psychotropic Drugs*

AUTHORED BY: Cara Tannenbaum, HPRP Women and Psychotropic Drugs www.emotionalhealth.ca;
www.santepsychologique.ca
WITH ASSISTANCE FROM: Anne Rochon Ford, Coordinator, Women and Health Protection   www.whp-apsf.ca

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AT ISSUE:

Women are avid users of anti-depressant and anti-anxiety (psychotropic) drugs and are far more likely to consume these medications than men. While efficacious in many but not all mental health disorders, the use of psychotropic drugs incurs significant risk. Effects on memory, heart problems, and an increased risk of falls, hip fractures, and motor vehicle accidents, are but a few of the potentially dangerous side effects of these medications. A possible over-medicalization of women's mental health - in the absence of mental illness - warrants immediate investigation in light of the excess use of these medications, the availability of other more conservative therapies, and the increased risk of future health problems. Additionally, the aggressive promotion of psychotropic drugs directly to physicians as well as to consumers through direct-to-consumer advertising (DTCA) may be distorting the doctor-patient role and incurring unnecessary prescribing. The interim reports of the Kirby Commission missed important opportunities to meaningfully and systematically address the issues of over-medicalization of women's mental health – especially for the expanding proportion of older women in our society – and the deleterious role that pharmaceutical marketing can play in the realm of mental health.

ANALYSIS:

Reflecting gender differences in expression rates of depression and anxiety and a gender bias on the part of prescribers, **excess psychotropic drug use in women is a serious health issue that affects the lives of women throughout the lifespan.** Medications for depression and anxiety (psychotropic drugs) have now surpassed estrogens and progestins as the leading therapeutic class of medications prescribed to women at visits to physician offices and outpatient departments [1]. In Canada, 13% of women versus 9% of men consume sedative-hypnotic drugs [2]. Older women are the highest consumers, with yearly prevalence estimates of 22% in Quebec [3]. Data from the Canadian Community Health Survey cycle 1.2 Mental Health Supplement 2002 indicates that 8% of women and 4% of men report use of anti-depressant drugs over a one-year time period [4]. Given these excess rates of psychotropic drug use in women, it is necessary to reflect on the reasons for this phenomenon, the negative health impacts that are often minimized, and policy recommendations that could improve the situation.

Women express emotional distress differently then men. The medical literature illustrates that women are more likely to suffer depressive and anxiety disorders, while men are more likely to abuse illicit substances, gamble and engage in criminal activities in the face of emotional distress [4]. This is one of many possible reasons why women receive more psychotropic medications than men. If they express more anxious or depressive symptoms, they will consequently receive more treatment. Data from the Canadian National Population Health Survey indicate that women are indeed more likely to experience a major depressive episode [5], with annual incidence rates of depression twice as high as those of men (4.1 per 1000 vs 1.8 per 1000 individuals aged 45-64 years) [6]. This gender difference in morbidity persists across race and ethnicity (despite variations in income), with East and Southeast Asian, Chinese, South Asian, and black women reporting overall poorer mental-health than their male counterparts [7]. The Ontario Mental Health Supplement reports that Canadian women are also more likely than men to

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experience anxiety disorders [8], with one-year prevalence rates for anxiety disorders of 9% for men and 16% for women.

Women are more likely to seek care for mental health problems than men. Although gender differences in morbidity rates of depression and anxiety are well established, several competing explanations exist for women's excess use of psychotropic drugs. The first of these focuses on women's more extensive use of health services. Canadian women are more avid consumers of health care resources than men [9]. As women tend to visit their physicians on a more frequent basis than men [10], higher rates of psychotropic prescriptions among women may be ascribed to higher service utilization behaviours, and more frequent expressions of psychosocial distress [11].

Research shows that physicians are more likely to prescribe psychotropic drugs to women than men. Office visits by women are 55% more likely than men's to result in an anti-anxiety or anti-depressant prescription [12], and 1.77% of office visits by women result in a diagnosis of anxiety disorder compared to 1.14% of visits by men [13]. Physicians themselves admit that they are more likely to attribute women's symptoms to "over-anxiousness," even in the presence of positive test results that indicate a physical disorder [14]. When differences in psychological morbidity among men and women are accounted for, women are still significantly more likely to receive a prescription for psychotropic drugs than men [15,16].

Aggressive marketing of prescription drugs is confounding the doctor-patient relationship. One factor contributing to the over-prescribing of psychotropics to women is the pharmaceutical industry's marketing campaigns, particularly of newer drugs with little or no proven track record. While the industry has long advertised prescription drugs directly to doctors, more recently, additional resources are being funnelled to advertising directly to consumers (DTCA) despite a ban on such advertising in Canada under the *Food and Drugs Act*. This growing practice has a number of negative consequences [32], not the least of which is that it is forcing up the cost of drugs to pay for the advertising, a burden felt disproportionately by women. Equally important is the impact on the quality of health care. The evidence is clear [28,30] that advertising of prescription drugs to consumers serves little educational function, does not promote public health, and can be extremely dangerous, as the Vioxx tragedy has shown. Of particular concern with women and psychotropic drugs is that DTCA can lead to unnecessary medical treatments for normal life events [29].

Women may be receiving inappropriate care. If there were equity in the provision of psychotropic drugs to men and women, then morbidity patterns should account for gender differences in prescribing patterns. This does not appear to be the case, and it is not clear whether these differences reflect inappropriate care. Differences may reflect a positive bias in favour of treating women's mental distress, or a negative situation with over-prescribing to the detriment of women's health. It is well recognized that the use of psychotropic drugs is not without risk, especially in elderly women. Benzodiazepines are the most frequently prescribed anti-anxiety/anti-hypnotic medications, with cognitive and psychomotor side effects that lead to an increased risk of falls, hip fractures, and motor vehicle accidents, especially in elderly women [17-21,31]. Anti-depressants also incur specific risks, such as electrolyte imbalances in the case of the serotonin reuptake inhibitors [22] and an increased propensity for cardiac arrythmias with the tricyclic anti-depressants [23]. Adverse drug-drug interactions are particularly common with these classes of medications [24,25]. The use of psychotropic medication is not only a potential indicator of women's emotional health, but also an important risk factor for future morbidity [18].

Primary care physicians tend to be more responsive to women's overall level of distress than to whether their clients meet formal criteria for depression [26]. As such, physicians will over-prescribe anti-depressants beyond what is formally recommended to treat major depressive episodes. Rates of prescription of antidepressants to older women in Ontario now exceed most estimates of prevalence of the disorder in this age group [27]. If anti-depressants are indeed being prescribed to treat lower levels of mental distress than what they were originally intended for, a more thorough understanding of this

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phenomenon is needed to ensure that the benefits of such an approach exceed the risks. It is also necessary to consider what the usage of these drugs implies about rates and levels of men and women's emotional health if drugs are preferentially being dispensed to women for lower thresholds of emotional distress than men.

RECOMMENDATIONS:

In light of the risks and possible over-utilization of psychotropic drugs, emphasis on a preventative/public health approach that targets the root causes of women's anxiety and depression is required. Important social policies should be focussed on reducing known correlates of anxiety and depression such as social isolation and marginalization, gender income inequity, single parenthood, caregiving responsibilities, lack of physical activity, and employment opportunity. Investment in non-pharmacological treatment of depression and anxiety is recommended, such as increased availability of group and individual counselling services and psychotherapy. Additionally, our legislators must enforce the current prohibition of all industry-sponsored advertisements of prescription drugs to the public, and must ensure the provision of independent, unbiased and publicly financed information on prescription drugs to Canadians.

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Women and Addictions*

AUTHORED BY: British Columbia Centre of Excellence for Women's Health, www.bccewh.bc.ca

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AT ISSUE:

There is an urgent need for women-specific prevention, harm reduction, and treatment approaches. While useful in some contexts, the integration of mental health and addictions issues in policy and programming has often hampered the development of women-centred responses to substance use that exist independently of mental health issues. The interim reports of the Kirby Commission missed important opportunities to meaningfully and systematically address substance use and addictions issues which are unique for girls and women.

ANALYSIS:

Reflecting both sex and gender issues, **substance use is a health issue that can be more serious for, more prevalent in, and present unique risk factors for girls and women** [1, 2]. Women's bodies are more susceptible to the effects of alcohol, tobacco, and other drugs, and women develop many substance-related health problems, such as alcohol-related liver disease, earlier than men. [3]. Some health problems related to tobacco use are unique to women, including cervical and breast cancers, some lung cancers, and reproductive health problems [2]. The health effects of some illicit drugs can also be different for males and females, and the risks, such as those for HIV, more serious. Given this, new evidence suggesting that women's use of alcohol, tobacco and some illicit drugs may be increasing to rates seen in men (particularly among some marginalized women and girls) is cause for great concern [2]. While British Columbia ranks among world leaders in the development and delivery of harm reduction programming, these innovative initiatives have yet to account for the specific risks, barriers and health concerns of vulnerable girls and women.

The high rates of licit substance use among women are commonly overlooked and the negative health impacts minimized. For example, since the 1970s the use of addictive prescription drugs, such as benzodiazepines, has consistently been twice as high for women[4]. While recent large-scale Canadian studies (including the *Canadian Community Health Survey* and the *Canadian Addictions Survey*) have provided insight into the ways women and men use alcohol, tobacco, and illicit drugs to cope with life stresses, both studies failed to ask people of both sexes about problems associated with tranquilizer and other prescription drug use [5, 6]. Problem prescription drug use, and benzodiazepine addiction in particular, is a highly gendered phenomenon differentially impacting women (especially elderly women and Aboriginal women). However, benzodiazepine addiction in women has been consistently neglected in Canadian health promotion, illness prevention, and addictions treatment.

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 [7-11]. 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 [12]. Women with substance use problems also commonly report surviving physical and sexual abuse either as children or adults [8, 10, 12]. International studies show strong correlations between sexual and physical abuse and earlier, more frequent, and larger quantities of substance use by girls and young women [13]. There is an

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immediate need to expand on promising piloted programming responses to women with concurrent trauma, substance use and mental health problems.

Research shows that women experience greater stigma attached to their addiction than do men, greater resistance from family and friends when they want to access addictions treatment, and more negative consequences associated with treatment entry [14]. Experiences of stigma and discrimination undermine women's abilities to report their substance use patterns and concerns, influence the rates at which some women are screened for substance use problems, and access to addictions treatment. Public discourse regarding pregnant women who drink been fundamentally judgmental, blaming, and unsympathetic [15, 16]. As a result, policy and research related to women who use substances has tended to focus on the potential harm that mothers who drink, smoke, or use drugs may cause to others (such risks of fetal alcohol syndrome or health problems caused to children exposed to tobacco smoke), and not on the health and welfare of women themselves [17]. While fear of child apprehension and separation from one's children is consistently reported to be a barrier to treatment for women, research shows that mothers who bring their children with them to treatment have better treatment outcomes [18-20]. However, such facilities are largely unavailable for women in most communities across Canada. In this context, it has been challenging to create health policies, systems, and responsive to women, to enhance health literacy in the areas of substance use and addiction, and provide women with supportive options for treatment.

RECOMMENDATIONS:

The gendered expressions and consequences of problem substance use and addictions are important considerations for health service providers and policy makers. In the context of the merged mental health and addictions fields, these considerations will improve continuity of care and provide a space for addressing women's unique needs and experiences.

Create an Advisory Committee on Women's Mental Health and Addictions to support the new Canadian Mental Health Commission facilitate the integration of women's substance use and addictions issues into federal policy and program development. The recent release of the *National Framework for Actions to Reduce the Harms Associated with Alcohol and other Drugs and Substances in Canada* provides another key opportunity to enhance leadership and inter-sectoral collaboration in drug policy from a women-centred perspective.

Bring a sex and gender analysis to data collection instruments in research on substance use and addictions, such as the Canadian Community Health Survey and the Canadian Addiction Survey.

Develop community-based health promotion initiatives that incorporate women's experiences (including those stemming from multiple roles as workers, mothers, caregivers, partners, and community members) and embrace a social determinants of health perspective. This includes health literacy and anti-stigma campaigns addressing the lack of specific information for women and girls about how substance use them and the impact of discrimination in creating barriers to care.

Support the development and evaluation of pilot projects in women-centred addictions care, including dedicated benzodiazepine tapering and withdrawal clinics for women and women-centred harm reduction initiatives.

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Women and Dementia:
The Generational Mental Health Challenge*

AUTHORED BY: Linda Furlini, Ph.D, McGill University, CWHN Board Member <u>www.cwhn.ca</u>

*The positions expressed in this document are the author's own, and do not necessarily reflect the views of the Ad Hoc Committee at large.

AT ISSUE:

The vast majority of caregivers who look after persons with dementia, such as Alzheimer's disease, are women. Of equal concern is the great number of older women affected by dementia. Due to the rising number of aging baby boomers, and the increase in longevity, the higher is the likelihood that women will care for persons with dementia and/or will be affected by this disease. These women lack support and resources. Their mental health is at serious peril and they need help urgently.

A gendered lens is required to attend to the unique needs of these women. The Kirby Commission has been remiss in addressing the present and future challenges presented by women, whether they are caregivers for persons with dementia or affected directly by this disease. Our current mental health policies ignore and undermine their needs. Formulating and implementing mental health policies that address these needs demand our immediate attention.

ANALYSIS:

Caregiving Issues

Eighty percent of family caregivers are women, mostly spouses and daughters (Canadian Study on Health and Aging, 1994). It is generally recognized and accepted that caring for a person with dementia is burdensome. Studies indicate that these women experience high rates of depressive symptoms and other negative mental health indicators (Canadian Study of Health and Aging Working Group, 2002; Grunfeld, Glossup, McDowell & Danbrook, 1997). Rather than being supported for dealing with conditions that would cause distress in any person, they are often "pathologized." Many factors, some of which are discussed below, contribute to the damaging impact of caregiving.

Most types of dementia destroy the brain irreversibly and express themselves in a myriad of symptoms such as personality and behavioral changes, memory loss and impaired physical functioning (American Psychiatric Association, 2000). Most significantly, this disease damages the ability to think and reason. Its effects are made worse because symptoms are variable and unpredictable and, therefore, one cannot even guess what will come next. As a result, the persons must be constantly monitored by the women who care for them, unless these persons are bedridden or in the late stages of the disease. Even then, women continue to actively provide care, often in situations requiring heavy physical care.

Dementia has still other detrimental effects. For instance, it creates enormous grief (Furlini, 2001). Caregiving women bear witness to the loss of personhood and changed relationships with those for whom they provide care. This experience has been coined as psychosocial death, meaning the psychological and social loss of the person that once was (Doka, 2002). Another factor that further magnifies the impact of caregiving on women's lives is the long course of most types of dementia. The disease can last from two to as much as 20 years, with its average course enduring some ten years (Cummings & Jeste, 1999). Throughout, given that the persons with this disease lack insight and judgment, women caregivers must also become decision-makers. They make decisions on behalf of

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others without adequate information, support, resources and access to them (Furlini, 2005). It is small wonder that they experience such incredible stress.

As women, they endure additional hardships. Many women who are required to become caregivers are spouses, mostly older and often have their own set of considerable health concerns. Caregiving may diminish their health further (Grunfeld, Glossup, McDowell & Danbrook, 1997; von Känel, Dimsdale, Patterson & Grant, 2003). Extreme loneliness, in addition to other significant negative mental health indicators, such as depressive symptoms, is also reported (Kiecolt-Glaser, Dura, Speicher, Trask, Glaser, 1991; Beeson, 2003). Daughters, too, have similar health concerns as they assume their caregiving roles (Furlini, 2005, Furlini, 1999). They are simultaneously in the workforce, and/or caring for their own children and dealing with other responsibilities of daily life. Juggling the provision of care, 24 hours a day, while tending to other responsibilities of daily life simultaneously is unsustainable. Caregiving also contributes to high employee absenteeism, loss of income and serious concerns about financial security, above and beyond the fact that women are already disadvantaged economically.

Notwithstanding that women provide the majority of unpaid caregiving, there is poor recognition of its complexity and burden. As a result, women remain isolated and powerless and with little recourse on how to balance their lives. The consequences of long-term and unrelenting emotional, physical and psychosocial strain of caregiving, without adequate support and resources, are cumulative and debilitating. These consequences are felt long after caregiving is over (Bodnar, Keicolt-Glaser, 1994). Pat Armstrong (2002, personal communication) affirms that women continue to provide care regardless of its cost to their mental and physical health. Romanow has acknowledged in his report *Building on Values: The Future of Health Care in Canada* (November, 2002) that the burden of care of looking after someone with dementia is "enormous." He highlighted that caregivers should receive tangible resources, such as home care and nursing home care. In the meantime, however, such resources are lacking, inadequate or inaccessible. Clearly, women's mental health is placed at peril by failing to address their needs.

Women And Dementia

Significantly more women than men are affected by dementia and their numbers are not only considerably underreported (Canadian Study of Health and Aging Working Group, 2000), but also rising. In 1991, 72% of institutionalized people with dementia were women, as were 63% of those residing in the community (Canadian Study of Health and Aging Working Group, 1994). Women also live longer with the disease (Wolfson, & Wolfson, 2001). Recent trends also indicate that the number of older women in the community who live alone is increasing (The Canadian Study of Health and Aging Working Group, 2000). According to Statistics Canada, in 2001, close to 40 % of women, aged 85 and over, lived in single person households as opposed to 23% of men (Statistics Canada, 2004). These high rates are generally attributed to divorce, widowhood, women having fewer or no children and children living far away. The risks to women with dementia who live alone are very high. Their failing ability to think and reason makes them very vulnerable to various hazards and types of abuse. Moreover, many older women are poorer and this makes them less likely to afford proper care and, in turn, further increases their vulnerability. As the population ages, who will care for these women and ensure that they are safe? Who will look after their special care needs?

RECOMMENDATIONS:

It is already evident that women who care for persons with dementia have common and specific needs (Furlini, 2005). It is totally unfair, unjustified, irresponsible and unsustainable for them to shoulder such responsibility under these conditions. The lack of attention paid to their needs fuels the devastating effects of caregiving on women's mental health. They require and deserve better.

Women with dementia are unable to represent themselves and must depend on others to defend their rights and to care for them. Considering that they will make up a significant portion of the aging

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population, identifying them and addressing their needs becomes an even more urgent mental health priority.

Dementia is debilitating both to those who suffer from it and those who care for them. It represents a major challenge to our generation. It must be addressed and resolved. The costs of ignoring these challenges incur heavy personal and societal costs. Women can, and will no longer accept a cavalier and neglectful approach to their mental health.

- Recognize dementia as a women's mental health issue
- Promote research with a gendered lens
    - to improve women's mental health of those who care for persons with dementia
    - to provide outreach and resources to care for women with dementia, especially those without social or financial support
- Develop:
    - A case management multidisciplinary approach to care that includes the voices of women caregivers (Furlini, 2005).
    - Programs for professional development that include special educational programs for professionals attending to dementia
    - Different types of support and resources, including home care and nursing home care for women with dementia and women caregivers require.

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Women and Eating Disorders*

AUTHORED BY:

Janet deGroot, University of Calgary and Merryl Bear, The National Eating Disorders Information Centre (NEDIC) www.nedic.ca

*The positions expressed in this document are the author's own, and do not necessarily reflect the views of the Ad Hoc Committee at large.

AT ISSUE:

There is a need for more reliable recognition of, funding for and effective, gender sensitive primary and secondary prevention and treatment strategies for anorexia nervosa (AN), bulimia nervosa (BN) and binge eating disorder (BED) as well as their 'subclinical' manifestations. These complex disorders with profound physical and psychological consequences are primarily found among women. That is, the relative risk for females to males for AN has been reported as 12:1 and BN, 18:1, based on cases detected by general practitioners in the UK (1). A coordinated approach to eating disorders and obesity, the latter considered an epidemic by the WHO, remains illusive as anti-obesity messages may act to perpetuate disordered eating attitudes and behaviours (2). Much misunderstanding and stigma regarding weight related concerns and eating disorders are present among health providers and the public.

ANALYSIS:

Disordered eating and weight dissatisfaction has a high prevalence beginning in adolescence among girls, compromising mental and physical health and social behaviour and may increase the risk of obesity. Monitoring the prevalence and changing trends in incidence of eating disorders is important to planning for prevention and treatment programs. Two large scale Canadian studies have documented that weight concerns begin at an early age and progress to disordered eating attitudes and behaviour with increasing age. Nearly a third (29.3%) of girls, most of whom were of normal weight and aged 10-14 endorse attempting to lose weight and 10% were likely dieting or using other extreme weight loss methods, both of which are risk factors for eating disorders (3). Over 27% of girls aged 12-18 report disordered eating attitudes and behaviours (4). Of note, only 4% of girls reporting binge episodes and 6% who endorsed purging had ever been evaluated or treated for the behaviours. Such behaviours are of additional concern as they are often associated with additional health-compromising behaviours, such as smoking, alcohol and drug use, depression and suicide. As well, dietary restraint, binge eating, and diet pill use is often associated with an increased risk of obesity (3,4,5).

Both AN and BN are most commonly diagnosed among young women aged 10 – 19 years (1) and until recently, the incidence of BN has been increasing (1,6). It remains a question whether diagnoses at later ages are not recognized. AN is found among almost 1 in 300 young women aged 15 -19, and less severe forms in another 4-5% at that age (7). BN is more common An Ontario study found that among women, the lifetime prevalence of BN was 1% (8), with a higher prevalence of 'partial syndrome' BN. It has been reported that the latter prevalence is approximately 5% (6).

Most evidence suggests that childhood sexual abuse is a risk factor for eating disorders, particularly for BN (9). Such abuse is more likely to be associated with eating disorders, when it occurs in the context of other physical and emotional abuse and when the family environment is chaotic and unsupportive and is more strongly associated with intrafamilial discord than is AN (9). It has been advocated that Individuals with eating disorders who have been abused, there is a great need for integrated comprehensive

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treatment sensitive to the power differential between health providers and those with eating disorders has been emphasized (10).

Studies, mainly from Britain, have found that second generation immigrants are at increased risk of eating disorders, during the process of acculturation (11) but this potential risk factor has not been examined in Canada, a country with a high proportion of newcomers.

BED is more common among women in their 30s and prevalence rates are reported to be between 1-2.5%, with higher rates among black women than white in the United States (6).

At mid-life, weight dissatisfaction is also ubiquitous, as it is endorsed by 80% of women and over half of women who are "normal" weight. Further, women with poor body esteem are more likely to avoid everyday activities (12).

Eating disorders and 'subclinical eating disorders' frequently co-occur with other psychiatric illness, while anorexia nervosa is associated with increased mortality rates. Co-morbid illnesses include depression, anxiety disorders (13) and substance abuse (14). A Canadian study found that juvenile onset diabetes mellitus is associated with an increased rate of disturbed eating behaviour and this combination contributes to increased physical complications (15), and has led to increased sensitivity to these issues among specialists in diabetes in adolescents.

Eating disorders are considered chronic, relapsing illnesses (16) with recovery in the range of 50%, with 30% partially recovered. The remainder either have persistent eating disorders or mortality. Women with AN are reported to have 1.5 to 18 times the standard mortality rate (17). In British Columbia, the standardized mortality rate (SMR) was 10.5 among adult women with AN treated on average 7 years previously at a tertiary care center, with death most commonly due to suicide (18). Further, 35% of women with AN were reported to be on disability at a cost of 2.5 to 101.7 million dollars to British Columbia annually (19).

Recognition, and treatment, of eating disorders by health practitioners is frequently limited by lack of training, fear of not being able to meet the needs of patients, and lack of specialized services to which to refer (20) denial of disturbed eating behaviours by affected individuals and in the case of BN, women are frequently of average weight. The Ontario Eating Disorder Outreach program has shown that it can increase knowledge of eating disorders and comfort in treating those with eating disorders or providing a curriculum on body image (21). Current treatment strategies are more effective for women with BN than those with AN. Treatment is provided in graduated intensity from self-help manuals (22), psycho-education (23), to cognitive behavioural therapy and/or pharmacotherapy, group therapies, day hospital programs (24) and inpatient treatment. Among those with AN, only familly therapy among affected adolescent girls with a short duration of illness is consistently shown to be effective. There is a desperate need for more research into the treatment of AN, as well as relapse prevention and motivational enhancement strategies (25). In recent years, the limits of access to current treatment programs in Ontario, Canada's most populous province, has led to dramatically increased out of country costs for funding treatment of those with eating disorders from approximately $0.5 million in 2000-1 to 5.6 million in 2004-5. Similar information for other Canadian provinces and territories has not been accessed. Community programs such as Sheena's Place provide hope and support for women and men with eating disturbances and their families that is not available through hospital based programs (26).

Prevention. School based preventive strategies are promising in the US and Canada. A 10-session interactive *Girl Talk* Peer Support Program for girls in Grade 7 and 8, facilitated by public health nurses in schools, to address life skills effectively enhanced body esteem, eating attitudes and behaviour three months later (27). As well, public/population health promotion (ParticipAction is an outstanding example) has the potential to contribute to overall wellbeing and ameliorate risk factors through out the life span.

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Prevention must also include education of health care professionals to ensure that preventive strategies for obesity and eating disorders are increasingly integrated (28).

RECOMMENDATIONS:

Senator Kirby must be lauded for ensuring broad community participation towards the objective of developing a more effective national mental health strategy. These comments are provided to emphasize the need for increased attention and gender sensitivity to the needs of those with eating disorders. Canadian researchers' and clinicians' findings form the basis of the following recommendations. It will be important to develop a national strategy to address these recommendations:

- Given the widespread prevalence of disordered eating attitudes and behaviours among Canadian girls and women, that there be a move from a traditional medical model of treatment to an increased emphasis on a public health model that focuses on primary and secondary prevention, with interactive interventions that increase self esteem and are sensitive to new understandings of female development.
- Public health models also need to address boys and men in ways that increase empathy but don't provide or reinforce sexist/prejudicial behaviours.
- That a national network of those in public health and practicing clinicians begin to research integrated models for prevention for eating disorders and obesity.
- That primary care practitioners be educated regarding the necessity of routine screening with non-judgmental questions to detect eating disordered attitudes and behaviour and their complications among young women.
- That primary care practitioners be provided with the knowledge and skills to treat individuals with eating disorders, and
- That specialized services along the continuum of care for eating disorders be established and appropriately funded.
- That barriers to access to care be researched and action taken on the findings.
- That an interdisciplinary and interdepartmental approach be implemented to reduce risk factors and increase early detection and treatment (e.g., collaboration between ministries of health, education, children's services, justice).
- That research attention and funding be provided to examine the prevalence of eating disorders among immigrant girls and women and their access to and satisfaction with treatment.
- That strategies to prevent the high rates of death and disability secondary to anorexia nervosa, through effective prevention and treatment receive greater research attention and funding.
- That the National Eating Disorders Information Centre become a truly national program with national funding.

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Appendix A: <u>Information sheets</u>

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Aboriginal Women and Mental Health*

AUTHORED BY:

Linda Day, Executive Director, Aboriginal Women's Health and Healing Research Group, www.awhhrg.ca; in collaboration with C. Wieman, University of Toronto.

*The positions expressed in this document are the author's own, and do not necessarily reflect the views of the Ad Hoc Committee at large.

AT ISSUE:

The 2001 Census of Canada reported just over 1.3 million people as having some proportion of Aboriginal ancestry (4.4% of the total population)[1]. People who identify as Aboriginal (i.e., First Nations, Métis or Inuit) accounted for 3.3% of Canada's total population.[1] Aboriginal females comprised approximately 52% of the total Aboriginal population. [2] The 2001 Census also showed that 49% of Aboriginal people lived in urban areas (approximately 117,000 women in the provinces) and that 25% were concentrated in 10 of the country's census metropolitan areas. [1,2] The birth rate for Aboriginal women is approximately double that of the overall Canadian female population, with significantly higher proportions of young Aboriginal mothers (e.g., 55% are under 25 years of age). [3]

Relatively little is known regarding the current mental health services, programs and resources available to Aboriginal women in urban settlings. An environmental scan of mental health services in First Nations communities across Canada was undertaken in 1999 but did not include urban communities of Aboriginal people. [18] In terms of what is known regarding the mental health status of Aboriginal women generally, the most common indicator studied is suicide.

In many different sources, it is estimated that the suicide rates for Aboriginal women is more than three times the rate for non-Aboriginal Canadian women. [3,5] Whether or not this higher rate is related to higher prevalence rates of depression among Aboriginal women is unclear. However, in one study, it was found that young Mi'Kmaq females reported symptoms suggestive of depression at rates approximately double that of their male counterparts (50% of young females vs. 25% of young males). [6] Although focused on First Nations and Inuit reserve communities, the 1997 First Nations and Inuit Regional Health Surveys offer some insight into the rates of possible depression among adults. [7] Nearly nineteen per cent of (18.4%) of First Nations female respondents reported feeling depressed for two or more weeks in the year prior to the survey compared to an estimated 9.4% of the Canadian female population. Of these respondents, 27.2% reported that their depression interfered with their activities of daily living and 19.4% of respondents had consulted a health professional regarding their emotional health in the year preceding the survey. [7]

These rates are approximately double those estimated for the general Canadian female population. In the 2002-03 iteration of the First Nations Regional Health Survey (FNRHS), preliminary summary data shows a similar picture. Of all adult respondents, 30% endorsed symptoms suggestive of a major depressive episode at some time during the year preceding data collection. Thirty-one per cent (31%) had suicidal thoughts and 16% of respondents had attempted suicide at least once during their lifetime. Women reported significantly higher rates of previous suicide attempts (18.5% females vs. 13.1% males). [19] Only one report was found that examined the health of the off-reserve Aboriginal population. [20] Data was extracted from the 2001 Census and found that 13.2% of the off-reserve Aboriginal population endorsed symptoms suggestive of a major depressive episode in the year prior to the Census. This rate was about 1.8 times higher than for the general Canadian population. [20] Unfortunately, the data did not break down into findings for females and males. It is apparent that there is

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a dearth of information on the mental health status of Aboriginal women, and in particular, for urban Aboriginal women.

ANALYSIS:

Many sources describe the need for women-centred mental health care. [3, 5, 15, 16] For urban Aboriginal women, this type of care would include an interdisciplinary approach that involves both health and social services, includes alternative and complementary therapies, and is culturally relevant. It becomes clear from reviewing existing literature that very little is known about the health and mental health status of urban Aboriginal women. There are some indications that urban Aboriginal women may have an increased burden of emotional distress and that their mental health needs are not being adequately met, for a variety of reasons. [3, 5, 15, 16, 20] Existing mental health services in urban areas may be underutilized, possibly because there is the perception by urban Aboriginal women that these services are not aware of, sensitive to or respectful of their needs. [5]

RECOMMENDATIONS:

Based upon review of the background and current context for urban Aboriginal women with mental health-related issues, and being cognizant of the gaps in what is known about their mental health status and the mental health care they receive, the following recommendations may be made:

- Policies need to be made based on the interpretation of good quality health and related data that is available regarding comprehensive aspects of the mental health status of urban Aboriginal women – such data at present is severely limited in its extent and scope. [17]
- Research funds need to be strategically focused on urban Aboriginal women's health issues. Projects would optimally involve collaboration between the Institute of Aboriginal Peoples Health, Canadian Institutes of Health Research (CIHR-IAPH) and other organizations involved with Aboriginal women and health. Prevalence rates of the major mental disorders (eg. depression, bipolar disorder, post-partum disorders, schizophrenia, anxiety disorders, etc.) would help inform policy and mental health service planning. It would also be helpful to become aware of the factors that influence access to and utilization of mental health services by urban Aboriginal women across Canada.
- An environmental scan of mental health services for urban Aboriginal women should be undertaken. Because the majority of urban Aboriginal people are concentrated in 10 Canadian cities [1], it would be strategic to focus initially on these locations.
- In order to have a positive impact on the mental health status of Aboriginal people, there must be an integrated approach across federal government and provincial departments, to work with Aboriginal communities to develop effective and sustainable policies.

The programs and outcomes of mental health-related services provided to urban Aboriginal women need to be analyzed and the knowledge gained appropriately transferred to other provinces, regions and local jurisdictions. There are existing models of large, multifaceted programs (e.g., The Aboriginal Healing and Wellness Strategy in Ontario [4]) and of smaller community-based programs (e.g., The Healing Place in Vancouver's Downtown Eastside [22]) from which knowledge and experience can be derived to begin addressing the complex factors related to the mental health needs of Aboriginal women.

It may also be that other municipalities, provinces and territories would consider committing funds to developing similar models to address the mental health needs of urban Aboriginal people in general, but also to Aboriginal women specifically.

Given the stigma associated with mental illness, there should be focused efforts on mental health promotion in urban Aboriginal settings. [23, 24] Aboriginal leaders and health organizations should increase their advocacy for addressing the mental health needs of urban Aboriginal women using a women-

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centred approach. [5]   The mental health needs of Inuit, Northern and rural Aboriginal woman also requires more research. A culturally appropriate and relevant women-centred approach to addressing the mental health needs of all Aboriginal women is critically needed.

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Impact of Immigration and Settlement on Women's Mental Health, Mental Illness, Substance Use And Addiction*

AUTHORED BY: Elina Farmanova-Haynes and Anu Bose (National Organization of Immigrant and Visible Minority Women of Canada), www.noivmwc.org, and Bilkis Vissandjée (University of Montreal).

The positions expressed in this document are the author's own, and do not necessarily reflect the views of the Ad Hoc Committee at large.

AT ISSUE:

There is an urgent need to address specific prevention, harm reduction, and treatment approaches for immigration induced mental disorders co-morbid with substance abuse among immigrant and refugee women in Canada. Women experiencing immigration and settlement issues are extremely vulnerable to pre- and post-migration stressors in Canada and risk being victims of social injustice and discrimination more frequently than women who do not have this added stress [1-3, 6]. Though immigration itself does not necessarily jeopardize mental health, immigration and settlement events are known to trigger the onset or deterioration of mental illnesses that may become co-morbid with disorders such as substance misuse [4,5].

ANALYSIS:

Well-recognized disorders such as depression and mania, alcoholism and drug dependence, panic disorder and specific phobias and psychoses are major mental illnesses [7]. These illnesses create personal and social problems in that their symptoms are obvious and the consequences are often disastrous. Even though each of these illnesses is now well researched and has an effective treatment, many afflicted with them are still untreated due to a number of reasons. These include the lack of recognition of mental conditions and adequate preventive measures, and weak service delivery, particularly with vulnerable immigrant populations. Further, as contemporary practices focus mostly on treating illnesses but not people, this often means that there is not enough attention directed toward learning about the context in which problems occur for immigrant women. [7]

Immigrant and refugee women in Canada are of different ethno-racial backgrounds.
Different aspirations bring women to this country of perceived hope. Many refugee women have lived through trauma, physical atrocity and seen many losses [1]. Upon arrival in Canada, they hope to obtain some sense of relief from the nightmares of persecution and torture; they hope to feel safe and satisfied starting with their immediate needs being met. Such happiness is often brief, as they soon find themselves confronted with a large number of cultural and other micro- and macro level barriers. Uncertainty of their future in Canada and concerns for their families back home become continuing stressors for many of these women [1]. A large proportion of female immigrants enter Canada as a family member of an economic immigrant, or through family reunification [2]. These women worked back home on the basis of their individual degrees and were considered highly skilled, but when they move to Canada they frequently become ineligible due to the lack Canadian experience, and so are unable to work.

Pre-migration events, the lengthy and draining process of immigration and the difficulties
encountered in settling in Canada put immigrants at high risk of developing emotional and psychological disturbances. Even though the physical health of many refugees improves due to better medical care and diet after settling in Canada, for many mental health remains problematic because of post traumatic stress disorder (PTSD), personal anxiety and depression associated with negative experiences at home, as well as the difficulty of settlement and adaptation in Canada as well as cultural shock [1].

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Language barriers, weather induced depression, reduced family ties, unemployment, lack of social integration, social prejudice, and discrimination are on the long list of post-migration stressors. Women generally have fewer opportunities than men to learn English during the post-migration period [2]. Ironically, however, females benefit more than males from programmes such as English and/or French as a second language. Ability to speak one of the official languages of Canada is also closely related to increased likelihood of staying in the labour market [2].

Unemployment, poverty, loss of status, and confusion caused by the dual culture these women live in and outside their homes are extremely traumatic and lead to the loss of self-esteem. The majority of women who manage to find employment are often underpaid, while others are simply rejected. In 2001, only 55.6% of recent female immigrants were employed, compared to 77.4% for Canadian-born women [2]. The 2001 Census report suggested that lower employment rates among recent female immigrants aged 25 - 44 might be due to their increased probability to be in school compared to Canadian-born women of a similar age. Another possibility, however, may be that this difference is the result of discrimination against immigrant women within Canadian society.

Canada has been taking steps to eliminate all forms of discrimination in its immigration policy for some time [8]. However, there are cases where immigrants have been living and working in Canada for years without having been granted the right to live permanently in the country [1, 8]. This can be characterized as discriminatory government policy directed to certain communities and its individual members [1]. Entry status is more likely to put female immigrants in social disadvantage because residency and employment rights and related entitlements often change by gender, and also because immigrant women are considered as "dependents," and, hence, their rights may become legally dependent on other family members [9]. Status defined at entry may affect a woman's capacity to gain legal citizenship, to access language-training classes, to obtain job training, and to access income security programs. Research has shown that immigrant women are more often denied full citizenship than men. Therefore, so are their civil, political, and social rights and responsibilities that come with membership in a society [9].

Issues that arise with immigration and settlement may produce profound family stresses, which may change traditional family values, structures and loyalties and increase the risk of marital conflicts. These changes require considerable negotiations. Resistance to change by both men and women can lead to conflicts and even violence against women [8]. This is not to suggest that immigration necessarily causes violence against women, yet it may cause as well as reinforce previously existing abuse. It is known that violent husbands foster isolation of their battered wives, who remain trapped and dependent on them [15]. Fear of ostracism is common among assaulted immigrant women as they are afraid of being condemned and isolated by their communities if they expose their husbands' violence. This fear prevents victims of violence from reporting cases of violence [15]. It has been found that the rate of sexual and physical abuse is much higher than previously suspected and is a major factor in women's depression. [16]. In some cases social isolation and abuse are also known to be compounded by exploitation and discrimination in workplaces [15]. There is a concern in the service providing community that the system does not make it easy for battered women to escape violence. As a result, assaulted immigrant women are a particularly vulnerable segment of Canadian society in that they are being exploited by the system as inexpensive labour, trapped in the social services with little hope to become independent, and abused by men, they find little or no support in their communities [15,17].

Mental illnesses often occur in co-morbidity with problem substance use. Research has shown that a large proportion of women with mental condition, such as depression, PTSD, panic disorder or an eating disorder also have a concurrent substance abuse problems [10]. Co-morbid substance abuse and mental illnesses are particularly common among the victims of domestic violence, sexual abuse and child physical abuse [11-14].

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Needs for mental health services of ethno-racial groups are considered equal if not greater than those of the mainstream population [1]. However, ethno-racial groups use less mental health services. This is because of an interplay among a number of reasons specific to immigrant and refugee communities, such as lack of recognition of mental illnesses and its treatment and stigmatization associated with mental illnesses within the communities [1,15,18]. Research has revealed a number of systemic service barriers encountered by immigrant and refugees, such as lack of access to specialized mental health services through available provincial Health Insurance Plan and Interim Federal Health program [1,15-18]. Affordability and accessibility are essential in the use of mental health services. However, most insurance coverage is inadequate for all but very short-term care [16]. Other barriers include cultural and language problems, and lack of sensitivity and cultural awareness among service providers; access to services hindered by a lack of referral to locally available services and appropriate providers; lack of follow-up that results in non-compliance with treatment; lack of awareness among immigrant communities about available counselling and similar services [1, 15-19].

In addition to the challenges of treating immigrants and refugees' mental health problems, there is also a great challenge in diagnosing them properly [1,19]. Misinterpretation of symptoms and inaccurate diagnosis are common with immigrant and refugee population [1]. Research has shown that there are several major barriers preventing or hindering diagnoses and subsequent treatment. These barriers include the above mentioned problems as well as linguistic and cultural barriers, and conflicting resettlement goals [18,19]. Due to cultural and language barriers diagnostic interviews produce imprecise and inaccurate history of mental condition. Questions about non-prescription medicines, traditional treatments popular among immigrant communities and the use of culturally specific substances and drugs are not asked consistently often because health care professionals have no specialized knowledge about such substances [1]. This undermines the success of treatments and efforts of immigrant individuals to get well.

RECOMMENDATIONS:

 Understanding and recognition of immigration-induced mental illnesses, co-morbid with substance misuse, by health care providers and policy-makers will improve continuity of care for disadvantaged groups, experiencing migration and/or settlement events and will particularly provide consideration for this population's unique needs, mental health issues and their causes. Therefore we recommend to:

- Expand and improve efforts at educating healthcare and social service professionals working with immigrant and refugee women in cultural sensitivity and immigration and settlement induced stressors to produce more accurate, culturally sensitive diagnosis and treatment in lieu of generalization about immigrant and refugee communities.

- Expand and improve accessibility and awareness about the availability of services targeting immigrant and refugee populations, and specifically women within those populations.

- Eliminate definition of entry status based on sex and gender differences.

- Establish strategies to allow for equal residency, employment rights and related entitlements of immigrant women and men. Concerning the legal status and definition of "dependant" immigrant women, when required allow the provision for the distribution of civil rights and entitlements independent from the principal applicant (male) and other family members.

- Create and introduce economic incentives for employers hiring immigrant skilled workers and immigrant women specifically, and those investing in the development of a skilled immigrant workforce and in immigrant women specifically.

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Appendix A: <u>Information sheets</u>

- Enforce transparency of the hiring processes in all domains and improve access to legal aid to address issues of xenophobia in the workplace.

- Assist immigrant women to become their own advocates through intensive human rights and legal education campaigns in immigrant and refugee communities, to ensure sustainability in addressing the needs of immigrant women-survivors of abuse.

- Examine existing support mechanisms and suggest how the support system should be improved to assist re-integration of victims of domestic violence into the larger Canadian society.

- Expand insurance coverage for mental health problems to match coverage for physical health problems.

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Rural, Remote and Northern Women's Mental Health*****

AUTHORED BY:

Joanne Havelock, Policy Analyst, Prairie Women's Health Centre of Excellence, www.pwhce.ca

*The positions expressed in this document are the author's own, and do not necessarily reflect the views of the Ad Hoc Committee at large.

AT ISSUE:

Living in rural, remote and northern areas has many positive features, but isolation, uncertain or cyclical incomes in primary industries, and rural depopulation, lead to particular stresses for women, and access to mental health promotion and healing services is limited. Some of these difficulties are recognized in the *Mental Health, Mental Illness and Addictions Interim Report.* "Some population groups in Canada encounter specific access problems and receive services of diminished quality due to cultural, linguistic and geographical barriers. They include Aboriginal peoples, individuals from culturally and linguistically diverse backgrounds, and people living in rural and remote areas. The absence of culturally appropriate services and supports has had a strong negative impact on many individuals." There is a recognition that simply transplanting urban professionals will not lead to services that take into account the different circumstances and cultural values of rural and remote communities. The report discusses the potential value of tele-health for mental health services and providing information on the Internet. The report also recognizes the need for an increased focus on women, along with other groups.[1] However, the Senate report does not have a gender-based analysis of these issues.

ANALYSIS:

Research on the health of women living in rural, remote and northern areas is limited. The 2004 Centres of Excellence for Women's Health (CEWH) study entitled *Rural and Remote and Northern Women's Health: Policy and Research Directions*, combined the knowledge of women from across Canada, community organizations and researchers to develop a policy framework and research agenda. The study included English-speaking, Francophone and Aboriginal women.[2] In Saskatchewan, the Rural Women's Issues Committee of Saskatchewan has held follow-up workshops in a number of communities, which add to the current research.[3] This paper also draws on research done by Aboriginal women in Saskatchewan and Manitoba, including work with Métis women.

Living in rural, remote and northern areas has many positive features including a sense of connection in smaller communities,[4] the quality of social relationships, and community participation.[5]

Living in these areas also has particular stresses. Due to depopulation in rural communities rural people face social and geographic isolation, loneliness and depression.[6] They face changed social organizations and family relationships and the burden of a small volunteer base and community responsibility: "if you don't do it, it won't happen."[7] Social expectations of women as caretakers are seen as overwhelming.[8] When children move away, women's morale, emotional and mental health suffers. Loneliness is worse for elderly widows or women who are new to a rural area. Not being able to drive or have the use of a car is a contributing factor because public transportation is limited. Youth experience stress in the long bus rides required when local schools close.[9] Limited employment, lay-offs[10] and the stress of living with unstable and falling farm incomes contribute to the significant level of poverty in rural areas. Rural poverty for necessities like food may be less obvious because farm families have a home and a land base but they may lack cash flow and face over-extended credit for input costs.[11] Women in rural areas are also disadvantaged by the lack of sufficient and subsidized childcare, inadequate

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employment opportunities, and lack of access to affordable housing.[12] These conditions can be amplified for women living further north and on Reserves.

Awareness of and access to health services is limited including general preventive services and services for mental health, addictions, violence prevention, children and adolescents, and support for caregivers or women who are sick at home.[13, 14] Young women and men need support to deal with alcohol and drug use, self-esteem, sexuality and bullying. Knowledge and acceptance of mental health issues is needed since even helping professionals may be unsure about what help is appropriate and where to get help.[15] High staff turnover prevents establishing therapeutic relationships. Service providers who do not live in the community may not grasp the complex social and economic realities with which their clients struggle. Rural and farm stress lines in Saskatchewan and Manitoba address this issue by having trained peer counsellors with rural or farm experience responding to the rural men and women who call the toll-free line for assistance with crisis, help for personal and family issues, financial situations and other concerns. The programs also include directories of organizations and services.[16] The CEWH study also highlighted the need for services in French or other languages across Canada. [17, 18] A proposal for an Aboriginal Health Centre in Saskatoon, included recommendations for interpreters since some people coming into the city from northern communities communicate more effectively in their own language than in English.[19]

Women may be reluctant to seek help in their communities for sensitive matters such as contraception and mental health because of compromised confidentiality. However, the costs of travel and being away from their families and other supports create stress for women.[20] Women have called for a greater number of female health practitioners, such as doctors, as women feel there would be greater understanding of their health problems.[21] In a Nipawin, Saskatchewan workshop, participants suggested a health centre providing complementary or alternative health services. The group articulated the need for appropriate health care, home care and housing sensitive to the physical, emotional and social needs of seniors and their need for independence. Patient advocates in health facilities could help guide patients and families to get the help they needed. [22] A study of rural family violence services also pointed to the need for rural solutions developed by rural people, with recommendations for a Women's Advocate on family violence and recommendations that led to the development of a Rural Family Support Centre.[23]

Métis women from Northwest Saskatchewan identified several services lacking in their communities, including female doctors, counselling, women's group therapy and how to deal with depression.[24] This study also stressed the need for holistic services that take into account the culturally appropriate care and access to traditional healing, the particular needs of northern Métis communities and the importance of involving women in decision-making concerning the services provided in their communities.

First Nations, Métis and other Aboriginal women have different entitlements and access to health services, including coverage of travel costs, and access to services varies for First Nations people depending on whether they are living on or off reserve. Services may also not be available locally. Determining the services available and accessing them is a challenge for the women themselves, and assisting women is also a challenge for the care providers trying to navigate the systems.

Supporting mental health is more than health services

Women acknowledge that more than increased physician services are needed for improved mental health care. In fact local women in many communities have suggested numerous other resources which would contribute to improved mental health. Prime among these is the need to reduce rural poverty. Other suggestions have included appropriate activities for young women and men (boys and girls), including inter-generational activities. Community and policy recognition of women's contributions are needed. The many elderly women and men who care for a range of needs of other seniors in small towns must be acknowledged. Women have called for more involvement in local leadership and policy decisions that reflect the local circumstances and women's daily lives. Women in Carlyle, Saskatchewan recommended

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efforts to help with adjustments to a changing rural society, re-establishing "right relationships" within families and communities, and to the earth and the environment. The importance of involvement in spirituality was emphasized, with recognition that the shape of this involvement may be different for today's youth. A group of farm and town women participating in a workshop identified the need to create a better understanding of the shared and different values with First Nations and Métis women, perhaps through a Talking Circle.[25]

This holistic approach has been strongly identified in research on supporting positive health for Aboriginal women. Women's identities are inseparable from their family, history, community, place and spirituality, and understood in the context of their whole lives.[26] One report also stressed the need to ensure Aboriginal women can achieve better education, better paying employment, suitable housing, day-care and family support services.[27]

RECOMMENDATIONS:

Implement collaborative primary care to increase the recruitment and retention of physicians and mental health practitioners in rural, remote and northern areas, including access to female practitioners.

Provide health services locally to reduce travel, including mental health and other health services such as midwifery and complementary health services.

Create community health centres that utilize gender, place and culture lenses to provide diverse physical, mental, dental and social health services in one location and with mobile units through interdisciplinary, integrated models of holistic family health care.[28]

Create a greater understanding and reduce the stigma regarding mental illness and addictions, and increase awareness of mental health promotion and services available. Promote the value to women that "self-care is not self-ish".

Support local programs, e.g. seniors' centres and community initiatives that reduce isolation and increase a sense of community in rural and remote communities, including recognizing the value of volunteer contribution of time and resources. Include inter-generational and cross-cultural programs.

Support already successful tele-health initiatives and 1-800 lines. Recognize that the Internet is valuable, not all rural and northern women have Internet access and that in-person communication is still an important and culturally appropriate public education and support tool.

Empower Aboriginal communities in the development of the infrastructure, human resources and administrative structures needed to create and control health care services that are rooted in the cultural practices and values of the Aboriginal women and men they are serving.[29]

Research the connection between the well-being and identity of Aboriginal women in remote communities.[30]

Recognize the different cultural approaches to mental health and the different entitlements and access to services among First Nations, Métis and other Aboriginal women to ensure that all women receive the care they seek.

Conduct research specifically on the health of rural, remote and northern living women and the positive ways to support and enhance their mental health. As mental health and addictions services are linked in several jurisdictions, research will need to refocus to reflect this interaction.

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Appendix A: <u>Information sheets</u>

Enhance the positive recognition of the contributions made by rural, farm, First Nations, Métis and other Aboriginal women, and women from rural, remote and northern communities and build their capacity to work together to improve their living situations and that of their communities.

Support initiatives that address factors creating stress and poor mental health for women in rural, remote and northern communities, such as economic issues, housing, childcare, and work-family balance.

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**Appendix B: *International Women's Mental Health Consensus Statement*
Recommendations (World Psychiatric Association)**

1. Support psychological health promotion programs that encompass the life context of girls and women to include equal access to basic human rights, education and employment, the elimination of violence and discrimination and the reduction of poverty.

2. Support women's marital, sexual and reproductive choices and ensure access to safe motherhood.

3. Support public education and awareness campaigns that increase recognition and reduce the stigma of mental illness in girls and women

4. Support safe, respectful, appropriate, gender sensitive comprehensive mental health and physical health services for girls and women across the life cycle irrespective of their economic and social status, race, nationality or ethnocultural background.

5. Support timely access to adequately skilled mental health professionals who provide quality of care consistent with best current knowledge and availability of appropriate therapy, technology or drugs and who take women's special needs into consideration.

6. Support the development and use of culturally appropriate diagnostic systems that consider the sociocultural context of women's lives, and biological differences when they are salient.

7. Support the provision of accurate information and respect choices in treatment decision making by girls and women whenever possible

8. Support the provision of mental health care for girls and women that is free from breaches in fiduciary responsibility

9. Support increased attention to research on girls' and women's mental health including those factors which enhance or inhibit the development of resiliency.

10. Support the provision of core training and education about gender issues for health, and mental health, professionals.

11. Support gender equality in practice and promotion within mental health services and organizations including equal opportunities for advancement and eradication of gender harassment, intimidation or unjustified discrimination on the basis of sex.

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