

National Women's Health Advisory Council

**#endgenderbias survey**

October 2023

# Advocacy and collaboration to improve access and equity

### About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is responsible for training, educating and representing psychiatrists in Australia and New Zealand. The RANZCP has more than 8000 members, including around 5800 qualified psychiatrists.

### Introduction

The RANZCP welcomes the opportunity to contribute to the National Women's Health Advisory Council's #endgenderbias survey. The recommendations contained within this submission are based on consultation with the RANZCP Committees, including the Committee for Professional Practice, the Committee for Research, the Faculty of Adult Psychiatry and the Family Violence Psychiatry Network. These Committees are made up of community members and psychiatrists with direct experience. As such, the RANZCP is well positioned to provide assistance and advice about this issue due to the breadth of academic, clinical and service delivery expertise it represents.

The RANZCP supports efforts to achieve gender equity in psychiatry and in the wider health system. Enhancing gender equity, diversity and inclusivity is fundamental to the maintenance of a healthy and sustainable health system. Improving gender equity in health care settings can improve safety and the quality of care. Gender-based issues permeate many aspects of the health system including the provision of high-quality and effective mental health care, from trauma-informed care to high quality research translating into better health treatment.

The RANZCP's [Gender Equity Action Plan](#) outlines the RANZCP's strategy to achieving gender equity in psychiatry. More details about gender equity in psychiatry and the health system can be found on the RANZCP website's [Gender Equity page](#).

### Survey questions

#### **Please describe the gaps in research on women's health and gender bias in the health system.**

The RANZCP consulted with membership on the perceived gaps in research regarding women and mental health. Members highlighted the key areas that require immediate and greater attention in research as: the impacts of family violence on girls and young women, the co-occurrence of mental health conditions and experience of family violence in consumers, and the deficit of Culturally and Linguistically Diverse (CALD) groups in study participants.

The RANZCP's [Position Statement 102: Family violence and mental health](#) outlines the significance of viewing family violence as a public health issue. Although there is a growing evidence basis for the effects of family violence on women as direct victims, there is a gap in research about the impact on girls and young women who develop in situations where they witness abuse. As noted by our members and in our position statement, there needs to be greater research on the collective health impacts and how they are affected by organisational responses and structural inequity. Family violence impacts on mental health are experienced in cross-sectional relationships and can have long-term implications. Funding and incentivising research into the cross-sectional impacts, especially those on girls and young women who are exposed to abuse as witnesses, is needed.

Further research is also required into the co-occurrence of mental health conditions and experiences of family violence. As noted in the RANZCP's position statement, women with mental health conditions are

more vulnerable to both victimisation and re-victimisation. There is also a need for greater research into the mental health conditions of perpetrators. Education and early-intervention programs have shown some success in mitigating or preventing offending, but a greater evidence basis is needed to inform their development and operation.

CALD populations are a vulnerable group in society. They are more likely to experience gender-based violence and require specific accommodations in the assessment, treatment and management of mental health conditions. There needs to be a greater focus on research that is aimed specifically at these populations, and for an increase in their inclusion in participation of wider studies. Research will help with understanding the unique requirements of this group and will also help to provide evidence-based and culturally safe practices for providing care.

### **How can health research studies, including inclusion and participation, be improved?**

The RANZCP has no further feedback at this time.

### **To what extent do you think Australian research guidelines foster inclusion of sex and gender in the design of health research?**

- Not at all
- Slightly
- Moderately
- Mostly
- Completely
- Unsure

### **What are the barriers and enablers to the development of research guidelines that better consider gender bias in health research?**

The RANZCP has no further feedback at this time.

### **What are the barriers and enablers to the implementation of research guidelines that would provide better consideration of sex and gender in health research?**

The RANZCP has no further feedback at this time.

### **To what extent are research findings in relation to women's health being implemented into clinical practice?**

- Not at all
- Slightly
- Moderately

- Mostly
- Completely
- Unsure

**What are the barriers and enablers for translating evidence into clinical practice?**

One of the key enablers of translating research into clinical practice is the Continuing Professional Development (CPD) program that psychiatrists are required to undertake. CPD ensures psychiatrists are kept abreast of current developments, either through self-directed learning or undertaking RANZCP modules. One CPD requirement is for a clinician to undertake peer review, which brings clinicians into direct contact with current research. The RANZCP has a strict CPD program requirement for peer review and facilitates peer review groups for clinicians via the [CPD webpage](#).

Members have noted one of the greatest barriers to engagement with research is current workforce issues. Members note there is minimal time to further engage with research beyond the requirements of CPD. Despite a desire to engage more fully with current research, either through participation in research or by reading and reviewing academic findings, the strain of workforce shortages means that clinical practice takes precedence.

**To what extent are research findings in relation to women's health being implemented into public health and public policy settings?**

- Not at all
- Slightly
- Moderately
- Mostly
- Completely
- Unsure

**What are the barriers and enablers for translating evidence into public health and public policy settings?**

The RANZCP has no further feedback at this time.

**How much choice do you think women have about their healthcare?**

- None at all
- A little
- A moderate amount
- A lot
- A great deal
- Unsure

### What are the barriers and enablers of choice for women in health care?

The greatest barriers to women having choice of health care are accessibility and cost, especially for those in rural, regional and remote communities and those who require culturally specific or sensitive services. The RANZCP [Position Statement 65: Rural psychiatry](#) outlines the unique challenges for consumers outside of metropolitan areas.

Telehealth services have increased the choice for women seeking psychiatric services, enabling access to a greater number of services and providers without travel. E-mental health services have also enabled a greater level of choice for women seeking mental health care – see [Position Statement 98: Benefits of e-mental health treatments and interventions](#).

### Please outline any barriers and enablers that have an impact on whether care for women is timely, appropriate, accessible, affordable.

One of the barriers to timely, accessible and affordable health care are workforce challenges in the mental health care system. As noted by the Productivity Commission [Mental Health Report](#) and the National Skills Commission's national [Skills Priority List](#), there is a shortage of psychiatrists and mental health nurses. The public system requires a greater commitment from government to build a strong and sustainable workforce. Greater commitments to the psychiatry workforce through initiatives such as the [Specialist Training Program](#), [Psychiatry Workforce Program](#) and the [Rural Psychiatry Roadmap](#) will help to provide more equitable care.

When looking to increase equity through the private system, affordability is the key factor. As noted in the RANZCP's [2023-2024 Federal Pre-Budget Submission](#), about 18% of Australians needing to see a psychiatrist have reported missing the service due to cost. One of the reasons for the high cost of psychiatric services is the current MBS rebate provided for psychiatric services. The RANZCP recommends increasing the MBS rebate for psychiatry services to 100% of the schedule fee from the current 85%, and providing the MBS billing provision for psychiatry trainees so they can bill at 60% of the consultant psychiatrist rate. This will lower the out-of-pocket costs for psychiatry services and will increase the functional workforce to increase access and timeliness of services by allowing trainees to provide services.

Appropriate care for women is enabled by a trauma-informed person-centred approach. The RANZCP acknowledges the importance of trauma-informed care in psychiatry in [Position Statement 100: trauma-informed practice](#). Women are more likely to have experiences of family violence and sexual harm, so trauma-informed care is of particular importance to the appropriate care of women in mental health. Models of care should be trauma-informed and person-centred as these have been shown to enable better health outcomes for consumers.

### To what extent do you think women feel heard about their health issues?

- Not at all
- Slightly
- Moderately
- Mostly
- Completely
- Unsure

**To what extent do you think women feel believed about their health issues?**

- Not at all
- Slightly
- Moderately
- Mostly
- Completely
- Unsure

**What are the barriers and enablers to women feeling confident they will be heard and believed about their health issues?**

One of the key enablers in making women feel heard and believed is a trauma-informed and person-centred approach to health care. It is also important that services are delivered by clinicians in a culturally safe manner. Culturally safe practice involves practitioners acknowledging how their own beliefs and biases can influence their practice and the way that consumers receive care. The RANZCP acknowledges in [Position Statement 105: Cultural safety](#) that respect for a consumer's background, gender and culture is integral to ensure a positive health outcome. Practicing culturally safe person-centred care also helps to address the inherent power imbalance between clinician and consumer, which can be a barrier to women feeling heard and believed, particularly when treated by male health professionals.

Another enabler is an increased emphasis on the inclusion of women in the psychiatric workforce, especially in leadership, teaching and supervision roles. As part of the RANZCP's [Gender Equity Action Plan](#), a leadership program for women trainees and early career psychiatrists will be developed to increase the number of women in these positions. This is part of the RANZCP's commitment to work towards gender balance in leadership roles within the RANZCP and the psychiatry workforce. Similar commitments from health services and government will aid women in feeling heard and believed, by reducing the perception that the health system is male dominated and thus based on male perception.

**What is the impact of not being heard and believed?**

One of the barriers to seeking care is past experiences, either individually or on a community level, with practices that have caused marginalisation, fear or harm. These experiences stigmatise mental health conditions and seeking appropriate treatment and influence a consumer's decision about seeking or continuing care. When consumers feel unheard or not believed, they are deterred from seeking help. This experience is often shared, which affects confidence in mental health care on a wider community level. The RANZCP acknowledges that harmful past experiences shape not just an individual but are also ingrained in a 'folk memory' – see [Position Statement 84: Acknowledging and learning from past mental health practices](#). In order to prevent individual and community stigma based on experiences of not being believed or heard, it is important that all models of care integrate a trauma-informed, person-centred and evidence-based approach to mental health care.

**Can women access tailored care?**

- Never
- Rarely
- Sometimes
- Mostly
- Always
- Unsure

**Can women access safe care?**

- Never
- Rarely
- Sometimes
- Mostly
- Always
- Unsure

**What are the barriers and enablers to culturally safe care for women? How does culturally safe care differ between different priority populations?**

***Some examples of priority populations are:***

- Pregnant women and their children*
- Women and girls from rural and remote areas*
- Aboriginal & Torres Strait Islander women and girls*
- Women and girls from low socio-economic backgrounds and older women with low financial assets*
- Women and girls living with disability and carers*
- Culturally and linguistically diverse women and girls*
- Members of LGBTIQ+ communities*
- Women and girls who experience violence and/or abuse*
- Women and girls affected by the criminal justice system*
- Women veterans of Australia's armed services*

As identified in the RANZCP [Position Statement 105: Cultural safety](#), culturally safe care is best enabled by routinely incorporating the needs of consumers into the mental health system processes, including recruitment of culturally diverse people into the care workforce and leadership positions, service funding, and hospital and health service design. Culturally safe outcomes should be monitored and reported on, including recruitment and retention. The tenets of culturally safe care should also be built into the training and CPD of clinicians. Culturally safe practice is also enabled in a more direct manner through health

services endorsing and applying codes of conduct. These codes should be reinforced with education, training and supervision at the individual service level in order to build knowledge and understanding within individual workforces.

While each priority population has its own cultural needs, the basic principles of culturally safe care apply to all. Care should acknowledge a fundamental respect for consumers, with regard to cultural status, age, gender, sexual orientation, ethnicity, location and the beliefs of each person, when planning and providing care. Consumers should be consulted on their needs and accommodations made where feasibly possible, while maintaining high-quality, timely and effective care.

Generational and community trauma needs to be acknowledged and managed for culturally safe care to be effectively provided, especially for Aboriginal and Torres Strait Islander peoples. Health services should be aware of cultural loading – where expectations of additional duties, experiential explanation or tokenism are placed on members of a priority population. This can lead to higher rates of burnout and mitigate the positive effects of culturally safe incentives, practices and recruitment. It is important for health services to support culturally diverse members of their workforce, as well as building culturally safe practice into their operational processes so as not to place the responsibility of ensuring culturally safe care on members of the workforce who are of a priority population.

### **What are the barriers and enablers to ensuring health care is tailored to the needs of women in all health care settings?**

One of the key barriers to women accessing tailored health care is the preconceptions and prejudices of clinicians and health systems. Culturally safe and trauma informed models of care mitigate the effects of bias in the health system. The best way to enable women to access to tailored health care is to build culturally safe and trauma informed care with a person-centred approach into the health system. This can include education and training for clinicians and health services personnel and tailored design of health care settings such as women only wards in hospitals and acute care institutions, or protocols to ensure women's safety