

A message from the College President

Our collective efforts to enhance equity, diversity and inclusivity are fundamental to maintaining a healthy and sustainable College. These values are reflected not just in our overarching vision, values and purposes as an organisation that represents over 7,300 qualified psychiatrists and trainees, but in our daily interactions with peers, colleagues, patients and the wider community.

Improving gender equity is an important part of this, particularly in health care settings, because it can improve the safety and quality of care we provide. Gender-based issues permeate many aspects of providing high-quality mental health care, from understanding trauma-informed and gender sensitive care, through to research translating into better health treatments. We all have an interest in improving gender equity, because it matters to the consumers, carers and communities we support.

Our membership is diverse, and it is important that we recognise the benefits that improving gender equity can bring for psychiatry. This paper is designed to open up a fresh conversation about how our College can evaluate and improve gender equity within psychiatry. We have been successful in some areas and are making progress towards improving gender equity in psychiatry including through greater balance in trainee enrolment and Fellowship attainment. However, we know that addressing gender equity is about more than just top-level statistics alone, and there is still much work to be done that will require more focused effort.

I hope that the information provided here will inspire both reflection and new action toward advancing gender equity. My thanks to the members of the Gender Equity Working Group, led by Professor Megan Galbally, as well as the Membership Engagement Committee for helping to shine a spotlight on this important long-term issue for the future of our profession.

Please consider taking part in the consultation that is now underway – and more importantly, be a part of contributing to changes that improve gender equity in psychiatry training, education and practice.

Associate Professor Vinay Lakra

RANZCP President

Share with us your ideas and reflections on gender equity

- Gender equity in health care matters.
- Starting a conversation about how we can all contribute to gender equity is an important part of promoting an inclusive and supportive, College for everyone.
- The College is committed to improving diversity, inclusion and equity, and to developing a meaningful College gender equity statement and action plan.
- This discussion paper, read together with our *Gender equity snapshot*, provides a starting point to better understand the status of gender equity in the College, highlighting areas of progress, as well as areas that can be improved.
- Your ideas and reflections are integral in helping us to take this work forward.
- We welcome your responses to our member consultation questions in the **final part** of this paper.

Why does gender equity matter?

Gender equity is about supporting a fundamental human right for individuals to be able to reach their potential without bias and discrimination limiting their opportunities to fully participate in all aspects of our community. Gender equity brings not only clear benefits for individuals, but is also associated with the safety, quality and economic prosperity of the community as a whole.

On the other hand, tolerating gender inequality can lead to ongoing issues such as gender-based violence and making communities less safe, and has implications for the longer-term impact on mental health for women today and the inter-generational impact on the next generation tomorrow. Gender inequality impacts on all people by limiting ambitions, learning and participation across all stages of life and this has consequences for productivity, profitability and leadership across all health sectors including mental health.

Facts on gender equity in Australia and New Zealand:

- If gender equity was to improve, the Australian gross domestic product would increase by 11% from the gender employment gap closing.[1] If New Zealand businesses were to achieve gender parity in leadership, the resulting participation benefits would lead to the economy being NZ\$881m larger (equivalent to 0.33% of gross domestic product).[2]
- Family violence costs the Australian economy more than A\$21.7 billion a year,[1] and costs the New Zealand economy up to NZ\$5.3 billion per year.[3]
- Female leadership leads to 6.6% increase in the market value of Australian ASX-listed companies, worth the equivalent of A\$104.7 million.[4] In the last 10 years, New Zealand public sector boards have progressed from 41.1% representation, to achieving 50.9% in 2020.[5]

Gender equity in psychiatry

In psychiatry, gender inequality leads to important gender-based issues in the provision of mental health care being marginalised – such as the long-term issue of sexual safety of women on mental health inpatient units, and the recognition of the impact of family violence on inter-generational mental health and community wellbeing.[6][7] In a research context, gender inequality can lead to an evidence base of the medical treatments used lacking relevance to half the population, with examples such as basic animal model research being undertaken mostly on male rodents and pharmacological treatments being untested and potentially unsafe for females.[8][9][10]

Furthermore, investment in understanding uniquely female risks and benefits of treatments remains inadequate, such as through pregnancy exposure to psychopharmacological treatments, or sex differences in response and adverse reactions to specific medications leading to a situation of low-quality evidence to support practice.[11][8]

What is clear in many of these examples is that a gender equity focus across training, service delivery and research in mental health will not just benefit women, but will have longer-term benefits to our wider community and in particular the next generation for all people. These broad and far-reaching benefits of gender equity, particularly for health outcomes, are well documented from impacting on infant mortality rates through to rates of mental health and wellbeing.[12]

An important starting point

It is in this context that the College has shown its commitment to a vision of equity for all. While the College may have limited direct control over some wider societal factors, as psychiatrists and mental health professionals it is important that we advocate for positive change in gender equity. An important starting point is a so-called 'self-examination' where the College determines how well it is doing itself with respect to gender equity.

Whilst this discussion paper has a focus on gender equity for women within psychiatry, this does not diminish from the important aim for inclusion, diverse representation and equity for all including Aboriginal and Torres Strait Islander people, Māori, Culturally and Linguistically Diverse, those with disabilities, and the LGBTQIA+ community.

Alignment with RANZCP vision and statement of commitment

Gender equity links directly to the current College Vision, Values and Purpose.

Ensuring gender equity and promoting equal participation and representation will **further improve the mental health of communities through higher quality psychiatric care, education, leadership and advocacy**. It will lead to improvements in care, education, leadership and advocacy by ensuring the College is inclusive of women (including in training and education, broader membership activities, and staffing), and by affirming the importance of safety and gender sensitive care for women accessing mental health care. It also supports the aim of broader representation of women in the development of models of clinical care and research priorities through inclusive leadership.

In the short and longer term, having an increased evidence base on aspects of mental health that differ for women from assessment, treatments and service delivery will lead to safer and improved outcomes for the treatment of mental health disorders in women. This will ultimately benefit the broader community and future generations and enhance the current vision for the College.

Likewise, the goal of gender equity supports the **College's values** of collaboration, excellence, integrity, respect, compassion, innovation and sustainability – enhancing each value through equal opportunity at participation in College activities, training, membership and leadership in mental health.

When it comes to our **purpose as a College**, gender equity will **advance the profession of psychiatry**, improve the delivery of training and continuing professional development, and increase the quality of psychiatric care delivered by members of the College. Equally, by embedding the principles of gender equity within our College we will lead the way in **improving the mental health of our community** by recognising and better understanding the differences in social and biological aspects of determinants of mental health as well as assessment, diagnosis and care across mental health services and treatments. Furthermore, we will support the provision of gender sensitive care that is safe and appropriate for women to access.

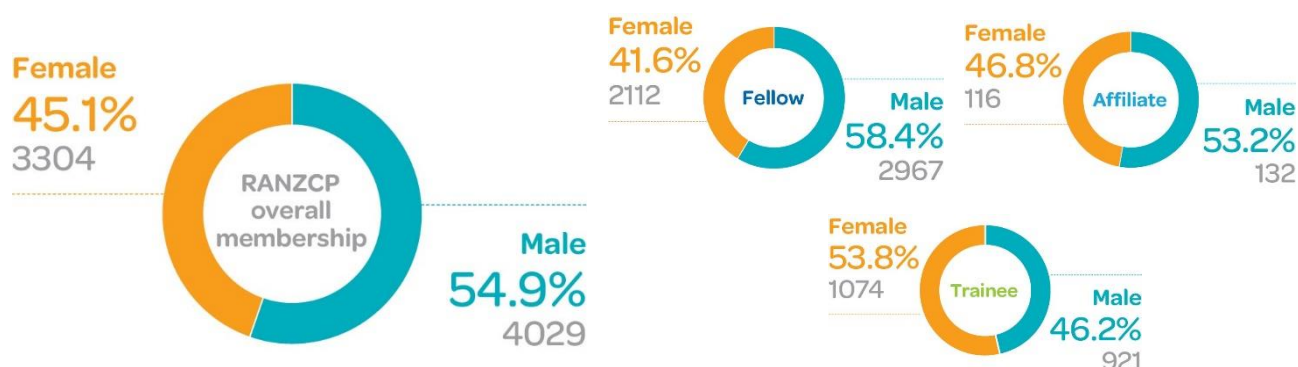
Our College membership demographic is continuing to trend towards a parity between male and female trainees and Fellows, and to **meet the needs of members** we need to address any inherent aspects of inequality and support all Fellows, Affiliates and those in training in an inclusive way.

When it comes to factors that lead to gender inequality, these impact mental health across all of our community, including for men, women, children and those who identify as gender diverse.[12] These factors include values in contrast to those of the College such as discrimination, and inherently disrespectful beliefs that preference differences in power between individuals and then lead to coercive, violent and controlling practices within societies. Furthermore, the lack of understanding and recognition of gender inequality leads to inherent unconscious bias across the delivery of mental health care, mental health systems and mental health research.

"I am a straight white middle-aged male, but am excited and enthusiastic that the College is undertaking work in this area. I have been researching the causes of under-represented groups in medical specialist training and senior positions, discovering that the barriers facing women at all levels of education and advancement negatively affect the health system as a whole – including female and male patients and professionals. By far the most prominent under-represented group, women are poised to significantly improve modern health and social systems by asserting their right to equitable treatment, and the RANZCP's statement is a symbol of the profession's determination not to stand in their way."

College members, leaders, and organisation

Of the 7334 College members based in Australia, New Zealand and overseas, 54.9% are male and 45.1% are female.



**Data correct as of 23 July 2021*

Previously, the College's membership database has recorded male and female categories only. This is now being expanded to recognise diverse and non-binary categories which will enable richer and more reflective reporting in the future. Other datasets contained in this discussion paper have been acquired at different times during 2021 and will evolve and change over time.

The College's membership by gender is proportionally similar to the Royal College of Psychiatrists (UK) that has 45% female and 55% male representation from 19,000 total members.[13 p8] Other medical colleges, such as the Australian and New Zealand College of Anaesthetists[14] and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists,[15] as well as the Australian Medical Association, have action plans to improve gender equity and diversity across their College structures.[16]

College female presidents and leaders

The first female President of the College was Dr Isobel Williams (1967-68) who, together with Dr Christine MacMahon and Dr Irene Sebire were the only three female psychiatrists out of the original 67 members of the Australasian Association of Psychiatrists, when it was first officially formed in 1946.

Since that time, the College has had a further seven female Presidents: Professor Beverley Raphael AM (1983–85), Dr Joan Lawrence AM (1987–89), Dr Karen Zelas (1989–91), Dr Janice Wilson (1997–99), Professor Louise Newman AM (2009–10), Dr Maria Tomasic (2010–13), and Dr Kym Jenkins (2017–19).

The current President-Elect is Dr Elizabeth Moore who will commence her term in 2023.

The College as an equal opportunity employer

The College is an equal opportunity employer and adopts a best practice approach to all policies, procedures and guidelines for all legislative requirements, including but not limited to equal opportunity recruitment and employment, and mandatory equal opportunity training conducted every two years for all staff. The College provides additional paid parental leave for both primary and secondary carers, as well as a dedicated parents' room located at our head office.

As of August 2021, female staff represent 80% of the College workforce across Australia and New Zealand. The College reports annually to the Australian Workplace Gender Equality Agency (WGEA), an Australian Government statutory agency created by the Workplace Gender Equality Act 2012 that requires all non-public sector employers with 100 or more employees to submit a report to the WGEA. The College commenced reporting last year, and the most recent 2021 report to WGEA has been completed. The College also undertakes annual reporting in areas including but not limited to gender remuneration and gap analysis, gender-based internal promotions, and gender-based employee recruitment and selection.

Gender equity: highlights

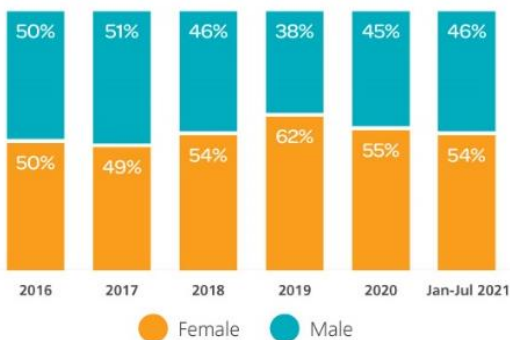
There are several areas within the College highlighting some of the significant progress that has been made in moving towards gender equity.



Many of these are indicative of shifts towards greater interest and involvement from females in pursuing a career in psychiatry. Just over 58% of current members of the Psychiatry Interest Forum are female, and since 2013 more than 50% of new College trainees joining the psychiatry training program have been female.

Of the 333 trainees who commenced from 2012 onwards, the average time of training for females (5.7 years, n=168) was close to that of males (5.6 years, n=165).

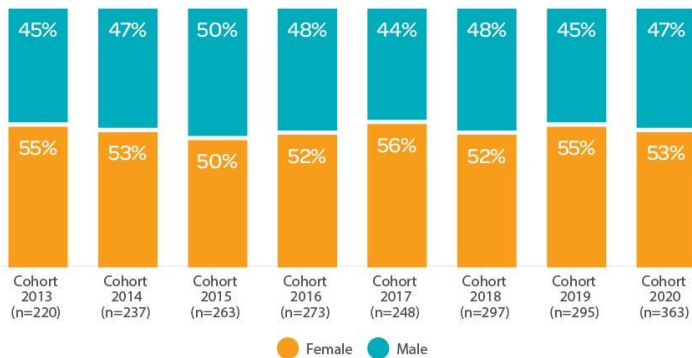
Enrolment by gender in RANZCP Certificates of Advanced Training



Enrolments in Certificates of Advanced Training reached gender parity in 2016, and since then there has been a general trend of more females enrolling than males, with females making up 62% of all new enrolments in 2019 alone. This trend has remained for 2021 enrolments so far. Completion rates have also improved over time, with 51% of certificates awarded to females in 2018–19, growing to 57% in 2020.

Until 2012, there was a clear trend where most newly admitted Fellows were male, with 2014 representing the first year where more females were admitted to Fellowship than males, and this has occurred on several other occasions since that time. The average age of admission to Fellowship has been almost identical for both males and females since 2012.

RANZCP Fellowship Program enrolment by gender



Admissions to Fellowship - gender comparison

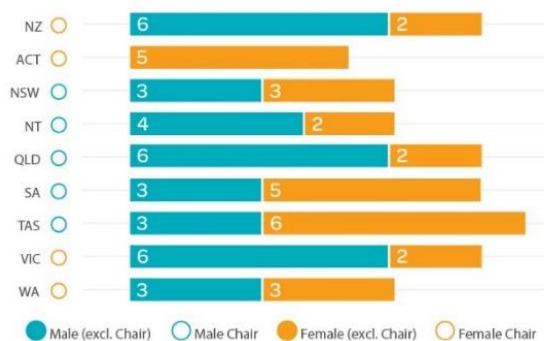


Committee representation across the College is relatively in line with that of the membership. Of the 884 filled committee positions on the 125 College committees included in the dataset evaluated, 57% are held by males and 43% by females. (Note, working groups and ex-officio members are not included in this review.)

Branch and New Zealand National committee composition is also generally balanced, with 55.6% of branch chair positions currently held by males.

There have historically been more male than female speakers at the College’s annual New Zealand conference since 2011, with 62% being male. However, 2019 saw the highest female representation at the conference, with seven female speakers making up 70% of the total number of keynote speakers. 2020 saw a relatively even split of three female speakers and four male speakers.

Membership of the RANZCP’s Australian Branch Committees and New Zealand National Committee



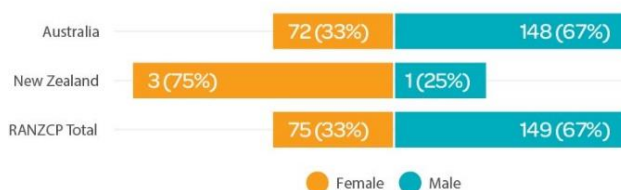
Gender inequities: areas for further action

Just as there are many positive areas to highlight, there are also several areas of College activity that could benefit from taking steps towards achieving gender equity. Many leadership positions and roles within psychiatry have a tendency to be less balanced overall. Academic, speaking and publication roles also tend to be under-represented by female College members, together with awards and prizes.

There are less current male trainees (799) than female trainees (977), and a lower proportion of male trainees are taking up part-time training options (4.6%) than their female counterparts.

There are also far more male Specialist International Medical Graduate candidates on the pathway to Fellowship (67%) than female candidates (33%) in Australia. New Zealand does have an additional pathway to specialisation registration that is not delivered by the College, and it should be recognised that many Specialist International Medical Graduate candidates choose to take this pathway and become Affiliate members of the College (who then also actively support training in New Zealand).

Specialist International Medical Graduate candidates on pathway to Fellowship



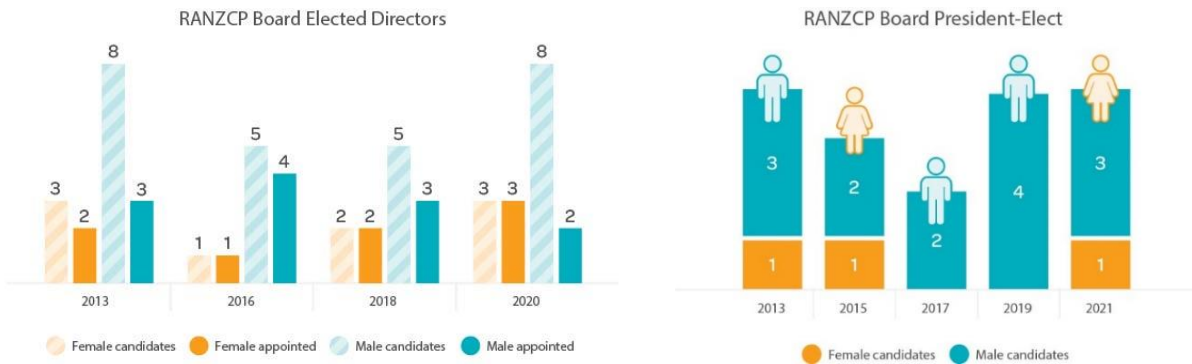
“During my interview for the Training intake, a male panel member asked whether I planned to have any more children and whether I had the intention to commit to full-time training (as a mother). I was also cautioned that taking days off to care for my children if they were unwell would be undesirable and advised against. I did not consider that my family planning, nor childcare arrangements, were the business of the interview panel and I wonder if the same questions would have been asked of me if I had been a male applicant.”



Although College committee participation is relatively reflective of the membership balance, males occupy 63.2% of committee chair roles.

This data only includes formal committees and networks which hold elections and excludes some committees with ex-officio membership (such as the Members’ Advisory Council and Branch Chairs’ Forum) and working and steering groups.

At the Board level, since 2013 of the 5 Elected Director positions available on the College Board at each election, there have been 26 male and 9 female candidates, resulting in 12 male and 8 female appointments. Of the last 5 President-Elect positions, 3 have been male and 2 female, however there were only 3 female candidates compared to 14 male candidates who nominated for this position.

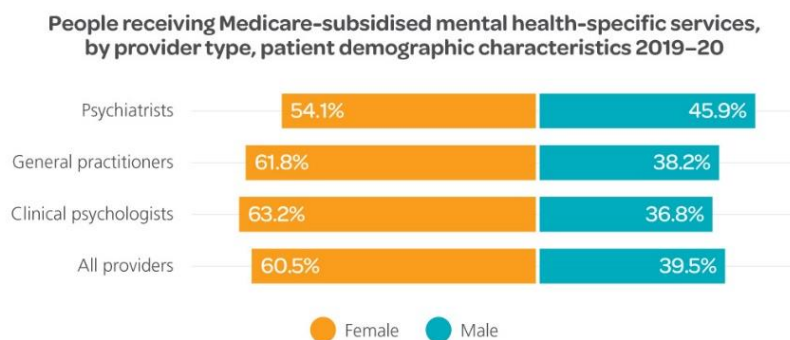


There are also opportunities to improve gender balance in workplace leadership roles, with 78.5% of Clinical Director positions held by males, and 21.5% by females across Australia and New Zealand. Directors of Training positions are similarly represented, with 74.3% held by males and 25.7% by females. Directors of Advanced Training positions are less imbalanced with 59.6% held by males and 40.4% by females.

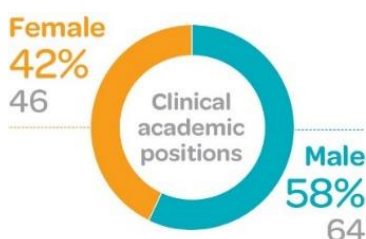


“As a Clinical Director, being told to shut up in a meeting where I was the only female is something that has stayed with me – so whilst not huge, things like this do contribute to the sense of a male voice being more important and more listened to. I think this leads women to then think they have to perform in a certain way to be accepted. I think these subtle putdowns create a culture which is improving but still exists.”

In terms of service delivery, female psychiatrists provided more Medicare-subsidised mental health specific services than male psychiatrists in 2019–20 at 54.1% and 45.9% respectively. However, this was below clinical psychologists at 63.2%, as well as general practitioners at 61.8%.



Source: Australian Institute of Health and Welfare database, Mental health services in Australia: Medicare-subsidised mental health-specific services (2019–20)



There are approximately 110 College members holding clinical academic positions within psychiatry at 24 universities across Australia and New Zealand. 58% of these positions are held by males, with 42% held by females.

However, 80% of the senior positions (e.g. Head of Psychiatry) are held by males.



236 male members (6.1% of the male membership) use a title other than 'Doctor', such as Professor or Associate Professor, whereas only 58 female members (1.8% of the female membership) use a title other than 'Doctor'.



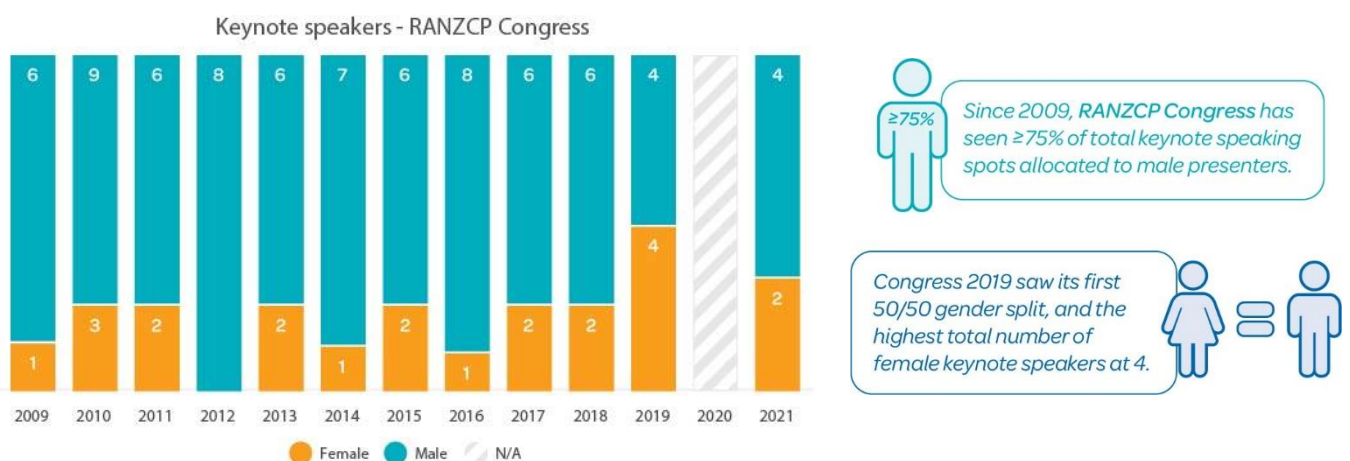
54 male RANZCP members hold conferred honorific postnominals (e.g., AM, ONZ) compared with 20 female members.

"I am a Professor with a senior leadership position within a medical school in Australia and also practice as a consultant psychiatrist. It is well known to those I work with clinically that I am a Professor and divide my time between my academic and clinical work. Despite that knowledge, a previous department I worked at consistently referred to me as Dr. in all correspondence. A male Professor then joined the department and was always referred to as Professor, without exception. Despite my fears of being perceived as arrogant, I raised the issue multiple times and asked that my correct title be used however nothing changed. I have observed this gender disparity frequently in the clinical setting where male Professors are always referred to as Professor and even more senior, salaried academic female consultants remain Dr. This undermines the accomplishments of female Professors, and these frequent microaggressions contribute to women leaving academic psychiatry."

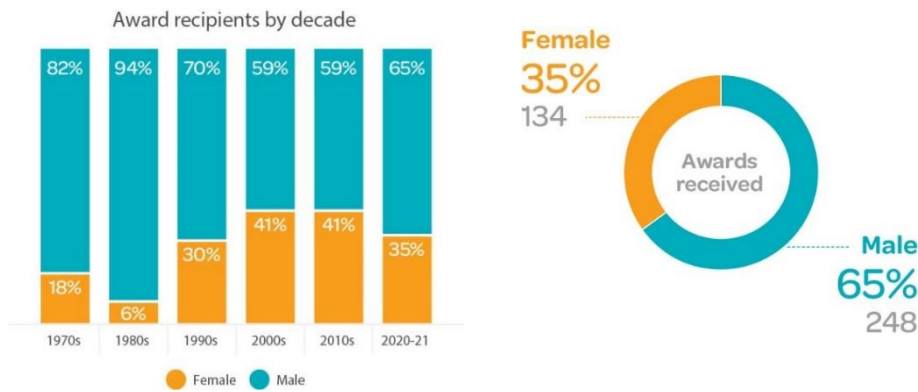
This data around academic representation may also link through to the composition of editorial boards for both of the College's scientific journals.

Over the past four years, females have held between only 23-27% of the *Australasian Psychiatry* and 24-27% of the *Australian and New Zealand Journal of Psychiatry* editorial positions. Editor and Deputy Editor positions have been 100% occupied by males in the last three years. In 2021, three female Associate Editors were appointed to the *Australian and New Zealand Journal of Psychiatry* editorial team.

Since 2009, the College Congress has seen $\geq 75\%$ of total keynote speaking spots allocated to male presenters across the period. The 2019 Congress saw the first balanced gender split with a total of four female keynote speakers.



Since the 1970s, a total of 382 College awards have been granted with 134 (35%) of these being awarded to females and 248 (65%) awarded to males. Less than 41% of the awards given out across each decade have been received by female members.



Share with us your ideas and reflections on gender equity

This latest research provides important insights into the current status of gender equity in the College, indicating several areas of progress, as well as areas that can be improved.

Taking this forward, the Membership Engagement Committee (MEC) and its gender equity working group are supporting efforts to improve gender equity in line with the College's ongoing commitment to enhancing diversity, inclusion, and equity. Work is already underway towards a College gender equity statement and a future action plan.

The ideas and reflections of members are integral in helping to advance gender equity in psychiatry. The Working Group and the MEC would be pleased to receive members' responses, and the below discussion questions are provided to assist with this.

1. In reviewing the College's gender equity data, which data or information stood out to you, and why?
2. How, in your experience, can gender equality or inequality impact gender-related issues in the areas of training, research, leadership, and service provision?
3. What are the areas of positive growth you have noticed within the College or more broadly in psychiatry, in working towards achieving gender equity?
4. What are some of the opportunities for improvement that you feel should be considered in addressing aspects of gender inequity in the College, and how could these be addressed?
5. What are some specific aspects of mental health care that the College could further advocate on, to enhance gender equity in mental health?

Definitions

Gender concept

An understanding of the socially constructed distinction between male and female, based on biological sex but also including the roles and expectations for males and females in a culture. Children begin to acquire concepts of gender, including knowledge of the activities, toys, and other objects associated with each gender and of how they view themselves as male, female or non-binary in their culture, possibly from as early as 18 months of age. This develops into how they should interact with others of the same or opposite gender within households, communities, and workplaces.

Gender

Gender is part of a person's social and personal identity. It refers to each person's deeply felt internal and individual identity and the way a person presents and is recognised within the community. A person's gender refers to outward social markers, including their name, outward appearance, mannerisms and dress. A person's sex and gender may not necessarily be the same. An individual's gender may or may not correspond with their sex assigned at birth, and some people may identify as neither exclusively male nor female.

Sex

Sex refers to the chromosomal, gonadal and anatomical characteristics associated with biological sex. Individuals may have a range of circumstances or undergo a variety of treatments that make it difficult to define a true biological sex.

Gender equity

The process of allocating resources, programmes, and decision-making fairly to all genders, without any discrimination on the basis of sex and addressing any imbalances in the benefits available to people depending on their sex or gender.

Gender equality

The rights, responsibilities, protections and opportunities of individuals do not depend on however they identify in gender or in their sex. It implies that the perceptions, interests, needs, and priorities of women and men will be given equal weight in planning and decision-making.

Gender equity vs Gender equality

Gender equality does not mean that all people have to become the same, but that their rights, responsibilities and opportunities will not depend on whether they are male or female. Gender equity means fairness of treatment for all people according to their respective needs. This may include equal treatment or treatment that is different, but which is considered equivalent in terms of rights, benefits, obligations, and opportunities.

Unconscious biases

Social stereotypes about certain groups of people that individuals form outside their own conscious awareness that then impact decision making.

References

1. Victorian Government, Gender Equality and women's leadership [Internet]. Melbourne, VIC: Victorian Government; 2021 [updated 31 March 2021; cited 7 July 2021]. Available from: <https://www.vic.gov.au/benefits-gender-equality>
2. Westpac New Zealand, Diversity Dividend Report [Internet], Deloitte Access Economics; December 2017 [place unknown] [cited 20 July]. Available from: <https://www.westpac.co.nz/assets/About-us/sustainability-community/documents/Diversity-Dividend-Report-Westpac-NZ.pdf>
3. New Zealand Government, Manatū Wāhine Ministry for Women, Our work: A snapshot of New Zealand women [Internet]. [place unknown] Manatū Wāhine Ministry of Women; 18 May 2012 [updated 11 March 2021; cited 20 July]. Available from: <https://women.govt.nz/about/our-work>
4. Australian Government, Workplace Gender Equality Agency, More women at the top proves better for business [Internet], Canberra ACT: Workplace Gender Equality Agency; 19 June 2020 [cited 7 July 2021]. Available from: <https://www.wgea.gov.au/newsroom/more-women-at-the-top-proves-better-for-business>
5. New Zealand Government, Manatū Wāhine Ministry for Women, 2020 stocktake of gender, Māori, Pacific and ethnic diversity on public sector boards and committees, [place unknown], Manatū Wāhine Ministry for Women [2020; cited 20 July]. Available at: https://women.govt.nz/sites/public_files/4573_MFW_Gender%20and%20Ethnicity%20Stocktake%202021_FINAL%203_web.pdf
6. Suparare L, Watson SJ, Binns R, et al. Is intimate partner violence more common in pregnant women with severe mental illness? A retrospective study. *Int J Soc Psychiatry*. Epub ahead of print 2020/01/07. DOI: 10.1177/0020764019897286. 20764019897286.
7. Kulkarni J and Galletly C. Improving safety for women in psychiatry wards. *Australian & New Zealand Journal of Psychiatry* (2017) 51(2): 192-194.

8. Zucker L and Prendergast BJ. Sex differences in pharmacokinetics predict adverse drug reactions in women. *Biol Sex Differ* (2020) 11(1): 32.
9. Shansky RM and Murphy AZ. Considering sex as a biological variable will require a global shift in science culture. *Nat Neurosci* (2021) 24(4): 457-464.
10. Wisner KL. The last therapeutic orphan: the pregnant woman. *Am J Psychiatry* (2012) 169(6): 554-556.
11. Galbally M, Crabb C and Snellen M. Designing research that can untangle the effects in pregnancy of pharmacological treatments for mental disorders. *Lancet Psychiatry* (2018) 5(8): 608-610.
12. Shannon G, Jansen M, Williams K, et al. Gender equality in science, medicine, and global health: where are we at and why does it matter? *Lancet* (2019) 393 (10171): 560-569.

Further reading

13. The Royal College of Psychiatrists UK, RC Psych Equality Action Plan 2021–23 [Internet] London: RC Psych; 2021 [cited 26 August 2021]. Available from: <https://www.rcpsych.ac.uk/about-us/equality-diversity-and-inclusion/equality-action-plan>
14. Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine, Gender Equity Position Statement [Internet], [place unknown]: ANZCA FPM, February 2019 [cited 26 August 2021]. Available from: <https://www.anzca.edu.au/about-us/our-culture/inclusion-and-diversity>
15. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Gender Equity and Diversity Report [Internet], [place unknown]: RANZCOG, 2019 [cited 26 August 2021]. Available from: <https://ranzocg.edu.au/our-college/gender-equity-and-diversity>
16. The Australian Medical Association, Diversity & Inclusion Plan 2020–2022 [Internet], [Place unknown]: AMA June 2020 [cited 26 August 2021]. Available from: <https://www.ama.com.au/articles/ama-diversity-and-inclusion-plan-2020-2022>

Disclaimer

This information is intended to provide general guidance to practitioners, and should not be relied on as a substitute for proper assessment with respect to the merits of each case and the needs of the patient. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances, information or material that may have become subsequently available.

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