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Original Research

Gender-based provisions in mental health legislation: a review of English language jurisdictions

Fiona Hoare[1], Niamh Murphy[2], Ann O'Donoghue[2], Siobhan Allen[3] and Richard M. Duffy[4]

[1]St. Vincent's University Hospital, Dublin, Ireland, [2]University College Dublin, Dublin, Ireland, [3]Global Legal Action Network and Womankind Worldwide, London, UK and [4]School of Medicine, University College Dublin, Dublin, Ireland

Abstract

Objectives: Legislation is a powerful tool for facilitating mental healthcare. Gender is an important social determinant of physical and mental health. Many jurisdictions are in the process of revising their mental health law, to align with human rights commitments. Consideration of gender in these revisions could enhance the mental healthcare received by women, transgender and non-binary individuals.

Aim: This paper examines gender-based provisions in mental health law published in English.

Methods: Countries that use English as an official language were identified. Jurisdictions in these countries with stand-alone mental health laws were included. Legislation was reviewed for gender-specific provisions.

Results: Seventy-five countries were evaluated; 71 jurisdictions were included. Thirty-eight jurisdictions had 88 gender-specific provisions. These addressed ten key areas, including: general gender-based protections, female representation on boards and review panels, protections during searching and restraint, gender separated facilities, protections in relation to parenting, fertility, sterilisation and termination. Fiji, Ghana, India, and the Australian jurisdictions had the highest number of gender-specific laws. However, gender-specific provisions are highly heterogeneous and are drafted from a cisnormative perspective and fail to adequately address the specific needs of individuals outside of that framework.

Conclusion: Gender-specific provisions can enhance the protections afforded by mental health law. However, as legislation can be a blunt instrument, careful consideration must be given to potential unintended consequences. During revisions of mental health law consideration should be given to gender-specific provisions and legislation must be inclusive of individuals identifying as transgender, non-binary and other genders.

Keywords: Jurisprudence; legislation and jurisprudence; mental health; gender

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Background

Legislation is a powerful tool for facilitating healthcare (WHO, 2016). Mental health legislation, in particular, has a long-established role in shaping practice. Many factors are currently prompting the revision of mental health laws. These include: the adoption of the Convention on the Rights of Persons with Disabilities (CRPD) (United Nations 2006), the World Health Organisation's (WHO, 2021) Comprehensive Mental Health Action Plan 2013–2030 and the QualityRights Initiative (WHO, 2012). These documents are reforming mental health law, from solely regulating coercive measures, to providing broader care and treatment for individuals.

Gender and gender-based discrimination are important determinants of physical and mental health (WHO, 2008; Manandhar *et al.*, 2018; Hawkes and Buse, 2020). Hosang and Bhui (2018) highlight how females bear a disproportionate burden of mental illness and describe how many aetiological factors for mental illness interact with gender.

The WHO and UN have long sought to address this inequality. The Convention on the Elimination of All Forms of Discrimination Against Women (United Nations, 1979) lays out the meaning of equality and explores how this can be achieved. The CRPD (UN, 2006), in its preamble identifies that women and girls are often at greater risk of abuse and maltreatment. In Article 6, it highlights how women with disabilities are 'subject to multiple discrimination'. Article 16, encourages the use of legislation to prevent exploitation, violence and abuse. Article 23, makes provisions relating to the home and family, with implications for reproductive choices and parenting. In addition to these conventions, many of the sustainable development goals directly target barriers faced by women (United Nations, Department of Economic and Social Affairs, 2022).

It is not only women who have gender-specific mental health needs and face barriers to care. Transgender, non-binary and individuals of other genders have an increased requirement for mental healthcare (Lin *et al.*, 2021;Valentine and Shipherd, 2018). For these reasons, they may also benefit from specific consideration within legislation.

Corresponding author: Richard M Duffy; Email: duffyrm@gmail.com

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This study was a narrative review of the primary, mental health specific legislation of all jurisdictions where English is an official language. The identified laws were examined for specific provisions that related to women, transgender, non-binary and individuals of other genders. The aim of this is to describe potential gender-specific provisions that could be considered for inclusion in future legislation and policy, and to discuss the strengths, weaknesses and potential unintended consequences of the provisions identified.

Methods

Countries were identified in which English was the *de jure* official language, the predominate language used in government and spoken by the population, or a de facto working language in government or education (CIA fact-book, 2022). Non-Sovereign entities were excluded. We obtained a copy of national or regional mental health laws depending on the country's legal structure. Only legislation published in English was analysed. Jurisdictions with specific legislation addressing mental healthcare were included in our analysis. Capacity and fusion laws, stand-alone forensic psychiatry legislation, and disability-based laws were not examined. Bills or repealed laws were also excluded. Countries were excluded if we could not obtain a copy of their legislation or if they did not have mental health law. Legislation from the United States of America was excluded, as it deserves its own specific consideration due to the number of jurisdictions present in the US and the fragmented nature of American mental health law. The legislation was referred to in the manner that is standard in that jurisdiction. Provisions that related to adults or minors were included in our analysis. Legislation that could be disproportionally applied to one gender, for example references to 'sexual exploitation', was not included in our study's findings, unless it contained direct references to gender.

Each piece of legislation was examined by two researchers; provisions were identified which referenced gender, sex, contraception, pregnancy, fertility, parenting, breastfeeding, or family, or which used of male and female pronouns in any context. Each of these provisions was then evaluated independently by two researchers to establish if it was gender specific. All gender-specific items were identified as described in Table 2 in the supplementary material. An iterative approach was used in developing themes. In a first review, all items that addressed the same topic were grouped together into initial themes, this was done independently by two researchers. In subsequent reviews, similar themes were amalgamated into common themes, this was done through discussion between the researchers. Themes were then reviewed to ensure they were distinct and that they represented the analysed legislation.

This research did not consider the implementation or realisation of the law, this analysis simply focused on the text of the legislation. Where the legislation is directly referenced, its terminology has been retained in relation to sex and gender. This study used open access data and as such was exempt from ethical committee review. This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Results

General

Seventy-five countries were identified which met our language based inclusion criteria, described above. Fifty of these countries, comprising 71 jurisdictions, had mental health specific legislation that we could access and was available in English (Figure 1). Thirty-three jurisdictions had no gender-specific provisions, a list of these jurisdictions and their respective legislation is included in the Supplementary Material (Table 1). The remaining 38 jurisdictions included mental health legislation with elements specific to gender, from these jurisdictions there were 88 individual provisions (Supplementary Material Table 2). Legislation with gender-based elements tended to be more recent compared to those without such provisions. The mean year legislation was enacted with gender-based elements was 2000 (median 2002, range 1948–2019), by contrasts for laws without such provisions the mean year was 1979 (median 1989, range 1895–2020). It was noted, that many countries used male pronouns throughout their legislation; an exploration of stigmatisation and other potential implications of this is outside the scope of this paper.

These 88 provisions were arranged into 10 themes (Table 1). Despite addressing common areas, there was significant variability in many of the themes. The nature of this variation is discussed below.

Specific themes

Fourteen jurisdictions require female representation or gender balance on mental health review tribunals, mental health boards, mental health authorities or bodies inspecting patient services. This is done most broadly by Ghana, which legislates for female representation at four different levels. However, many jurisdictions, for example Northwest Territories and Queensland require a gender balance, rather than simply female representation. No jurisdiction explicitly includes individuals who do not identify as having a binary gender, however New Zealand makes a provision for the inclusion of someone who is 'the same gender as the patient' on review tribunals.

Twelve jurisdictions offered general protections on the basis of gender. Some took a broad proactive approach, requiring gender-specific needs to be considered in any treatment plan (e.g. Fiji), by contrast others (e.g. The Philippines) simply prohibit discrimination on the basis of gender. South Australia requires clinicians to take gender identity into consideration and Scotland prohibits 'transsexualism' as being grounds for determining a mental illness. India prohibites discrimination on the basis of gender but also gave specific consideration to practical needs, this included legislation relating to the provision of sanitary products to in-patients. The general nature of many of the laws may prove hard to enforce but may also allow for helpful interpretations of the law to emerge.

Eight jurisdictions have protections for female patients during nursing care, searches or restraint. Fiji prohibits male staff members from 'attending on' a female patient unless a female staff member is present, Kiribati takes a more general approach requiring that the attending staff member must be the same gender as the patient. Three Australian jurisdictions deal with the searching of patients, requiring the searcher to be of the same gender. Tasmania addresses searches in the most detail giving consideration to gender-based provisions during different types of searches. Namibia, Eswatini and Botswana all have provisions preventing males from being involved in the restraint process of a female patient, however these all also describe exceptional circumstances where this can be set aside. Namibia provides the most oversight with a male staff member only being able to restrain a female patient under the supervision of a female staff member and with the approval of a superintendent. Botswana and Eswatini only require it to be an emergency situation.

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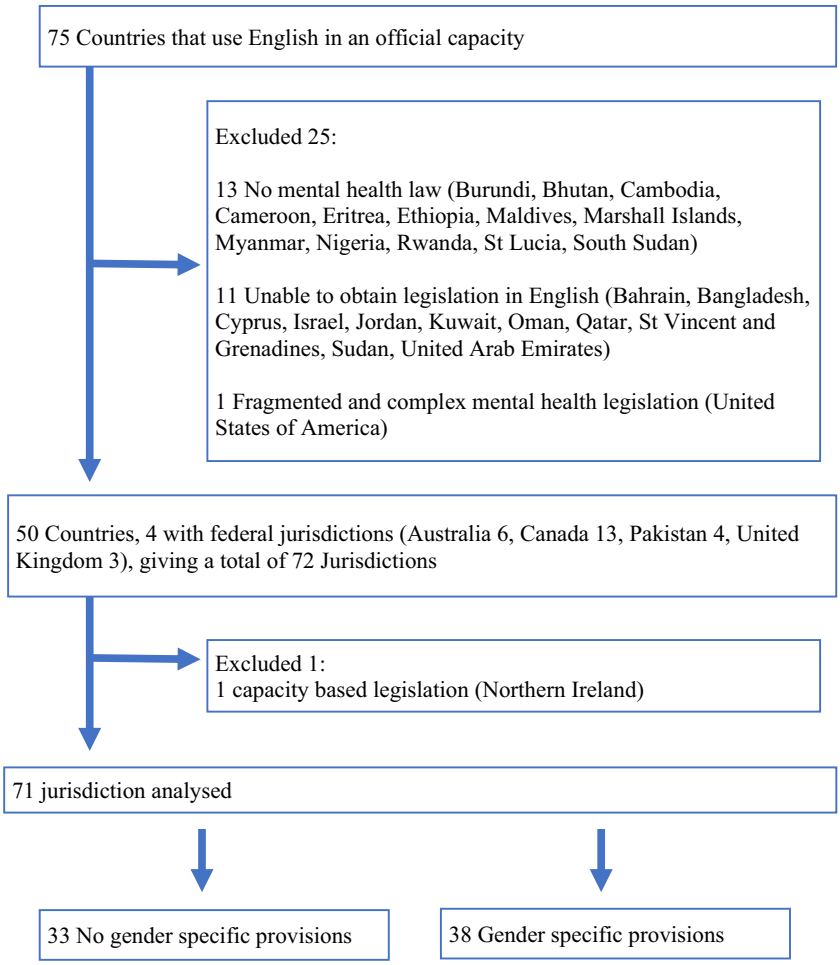

Figure 1. Jurisdiction and countries with English as an official language included in analysis of gender-specific provision in mental health law.

Seven jurisdictions make provision for male and female patients to be treated in separate environments. Khyber Pakhtunkhwa only necessitates the separation of men and women when they are receiving treatment for substance misuse. Some, like Ghana only segregate sleeping areas. Fiji requires separation of male and female patients in the acute phase but identifies that a more natural environment may be required to aid rehabilitation.

Seven jurisdictions provide protections concerning parenting, these are quite varied and relate to the local context. Scotland sets a very high standard by compelling teams admitting a postpartum woman to seek a bed in a Mother and Baby Unit, this would not be feasible in other jurisdictions. India and Fiji also attempt to limit the separation of a young child from their mother. In cases where the mother is admitted for mental healthcare in these two jurisdictions it is suggested that the child is admitted with the mother, if this is a safe course of action. Alberta, Manitoba, Jamaica, and England and Wales state that there is no preference given to one gender over another in establishing who the legal guardian of a child is. England and Wales also give additional protection and recognition to mothers who are not married. Jamaica provides a provision to mothers who are under 18, giving them the same rights as adults to make treatment decisions for their children.

Six jurisdictions, including four from Pakistan, have provisions that allow women not to appear in public for a review of their detention if this would violate their cultural norms.

Belize, Jamaica, Lesotho, Namibia, and the Solomon Islands have provisions that attempt to protect individuals from 'sexual exploitation'. Belize and Namibia prohibit sexual relations with detained female in-patients. Jamaica prevents a person who has sexually exploited a minor from being that child's guardian. The Solomon Islands and Lesotho prohibit staff from having sexual relations with female in-patients. Lesotho's 1964 legislation prohibits anyone from having sexual relations with a female with a 'mental illness', with the exclusion of their husband.

Three jurisdictions make gender-specific provisions in relation to reproductive health. Tasmania and Ghana prohibit the termination of a pregnancy on the grounds of mental illness. Zimbabwe, by contrast, has a provision (Section 110A) that allows for a 'parent, guardian, spouse or any other person capable in law of giving consent on behalf of a mentally disordered or intellectually handicapped female' to 'apply to the High Court for an order authorising her sterilisation'. For this to occur a medical practitioner must state that this is in her 'best interest'.

India and British Colombia both have provisions for advocacy in certain settings. Indian law requires female minors to have a family member or guardian present during admission. British Colombia requires females to have an advocate from the time that an involuntary admission is sought until a decision is made regarding admission.

The Philippines is the only country that legally requires routine mental health data to be collected disaggregated by sex (not gender).

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Table 1. Key gender-specific themes in mental health legislation and the jurisdiction they occur in

Theme	Jurisdiction
Female representation or quotas on mental health review tribunals, mental health boards and authorities	Australia (New South Wales), Australia (Queensland) Australia (Victoria), Canada (Northwest Territories), Canada (Yukon), Fiji, Ghana, Ireland, Malawi, Malaysa, New Zealand, Pakistan (Balochistan), Pakistan (Sindh), Uganda
Recognition of gender-specific needs, and protections against discrimination, including consideration of individuals who do not identify as having a binary gender	Australia (New South Wales), Australia (Queensland), Australia (South Australia), Australia (Tasmania), Australia (Victoria), Fiji, Ghana, India, Matla, Republic of the Philippines, United Kingdom (Scotland), Zambia
Protections for females during restraint or a bodily search	Australia (Queensland), Australia (Tasmania), Australia (Victoria), Botswana, Eswatini, Fiji, Kiribati, Namibia
Provision for separate sleeping facilities, living space or wards for men and women, or maximum ward capacity for males and females.	Belize, Fiji, Ghana, Kiribati, Namibia, Pakistan (Khyber Pakhtunkhwa), Papua New Guinea
Protection for mother in their parenting role who are receiving care.	Canada (Alberta), Canada (Manitoba), Fiji, India, Jamaica, United Kingdom (England and Wales), United Kingdom (Scotland)
Permitting women not to appear in court proceedings if public appearance is culturally inappropriate	Kenya, Malawi, Pakistan (Balochistan), Pakistan (Khyber Pakhtunkhwa), Pakistan (Punjab), Pakistan (Sindh)
Protections from sexual abuse and exploitation form staff, other patients or members of the public	Belize, Jamaica, Lesotho, Namibia, Solomon Islands
Gender-based consideration relating to fertility and contraception, sterilisation, or termination of pregnancy	Australia (Tasmania), Ghana, Zimbabwe
Female patients provides with female advocates, supports or female family members during assessment, admission or detention	Canada (British Columbia), India
Data collection considers gender	Republic of the Philippines

Discussion

General

Targeted mental health legislation addressing the specific healthcare needs of women is found in the majority of analysed jurisdictions. However, the content of these laws is highly varied and severely limited. These provisions fall short of the 'gender responsive' legislation described by Hawkes and Buse (2020). Such legislation would recognise and address the interactions between gender and mental health. Our study also identified areas where legislation had the potential to be actively harmful or stigmatising. The majority of these provisions were found within out dated legislation and require urgent revision. Despite significant differences in mental healthcare experiences across genders (Judd *et al.*, 2009), specific provisions to address this are often absent in mental health policy (McGuire *et al.*, 2020). This may be enhanced through greater consideration in legislation.

Individuals who do not identify with the gender assigned at birth have higher rates of mental illness (Bauer *et al.*, 2015; Lin *et al.*, 2021); legislation needs to give significantly more consideration to their specific needs. Currently, there is a failure to give any consideration to transgender, non-binary, or gender diverse individuals in the vast majority of legislation. Whilst gender-specific provisions enhance protections for women, the binary division and cisnormative approach to legislative drafting may actually exacerbate the vulnerabilities of individuals of other genders who are then excluded, either from the protections that they should be benefitting from or excluded entirely from the legislation if they don't fit into any category explicitly articulated. This further invisibilises already marginalised gender groupings, perhaps reducing their mental healthcare further than if the legislation was entirely gender neutral. For example, legislation relating to gender separation on wards may be harmful to transgender and non-binary individuals depending on how jurisdictions choose to determine gender (Kealy-Bateman *et al.*, 2019).

Specific themes

Female representation on mental health review tribunals, boards and authorities

Female representation on mental health bodies is essential. Global Health 50/50 (2022) highlights that gender equality remains a major issue at the highest levels in healthcare management. Herrman (2010) observed that gender-based professional barriers are present in psychiatry. Legislative measures, as described above, are practical steps that begin to address this. The aim of gender equality, rather than representation is preferable; and is required in jurisdictions like Queensland. With higher rates of mental illness seen in women (Seedat *et al.*, 2009) it is important that female representation on review and oversight bodies are not just the tokenistic inclusion of a single female but that these bodies are comprised of individuals who represent the relevant cohort. However, in areas where systemic inequality has resulted in lower levels of female doctors, such provisions could actually be counterproductive (Sood and Chadda, 2009).

There is a growing awareness of the aetiological role of trauma in mental illness and the need to minimise re-traumatisation in the delivery of services (Sweeney *et al.*, 2018). Women disproportionally suffer sexual trauma, coercion and control (Sardinha *et al.*, 2022). Consequently, it is essential that there is a diversity of perspectives and experiences on committees that design and deliver mental healthcare. In particular, mental health panels that review involuntary detention can be highly intimidating experiences (Smyth *et al.*, 2017). Jurisdictions, like New Zealand, that ensure female representation in such scenarios, may partly mitigate further traumatisation.

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Restraint and searching

The absence of consideration of gender in relation to searching and restraint is problematic for many of the reasons raised above. The paucity of legislation addressing physical searches is worrying, particularly in light of the need to deliver trauma informed care (Hosang and Bhui 2018; Oram *et al*., 2017). Many regions address this in policy, but incorporation into legislation could enhance protections.

Restraint continues to come under increased scrutiny. Females describe a different experience of restraint compared to males, including increase use of sedation (Strout, 2010). Maker (2020) discusses the need for gender informed legislative provisions in relation to restraint. The identified legal provisions are generally superficial and tend to relate to searching and restraint being performed by members of the same gender, as is the case in Kiribati. The provisions in Queensland's legislation are an improvement on this but still falls short of addressing the difficulties raised by Strout (2010). More detailed provisions could be included, for example mandatory training in trauma informed care and compulsory debriefing.

Separation of genders

The separation of genders during mental healthcare is an example of where a blunt tool like legislation may not serve a population well. Fiji have tried to address this in their legislation with a more detailed description of the context in which genders are separated and where they can mix freely. Gender separation on wards may provide individuals with an environment in which they feel safer, however it may also deprive individuals of appropriate treatment. This is especially true for highly specialised care, for example in-patient eating disorder units or forensic mental healthcare. Single gender mental health wards can present challenges for individuals whose gender identity differs from their biological sex (Kealy-Bateman *et al*., 2019).

In the UK, a same gender accommodation policy has been adopted across the health service (Department of Health 2011), this is seen as necessary to protect patients' dignity and privacy, however this is not a universally accepted perspective. Morton *et al*. (2022) suggest that separation simply by gender is overly simplistic and that individualised care, that considers intersectional vulnerabilities, would be more helpful for patients. Such flexibility may also address the needs of individuals whose gender identity differs from their biological sex.

Family

Only two jurisdictions (India and Scotland) provide protections to prevent the separation of mothers and children during admissions. This is important in light of the high rates of in-patient care required in the postnatal period (Munk-Olsen *et al*., 2016). Scholes *et al*. (2021) highlighted that women admitted to in-patient units have expressed a strong desire to maintain parenting roles, therefore it is vitally important, even in settings where mother and baby units are not available, that provisions are put in place to facilitate this when appropriate.

Some other jurisdictions, like Jamaica, have legislation that ensure both parents are equal in making decisions relating to a minor, rather than give one gender preference over another. This provision may empower women in highly patriarchal societies or in situations where there is significant stigma relating to mental illness. However, it may also allow estranged or abusive partners to continue to exercise coercion and control. Explicitly laying out the intention for these provisions may reduce the potential for their abuse.

Cultural provision

The importance of cultural and religious factors in healthcare is often poorly addressed (Attum *et al*. 2024). The only gender-specific cultural provisions described in mental health law prevent women from having to appear before a court. The majority of these (4/6) occur in Pakistan. Niaz (2004) describes the 'dehumanizing attitudes towards women' and the challenges in relation to mental healthcare in Pakistan. Consequently, it is important that protections of cultural norms do not deprive women of a review process. An alternative solution, for example an all-female court setting, may adhere to the cultural norms while not preventing a review process.

Protections from sexual abuse

Countries that have included gender-specific protections from sexual abuse in the context of an episode of mental illness, often introduce patriarchal and desexualising provisions for women. For example, Belize's legislation is problematic in a number of ways. Section 59(a) assumes that the taking of 'any indecent liberty' is perpetrated by males and impacts females; the legislation does not envisage females breaching this legislation. It is also hetero-normative and does not provide protections for an individual experiencing sexual violence perpetrated by an individual who is the same gender as them. Sections 58 and 59 assume that individuals admitted to a mental health facility lack the capacity to consent to sexual activity. Section 58 criminalises such activity on the basis of an individual being of 'unsound mind' rather than them being unable to provide informed consent. This uses mental illness to deprive someone of their rights of sexual and bodily autonomy.

It is important that persons with mental health disorders are protected from sexual assault or exploitation, however an individual's capacity to consent to sex should not be linked to their status as a detained patient. Gender-specific provisions in this area desexualises females, excludes males from legal protections and may not provide the same protections to people who assaulted or exploited by an individual of the same gender. It is also vital that the inclusion of protections within mental health legislation does not detract from similar protections in criminal law.

Punjab (Pakistan) has avoided many of these pitfalls in its legislation. It has included protections from sexual abuse without making the legislation gender specific and without criminalising sexual activity for individuals with mental illness.

Reproductive rights

Only three jurisdictions directly protect the reproductive rights of women with mental illness. However, many other jurisdictions (e.g. the Bahamas and India) have opted to do this in a general, rather than gender specific, manner. The majority of jurisdictions however, have no protections at all. While this may be covered in other legislation, such an omission may well be premature in light of how extensively this occurred historically (Amy and Rowlands, 2018). While the vast majority of countries have removed formal barriers to having a family for women with mental illness many societal and cultural barriers persist (Ozcan *et al*., 2014). The Zimbabwean legislation is a significant outlier in that it makes provisions for the sterilisation of women with major mental disorders.

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Women with mental illness have higher rates of recurrent miscarriages, terminations of pregnancy, and have higher rates of emergency contraception use (Hope *et al.*, 2022), these point to the indirect limitations of the reproductive rights for women with mental illness.

Advocacy

The provision of advocacy on the basis of gender as it occurs in India and British Colombia may be counterproductive. The contexts where enhanced advocacy is required for females, are particularly vulnerable times for *any* individuals. Consequently, such gender-specific legislation in these contexts may actually deprive other vulnerable individuals of the supports that they need. In the absence of local considerations that necessitate a gender-specific response, legislation should provide for all individuals in such situations. It is important that gender-specific legislation addresses matters that are gender specific.

Data

The Philippines is the only jurisdiction with a legal requirement for gender disaggregated data on mental health. The WHO's sustainable development goals (target 17.18) highlight the need for gender disaggregated data in healthcare. While, Manandhar *et al.* (2018) acknowledge the limitations of this, it is a key step in addressing inequalities in mental healthcare caused or exacerbated by gender. It is important that gender disaggregated data is not collected in a cisnormative framework, this is not addressed in the legislation.

Strengths and limitations

Strengths

This is the only study of its kind that was identified. The range of analysed legislation was a particular strength, jurisdictions were included from six continents, with highly diverse cultures and varied financial resources; modern and long-standing mental health laws were included.

Limitations

This study was an analysis of the text of the primary mental health legislation, no consideration was given to implementation, other laws relating to mental healthcare, or policy. Jurisdictions could have comprehensive policies addressing the mental health needs of women and/or individuals of other marginalised genders; however, these were outside the scope of this study. There may also be legislation outside of mental health law that adequately addresses a given topic. For example, sexual abuse and exploitation may be more appropriately addressed in criminal law.

In addition to the content of the legislation, the application of legislation may be highly variable, this was not explored in the study. In practice, the most important outcome is the realisation of the law (Sen, 2009) rather than its content.

This paper did not examine the broader implications of cisnormative legislation, instead focusing on specific provisions.

Conclusions

Individuals of different genders have different experiences of mental healthcare in terms of access to services, stigma and treatments provided. Despite this, gender gets limited consideration in mental health law. Fiji, Ghana, India and the Australian jurisdictions are notable for including multiple gender-specific elements in their mental health legislation. However, even in these jurisdictions provisions are limited and highly variable. Overall, from the 71 analysed jurisdictions, we identified ten key themes that could be included in gender responsive legislation. Many of these themes can enhance female experiences of mental healthcare if incorporated appropriately into legislation. The provisions identified in this paper could alternatively be addressed in policy rather than legislation, this may allow them to be applied with a degree of flexibility that may better meet the needs of individuals.

Despite the identified potential protections of gender responsive legislation, there can also be unintended negative consequences. For example, attempts to prevent sexual exploitation may either limit the rights of women with mental health problems or divert attention away from the sexual exploitation of other groups. Some countries, for example Zimbabwe, have retained outdated paternalistic legislation which is urgently in need of revision.

Across the board, there are very limited provisions addressing or including transgender, non-binary or individuals of other marginalised genders. These need to be directly addressed and improved as there are specific and increased mental health needs seen in these populations.

Countries currently in the process of revising their mental health legislation should examine the identified topics and consider incorporating items that address gender-specific needs. Legislation remains a powerful but underutilised tool to address the interaction between gender and mental illness.

Supplementary material. The supplementary material for this article can be found at https://doi.org/10.1017/ipm.2024.48.

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Competing interests. The authors declare none.

Ethical standard. The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008. This study used open access data and as such was exempt from ethical committee review.

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