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# Psychiatric services for women

Dora Kohen

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*This paper continues the series of contributions to APT concerning gender and mental health (Bartlett & Hassell, 2001; Cremona & Etchegoyen, 2001; Kennedy, 2001; Kohen, 2001; Kohen & Arnold, 2001; Ramsay et al, 2001).*

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The need for specific psychiatric services for women has been debated by many practitioners involved in care delivery and management of women with differing degrees of mental health problems.

Many authors believe that women, who represent 52% of the population, should not be classified as 'special' but should be regarded as mainstream. Their mental health needs, assessment, treatment and service requirements should receive a mainstream approach. Trying to designate special units and different treatments may lead to 'segregation by specialisation'. This may further lead to evidence that women's mental health problems are distinctive and require speciality expertise. Setting women's mental health apart may result in the mistaken belief that clinicians do not need to know about it and should leave everything to the specialist (Satel, 1998).

The response to this argument is that most of women's needs are accepted to be mainstream by the majority of practitioners. However, there is evidence that those needs have been neglected. Many issues have not received the attention they deserve, for example: mental illness in pregnancy, motherhood and pre- and postnatal care; comorbidity; care and custody of children whose mothers have mental illness; trauma; domestic violence; child sex abuse; vulnerability; stigma and victimisation; and differences in presentation of some mental health disorders.

It is clear that there is a need for a gender-sensitive understanding in all generic psychiatric services. Nevertheless, mental health issues that arise from

the social (Holmshaw & Hillier, 2000), psychological (Haw, 2000) and physiological differences (Scott, 2000) between the genders need to be addressed specifically.

Gender-focused management is still a new concept and it has not yet entered into wide practice. Proponents of women's issues stress that women have been underrepresented in the decision-making process and in medical and clinical research.

Data on the epidemiology of mental health issues, general and specific needs and the present state of generic services will help to establish future philosophy and policies on generic and specific services.

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## Epidemiology

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There are established gender differences in the frequency, clinical expression and outcome of psychiatric disorders in women. Women have higher prevalence of depression, dysthymia, seasonal affective disorder, generalised anxiety disorders, panic attacks, phobias and deliberate self-harm (Meltzer *et al*, 1995). Women show differences in the social concomitants, relapse and outcome of schizophrenia. Perinatal psychiatry is exclusive to women, and women comprise the majority of cases with eating disorders.

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## Depression

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The lifetime prevalence of major depression in women is almost twice that in men. According to some studies, depression affects over 20% of the female population (Kessler *et al*, 1994). Prevalence rates of the mild but chronic forms of depression

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Dora Kohen is a consultant psychiatrist in London with a special interest in women and mental health. She works on service delivery for women with severe mental illness and the management of women with psychosis. Correspondence: 31 Derwent Avenue, Mill Hill, London NW7 3DY.

and dysthymia are considered to be higher in women, although it is accepted that studies on mild depression and dysthymia are difficult to interpret because of differences in definition and problems of reliability. The presence of certain mood abnormalities such as premenstrual dysphoric disorder may contribute to the higher prevalence of depression.

### **Generalised anxiety disorder**

Generalised anxiety disorder is more prevalent in women, and the risk of panic disorders is three times more common in women (Bourdan *et al*, 1988). Women are also more likely to experience post-traumatic stress disorder (Robins *et al*, 1984).

### **Deliberate self-harm**

Deliberate self-harm (DSH), which is an index of social deprivation, is closely linked with unemployment, overcrowding, substance misuse, physical and sexual abuse during childhood and domestic violence. There is a higher prevalence of DSH in women of all ages. The proportion of women in need of hospitalisation for DSH is on the increase (Hawton *et al*, 1997).

### **Perinatal psychiatric disorders**

Post-partum psychosis and pre- and postnatal depression are a class on their own because of their gender specificity. The prevalence of post-partum psychosis is about 0.2% and that of postnatal depression 10–15% (Kendell *et al*, 1987).

### **Women and forensic psychiatry**

There are about 3000 women in prison in the UK, half of whom warrant a psychiatric diagnosis (Maden, 1996). It is rewarding to see that the different needs of women with psychiatric diagnoses in the criminal justice system are well recognised by the special hospitals and secure units, which either have or are in the process of establishing specialist women's units.

### **Eating disorders**

These syndromes, predominantly seen in women, show a male-to-female ratio of 1:10. In Britain the incidence of anorexia nervosa is 7 per 100 000 population, which may mean 4000 new cases per year (Turnbull *et al*, 1996). Of individuals suffering

from bulimia nervosa, 90% are female, and the incidence in young women is 52 per 100 000 (Turnbull *et al*, 1996). Binge eating disorders have a female-to-male ratio of about 3:2 (Levine & Marcus, 1998).

### **Drug and alcohol dependence in women**

Although it is accepted that women are less likely than men to misuse alcohol and illicit drugs, recent studies suggest that this gap is closing. The male-to-female ratio of alcohol dependence in the Epidemiologic Catchment Area (ECA) study (Helzer *et al*, 1991) was 5.2:1, compared to 3:1 in the National Comorbidity Survey (Anthony *et al*, 1994).

The British Household Survey (Thomas *et al*, 1998) indicates that there has been a gradual increase in alcohol consumption by British women and that the proportion of women drinking over 14 units per week had increased to 14% in 1996.

The Psychiatric Morbidity Survey (Meltzer *et al*, 1995) shows that men have a higher prevalence of drug dependence (3%) than women (1.5%).

### **Severe mental illness**

Diagnoses such as schizophrenia, psychosis and bipolar affective disorder ('severe mental illness') do not show major differences in incidence or prevalence between the sexes, but there are specific demographic, clinical and outcome differences that need special attention.

Schizophrenia appears at younger age in men (Murray, 1994) and perinatal insults to the central nervous system appear to affect more men than women (O'Callaghan *et al*, 1992).

Premorbid behavioural problems that have strong predictive value are found more predominantly in males (Foerster *et al*, 1991).

Women with schizophrenia have better premorbid, sexual and social competence (McGlashan & Bardenstein, 1990). The course of schizophrenia in women tends to be more benign and remitting, with a more favourable social adjustment (Flor-Henry, 1990).

It is a well-known fact that admission variables are different for women and men. Women have lower levels of rehospitalisation and shorter length of stay (Angermeyer *et al*, 1990).

Difficulties in social and interpersonal interaction, which are associated with higher relapse rates, show a marked difference. Women show lower rates of sensitivity to and lower responses to expressed emotion (Vaughn *et al*, 1984) but higher risk for suicide (Mortensen & Juel, 1993).

## Specific needs

A gender-sensitive approach to the psychiatric needs of women that explores issues such as motherhood, parenting, sexual and physical abuse, social support, physical well-being, side-effects of psychotropic treatment and personal and professional relationships has shown to be successful in addressing the unmet needs of female patients (Seeman & Cohen, 1998; Ramsay *et al*, 2001).

Women with mental illness exhibit fewer behavioural disorders and much less aggression towards others than do men. There is a general understanding that women seem to be more appreciative of social support and may make better use of psychological input.

The needs for safety, privacy and dignity of female patients in mental health units have been recognised, and there are established guidelines on mixed-gender acute psychiatric wards (NHS Executive, 2000). There is a growing need to address issues around pregnancy, motherhood and social, personal and practical perinatal needs. (Kohen, 2000). Psychopharmacological issues including the side-effects of psychotropic medication, possibly increased risk of tardive dyskinesia, fertility problems and high prolactin levels should be openly discussed.

It is well accepted that all generic services should respond to safety and privacy needs. But specialist services such as perinatal psychiatric services and mother-and-baby units (MBUs), drug and alcohol, forensic psychiatry and eating disorder services should be established to meet specific clinical, treatment and rehabilitation needs (Boxes 1 and 2).

## Psychiatric services for women in 2001

The National Services Framework for Mental Health (Department of Health, 1999) has laid the foundation for trusts to establish gender-designated facilities in all NHS services. Its main objective has been the protection of privacy and dignity and the establishment of a more therapeutic and gender-sensitive environment. This has been a major impetus for many community and acute hospital trusts to start to look at how they can improve their services.

Although financial constraints in many parts of the UK may lead to ineffective and cosmetic changes in some acute psychiatric wards, it has to be admitted that real changes are taking place. Various

### Box 1 Meeting the needs of women patients in generic acute psychiatric services

**The ward environment should provide safety, privacy and dignity for women**  
**Professionals should be trained to have a female-sensitive approach, attitude and management policy**  
**Priority should be given to the mental health needs of pregnant women and mothers**  
**All mental health professionals should recognise that the needs of male and female patients may be different**

models have been established to respond to local needs of the female population with severe mental illness.

## Admission facilities

There are a number of single-gender acute psychiatric wards for women with severe mental illness (Kohen, 1999*a,b*). In such centres motherhood takes priority in the assessment of the needs and management of the patient. The main problems arise when there is no community service attached to the women's unit. In such cases, it is the duty of the in-patient team to prompt the mental health management to acknowledge the need for a community mental health team (CMHT), which would contribute to the in-patient work.

Superficial links with busy local catchment area CMHTs could be frustrating for both the patients and the professionals and could lead to fragmentation of services and unstructured communication.

A model in which women's wards and community services are closely linked provides a seamless service and continuity of care. Clearly established links encourage earlier discharge and more effective use of acute beds. Furthermore, the CMHT gains expertise on women and mental health.

There are also short-term community facilities that admit as a crisis response and provide a safe alternative to hospital admission for women with severe mental illness (Killaspy *et al*, 2000).

Hostels admitting women with severe and enduring mental illness are well established and are perhaps the best recognised and most widely distributed facilities of their kind. Although most of them may not fit the criteria for residential care alternative to hospital treatment, there is now steady progress towards community treatment of acute mental illness and women-only community

placements are becoming more common (Fenton *et al.*, 1998).

Day hospital facilities with a priority for women with personality disorders and offering cognitive-behavioural approaches have reduced admissions to acute psychiatric beds. Community day units attached to CMHTs with a strong psychology input have been successful in serving women with personality disorder.

### ***Mother-and-baby units***

The UK has a large number of mother-and-baby units (MBUs). Unfortunately, inappropriate admissions to MBUs and problems in establishing guidelines have led to difficulties in both admissions and discharges. This has resulted in underusage and untenable vacancies, which in turn have led to bed closures (Royal College of Psychiatrists, 1992).

In-patient MBUs are either with or without community, domiciliary or specific out-patient services linked to them. It is clear that units that have a community service link and can follow women in their homes will be more successful than those that consist simply of acute psychiatric beds and cots for the babies.

### ***Community services***

Community services with specific female-sensitive agendas are on the increase. There are many local statutory and voluntary organisations trying to meet the needs of women with mental health problems. These range from informal voluntary support groups to fully staffed community mental health groups with specific briefs and training. Some services are provided by CMHTs as part of their local commitment.

#### **Box 2 Women in specialist psychiatric services**

##### ***'Women-only' requirements***

**Mother-and-baby services in a perinatal psychiatric unit**

***General services that should respond to the specific needs of female patients***

**Eating disorder services**

**Forensic psychiatric services**

**Drug and alcohol units**

**Personality disorder services**

## **Innovative psychiatric services for women in the 21st century**

### ***Philosophy***

It is important that the philosophy of caring for women with mental health problems is well established. It is also important that all members of the local unit, ranging from senior management to the mental health workers delivering the services, are clear about the objectives of this service.

Psychiatric services for women will be successful if there is agreement that they are a way forward to improve quality of life and decrease suffering. Well-funded, accessible, multi-agency, integrated, tiered local services with access to specialist services should be our goal.

### ***Recognition of local needs***

Recognition of the specific needs of the local community will lead to a better understanding of the services required. National surveys, publications of the Office of National Statistics, demographic variables about the area, general practice statistics and information from local hospitals and accident and emergency departments offer invaluable data on the specific needs of a locality.

Comparison of admission and readmission rates in different areas with the index district will also help build up a picture of the psychiatric needs of women.

Areas with a greater ethnic minority population, high deprivation indices, many single parents, large families and homelessness should be identified. Those areas will have a population with increased social, psychological, economic and personal problems. The characteristics and religion of the ethnic minorities will also help to shape a specific service to meet the needs.

The number of births per year can be an important index in the establishment of perinatal psychiatric services. Antenatal obstetric services could be a useful source of information on the number of women who have depression or psychosis. Since many cases of post-partum psychosis and post-partum depression show their first clinical signs while the women are in obstetric clinics, close links with these clinics may help to clarify the local needs.

Domestic violence figures from the police, although an underrepresentation, may give insight into the number of women who will need services. Identification of the number of women readmitted



**Box 3 Factors to consider in planning psychiatric services for women**

**Demographic variables, including birth rates, single parenthood and ethnic distribution**  
**Deprivation indices of the area**  
**Statistical information on deliberate self-harm, domestic violence and sexual abuse**

to psychiatric services will give insight into the need for rehabilitation services as well (Box 3).

A clear description of the voluntary and statutory organisations and their accessibility should be taken into account in planning services.

Primary care groups and trusts should take part in the planning and implementation of mental health services. Child and family social services, voluntary groups and representatives of ethnic minority groups should be involved in the wider discussion.

Psychiatric services for women will fulfil their role if integration between voluntary and statutory agencies were to take place.

## **Community provisions**

### **Community psychiatry for women**

The first step is to set up a community psychiatric group within a larger community psychiatric team, which will accept referrals for keyworking with women with perinatal psychiatric problems, schizophrenia in pregnancy and mothers with severe mental illness. This group will liaise with the consultant in adult psychiatry in the index locality. The group will be able to audit the work of the first 2 years, studying unmet needs and relationships with patients and professionals, and to contribute to future planning of the most effective services.

It will also be able to answer many of the questions about pregnancy, breast feeding, drug and alcohol misuse and motherhood that arise in the treatment of women with mental health problems. It will generate information and contribute to teaching on treatment and management.

This group will liaise with services for women with mental health problems, such as DSH prevention groups, motherhood and mental illness groups, learning disability teams and eating disorders units. It will also have close links with ethnic minority women's organisations and with local branches of national organisations such as NEWPIN, MIND, the Association for Postnatal Illness and the National Childbirth Trust.

Family centres that offer daily assessment of the parenting skills of mothers with severe mental health problems can be a good alternative to other mental health facilities.

Women with long-term severe mental illness have rehabilitation needs that differ from those of male patients. Mixed-gender rehabilitation teams may not been very attractive to women, who may be shy and unwilling to participate. However, there are occupational therapy indicating reports that when the choice of specific groups with female-designated tasks are offered, vulnerable women perform well.

## **Summary**

Both women and men deserve the best of services. The discussion of services for women is intended to draw attention to the specific needs and the physiological, psychological and social concomitants of mental illness in women. Once these needs are recognised and management plans are set, services will be provided not just by a small group of specialists but by all involved in mainstream and generic psychiatry.

The next step now should be to conduct wider discussions highlighting women's distinctive needs and raising awareness of them within the profession. Increased awareness usually leads to increased detection, which in turn leads to increased demands for different specific services. Provided that the discussion on demands and services has been wide enough to include professionals at every level, there will be sufficient expertise to respond and to contribute to the planning of services.

Dealing with mental health issues specific to women will require trained professionals and more research on the subject. Adequate research, informing local expertise, will yield the best patient satisfaction.

It is hoped that the emerging evidence on gender and physiological, social and psychological aspects of mental health will lead to the establishment of academic departments of women's mental health.

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## Multiple choice questions

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- Mixed-gender acute psychiatric wards:
  - can be doubly demanding and stressful for female patients
  - can increase the vulnerability of women under heavy sedation with neuroleptic medication
  - can increase the risk of aggression, sexual and physical abuse towards female patients
  - are not as effective as single-gender wards in offering privacy and a drug-free environment
  - can be made more therapeutic by improving design and having private facilities, single-gender sleeping areas and common day areas.
- Studies show that:
  - increased frequency of some mental health problems in women is an artefact
  - possible increased frequency of mental health problems in women may be fully explained by the biological concomitants of mental illness
  - perinatal psychiatry is the only diagnosis in women that needs special attention
  - lifetime prevalence of depression in women is almost twice that in men
  - the gap in prevalence of DSH between men and women is closing.

3. Evidence shows that:
- a specialised psychiatric services for women will lead to segregation of services
  - b mainstream psychiatric services have been dealing with gender and mental health issues successfully
  - c specialised psychiatric services for women may discourage mainstream psychiatrists from treating any women at all
  - d informed discussion on women's mental health issues will lead to raised awareness, better understanding and more successful management
  - e a gender-sensitive approach will explore the unmet needs of women more successfully.
4. Research into services shows that:
- a the philosophy of psychiatric services for women should be understood and local needs widely discussed before new services for women are set up
  - b the support and expertise of regional specialist services (e.g. for eating disorders, DSH, learning disability) should be utilised in setting up services for women
  - c the voluntary sector does not have valuable input into community services
  - d local needs are secondary in the planning of gender-specific services
  - e deprivation indices in a local area may be a predictor of unmet needs.

## MCQ answers

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>a T</b>	<b>a F</b>	<b>a F</b>	<b>a T</b>
<b>b T</b>	<b>b F</b>	<b>b F</b>	<b>b T</b>
<b>c T</b>	<b>c F</b>	<b>c F</b>	<b>c F</b>
<b>d T</b>	<b>d T</b>	<b>d T</b>	<b>d F</b>
<b>e T</b>	<b>e T</b>	<b>e T</b>	<b>e T</b>



## Mental Health Outcome Measures

### Second Edition

Edited by Michele Tansella and Graham Thornicroft

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