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Issues for Women in the Development of Mental Health Services

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> "Except as occasional consultants, the less men doctors have to do with female lunatics the better". (Lowe, 1883)
>
> "As long as women are over-represented among mental patients and family caretakers and under-represented among psychiatrists, administrators and politicians, their lives will continue to be unhappily affected by decisions in which they take no part". (Showalter, 1987)

As in other health authorities, we have been involved over the last few years in developing plans for psychiatric services – driven particularly by the need to find alternatives to long-term institutional care, and also, in Camberwell, by the intended integration of two neighbouring 'providers of mental health care'. Many meetings were held and papers written on the services for in-patients, out-patients, day patients, children, the elderly and so forth, the basic required approach being to test the provision against various principles of good practice. However, none of this generated any attention to the specific needs of women. How could this be remedied?

In this paper I decribe our first attempts to establish principles for good mental health services of relevance to women, and to consider them in relation to the current local services, using a woman's life-cycle approach.

Developing principles

Women's views can be sought and brought into the planning process from a variety of levels, as in the examples below.

(a) Historical overview

The two classic, avowedly feminist, texts in this field are Phyllis Chesler's *Women and Madness* (1972) and Elaine Showalter's *Women, Madness and English Culture, 1830–1980* (1987) both of which consider the 'equivalence' of madness and femininity, adducing many examples of this process at work, and describe fashions in the presentation of women's symptoms and in the (usually) male medical response. Both conclude that women must have power within the institutions and speak for themselves rather than be spoken for.

(b) National and 'expert'

A report from the Women's National Commission (1988), *Stress and Addiction among Women*, particularly recommended:

(i) more training on stress management and improving working conditions to reduce stress on employees, including parents with young children

(ii) district health authorities and social services departments should support and help to fund administration of voluntary groups which are contributing positively to the prevention of stress among women and to education in handling stress, including parent support groups

(iii) in undergraduate and postgraduate medical education, attention should be brought to the reality of the stress caused by pre-menstrual tension and post-natal depression and to the need for early recognition of symptoms and prompt application of effective treatment

(iv) counselling should always be available for those under stress of bereavement, including losses such as miscarriage and stillbirth; pre- and post-operative counselling should be available for those undergoing hysterectomy, mastectomy and abortion

(v) the role of health visitors and school nurses should be recognised and supported.

Ashurst & Hall (1989), consultant psychotherapists drawing upon their experience "as women, wives, mothers and doctors", suggest, "The way to help a woman with physical or mental symptoms due to emotional causes is by understanding her predicament in terms of her image of herself as a woman, particularly in terms of her reproductive function, and by tracing her story back to the key events that precipitated her distress".

(c) Local service professionals

Using the equal-opportunities policy of the health authority as a way of looking at existing services has, in Camberwell, begun to raise issues concerning women through the mechanism of an "equal opportunities implementation group" and two quality circles to address women's issues and black and ethnic issues. So far the women's issues quality circle has emphasised the need for:

(i) liaison between psychiatry and obstetrics/gynaecology
(ii) availability of female staff for women patients
(iii) better access for push-chairs and wheelchairs
(iv) the development of specialised services
(v) better information about resources
(vi) attention to safety issues for women staff
(vii) more women in senior staff positions.

(d) Local service users

A group set up to consult with women users of in-patient services revealed concerns about:

(i) violence and sexual harassment on the wards
(ii) not enough private washing and bathing facilities for female patients
(iii) general lack of privacy for women
(iv) the need for a mixed staff group.

(e) Local outside forum

Other ideas have emerged through the recent development of an interested local group in Camberwell, the Southwark Women and Mental Health Forum:

(i) childcare for users and visitors
(ii) 'women-only' space
(iii) access to women staff
(iv) access to community languages
(v) training for staff in issues concerning child sexual abuse, sexual abuse and equal opportunities
(vi) low-cost counselling
(vii) befriending, advocacy
(viii) consumer involvement.

Services through the life-cycle

Childhood

Services involved with children's mental health are not confined to child psychiatry, but include the general and specialist aspects of education, social services work, primary health care and paediatrics. For an inner-city area the deprivation factors for children are known to be high and are reflected in the high numbers of children on the child protection register, the high infant mortality rate (Camberwell Health District Department of Public Health, 1989) and the high rate of childhood disturbance (Rutter *et al*, 1975).

Within this high level of need, girls have not usually been considered separately, although there is evidence of differential provision of service. Annual reports show that the local child psychiatric services tend to see more boys than girls (ratio of about 2:1), with a slightly decreased ratio for the hospital clinics in comparison with the community clinics. These rates have been very consistent over the years, despite considerable alterations in some referral patterns, and despite the increased awareness of child sexual abuse, which might have been expected markedly to increase referrals of girls. However, the proportion of girls was higher when a child psychiatric session was provided within a primary health care setting and from links made with the voluntary agency Victim Support, so there might be a value in developing and circulating information about specialised services for girls.

Child psychiatric assessments for special education are requested less commonly for girls (Subotsky, 1990) and the special education facilities available for emotionally and behaviourally disturbed children are so predominantly occupied by boys that the environment is unsuitable for girls. The major reasons for this sex difference are evidently to do with 'troublesomeness' rather than other criteria for disturbance or distress, and reading difficulties are often associated, which are less common in girls.

An improved information system would enable systematic evaluation of the use of resources for girls – is more, or less psychotherapy provided, are outcomes different?

Adolescence

Both adult and child psychiatry services are involved with two particular types of serious problems of adolescence where young women present more often than young men – eating disorders and self-harm. Anorexia nervosa is a life-threatening disorder, for which considerable and expert intervention is necessary; fortunately it is well recognised and the appropriate expertise and back-up of in-patient beds are usually readily available.

Self-harm, or parasuicide, presents through the hospital accident and emergency department and both the adult and children's psychiatric services are able to respond readily, being based within the hospital and having well organised systems of multi-disciplinary response. Methods of intervention need

continued development, as the risk of further self-harm and/or depression is clear, but the failure rate for follow-up is high. It is now thought that sexual abuse may be an important predisposing factor in both self-harm and anorexia nervosa. It is therefore important for all staff to receive adequate training in order to be able to elicit this type of history and intervene appropriately.

Menstruation and fertility

Psychological problems surrounding menstruation, especially pre-menstrual tension, are largely dealt with by general practitioners, with only occasional referral to specialists, whether gynaecologists or psychiatrists. However, effective treatment is not yet standardised (Gath & Iles, 1988) and there has been little formal trial of psychological treatment, a situation compounded by definition problems.

Camberwell has a higher fertility rate, abortion rate and birth rate than the regional and national averages, suggesting that although there are family-planning services these are not effectively reaching girls and women; this might well be one of the key preventive areas for women's mental health. Infertility can also be a source of major stress, and the development of 'high-tech' methods of investigation and treatment, especially when unsuccessful, could be expected to add to this.

Sexual relationships, marriage and separation

Women's experiences of difficulties with their sexual relationships range from communication problems to severe physical and sexual abuse, which increase their vulnerability to psychiatric disorder (Mullen *et al*, 1988). Facilities for these sorts of problems include voluntary agencies such as Relate, Victim Support, Women's Refuges, and psychosexual and marital therapy in the hospitals. However, liaison with the mainstream psychiatric services could be improved, and further specific services for treating the aftermath of abuse are needed.

Pregnancy and its loss

Counselling is generally available in association with termination, especially for younger women through teenage pregnancy clinics, and there are well developed multidisciplinary psychological and psychiatric liaison services to obstetrics and gynaecology. Nevertheless, clinical experience indicates that single and repeated losses through termination, miscarriage or stillbirth may have effects on a woman's emotional adjustment over many years, and the development of policies of good practice such as suggested by Savage (1988) for the management of perinatal death could be useful. Support groups such as the Miscarriage Association and the Stillbirth & Neonatal Death Association are valuable, but are they accessible to the ordinary local population?

Child-birth and post-partum

'Baby blues' are well known to midwives, health visitors and district nurses, who effectively deal with most early problems of motherhood and should have good liaison and training links with the more specialised services. Severe post-natal mental illness occurs in about 1 in 600 pregnancies and needs urgent and intensive intervention; fortunately there are specialist services available, with in-patient back-up, but extra community nursing support would enable more women to stay safely in their own homes while ill (Oates, 1988).

Motherhood

Women's experience of psychological distress as mothers, especially of young or handicapped children, is likely to be recognised particularly by the primary health care, paediatric and child psychiatry services. The importance of this is underlined by Brown & Harris' major study *Social Origins of Depression* (1978) which was carried out in inner London and revealed four major factors leading to "the provocation and generalisation of hopelessness":

(a) the loss of the mother to a child under 11 years
(b) lack of an intimate confiding marital relationship
(c) lack of paid employment outside the home
(d) three or more children under 14 years.

It has been estimated that depression in mothers of young children in the inner city may be as high as 30–40% (Wolkind, 1985) and this can have an impact on the children (Pound *et al*, 1988), leading to a vicious circle of family stress. Single parenthood is very common in inner cities. Developing and supporting voluntary services and self-help groups may be one of the most effective interventions from the health service, and there are a number of useful agencies, including the Family Service Unit, the Family Welfare Association, Welcare and Newpin.

Middle age and the doctors

Body and mind connections surround much hospital involvement of women in their middle life, even though classic 'hysterical' symptoms are now rare. For instance, a gynaecologist comments "the greatest challenge to the clinician is establishing whether psychological disturbances are due to oestrogen

deficiency or result from coincidental but concurrent socio-domestic-economic crises'' (Whitehead, 1983); hysterectomy is ''not likely to lead to adverse psychiatric sequelae in patients who are psychiatrically healthy before the operation'' (Osborn & Gath, 1983), while on the other hand mastectomy ''is predictive of a depressive state'' (Deadman *et al*, 1989). Obviously, much will depend on the meanings and values ascribed to the menopause, hysterectomy and mastectomy by individual women, as well as the resultant alterations of physical state. Perhaps just as male 'shell-shock' provided a model of psychologically caused disturbance to legitimise female 'hysteria' (Showalter, 1987), so will 'post-traumatic stress disorder', another special diagnosis for male soldiers, promote the acknowledgement of severe perceived stress in women's lives as causal in their distress/disturbance and encourage the further development of effective treatment. Meanwhile, most hospitals do have mastectomy counsellors, with active psychiatric services to obstetrics and gynaecology departments, and there is research into many aspects of psychosomatic disorder. The hospital social workers also provide a crucial contribution to the relief of emotional, social and family stress.

Women and the general psychiatric service

Women frequently consult general practitioners for psychological problems and, at least in the past, were quite likely to be prescribed minor tranquillisers with the risk of later dependency. A greater use of non-medical counselling as well as of specialist resources in primary health care rather than hospital out-patient departments would have the advantages of accessibility, less stigma for the patients and greater continuity of care (Tyrer, 1984).

As 'acute' bed provision has declined, the remaining in-patient beds have altered in their use, with a higher turnover of a younger and more disturbed population (Patrick *et al*, 1989). Since the wards within Camberwell are admittedly cramped and old-fashioned, with few single rooms, it is not always easy to safeguard vulnerable patients from those with a tendency to 'act out'. The incidence of sexual harassment and even assault has become a major issue, although of course very difficult to gather accurate information about. It has been helpful to understand that this is a general risk in institutions caring for vulnerable people. Initial policies to promote patients' safety have been worked out following consultation with staff, patients and community groups. The ''Statement on abuse and harrassment'' from the Royal College of Psychiatrists (Gath, 1989) has been useful, as has *Thinking the Unthinkable* (Brown & Craft, 1989) but it is clear that there are major training needs for staff in this area and that enabling women patients to speak out effectively, perhaps with advocacy services, would be an advantage.

Within inner London, some funding has been available for voluntary groups and it has been possible to provide financial support from the psychiatrist budget towards a women's befriending scheme, a local MIND advice and information scheme and the Lambeth Mental Health Forum, all of which are available for informal access and can provide important feedback on the quality of services for women.

The appropriateness of services for ethnic minority women, especially those of Afro-Caribbean origin, remains largely unknown, and needs urgent evaluation. In Camberwell, links with the Afro-Caribbean Mental Health Association are fostered and a specialist community mental health team has been set up, but much remains to be done. It is unfortunate that 'Shanti', a counselling service for ethnic minority women in a neighbouring health authority, is currently at risk owing to lack of funds.

Old age and its care

Alzheimer's disease affects women disproportionately as sufferers, because of their greater life expectancy, and as carers. Gilleard *et al* (1984) have shown that emotional disturbance is common among the 'supporters' of the elderly mentally infirm, especially women, but there is some evidence (Gilhooly, 1984) that community provision can help to relieve the distress. The psychiatric services for in-patient and community care for the elderly severely mentally infirm are generally well co-ordinated and do provide support for carers. In contrast, the in-patient environment can be extremely unsuitable. In Camberwell these facilities need urgent replacement; there is also a considerable shortage of day places. For women over 65 there is a particularly high risk of suicide and self-inflicted injury (standard mortality rate = 195, England and Wales 1986 = 100; Camberwell Health District Department of Public Health, 1989), which underlines the necessity for continued pressure to separate in-patient provision for the 'elderly functionally ill' from younger patients.

Countrywide there is a need for good collaboration between the elderly services and voluntary groups such as the Alzheimer's Disease Society and Age Concern.

The service providers

Nationally, there are more women in psychiatry at a senior level than in many other medical specialities (Medical Manpower and Education Division, 1989), despite Henry Maudsley's (1874) view that, as

woman's mental and physical organisation was inferior to that of man's, she should be prevented from taking up a career, particularly medicine. Indeed, staff in most of the mental health professions are mixed, so that specific access to women for women should be possible if wished. Both women and men, however, have undergone the same educational experiences and work in the same system, in which equal-opportunities policies may only receive bare compliance, so that a more 'woman-orientated service' does not automatically follow, unless specifically fostered, and women may continue disproportionately in the lower career grades.

Conclusion

Whether or not one agrees with Hilary Allen's (1986) view that "deeply ingrained sexism characterises much psychiatric practice", as she also says, a reformist rather than a revolutionary approach may be more constructive. From the above exercise it is clear that improving and extending the processes of consultation about women's needs and wishes is more important than finalising conclusions at present. Two clear themes emerge: the importance of lessons learned from growing knowledge about sexual abuse, especially listening to and believing the victim; and the importance of the role of the consumer, as patient or carer, in influencing the health services received. All those involved in drawing up the new 'service specifications' please note.

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