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Addressing unmet needs in women's mental health

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Key messages

1. Women and girls have distinct and specific needs and, therefore, policies, services and practice need to be gender-informed.
2. Clear leadership and accountability is required to ensure gender sensitive policy and provision.
3. Data collection and reporting should take account of differences between women and men and include gender as a standard variable.
4. Policies, services and therapeutic options should be co-designed with women with experience of poor mental health.

Introduction

For several decades it has been apparent that there are differences between women and men in how they express mental distress. This is seen in the prevalence of mental illness (particularly common mental disorder such as anxiety and depression, self-harm, substance misuse and suicide); pathways into treatment and support and in therapeutic preferences. There are well established links between the risks of mental illness and the social realities of women's lives. These include women's relatively lower incomes and access to household resources and responsibility for childcare and other caring responsibilities, as well as sexual abuse and domestic violence. Gender neutral approaches to service provision fail to recognise the specific needs of women.[1] If health and social care truly is to be personalised, it must recognise the social context for women's lives and respond appropriately to gendered differences in mental health. This briefing paper provides an overview of the mental health of women in the UK today and some recommendations for actions towards gender-sensitive practice.

Background

In 2002 and 2003, two landmark policies published a clear rationale for change in thinking about women's NHS services, stressing the need for gendered responses to mental health.[2,3] Unlike most psychiatric practice at the time, it asked mental health professionals and services to recognise elements of the (now well respected) feminist purview which locates the origins of women's distress and mental illness both within social inequalities and the social construction of their difficulties.[4] Therefore, the solutions to such distress were not simply better treatments but better solutions to that inequality and to the discrimination that women face.

Although the need for, and the design of, gender specific and gender sensitive mental health provision for women had been clearly articulated, the challenge for services was the lack of an evidence-base for what service to deliver or how to deliver gendered services. Practice development, feminist scholarship and activism and the exposure of abuse by mental health professionals, including rape and abuse of women in inpatient settings,[5] led to 'Into the Mainstream': an evidence-based guide for service development and practice which remains relevant today. Consultation with women for the development of 'Into the Mainstream' enabled components of women-friendly services to be identified, as summarised and updated from Barnes et al (2002) in Figure 1.

Figure 1: Characteristics of gender sensitive services (adapted Barnes et al., 2002)[6]

Women-friendly services:

- Prioritise understanding mental distress in the context of women's lives
- Are co-designed with women with lived experience
- Enable all dimensions of problems experienced to be addressed
- Address sexual abuse, domestic violence, body image concerns, reproductive and life stage elements of health and wellbeing
- Are sensitive to the diversity of women's needs, experiences and backgrounds including race, sexuality and disability
- Enable women to make choices about their care and treatment
- Provide women-only spaces, particularly in-patient settings, which enable women to feel secure, safe and respected
- Empower women to develop skills for addressing their difficulties
- Promote self-advocacy and advocacy for women who need support to voice their views
- Value women's strengths and potential for recovery

'Into the Mainstream' (Department of Health, 2002) called for a reappraisal of women's mental health presentations in the context of their complex and often traumatic lives.[7] Specifically, it advocated that women of working age should be considered differently from men of working age. Women were far more likely to have experienced or be experiencing violence and sexual trauma; to be poor; to be undertaking multiple roles as mothers, partners and carers to elderly and disabled relatives and because the way they accessed support and what they valued was frankly different in many ways from men.

The creativity of 'Into the Mainstream' was accompanied by a detailed implementation guide[8] clearly outlining ways in which services could be modified and care delivered at little or no extra cost in a gender-sensitive and often gender-specific way. It provided a series of models of good practice and, in particular, was one of the first policies on NHS care pathways to acknowledge the major role of the third sector in care provision to women e.g. crisis housing and Women's Centres (Mainstreaming Women 2003). A pivotal element of the implementation plan was the appointment of national and regional leads for gender equality and a women's mental health lead by the National Institute for Mental Health in England (NIMHE). Some NHS Trusts followed suit and appointed a lead to support implementation. This implementation programme included:

- Support to implement the gender equality duty in mental health (incorporated into the Equality Act in 2010).
- Improving access to perinatal mental health services.
- Addressing violence and abuse through routine inquiry.
- The roll out of single gender provision in acute in-patient settings.
- Provision for women from black, Asian and minority ethnic communities.[9]

The closure of NIMHE in 2010 meant these measures were short-lived leaving a long way still to go.[10,11] Since then, mental health policy has paid scant attention to the differentiated needs of women, with the recent Five Year Forward View focusing almost exclusively on perinatal mental health. This previous work, therefore, provides a useful resource for making progress on gender today.

Mental health in women in the UK today

It is in this context that the household adult psychiatric morbidity survey (APMS) reports that rates of common mental disorder in women have been increasing steadily between 1993 and 2014, compared to stable rates in men since 2000.[12]

Figure 2: Current Trends in Women's Mental Health in UK (APMS 2016)

- 1:6 adults (17.0%) had a common mental disorder.
- 1:5 women (20.7%) compared with 1:8 men (13.2%).
- Overall the rate is largely stable in men compared with a steady increase in women.
- Young women are at especially high risk.
- 1:5 16-25yr women report recent self-harm.
- Suicide rates in women are at their highest for a decade.

More women than ever are now presenting with common mental disorder: 25% of young women between the ages of 16-25 (APMS 2016) report symptoms of common mental disorder (mainly anxiety and depression); rates of self-harm in women are higher than ever, again especially in young women.

Figure 3. Adult Psychiatric Morbidity Survey showing rates of common mental disorder (CMD) for women and men aged 16-64. Clinical Symptom or CIS-R scores 12 or 18+ denotes severity of clinical symptoms i.e. 12 mild and 18 equate to either moderate or severe symptoms (Source: NHS Digital, 2016).

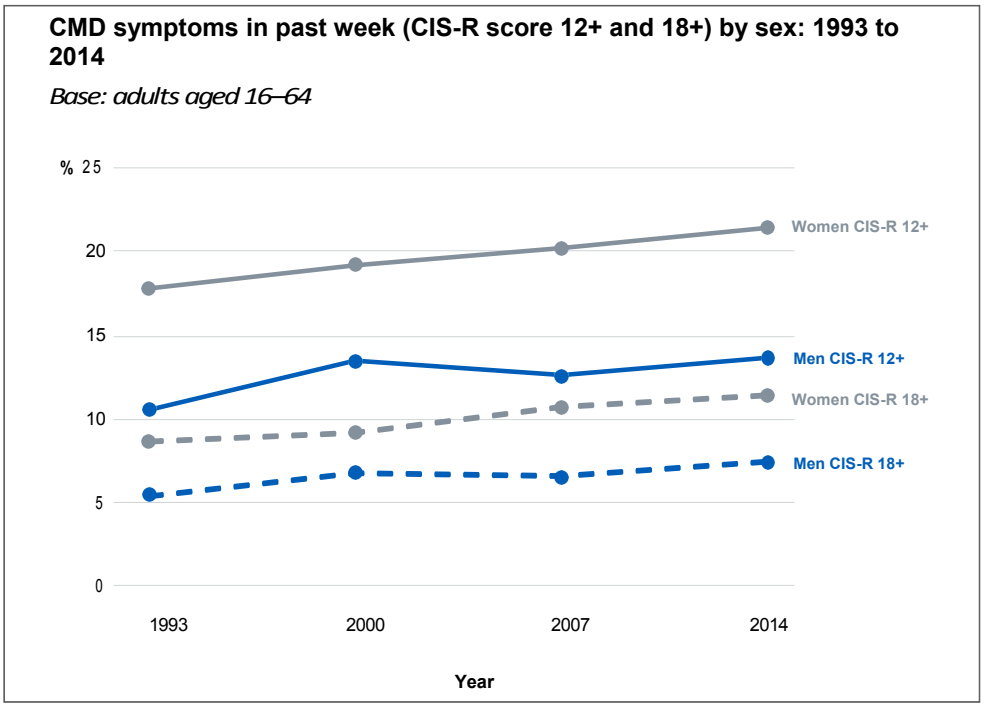
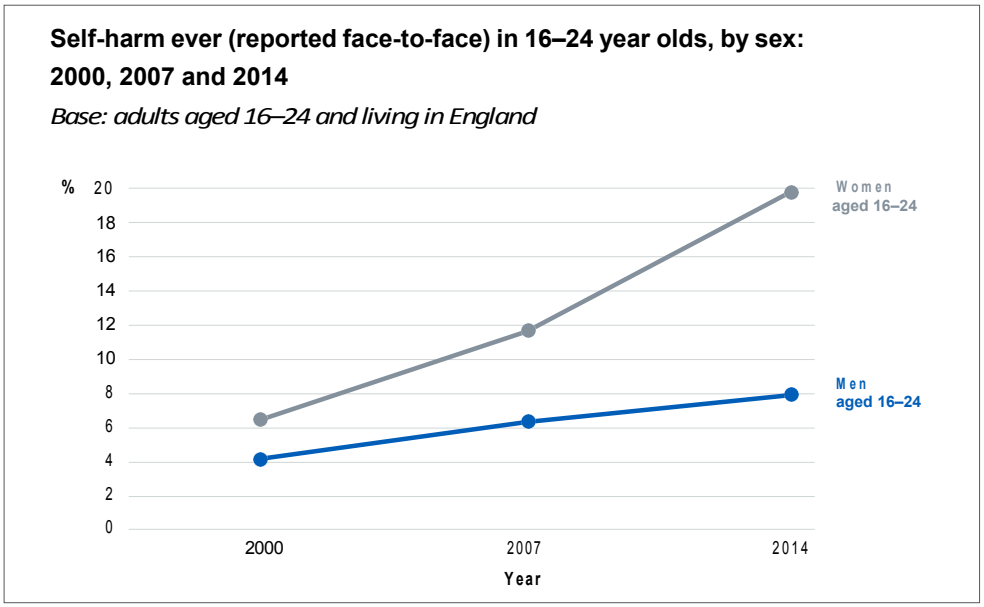
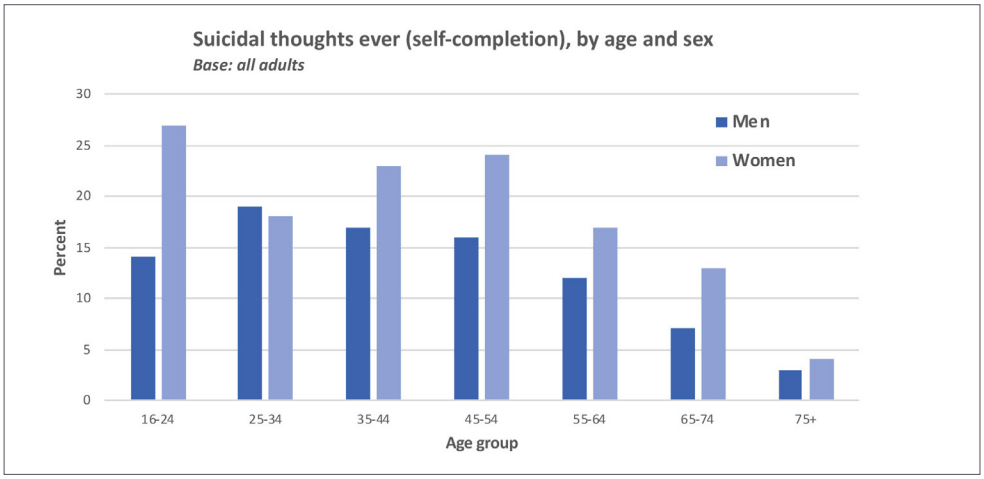


Figure 4. APMS 2016 data on rates of reporting of self-harm in young people



And, in spite of significant funding for suicide prevention and the National Confidential Inquiry into Suicide, rates of suicide in women are at their highest for a decade (ONS 2017).[13] Alarmingly, the number of suicides in women is dwarfed by the very large numbers of women reporting suicidal ideation, especially young women.

Figure 5: Suicidal thoughts by age and sex

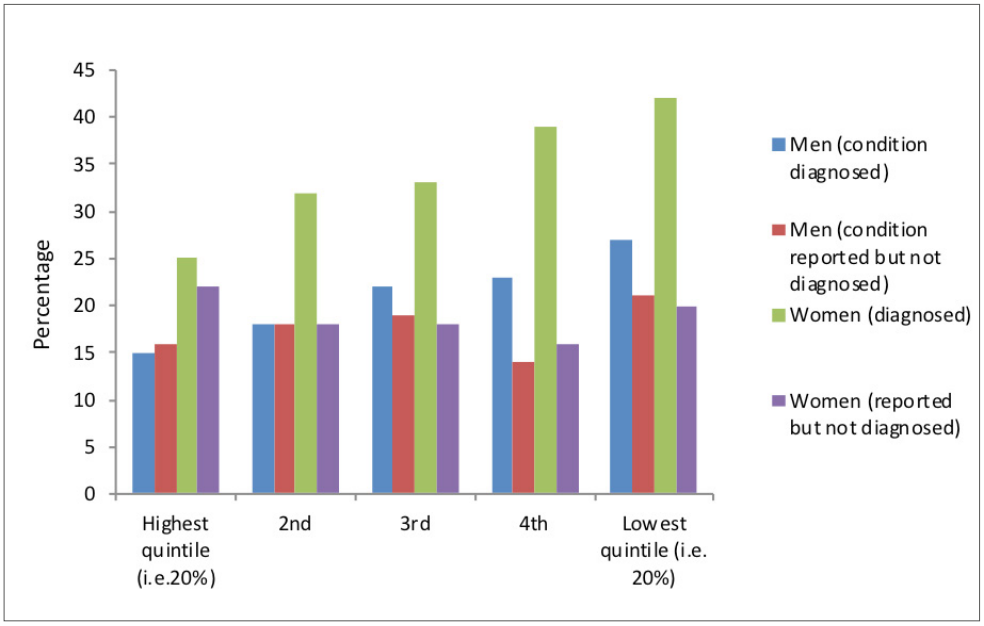


Rates of self-harm and suicidal behaviour are higher for women in minority ethnic communities than for women in the majority community, although most studies report rates for South Asian women.[14] The role of family-based problems, including domestic violence, community pressures, acculturative stress, discrimination and barriers to help-seeking are important precipitating factors.[15] They point to the necessity of considering the intersection between gender, race, sexual orientation, age, disability and other factors when developing accessible and appropriate services.

Recent global trends of increasing mental illness and lack of wellbeing, especially in girls and young women, beg many questions about causal mechanisms; sex and gender effects. We cannot blame the internet or media pressures, as many commentators searching for simplistic answers are keen to do.[16] A range of explanatory mechanisms is likely to be in play, not least of which is inequality. The World Health Organization (WHO) identifies the power differential between women and men and their access to resources in society and in the home, alongside sexual and domestic violence, as profoundly shaping women's mental health and the global disparities in their wellbeing.[17]

Thus, the gender differences in mental health are underpinned by socio-economic realities which can disadvantage women and restrict their ability to access the support and resources they need to cope in the face of adversity. In turn, this continues to be heavily influenced by the social construction of gender roles and expectations; and by women's seemingly immovable tenure in part-time, low skilled, high strain jobs and low paid work.[18,19] This phenomenon has increased with the 'marketisation' of care and the growth of zero hours contracts. The results of the 2014 Household Survey illustrate the link between gender, household income and mental ill-health: women in the lowest quintile for income are 2-3 times more likely to be diagnosed with a mental illness than men in the top income quintile.

Figure 6: Diagnosis of mental illness by 'equivalised' household income and gender (Source: NHS Digital, 2015)[20]



Gender inequalities have become systematised through policy which is shaped by the dominant social norms ('malestreaming') and may adversely affect women's mental health. For example, accumulating evidence suggests women have been disproportionately disadvantaged by the welfare policy agenda and austerity measures.[21] These have led to reductions in welfare benefits and reductions in services, with the voluntary sector and carers increasingly expected to fill gaps in public provision. In spite of this, the last seven years has seen drastic cuts in local authority funding for a wide range of third sector services designed to support women dealing with adversity, e.g. domestic violence, and to provide support with caring responsibilities. Ageing also disadvantages poor women and their mental health disproportionately. At older ages, women are increasingly involved in long term caring roles and make up 60% of informal carers and 80% of the low paid care workforce.[22] So, as women grow older, they are more likely to experience financial hardship as a result of gender inequality in pay and to become unable to afford good quality care for themselves.

Service implications of increasing mental ill health

As the more recent survey data (APMS, 2016) are suggesting, the great majority of mental health presentations by women will be anxiety or mood related; including the significantly increased rates of post-traumatic stress disorder (PTSD) symptoms in young women. However, in spite of longstanding calls for women to have control of their own health[23] and, thus, to access talking therapies rather than medications for mood and anxiety-related conditions, recent studies from the UK and Canada report that young people, and particularly young girls, are increasingly being treated with psychotropic drugs.[24] Researchers from the University of Manchester report that antidepressant prescribing for depression and other indications has been rising most rapidly in 15 to 17-year-old girls.[25] Antidepressant prescribing in children increased between 2006 and 2015 and, at

least in part, this is because these medications have been strongly marketed for use in a much broader range of presenting symptoms than depression, including anxiety, chronic pain, sexual disorders and migraine. The use of psychotropic medications, including antipsychotics, has special significance for women in psychiatric services of whom the majority are within the reproductive age range. Women show more severe side effects from psychotropic medication, including greater weight gain, cardiovascular and metabolic side effects per dose of medication than men but mental health clinicians are largely unaware that side effects are gendered.[26]

Figure 7: Gendered effects of psychotropic medication

- Women exposed to prolactin-raising psychotropic drugs produce more than twice as much prolactin (PRL) as men
- This effect is dose-dependent
- Young women with severe mental illness have 10-fold increased risk of osteoporosis and fracture
- Prolonged hypo-oestrogenaemia associated with high PRL causes a syndrome akin to premature ageing and menopause
- Premature aging appears unacknowledged by clinicians
- Most focus on metabolic syndrome
- Many mental health professionals are unaware that women have more severe metabolic syndrome for lower dose of drug than men

This illustrates how existing practice needs to be adapted to become gender-informed. New initiatives will also need to consider the particular challenges for women in services. Thus, routine inquiry about abuse and domestic violence, supported by appropriate therapeutic and support services, is an example of gendered practice currently being implemented in Scotland (NHS Scotland, 2018).[27] Trauma-informed care and trauma-specific services need to be more widely available because they recognise the pervasive impact of trauma and abuse and the potential for services settings and practices to be retraumatising.[28] They are tailored to enabling women and girls to build their resilience, ensure their safety and negotiate the impact of trauma on their lives, with recovery from the trauma as the primary goal.[29] Progress on initiatives developed through 'Into the Mainstream' must also be maintained and most notable of these is the provision of gender-specific inpatient care and other measures to ensure the security, safety and dignity of women using mental health services.

This needs to be underpinned by well-developed partnership working with the voluntary sector. Women's Centres in particular (see for example WomenCentre in Calderdale and Kirklees), have been at the forefront of innovations in women's mental health. However, recent cuts to local authority budgets have meant this sector is struggling to provide sustainable support to women; notably domestic violence provision.[30] Such services are vital for a systemic approach to women's mental health and for GPs and mental health professionals to be advocating for their role.

Future solutions

The Five Year Forward View for Mental Health makes little reference to gender inequalities or, indeed, to women's mental health or consideration of women-specific treatment needs. With the exception of perinatal services, the needs of women for gender sensitive and gender specific services are largely ignored. Whilst the shortfall in mental health provision for new mothers should remain a priority, the needs of women are far broader than this and yet remain overshadowed by the dominant narratives of perinatal depression or suicide reduction.

Similarly, the search for causal explanations of the rising rates of common mental disorder in young women compared to young men is important, but should not be prioritised over a stakeholder-led search for sustainable ways to support young people using gender-informed approaches. This is critical as the implications of these findings for the health and wellbeing of future generations are clear. Children and young people's wellbeing must be at the centre

of our future mental health strategies. These approaches should begin as early as possible with schools playing a critical role. This means emotional and mental health is embedded within education alongside physical health through a concerted, joined-up public mental health strategy. Two easily identifiable at-risk groups are the increasing number of children and young people living with parental mental illness and young people in the care system.

The Equality Act (2010) provides a framework for policy makers and practitioners to assess and identify priorities for action and ensure equalities for a range of population groups with protected characteristics. For women, this means developing policies and services with an eye firmly on gender sensitivity, and trauma-informed approaches, which will also benefit men. For example, a better understanding of treatment preferences in terms of gender (and other dimensions) could influence the disproportionate numbers of African Caribbean men currently being detained under the Mental Health Act. There is much that can be done within existing practice: routine enquiry about interpersonal violence and recording of responses in the clinical digital dataset is crucial for future service provision. The same is true for routine inquiry about women's sexual and reproductive health which can already be supported by available provision within primary care. Whilst digital innovations may offer new solutions for genuinely personalised psychiatry, and may benefit women in particular, approaching data from a gendered perspective is also an important future requirement if we are to understand the causes and mechanisms of women's mental health inequalities. Thus, surveys must ask about individuals' access to household resources, as these are often unequally distributed rather than simply recording household or area level socioeconomic data. And future commissioned service evaluations and research should specify gender as a key variable.

Future service provision also means co-producing collaborative care models which encourage service users and clinicians to engage in a shared understanding of care needs, treatment and support preferences. Such approaches chime well with an agenda promoting greater public mental health and preventive self-management and include current initiatives that seek to personalise care and make it more collaborative, including decision-making about medication.

For now, slow progress and scarce acknowledgment of women's needs in current mental health policy requires local champions and radical action so that the needs of women are put back at the centre of new service design and modern professional practice. This requires national and local leadership in partnership with women. The recent Department of Health Women's Mental Health Taskforce is encouraging; it must be underpinned by clinical and managerial leadership supported by governance arrangements that have the diverse needs of women in their sights.

Implications for policy makers and practitioners

Policy

- Needs a gender-informed approach so that service design takes account of the differential needs of women and men.
- Recognition of the need to collect gender-informed health and social care data and to report data in a gendered format.
- Welfare policy should be scrutinised, in line with the Equality Act, to identify whether it is disproportionately affecting women and their mental health.
- A national women's mental health strategy needs implementation, supported by both infrastructure and accountability at a local level.
- Reversing cuts and ensuring sustainable investment in third sector organisations that provide support to women, particularly domestic violence services; and ensuring access to a Women's Centre in every local area.
- A focus on the sexual, reproductive as well as perinatal health of women.
- Violence and abuse safe spaces for women should be a priority.
- Successful implementation requires a workforce trained in gendered differences in mental health including trauma-informed approaches to care and services.

Actions for practitioners

- Routine enquiry about reproductive health, body image, domestic violence and sexual health including abuse.
- Become informed about the role of gender and complexity in mental health presentations and response to treatment.
- Develop and provide trauma-informed care.
- Develop collaborative approaches/shared decision-making with women under your care including medical and social prescribing.

Conclusions

Services and research which is gender-informed and actively addresses gender and sex differences is beneficial to men as well as women, informing greater understanding at a societal and individual level of what protects and sustains mental health and wellbeing. It must take account of their diversity in terms of age, ethnicity, sexual orientation and disability if support is to genuinely be person-centred. This must go hand in hand with service provision that has women at the heart of decision-making and a stakeholder-led search for sustainable ways to support gender-informed approaches. We have recommended low cost, immediately implementable actions that all services and practitioners can consider, as well as recommending the urgent development of policy to promote women's mental health.

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