editorial

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Women's Mental Health: Into the Mainstream

> "Do we want to live on our own? Frederica asked the others. More and more of us do. What sort of creatures would we be if we were independent, if marriage didn't come into it, if men were optional? Julia said we wouldn't be like the great virginal heroines of the last century. Florence Nightingale. Emily Davies. We might live as Mary Wollstonecraft wanted us to, in separate establishments, lovingly visiting chosen males, in charge of our own space, our own time."
>
> Byatt, 2002: 146

Permeating A. S. Byatt's latest major novel are both contemporary issues for women, and an awareness of history and the unchanging nature of many questions about how women want to live. One of these questions is the extent to which women want to live with, or without, men. It may seem strange to begin a commentary on a recent government document about mental health services for women patients with reflections that seem such a long way from the document itself. However, the truth of it is that *Women's Mental Health: Into the Mainstream* (Department of Health, 2002) is as much about the woman on the Clapham omnibus as it is about women in receipt, as we currently, but often ironically, put it, of mental health services. This is for two reasons. First, as other authors have eloquently pointed out (Showalter, 1987; Ussher, 1991), so many women are thought to be mad that any document about mad women is necessarily about many, many women. Second, this long-awaited consultation document on women and mental health services starts as much with the woman as with the patient. As its title implies, *Into the Mainstream* is wedded to models of illness and mental ill health, but, unlike much conventional psychiatric practice, it is willing to expand them to incorporate social identity. This marks a radical and welcome departure from the philosophical position of many in the mental health field, and drives the policy proposals and recommendations for service development. This is still some distance from the earlier feminist critique of psychiatric practice, which jettisons illness concepts to focus almost exclusively on gender-based social inequalities. Within this critique, such inequalities are seen as the origin of women's distress, for which the solution is to address the inequality, not to medicalise the individual woman (Penfold & Walker, 1984). *Into the Mainstream* sits somewhere in between traditional, medical model psychiatry and such feminist analysis.

The consultation document begins with difference. Men and women are different, as are their patterns of mental ill health. Therefore, they require different treatment approaches. The explicit premise is that mental health services have failed, to date, to respond to this important gender difference. This has included neglect not only of differences in the nature and prevalence of psychiatric pathology, but also of the reality of women's lives, their expectations, their responsibilities and the concomitant stresses that lead to mental health problems.

Into the Mainstream restricts itself to adults of working age. Although this is in line with the National Service Framework, it is unfortunate. The authors do not specify an age at which a woman might stop working. This fits badly with the fact that many women never stop working because a significant component of their work is in the home, therefore unrecognised and unpaid. In later life, it may well include additional carer roles. Also, women constitute the majority of the older adult population and do not, at that point, cease to be women. Rather, the issues of gender that they confront are different, often involving the consequences of bereavement and the invisibility society imposes on elderly women. Categorical age distinctions, created for the convenience of government, undermine otherwise very helpful principles. Foremost among the principles is an emphasis on service user 'expertise and experience' and that 'addressing gender should be an integral activity and not an afterthought'.

Evidence-based practice

Much of the document is concerned to back up, with what evidence exists, the importance of these two key themes. One difficulty is that although well able to present prevalence data on mental health problems in women, there is little major evaluative research on the treatment models the authors propose. The document falls back on what it terms examples of 'positive practice'. The lack of a research or audit base on new style gendered intervention is acknowledged. The current danger is that it may provide antagonists, reluctant to implement new but non-evidence-based recommendations, with a ready-made reason simply to do what they

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have always done. This is a pity. It remains to be seen whether research funding bodies will be enthusiastic enough to fund adequate research of the kind recommended. To date, a focus on gender has not been evident in mainstream psychiatric funding bodies' priorities for research – even though we are talking about services to half of all mental health patients.

Segregation and integration

Despite this, in some quarters, the government is leaving Trusts with apparently little room for manoeuvre. At present, most mental health care for women is provided within mixed sex services. The Government itself committed to several targets including:

> 'mixed-sex accommodation to have been removed in 95% of NHS trusts by 2002'
>
> 'women-only community day services developed in every health authority by 2004 (NHS Plan)'
>
> Department of Health (2002)

It was confirmed that the first of these has been achieved. The rationale for some degree of segregation of services is supported by concerns about safety that have been widely reported and, to some extent, by an expression of preference by some women. Whether or not there are sanctions for Trusts that fail to deliver on these targets, or future implementations, is left open. This could be read as a recognition of the difficulty of achieving these goals without additional resources. There is a degree of paradox here between a renewed emphasis on the separation of the sexes and the idea that women choose the services they want. Previous moves to segregate early psychiatric services and subsequently to integrate men and women, even within residential settings, was determined not by critical appraisal of research but on policy whim and notions of normal gender relations. Services were developed, and then changed, in a wholesale manner, so that mixed wards became the 'norm'. There are current examples, within more than one Trust, of women in-patients being offered a choice of mixed or single-sex accommodation. However, for some services, in practice, the existence of only one specialised service, segregated or not segregated, may preclude any real notion of choice. In addition, there is an element of ambiguity in the government's commitment to the removal of 'mixed-sex' accommodation, by last year, emphasising the definitional problems around the concept of a single-sex or mixed facility.

Gender-sensitive care

Probably the greatest strength of *Into the Mainstream* is its practical guidelines on how to create and manage gender-sensitive services. Regardless of the character of services, i.e. single or mixed sex, many of its recommendations can be implemented and are clearly sensible. It is hard to argue with recommendations for access to women staff and chaperoning, or for the need for women-only therapeutic approaches to trauma, where that trauma has usually been inflicted by men. Equally, the statistics on women's wider role as mothers in particular are unarguable and to ignore them, as historically has been done, flies in the face of common sense.

This important document addresses, for the first time, an issue with which some staff have grappled for some years, i.e. how to translate the good intention of providing gender-sensitive care into something that is recognisably just that. Clear advice on service user empowerment, training, staff support and key clinical issues that come up independent of diagnosis may well facilitate the development of more appropriate and more responsive services. Gender, the social category, should be part of any woman's care plan. With the help of this document, staff are being told that gender issues are not only legitimate, but necessary clinical issues. They are also being helped to discuss such issues in clinical forums.

The document stresses the lead taken in the area of service provision by the voluntary sector, including alternatives to in-patient care in the form of crisis houses. It emphasises the need for 'joined up thinking', not only at the level of the individual patient, but also at service level. It is not clear whether it is either desirable or feasible for such examples of innovation to cross over into the NHS, a hugely bureaucratic organisation with arguably very different values from the voluntary sector. It seems all too possible that such initiatives might find their core eroded by incorporation into such a monolithic structure. The NHS might not so much replicate good practice as mutate it.

Mandates and managers

An unspoken but key question is whether NHS managers are willing to sign up to a gender agenda. In gathering all manner of clinical issues, from high-security provision to crisis houses, under the same umbrella, managers could be forgiven for feeling uncertain about priorities for their own areas. For clinicians, document fatigue may sap their willingness to contribute to a priority setting exercise. *Into the Mainstream* is simply the latest in a long list of mental health initiatives from central government. Its merit is its distinctiveness and clarity. This makes it not only an accessible policy document, but also a recipe for practical service improvement. But the danger is that without a much stronger government mandate, a combination of forces at local level, including institutional sexism, may render achievable goals impossible. Responses to the consultation are currently being processed. It remains to be seen what will follow by way of imperatives to Trusts.

One of Wollstonecraft's goals (Byatt, 2002: 146) was that women should have their 'own space' and their 'own time'. This is curiously, and across centuries, in line with the recommendations of *Into the Mainstream*. This is perhaps testament to the difficulty in realising such basic objectives, at least for women with mental health problems. Without imperatives, rather than suggestions, from government, it is hard to see that the inadequacy of mental health services to women and the marginalisation of their needs could be effectively remedied.

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