



The Journey Forward

MEETING THE MENTAL HEALTH NEEDS OF WOMEN IN ACUTE AND CRISIS SETTINGS

Donna, Mental Health Consumer Consultant and Dr Jacqueline Short, Consultant Forensic Psychiatrist (Women's Services)

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INTRODUCTION

This discussion document has been prepared to assist the Acute and Crisis Workstream of The Journey Forward, Capital & Coast DHB Mental Health and Addiction Service Development Plan 2005-2010, in ensuring that the needs of all female clients, including lesbian and other minority women's groups, who access the acute and crisis mental health services, are recognised and met. Our remit is to consider two specific areas identified as barriers to engagement with mental health services by the Process Mapping Workshops, namely the lack of gender-sensitive treatment interventions for women and the particular difficulties faced by lesbians when they utilise mental health services. It does not include issues of trauma and traumatic experiences in mental health services, also identified through Process Mapping, as these have already been addressed on behalf of the workstream by Emily Street, Consultant Clinical Psychologist.

The document is a guide for best practice when designing new services, and summarises the issues and possible solutions in the Process Mapping Workshops Outcomes Table. It is not intended to be a comprehensive implementation guide, as this will be influenced by local factors. The document primarily draws on evidence from Australasia, the UK, USA and Canada. The recommendations are in keeping with the challenge of Responsiveness, as set out in "*Te Taahuhu: Improving Mental Health 2005-2015. The Second New Zealand Mental Health and Addiction Plan*" (Ministry of Health 2005), which "reinforces the importance of services meeting the unique needs of specific population groups" and recognises that "women face particular cultural and gender issues when they access forensic and acute services".

WHAT IS GENDER-SENSITIVE MENTAL HEALTH CARE?

Gender describes those characteristics of women and men that are socially determined as opposed to "sex", which is biologically determined. At the United Nations Fourth World Conference on Women, held in Beijing in 1995 (at which New Zealand was represented by Jenny Shipley, then Minister of Women's Affairs), gender was defined as follows:

"The term 'gender' refers to the economic, social, political and cultural attributes and opportunities associated with being male and female. In most societies, men and women differ in the activities they undertake, in access and control of resources and in participation in decision-making. In most societies women as a group have less access than men to resources, opportunities and decision-making".

The Beijing Platform of Action (1995)



The Department of Health (UK: 2003) considers that gender is fundamental to our sense of who we are, the roles we adopt, the way in which we experience and perceive others and in which they perceive us. Gender sensitive mental health care is informed by a knowledge and understanding of gender differences in women and men and their inter-relationship, with respect to:

- **Childhood and adult life experiences**
eg. Women are more likely to experience violence and abuse; young male victims of abuse have a propensity to become abusers.
- **Day to day social, family and economic realities**
eg. Women are more likely to live in poverty and be lone parents; men are more likely to be in full time employment and not be primary carers.
- **Expression and experience of mental ill health**
eg. Women are more likely to self-harm, suffer from depression and anxiety; men are more likely to receive a diagnosis of antisocial personality disorder, experience an earlier onset and more disabling course of schizophrenia; women are more likely to attempt suicide and men more likely to succeed.
- **Pathways into services**
eg. Women with dual diagnosis with substance misuse are more likely to be seen initially in mental health or primary care services; men are more likely to present to drug/alcohol services.
- **Treatment needs and responses**
eg. Women are more likely than men to actively seek ‘talking therapies’ and benefit from self-help.

MENTAL DISORDER AND GENDER DIFFERENCE

It is now accepted that there are differences in the frequency, clinical experiences and outcome of psychiatric disorders between women and men. The lifetime prevalence of psychiatric disorders by gender in the general psychiatric population can be summarised in the table below:

DISORDER	WOMEN	MEN
Depression	21.3	12.7
Social phobia	15.5	11.1
Dysthymia	8.0	4.8
Generalised anxiety	6.6	3.6
Seasonal affective	6.3	1.0
Panic	5.0	2.0
Schizophrenia	1.7	1.2
Bulimia	1.1	0.1
Bipolar I	0.9	0.7
Bipolar II	0.5	0.4



	MEN	WOMEN
Alcohol dependence	20.1	8.2
Alcohol abuse	12.5	6.4
Drug dependence	9.2	5.9
Antisocial personality	5.8	1.2
Drug abuse	5.4	3.5

Burt & Kendrick (2001)

Women have a higher prevalence of depression, dysthymia, seasonal affective disorder, generalised anxiety disorders, panic attacks, phobias and deliberate self harm (Meltzer et al 1995; Robins et al 1984). Depression and dysthymia are more likely to be accompanied by anxiety disorders in women and depressed women are more likely than men to experience “atypical” symptoms such as increased sleep and appetite (Young et al 1990) and to have more somatic symptoms (Frank et al 1988). Women with chronic major depression tend to have a younger age of onset, greater family history of mood disorder, poorer social adjustment and poorer quality of life than chronically depressed men (Kornstein et al 2000). The Otago Women’s Health Survey (Romans et al 1993) demonstrated a distinct gender difference in remission rates of non-psychotic disorders in New Zealand, with low rates of remission for women over the age of 30 years.

Whilst there are no major differences in the incidence or prevalence of psychoses between the genders, women with bipolar disorder are more prone to rapid mood cycling, to develop lithium-induced hypothyroidism, to experience more depressions and possibly more dysphoric manias (Burt & Kendrick 2001). There are differences in the social concomitants, relapse and outcome of schizophrenia (Kohen 2001). Men appear to have a more severe form of the illness characterised by an early age of onset, poor pre-morbid adjustment with both positive and negative symptoms and a poor outcome, whereas in women the onset is later, a more affective component is apparent (Castle & Murray 1991), with fewer negative symptoms and a better treatment response (Szymanski et al 1995).

Women also comprise the majority of cases with eating disorders and the gap between men and women with regard to substance misuse is closing, particularly with alcohol dependence. The male to female ratio of alcohol dependence in the Epidemiologic Catchment Area study (Helzer 1991) was 5.2:1, compared to 3:1 in the National Co-Morbidity Survey (Anthony et al 1994).

Perinatal psychiatry is, of course, exclusive to women and demonstrates the interface between women’s reproductive and mental health (Semsak et al 2005). There are anatomical and hormonal differences between male and female brains and a growing understanding of the psychoactive effects of male and female hormones, particularly oestrogen and progesterone (Collaer & Hines 1995; Pearlstein 1995). Puberty, childbirth and the menopause are associated with a higher risk of mental health problems (Brockington 1996), as are miscarriage and termination of pregnancy (Frost & Condon 1996; Klier et al 2002; Bradshaw & Slade 2003; Kero et al 2004). Recent research demonstrates differences in the presentation and course of mental health problems following miscarriage and induced abortion (Broen et al 2005). It is therefore essential that, in addition to their different social and personal needs -



differences which are greater at times of crisis and relapse, women's differing experiences of mental disorder and the interplay with reproductive health, are recognised and responded to promptly and effectively (Kohen et al 2006).

SEXUALITY, CULTURE AND ETHNICITY

• GENDER SENSITIVITY AND SEXUAL IDENTITY

There is a paucity of literature regarding the mental health needs of lesbian women in New Zealand, which reflects the ignorance of service providers. It is important for clinicians to recognise that "lesbian identity is not limited to sexual activity but encompasses a primary and ontological orientation towards women, a lifestyle preference that is women-orientated and a way of being that is women-relating" (Pouse 1978).

How mental health services can be effective for women and lesbians

- Assumptions on sexuality should not be made
- Women should have their choice of workers/professionals; e.g. female, lesbian
- Sensitivity to needs of lesbian/women clients
- Not invite unpleasant situations because of denial of sexuality.; e.g. unsafe feelings, culture & safety issues
- Cultural needs to be recognized.
- Lesbian relationships and break-ups need to be recognized.
- Non-prejudicial questioning
- To be taken at face value
- Respectful of individual boundaries
- Lesbian friendly services like lesbian support groups
- Lesbian or women only spaces
- Displaying posters and pamphlets aimed at lesbians
- Availability of lesbian staff, support workers, counsellors etc
- Referrals or advising of lesbian groups and services
- Promoting lesbianism as a healthy way of living for any woman

Welch (1995)

How homophobic attitudes may be expressed

Homophobic attitudes may consciously or unconsciously be expressed through:

- Stereotyping
- Pathologising (not normal/deviant – mad, bad or sick)
- Hostility/aggression (verbal & physical abuse)
- Ridiculing (eg. jokes, offensive slang)
- Pitying (eg. "what a shame")
- Ignorance/confusion/embarrassment/voyeurism (eg. prurient interest in what lesbians do in bed)
- Sexism (eg. "not a real man/woman", "all she needs is a good *****")
- Marginalisation/being seen as "other"



- Rejection
- Indifference to suffering caused
- Confusion of homosexuality with paedophilia, leading to the belief that lesbians and gay men should not be around children
- Discrimination – aware or unaware, formal/institutionalised or informal
- Over-compensation (eg. insincerely “nice”, “some of my best friends...”)

Mautner Project & US Dept of Health & Human Services (1997-2001).

All of the above are at best hurtful and disrespectful; at worst they may lead to considerable pain, social isolation, unhelpful strategies for dealing with the pain (e.g. substance misuse) and mental health problems.

If you are heterosexual, you can help by being aware of your own attitudes and behaviour, and learning as much as you can. You can also not join in with other people's homophobic behaviour, and remind them that it is offensive and harmful.

Mental Health professionals should be given training about issues of sexuality and sexual orientation, to enable them to explore and confront their own attitudes towards sexuality. Training should also include education about lesbian culture and the particular mental health issues that may be pertinent to lesbians. As efforts are made to recruit and train staff from within other minority groups, so mental health services should ensure that lesbian mental health professionals are part of the workforce and that their working environment feels safe and comfortable.

• CULTURE AND ETHNICITY

New Zealand has a diverse and rich cultural and ethnic mix of Maori, European and Pacific peoples, and immigrants and refugees primarily from Northern Asia. Minority groups experience prejudice and discrimination worldwide. While the challenge of inclusion is being addressed by others within the Acute and Crisis workstream, it is important to acknowledge that women from these groups may find themselves further marginalised, disadvantaged and therefore more vulnerable to mental ill-health, if their culturally determined roles are at odds with the role of women in New Zealand.

Maori Women

Romans et al (1997) describe the “special role [*of Maori women*] in nurturing and protecting themselves, their whanau and future generations. The fostering of mental well-being and the prevention of mental disorder in Maori women will benefit all Maori”. The rate of psychiatric admissions and readmissions for Maori has increased over the past 30 years. Maori women are over-represented in custodial settings, secure mental health services and women’s refuges. In its Blueprint document (1998), the Mental Health Commission states that “to work effectively with Maori it is necessary to know and understand the components that contribute to their well-being. This includes knowing how Maori cultural identity is defined and the values, beliefs and behaviours which are part of that identity”. Acute and crisis services need to operate in accordance with the Treaty of Waitangi and to be culturally as well as clinically responsive to the needs of Maori women.



Pacific Island Women

There is considerable diversity in the experience, culture and religion of Pacific peoples. The social roles and cultural expectations of Pacific women varies between islands and for those who live in New Zealand. There are also differences in the cultural construction of mental ill-health and in the interplay between religious and spiritual belief. Specific information regarding the mental health of Pacific Island women is sparse. According to the New Zealand Mental Health Survey (2006), Pacific people experience mental disorders at a higher level than the general population. Twenty-five percent of Pacific people had experienced a mental disorder in the past 12 months and 46.5% had experienced a disorder at some stage during their lifetime. The most common disorders are mood disorders and generalised anxiety, and are likely to be more prevalent in women (Ministry of Health 2005). Acute and crisis services need to be culturally attuned to the diversity of expression of mental distress when engaging with Pacific Island women.

Asian Women

In its first Asian-focused literature review, the Mental Health Commission (2003) identifies Asian women as a high-risk group requiring further research – *“While learning the skills of housekeeping and child-rearing in a new cultural system is already a demanding task, many immigrant and refugee women are also forced to seek jobs in order to help support the family financially. For many, lack of English language and proficiency creates problems when seeking employment. This often results in women accepting unskilled jobs at the lowest level of the labour market which, in turn, limits the development of their English skills. There is also a need to assess the mental health needs of women from smaller ethnic communities. Many are likely to suffer intense social isolation because migration has cut up their traditional sources of support and the lack of English language ability has deepened their dependence on children and relatives. In addition, lack of a local ethnic community delays opportunities for them to develop social networks”*.

Studies undertaken in New Zealand are limited but international literature indicates that many immigrant and refugee women are at high risk of mental illness. Given the high degree of stigma attached to mental illness, it is understandable that many Asian women express their mental distress through physical symptoms. Refugees from Indo-China in particular, may have histories of severe trauma and torture prior to resettlement leading to PTSD, depression and psychosomatic problems (Ho et al 2003). Factors that affect the use of effective mental health services include: accessibility, appropriateness, availability of services, existence of alternative services, language barriers and stigma. Immigrant and refugee women also experience an additional cultural stigma attached to mental illness as well as cultural differences in the assessment and treatment of mental illness (Ministry of Women’s Affairs 2005). Recommendations for improving cultural responsiveness for Asian, immigrant and refugee women include promoting the development of educational materials, the provision of professional interpreter services and improving service providers’ awareness of Asian cultural issues (Ho et al 2003).



GENDER-SENSITIVE & SPECIFIC TREATMENT APPROACHES

Epidemiological, genetic and neuroscientific findings of differences in mental disorder between the genders are informative both for causality and for gender-specific treatment approaches and improved treatment outcomes. With a focus on community treatment and shorter stays in the acute and crisis facilities, it is even more important to provide timely, relevant treatment interventions that restore women, who still predominate as care-givers, to their optimum function.

To provide effective treatment, there needs to be relevant, informed assessment. For example, when a middle-aged woman reports poor sleep, the possibility of this being due to perimenopausal night sweats needs to be considered (Burt & Hendrick 2001). Suggested guidance on clinically-significant considerations when undertaking the psychiatric assessment of women (Burt & Hendrick 2001) is attached (Appendix 3).

While there is good evidence for the effectiveness of a range of medication in the treatment of mental illness, user research with women often highlights a perceived over-reliance on medication (Dept of Health 2002). For women, there are specific prescribing issues (Jensvolvo et al 1996):

- Women are more likely than men to be prescribed psychotropic drugs, particularly antidepressants, anxiolytics and hypnotics. This is likely to be the result of an interplay of factors; the response to higher levels of depression and anxiety in women, higher levels of help-seeking behaviour by women, views on gender and mental illness and consequent prescribing behaviour of clinicians.
- Women may require lower doses of drugs than men
- Weight gain, loss/restart of menstruation and hair loss is problematic with some drugs
- Some psychotropic drugs alter the effectiveness of oral contraceptives
- Some psychotropic drugs may have a damaging effect on foetal development and are contraindicated in pregnancy, others are required at lower doses in pregnancy; some are excreted in breast milk.

Department of Health 2002/3.

Women want to be fully informed about prescribing rationales and possible side effects. However, while medication may be the treatment of choice, it is not the only option. Psychological therapies are a vital component of treatment and can help to ameliorate the emotional numbing that some women experience from antipsychotic medication in particular. While both men and women can benefit from the same range of psychological interventions, including art and creative therapies (Department of Health 2001; Mental Health Foundation 1998), there are differing emphases in their delivery. For women:

- Gender inequalities in society which impact on women's mental health need to be acknowledged, particularly those aspects of women's lives that can create dependence and powerlessness
- Connections between women's lives and their mental health difficulties remain highly visible within the therapeutic process, which should address both the causes of women's distress and the distress itself



- Individual and/or group therapy should be offered to enable women to benefit from the strong support of other women

Department of Health 2003

Complementary therapies such as aromatherapy and reflexology are often highly valued by women service users and are increasingly available, alongside more traditional therapeutic approaches. Formal evaluation of effectiveness was often lacking.

SPECIAL TREATMENT CONSIDERATIONS

The following are examples of some of the particular issues that have to be considered for women with mental health problems. It is important to note that this is not an exhaustive list.

Schizophrenia

Kulkarni (2007) notes that *“the tasks involved in assisting a 17-year-old man with schizophrenia to find a career and relationship are quite different from the tasks involved in the loss and grief work required to help a 25 year old woman after an episode of schizophrenia”*.

Special issues in treating women with schizophrenia (Burt & Hendrick 2001)

- Assess for possible symptomatic variation across the menstrual cycle.
- Enquire about menstrual irregularities, amenorrhoea, galactorrhoea; measure serum prolactin levels.
- Counsel about avoiding unwanted sexual advances.
- Counsel about birth control.
- Inquire about recent unprotected intercourse; consider obtaining pregnancy test.

The pharmacokinetics and pharmacodynamics of drugs differ between men and women (Seeman 2004). Women respond better to treatment than men. They are more likely to develop tardive dyskinesia (Yassa & Jeste 1992) and tend to need lower doses of medication. Some women experience a worsening of symptoms pre-menstrually and benefit from a temporary increase in antipsychotic medication. Although traditional neuroleptics are associated with anovulatory menstrual cycles and amenorrhoea, occasional ovulation and pregnancy can occur (Smith et al 2002). Women are more likely to require mood stabilisers for the affective nature of their presentation. The greater understanding of the complex interplay between oestrogen and the dopamine and serotonin systems suggests that the overall effect of oestrogen is similar to atypical antipsychotic medications. The augmentation of antipsychotic medication with transdermal oestradiol has been found to result in a greater improvement in a significant number of women (Kulkarni 2007).

Psychosocial interventions need to reflect the later age of presentation. Women with schizophrenia tend not to be living with their parents and for those who are mothers, help should be directed towards supporting the mother-child relationship, and the



relationship with any partner who may be helping to look after the children. Admission to the acute and crisis units may mean separation from children and families. Feelings of loss may be accompanied by a fear of losing custody of children (Zolese 2000). Work rehabilitation has tended to focus around the needs of men. Women also need help either returning to work or finding employment.

Depression

Depressive disorder is a long term, recurring disorder, in which the risk of recurrence is higher for women earlier in the course of the illness. The contribution of adverse life events to the development of depression is well-recognised in men and women, but for women, it is important to consider correlation with reproductive life events. Some women experience pre-menstrual worsening of symptoms, which can be clarified using a prospective daily mood-rating chart. For those being treated with antidepressant medication, it may be helpful to make small dosage adjustments 7-10 days before the onset of menses (Jensvold et al 1992). Women who are sexually active should be advised regarding contraception and those who may be planning a pregnancy and who require ongoing medication during pregnancy should be fully informed of the options (risks and benefits) available to them, so that the safest, most appropriate antidepressant is prescribed. The increased risk of depression 4-8 weeks post partum is also well-recognised and antidepressant prophylaxis may be needed to prevent a recurrence (Wisner & Wheeler 1994).

Gender differences are apparent both in the response to medication and to psychotherapy. Women respond better to more focused forms of psychological therapy and 'problem-solving', such as cognitive behaviour therapy, and work better in a group therapy setting (Pajer 1995).

Bipolar disorder

A menstrual history is necessary to assess patterns of bipolar disorder symptom exacerbation in relation to the menstrual cycle and for monitoring medication-induced disturbances of the menstrual cycle. Women over the age of 40 are at particular risk of developing thyroid problems and when taking lithium, they are at greater risk of developing lithium-induced hypothyroidism. Measurements of thyroid function should be taken every six months.

Special concerns in treating women with bipolar disorder (Burt & Hendrick 2001)

- Symptoms may recur or worsen premenstrually
- Medication levels may fluctuate across the menstrual cycle
- Carbamazepine may render oral contraceptives ineffective through its induction of liver enzymes
- Psychotropic agents (eg. neuroleptics and valproic acid) may produce menstrual cycle disturbances
- Mood stabilising medications, especially valproic acid and carbamazepine, are associated with relatively high rates of foetal anomalies when used in the first trimester of pregnancy.
- Women with bipolar disorder are at significant risk of postpartum psychosis



Anxiety Disorders

It is essential to exclude physical illness that can present with anxiety symptoms. Women with chest discomfort, excessive sweating and a rapid pulse are less likely than men to have a cardiac assessment and are more likely to be misdiagnosed as having an anxiety disorder (Zerbe 1995).

Thyroid disease is more prevalent in women than men, especially in women over the age of 40. Systemic lupus erythematosus, iron deficiency anaemia and irritable bowel syndrome can all present with symptoms of anxiety and are more common in women.

Symptoms need to be evaluated in relation to menstrual cycle. Perimenopausal vasomotor symptoms may be mistaken for anxiety or panic attacks and treatment with HRT may be more appropriate than anxiolytics or antidepressants.

Alcohol and substance misuse

Special issues for substance-misusing women

- Co-morbid depressive and anxiety disorders are common
- Pre-menstrual tension may exacerbate substance misuse
- Women become intoxicated on lower doses of alcohol than men, even after controlling for body weight
- Medical consequences of alcoholism progress faster in women
- Child care concerns may prevent a woman from obtaining treatment
- Stigmatisation by society may inhibit a woman from admitting her alcohol or drug abuse
- Excessive preoccupation with weight control may lead to stimulant abuse

PTSD and trauma interventions, particularly for the sequelae of physical, sexual and emotional abuse, have been addressed in a separate paper, as have the needs of mothers with young children.

SUMMARY

It is now recognised that there are established differences in the frequency, experiences and outcomes of mental ill-health between women and men. Whilst women are not an homogenous group, and vary in their experiences and expressions, they have a fundamental need to feel safe in mental health services. Current service provision fails to adequately address that need and can re-traumatise the women in its care. Through the exercise of “process mapping”, barriers to care and possible solutions have been identified. These have been further developed to take account of the needs of women and, as previously, the language used by the workshop participants has been preserved wherever possible. While our focus has been on women, it is hoped that by placing gender on the agenda, acute and crisis mental health services can be developed that are responsive to the needs of both genders.



Barriers to overcome	Solutions
<p>Access and Entry to services Primary Health / Intervention Primary Care Services such as GPs and counsellors not responding to mental health needs and being unaware of sexuality identities and gender issues; e.g. homophobia, stigma & discrimination, and being a minority group</p>	<p>1. Education for all to be aware of issues around sexuality and gender issues. Awareness needs to be driven from Ministry of Health, cascading to all levels of the organisation. Staff training to be a core practice competency</p>
<p>Use of Police Implied threat when Police are involved. Traumatic experience for person who is unwell, particularly for some women when a male police officer is present and restraint may be used.</p>	<p>6. Development of protocols within mental health services that promote decreased use of the Police. Where it is necessary for police to be involved, the risk of trauma re-enactment, especially for women who may need to be restrained, should be considered and a female officer be available.</p>
<p>Location for mental health assessment Acute units, Police cells and A&E – traumatic and frightening places – invalid assessments. Women especially, do not feel safe. Why does assessment have to be inpatient? What is the purpose of admission? Why separate the person from their child and/or family/whanau?</p>	<p>10. Places where consumers/tangata whaiora, especially women, feel safe when seeking a mental health assessment and to be free from homophobic / women stereotypical and/or stigmatizing attitudes.</p>
<p>Assessment Not taking time to understand what is going on for that person, or finding out who their supports etc are. Not understanding lesbian issues, women's issues. Too many assumptions made. Lack of understanding as to precipitating events such as loneliness and identity issues. Lesbian women are informed that they are “just going through a phase” and “it will pass”. Assumptions are made that women are lesbian because of suffering past abuse; being lonely or that they choose this lifestyle. Mental health “label” can be a barrier to accessing services.</p>	<p>11. Assessment to be holistic and time taken that allows for the development of a range of options to be considered in the context of the person's social situation. Relevant, gender-informed questions that allow for all issues and information to be accessed. Having a peer/support person of their choice at all times or as requested. Being lesbian is not a choice but how that person is and relates in life and is comfortable with that lifestyle <i>See Appendices 1, 1a, 2.</i> Assessments redefined. Assessment to describe symptoms in the first instance – no diagnosis until a careful and thorough assessment has occurred.</p>



<p>Diagnosis can be wrong Stigma of certain diagnoses</p>	
<p>Treatment Services Alternatives</p> <p>Admission to an inpatient unit seen as unnecessary, unsafe or inappropriate. Lack of gender safe places.</p> <p>Lack of cultural understanding and of trust and confidence between the person and clinicians, to be open and honest about gender/sexuality/abuse issues.</p> <p>Lack of practical solutions led to further escalation of symptoms eg. Rubbish collection for person with phobia and no way to visit pharmacy.</p> <p>Treatment is medication based – no other options to drugs explored. Treatment offered doesn't always work.</p>	<p>17. Alternatives to admission to acute inpatient units. Many women prefer women-only services run by women. In the absence of a dedicated service for women, need women- only spaces / facilities without the threat of men being able to overtake space</p> <p>Access to same sex & lesbian-friendly staff, out lesbians who are trained to be aware of such issues</p> <p>19. Choice of therapeutic interventions important, to include 'talking treatments', Rongoa, creative therapies and medication. Complementary therapies to be available as alternative/adjunctive interventions eg aromatherapy, reflexology, homeopathy, osteopathy. Choice includes being fully informed of all options, their benefits and limitations.</p> <p>20. Choice of service providers, location of services and individual workers.</p> <p>21. Safe places for people to try to be medication free.</p>
<p>Responsive Services</p> <p>Trauma associated with admission to inpatient services.</p> <p>Past trauma not recognized or acknowledged; e.g.abuse, homophobic attitudes/treatment. Lack of appropriate support.</p>	<p>22. Develop trauma responsive options.</p> <p>Commitment to reduce the use of compulsory treatment and to cease to use seclusion. Trained sexual abuse workers, Out lesbian workers</p>



	<p>25. Gender specific services inclusive of family/whanau of the women's choice including women with children. Greater awareness of the differing mental health needs of men and women, the differing approaches to treatment interventions and the provision of appropriate gender-sensitive services (See paper).</p>
<p>Support Services Peer Support Stigma, shame and lack of hope for recovery. Isolation from peers. Lack of understanding of what is happening. Lack of understanding of issues affecting women and sexuality and lesbian issues.</p>	<p>Support that is responsive to the needs of lesbian women by having out lesbian health workers, counsellors etc and peers who have had mental health issues themselves</p> <p>Development and support of peer run groups such as the previous Dykes Supporting Dykes group, Women's groups, drop in centres; e.g. Courtney's.</p>
<p>Respite Lack of appropriate service and/or options so end up in acute unit.</p> <p>Inpatient environment not helpful – frightening and traumatic.</p>	<p>30. Respite to be redefined as retreats (places where people can be pampered).</p> <p>Options for both planned respite in facilities and in people's own homes as well as family retreats. Options to include women only places, lesbian culture and issues awareness and respite in a choice of place that is suitable for the women</p>
<p>Resources</p>	<p>32. The development of information resources that can be accessed in a variety of formats such as; Web based, Mental Health Line, Written.</p> <p>Information regarding lesbian/women issues, how and where to get help, self help and variety of options</p> <p>Accessing and hooking into any current resources available.</p> <p>Availability of lesbian and female counsellors at an affordable cost or funded</p> <p>Separate resources that target young women/lesbians and coming out lesbians of any age.</p> <p>GP's and Primary Health services to have knowledge of women/lesbian services available in the community.</p>



<p>Education Homophobia, heterosexism, stigma & discrimination</p>	<p>33. Stigma and discrimination, suicide and that people recover from mental illness, be priorities for community education. Providing anti- homophobia, stigma and discrimination, internal stigma and discrimination. Workers address their own homophobic attitudes. Include “alternative” lifestyles fully in all training for mental health students and challenge their homophobia from the outset. Counsellors, support workers, GPs etc need to be less homophobic and have training so that they are more sensitive to lesbian needs and more knowledgeable of lesbian relationships etc.</p>
<p>Systems Homophobia, stereotyping, discrimination in mental health services.</p>	<p>44. See appendix 3.</p>



Appendix 1

CHECKLIST FOR OPTIMAL CARE OF LESBIAN AND BISEXUAL CLIENTS

Client Rapport and Approach to Clients

- Use inclusive language on admissions and information forms and sexual and social history forms.
- If the client wishes, include her significant other(s) or family or choice in health care discussions.
- Use open-ended questions about health behaviours and health care needs.
- Make no assumptions about the client's behaviour or health needs. Ask the client what language to use to describe her relationships, sexual behaviours, and health concerns. Use the language. If the client is legally married, do not assume heterosexuality or monogamy.
- Discuss confidentiality, including documentation and access to records.
- Respect the client's wishes or needs to disclose (or not disclose) her sexual orientation.
- Provide access and referrals to print resources and area services for lesbians and bisexual women.
- Advertise and "come out" in the community as lesbian affirming.
- Be aware of your own biases, values, and limits of knowledge.
- Remember your commitment. Ensuring high-quality care for all.

Organisational Policies and Practices.

- Train and routinely update health care providers and clinical and administrative staff about lesbian issues.
- Prominently post a non-discrimination policy for employees and clients that includes sexual orientation and gender identity.
- In waiting rooms and offices, place magazines, newspapers, posters, and brochures that are inclusive of and specific to lesbians.
- Provide educational screening services that are specifically geared toward lesbians and bisexual women.
- Advocate for all clients, enact durable powers of attorney for health care and respect those choices when they are implemented.
- Review and revise all policies, forms and patients literature to eliminate heterosexual bias and heterosexism.
- Revisit implementation and efficacy of confidentiality policies and procedures.
- Review policies on confidentiality with all clients and staff, including administrative staff.
- Form an advisory committee made up of staff and clients to address lesbian health issues.
- Be an ally. Confront heterosexism and oppression of lesbians and gays wherever you see it.



Disease Screening and Treatment

- Begin with client-not from your assumptions about gender identity, sexual orientation, identity presentation, or sexual health and behaviours. Let the client tell you who she is.
- Take a thorough sexual behaviour Survey. Order diagnostic tests and treatments accordingly.
- Be non-judgemental in response to information or answers the client gives you.
- Ensure appropriate use of pre and post test guidelines for client consent, counselling, confidentiality, and follow-up care when screening for HIV/STIs, substance abuse, and mental health.
- Instruct the client on appropriate harm reduction guidelines for HIV/STIs, based on sexual behaviour, not on sexual identity or sexual orientation.
- Screen sexual partner(s) for STIs as appropriate.
- Ask open-ended questions to solicit information about psychosocial supports and stressors.
- Screen for, address, and treat client concerns linked to mental health and substance abuse.
- Screen for, address and treat client concerns related to abuse and violence, whether domestic, sexual or bias related.
- Acknowledge your limits: you may not know the screening or treatment answer, but you can work with your client to ensure that she is referred to helpful resources.



Appendix 1a

SUGGESTIONS FOR INCLUSIVE INTAKE AND HEALTH HISTORY FORMS

Intake Forms	Health History Interview Forms
<i>Non-inclusive Language (Alienating to Lesbians)</i>	<i>Non-inclusive Language</i>
	Are you sexually active?
Single, Married, Divorced, Widowed	
	What form of birth control do you use?
Husband's Wife's Name	
	<i>Inclusive Language</i>
Spouse's Name	
	Are you currently sexually active?
<i>Inclusive language (A better Option)</i>	YES NO
Single, Married, Divorced/Separated, Widowed, Same-Sex Partnership, Opposite-Sex Partnership	If YES, with one partner or more than one partner?
	If YES. With men, women, or both?
With whom do you live?	
	Have you been sexually active in the past?
What is his/her/their relationship to you?	YES NO
Who is your emergency contact?	If YES. With men, women, or both?
<i>Inclusive Language (Another Good Option)</i>	Do you need to use birth control? YES NO
Relationship Status	<i>Explanation: By asking "men, women or both", the provider is signalling to all patients that it is okay to discuss a variety of sexual behaviours.</i>
Spouse/Partner/Nearest Relative	<i>Not all sexually active women need birth control.</i>
Emergency Contact	
<i>Explanation: Many lesbians feel uncomfortable if the intake form does not allow them to indicate a same-sex relationship.</i>	
<i>If the only option given for emergency contact is for a "husband, wife, or</i>	



<i>spouse”, many lesbian clients assume it is unsafe to list a lesbian partner.</i>	
<p>From <i>Removing the Barriers: Providing Culturally Competent Health Care to Lesbians and Women Who Partner with Women</i>. The Mautner Project for Lesbians with Cancer and the United States Department of Health and Human Services. Copyright 1997-2001. Reprinted</p>	



Appendix 2

Good Practice Guidelines in Working with Lesbians, Gay Men and Bisexuals in Mental Health Services (Department of Health)

Introduction

These guidelines are based on the new National Service Framework for mental health, so that their implementation can easily slot into health authority plans (despite the fact that lesbians, gay men and bisexuals do not get a mention in this document). They are informed by research evidence, the experience of those organisations providing services to lesbians, gay men and bisexuals and consultation with lesbian, gay and bisexual mental health services users. They are also informed by demands from the user/survivor movement.

What users want

The statement (“Telling it as it is”) produced by the User-Survivor Advisory Group to the new London Mental Health Strategy for Action is a clear account of what users in general want from mental health services:

- A holistic approach to mental health, where people are treated as whole individuals rather than as “illnesses” or diagnosis;
- Recognition of different experiences, communities and identities, and the effects of racism, sexism, homophobia etc;
- Use of the social model of disability, taking social factors into account, rather than the medical model which defines people as “ill”;
- Assisting people to develop their own coping strategies through talking treatments and other alternatives to reliance on medication.

The effects of homophobia

Homophobia, based on the belief that heterosexuality is the only normal, valid, and moral basis for partnerships, can manifest itself as:

- Physical and verbal abuse, bullying, harassment, intimidation
- Rejection, exclusion, invalidation, marginalisation, denial, making invisible, silencing
- Negative stereotyping, pathologisation (seeing homosexuality as an illness or abnormality; believing that the problems that gay people experience are a result of their sexuality itself, rather than other people’s treatment of them)
- Teasing, joking, ridiculing, patronising
- Discrimination, treating as second class citizens
- Treating as sinful, immoral, predatory, dangerous to children.

These forms of prejudice and mistreatment, as well as the internalising of negative messages which come from every direction on a daily basis, can have a very adverse effect on mental health; low self-esteem, drug and alcohol abuse, self-harm, depression, difficulty with intimacy, neuroses, suicide. Some people find it difficult to come to terms with their sexuality, or are confused about their sexual identity. Some may be forced, or may choose, not to disclose their sexuality either at all or only under certain circumstances, and may thus suffer the stresses and psychological



damage of such a “split” existence. There are very few role models for lesbians and gay men, and relationships are generally not widely validated; this may lead to difficulties in creating and sustaining nurturing relationships. The stigma attached to HIV has compounded prejudice against the gay community, and feelings of guilt among those affected.

Knowledge-based practice

There is now sufficient research evidence of both the effects of homophobia on mental health and the experiences of lesbians, gay men and bisexuals in mental health services to inform practice (e.g. “Without Prejudice”, Jackie Golding MIND 1997; “Diagnosis: Homophobic”, Linda McFarlane 1998; “Social Inclusion; reaching out to bisexual, gay and lesbian youth”, Andy Mullen ReachOUT 1999 – and all the studies quoted therein). This research demonstrates that many lesbians, gay men and bisexuals (both users and workers) do not feel safe to be “out” in the mental health system. They frequently encounter prejudice, discrimination, abuse and inappropriate treatment which does not meet their needs – this mistreatment comes from both professionals, and from other users, often not challenged by staff. Even where practices occurred some years ago, such as aversion treatment; this can make individuals very reluctant to access services and so continues to have an effect.

Lesbian, gay and bisexual mental health service users, both according to this research, and to those who have been consulted, are very clear that they want these findings to be acted upon and recommendations put into practice.

The NSF Standards

Standard One

Promote mental health for all

- Include reference to and information about lesbians, gay men and bisexuals, including relevant organisations, in all publicity – promote positive images.
- Liaise with relevant lesbian and gay user and community groups, including those providing services.
- Recognise effects of homophobia and develop materials which challenge it – use the social model of disability.
- Challenge notions and negative images of mental “illness” that are prevalent in lesbian, gay and bisexual communities as elsewhere.
- Include information about and positive images of lesbians, gay men and bisexuals in schools and other educational establishments.
- Promote self-help, counselling, advocacy and other support available from lesbian, gay and bisexual organisations.
- Develop resource specifically targeted at lesbians, gay men and bisexuals, especially those “coming out”.

Combat discrimination and promote social inclusion

- Recognise and highlight the particular experiences of lesbians, gay men and bisexuals, and the forms of discrimination and social exclusion they



encounter; include particular discrimination experienced by Black, disabled and other lesbians and gay men from marginalised communities.

- Support those non-statutory agencies working towards social inclusion for lesbians, gay men and bisexuals, and work in partnership with them.
- Undertake more research into the needs of particular groups within the lesbian, gay and bisexual communities, e.g. lesbians, Black/minority ethnic, disabled, etc.
- Provide training for all mental health promotion staff in awareness of lesbian, gay and bisexual issues, and in developing equality strategies.

Standards two and three

Making contact with mental health services

- Provide training to all NHS, social services, housing and other relevant staff, to ensure consistent good practice to lesbian, gay and bisexual users, from identification of needs, through assessment to provision of appropriate and effective services.
- Recruit lesbians, gay men and bisexuals as staff members and ensure that they are guaranteed protection against harassment, discrimination and other mistreatment; develop support systems.
- Develop a holistic approach which takes account of the effects of homophobia, as well as other social and environmental factors including racism.
- Provide resources for specialist services for lesbians, gay men and bisexuals in the community – ensure sufficient funding for 24-hour services.
- Ensure that all staff are aware of what specialist services are on offer for lesbians, gay men and bisexuals – develop website for staff.
- Make services more accountable – recruit lesbians, gay men and bisexuals as lay visitors and Mental Health commissioners. Ensure access to advocacy services, including lesbian, gay and bisexual-specific ones.
- Develop sanctions for homophobic behaviour, and ensure their implementation.
- Introduce anonymous monitoring for use of services by lesbians, gay men and bisexuals while ensuring total confidentiality, evaluate services through feedback.
- Recognise the partners of lesbian, gay and bisexual mental health service users, and treat them with same respect and consideration as heterosexual partners.

Standards four and five

In addition to those points identified for Standards 2 and 3:

Rights under the Care Programme Approach

- Ensure that care plans incorporate the needs and concerns of lesbians, gay men and bisexuals; try to ensure lesbians, gay men and bisexuals can request a co-ordinator of the same sexuality.



- Ensure that users are informed about direct payments, and appropriate places where they can access care in this way.

Periods of care away from home

- Develop provision of lesbian, gay and bisexual crisis houses, supported housing, day centres etc; provide for Black/minority ethnic lesbians, gay men and bisexuals.
- Recognise that some specialist services for lesbians, gay men and bisexuals are best provided on a cross-borough or even pan-London basis; liaise with other relevant health authorities.
- Ensure single sex wards are available for lesbians; however consider impact of all-male wards on gay men, and ensure suitable provision.
- Ensure that the wishes of users as regards who they deem to be their “nearest relative” are understood and acted upon – for example their parents rather than their family. Although a lesbian or gay partner can only be recognised under the Mental Health Act 1983 if they have lived together for more than 5 years; a patient can nominate as their nearest relative in writing to the appropriate personnel; they should be informed of this right.

Standard six

Carers of those on CPA

- Acknowledge the validity of same-sex partners and the importance of friendship networks, as well as family; service users should be able to identify their carers, and care planners need to be flexible about who “counts” as a carer.
- Care planners should be non-judgemental and not make assumptions about the sexuality of carers.
- Carers should be involved in care plans and be able to attend meetings and tribunals if users want that; be aware however that like any other carers, partners can have their own agendas and there may be a conflict of interest.
- Carers be isolated and may want support from other lesbians, gay men or bisexuals; generic carers’ groups may feel unsafe or inappropriate; support the establishment of a pan-London lesbian, gay and bisexual carers’ service, including support, advocacy, information and respite care.
- Ensure that lesbians and gay men who provide a substantial amount of care on a regular basis know that they are entitled to an assessment of their own support needs.
- Lesbian and gay carers should never be excluded from visiting a patient on the basis of objections from family members; any grounds for exclusion should be exactly the same as those used to exclude heterosexual carers.
- A carer is entitled to access to the medical records of a deceased partner if they are the patient’s nominated “personal representative”, or were authorised to see the patient’s record while they were still alive, or where they may have a claim arising out of the patient’s death.



Standard seven

Preventing suicides

Lesbians and gay men, particularly those who are young, face an enhanced risk of suicide; studies show that one in four and one in six young lesbians and gay men attempt suicide at least once (slightly higher rate for young men). In addition to the points listed above:

- Prison staff should receive training to increase their awareness of the needs of lesbians, gay men and bisexuals; policies should be introduced to challenge homophobia, bullying and harassment.
- “Zero tolerance” of homophobia and harassment should also apply to all other settings.
- Where local audits have indicated that homophobic bullying and harassment is the major cause of suicide this needs to be taken seriously and acted upon.
- All those involved in assessment of risk and suicide prevention should receive training so that they are able to understand the damaging effects of homophobia and recognise the triggers for suicide, such as crises of identity, lack of self-worth, family conflicts and the breakdown of relationships which may not be validated by society in general.

Implementation – Summary

- Audits of local need must include assessments of the needs of lesbians, gay men and bisexuals and mapping of existing services.
- Health Improvement Programmes should take lesbian, gay and bisexual mental health needs into account.
- Service planning should include consultation with lesbian, gay and bisexual individuals, user groups and community groups from the earliest stages.
- Local performance measures should include indicators based on monitoring of and feedback from lesbian, gay and bisexual users and carers.
- Commissioners should ensure funding for a range of appropriate services, including those provided specifically for lesbians and gay men, some of which may be on a cross-borough or pan-London basis.
- Commissioners should also ensure that all services which they fund should meet standards in relation to access by and treatment of lesbians, gay men and bisexuals; monitoring should require any service providers failing to meet these standards to improve or change their policies and/or practices.
- Primary Care Groups and Primary Care Trusts should ensure consistently good policies and procedures across the health authority.



Appendix 3

PSYCHIATRIC ASSESSMENT OF WOMEN: CLINICALLY SIGNIFICANT CONSIDERATIONS (Burt & Hendrick 2001)

COMPONENT	CONSIDERATION
History of present illness & past psychiatric history	Characterise symptoms in relation to <ul style="list-style-type: none"> • Phase of menstrual cycle • Use of hormonal contraception • Pregnancy • The postpartum period • Breast-feeding or weaning • Abortion • Infertility treatment • Hysterectomy • Perimenopause
Medications	Include: Exogenous hormones (oral or injectable contraceptions, postmenopausal hormone replacement, fertility medications) & all over-the-counter medications
Dietary assessment	Ask: Ritualistic or restrictive eating patterns, bingeing, self-induced vomiting, use of diet pills, laxatives, emetics, diuretics.
Alcohol & Drugs	Ask: Covert use, especially of prescription medications
Family psychiatric history	Include: History in female family members of premenstrual dysphoric disorder, postpartum mood disorders.
Medical history	Consider autoimmune diseases (eg lupus, thyroiditis, fibromyalgia) that may present with psychiatric symptoms. Exclude history of STD that may affect current sexual functioning and childbearing capacity.
Menstrual history	Rule out pregnancy, menstruation-related symptoms (eg. bloating, weight gain, cramping, breast tenderness) Rule out perimenopausal symptoms (eg irregular menstrual periods, hot flushes)
Social & developmental symptoms	Note sexual preference, relationship styles, level of satisfaction with current relationships. Document tendency to take on certain roles in relationships (eg.



	caregiver, nurturer, or dependent or helpless). Note current or past sexual, physical or emotional abuse.
Socioeconomic status	Note level of economic support & ability to meet ongoing financial needs. If patient is a single mother, enquire about child support.

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