

# Women and mental health: a gender-sensitive survey on determinants of health and care satisfaction in outpatient psychiatric services

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**Summary.** *Objectives.* Sex and gender influence the presentation, diagnosis, and treatment of mental disorders. However, specific tools that assess sex and gender-specific health determinants are lacking, and clinical services are rarely equipped to provide sex and gender-based treatments. This study describes the implementation of a comprehensive questionnaire to investigate such determinants in women accessing mental health services. The goal was to identify areas of improvement to promote sex and gender-sensitive care for women. *Design and methods.* A convenient sample of 100 women accessing the outpatient psychiatric and addiction service in Ferrara, Italy, between May and September 2022, were invited to complete a questionnaire specifically designed by the authors. The questionnaire investigated social-health domains, including trauma, and assessed care satisfaction. A descriptive analysis of the responses was conducted. *Results.* The women involved had an average age of 44 and were already receiving care (79%). Most were unemployed (72%), with a yearly income <15,000 euros (61%). Most of them (55%) were prescribed multiple psychotropics, reporting weight gain and reduced sexual desire as the most frequent side effects. Most (57%) were not using any contraception and did not undergo regular check-ups for breast and cervical cancer screening. Thirty-two participants reported having experienced sexual harassment/abuse. The majority (71%) felt that their suffering had been underestimated by relatives. Overall, they expressed satisfaction with the quality of care received. *Conclusions.* The study confirmed the sex and gender-specific needs of female users, especially regarding traumatic events, incentives for prevention and healthy sexuality, interventions supporting education and job placement. Further studies with larger and more diverse samples are needed.

**Keywords.** Gender, women health, trauma, mental health, prevention.

## Introduction

A significant difference between sexes and genders has been observed in mental health disorders regarding their epidemiology, clinical presentation, and treatment offered.<sup>1-3</sup>

Overall, men and women have a similar incidence of mental health disorders. However, the way in which men-

tal distress is expressed differs considerably between the sexes: women more often experience disorders belonging to the internalizing spectrum (such as depressive, anxiety, eating, and somatoform disorders), while externalizing spectrum disorders are more prevalent in men (including substance use, impulse control and antisocial personality disorders).<sup>4</sup> Higher rates of suicidal behaviors (i.e., suicidal ideation, suicidal attempts) among women are attributed to their increased risk of internalizing disorder and culturally-related issues:<sup>5</sup> for example, violence against women is often a symptom and an expression of patriarchal society and suicide is one of the major mental health consequences in women exposed to violence.<sup>6</sup> On the other hand, higher rates of fatal suicide are associated with health-related and life-threatening behaviors, such as alcohol or drug misuse, which are more prevalent in men.<sup>4</sup>

The male excess in alcohol use disorders has often been considered the result of a combination of psychosocial and biological factors. Firstly, drinking and drunkenness are widely perceived to be consistent with gendered notions of masculinity. Secondly, drinking is considered a coping strategy for men.<sup>7</sup> Lastly, certain psychiatric illnesses occur exclusively in females, such as premenstrual dysphoric disorder.<sup>8,9</sup>

Clinical presentation could also differ between the sexes. For instance, the onset of schizophrenia in women is often characterized by marked mood symptoms and preserved cognitive functioning, while disorganized or disruptive behavior is more frequent in men.<sup>1</sup> Age of onset and risk factors for psychiatric disorders also differ between the sexes: psychotic disorders have a peak onset in early adulthood in men, while women experience a peak in their 50s that men do not present.<sup>10,11</sup> Women are more sensitive to sex hormones fluctuations compared to men during specific period of their life: this hormones imbalance could explain the increase in psychotic and mood disorders during pregnancy and menopause.<sup>12</sup> Moreover, the incidence gap between the sexes for depression and other serious mental illnesses (SMI) (including post-traumatic stress disorder - PTSD, suicidal behaviors) can be explained by the higher rates of

risk factors to which women are exposed more than men. This includes domestic violence and abuse, child abuse maltreatment, and structural gender inequity.<sup>13-15</sup> Also, the “cult of thinness” propagated by social pressures has been cited as a key reason behind the rise in incidence of eating disorders and its higher prevalence in women.<sup>7</sup> Finally, women often suffer from being misdiagnosed, experiencing delayed treatment, and reporting an increased risk of metabolic and endocrine side effects induced by antipsychotic drug use.<sup>16-18</sup>

For these reasons, scientific societies and academic institutions are increasingly promoting the implementation of a sex- and gender-based sensitive approach to mental health.<sup>19-21</sup> However, this is rarely translated into clinical routine, and it could negatively impact the satisfaction of female users regarding the care they receive.

In a study conducted in Canada, 28 women with schizophrenia or schizoaffective disorder were interviewed about the perceptions of their illness and corresponding health needs. They revealed that they were not adequately informed about family planning, parenting, or menopause in light of their illness and psychopharmacological treatment.<sup>22</sup> Alvidrez et al. conducted a survey of 105 women admitted to a women's psychiatric clinic in San Francisco to identify their treatment preferences and priorities. Many expressed the willingness to receive individual and group therapy, as well as psycho-educational classes for parenting and coping with abuse.<sup>23</sup> Women's needs might also vary with age:<sup>24</sup> younger women may require counseling on contraceptive methods, prevention of sexual abuse, and interventions targeting the perinatal period. More mature women, on the other hand, might need interventions targeting the reinvestment in social roles, and those to improve physical health, especially on cancer screening.<sup>1,25-27</sup>

A good practice in sex- and gender-oriented mental health services example comes from a recent intervention conducted in Barcelona, Spain. A community mental health service is planning to implement a specialized clinical unit for the treatment of women with schizophrenia. The innovation lies in the proposed program, which will include the provision of perinatal mental health, liaison with a medical unit, prevention of suicide risk, interventions on parenting, domestic abuse, and sexual exploitation, home-based services, peer support, and occupational therapy.<sup>28</sup>

The present pilot study aims to describe the ideation and implementation of a structured questionnaire as a tool to investigate key determinants of mental health and satisfaction with care among women accessing outpatient psychiatric services. The goal is to raise awareness among users and providers regarding specific women's needs in mental health care and then to identify clinical and organizational areas of improvement to promote gender-sensitive care for female patients.

## Methods

### Setting

The study was conducted in the Integrated Department of Mental Health and Pathological Addictions Service (DAISM-DP) in Ferrara, Italy. The province of Ferrara covers an area of 2,630 square kilometers and has a population of approximately 342,000 (ISTAT, 2020).

The DAISM-DP offers mental health care to the entire province under a universal healthcare system. It includes five outpatients Community Mental Health Centers (CMHC) for adults, a 15-bed inpatient acute unit, two intensive residential units, two prolonged treatment units, two day-treatment facilities, and five outpatient Services for Addictions and Dependence (SerD). The DAISM-DP provides psychiatric services free of charge under the Italian universalistic healthcare system.<sup>29</sup> Referrals to the CMHC are primarily made by general practitioners (GPs),<sup>30</sup> or self referrals.

### Instruments

For the purpose of this study, two instruments were developed: the “Personal History Form” (Appendix 1 and 2) and the “Psychiatric Care Satisfaction Survey” (Appendix 3) (all three Appendices are available online as supplementary material in the Addenda section).

The Personal History Form covered various dimensions of a woman's life. Specifically, it inquired about:

- biographical data, educational level, employment status, living and socio-economic situation;
- pregnancy and motherhood;
- physical health;
- medications;
- leisure time;
- barriers to accessing mental health services.

Traumatic experience, including child maltreatment, abuse, and interpersonal violence, are 2-3 times higher in the female population than in the male population. These are considered risk factors for multiple psychiatric disorders and psychological suffering,<sup>13-15,31</sup> but are not routinely explored during a regular psychiatric assessment. Therefore, we decided to include a few questions exploring this theme. Modified selected questions from the “Trauma History Questionnaire”<sup>32</sup> were also included to investigate exposure to traumatic or particularly stressful events during the lifespan. Additionally, some questions from the Alcohol Use Disorders Identification Test (AUDIT) were included, given the observed growing trend of alcohol use in females during adolescence, and binge drinking behaviors in women of child-bearing age.<sup>33,34</sup>

The final version of the Personal History Form includes 47 questions.

The Psychiatric Care Satisfaction Survey was created to assess the perceived quality of care received at mental health services. It was developed by adapting the "Primary Care Satisfaction Survey for Women" used in the assessment of women's satisfaction in primary care.<sup>35</sup> The survey comprises 14 questions with 5-point Likert scale answers, ranging from completely dissatisfied to completely satisfied. The scale explores aspects such as the courtesy of the staff, the flexibility of appointments, the staff competence in addressing women's health problems, and the attention given to gender-specific needs.

A second section was added to inquire about users' preferences for interacting with a male or female mental health professional. Finally, the user was asked to rate the quality of the service on a scale ranging from 1 to 10, where 1 corresponds to poor, and 10 is good. Free notes for suggestions were also provided as an option.

The tools described above were reviewed by both users and staff, seeking suggestions and edits. They were also submitted for review to a group of five users, who filled out the two questionnaires and reported their concerns and suggestions regarding the clarity of the text and the topics discussed. Finally, the forms were edited to adapt the text to the CMHC vs SerD settings.

The time required for completing both forms was a maximum of 20 minutes.

#### *Implementation and target population*

Designated professionals within the CMHC and SerD in the city of Ferrara distributed the two forms to a convenient sample of 100 female users aged 18 and over, fluent in Italian, and accessing the services for their first or follow-up visit from May 10, 2022 to September 2, 2022, regardless of their psychiatric diagnosis or duration of illness. Users who were in emergency visit were not invited to participate in this study.

Users filled out the anonymous questionnaires in the waiting room, and in rare cases, they were allowed to take the forms home and return them to the staff at their earliest convenience. The provider was available to clarify any doubts about specific questions and to support the comprehension of the text.

#### *Data analysis*

The anonymized data collected through the two tools were entered into a Microsoft Office Excel form created ad-hoc. A descriptive analysis was performed, focusing on socio-demographic and clinical characteristics. The average duration of psychiatric care was calculated as the time interval, in years, between the first year of accessing the Service and the date of entry into the study. The

frequency of use of psychotropic medications and drugs prescribed for physical illnesses (e.g., hypertension, diabetes) was also reported. Additionally, a narrative report of feedback received from participants was provided.

As this project was classified as an audit of current practice and service evaluation, full ethical approval and written informed consent were not required. However, this study had been discussed with the local multi-disciplinary team, and approval by the head of the department (PC) was obtained locally. All data were handled in accordance with the General Data Protection Regulation (EU) 2016/679.

## **Results**

### *Socio-demographic characteristics*

A total of 100 forms were collected, the majority of which were collected at the Ferrara CMHC (86%). Users positively welcomed the questionnaire. They reported that the questionnaire could benefit from further reduction in items to meet the needs of patients with cognitive difficulties or ongoing psychopathological challenges. On the other hand, the questions that investigated the areas of physical health and traumatic events were deemed of value, as respondents reported that these topics are not routinely explored in clinical practice, and the questionnaire offers the possibility to discuss them more easily.

As detailed in Table 1, participants' age ranged from 19 to 75 years, with a mean of 44 (SD = 10.89). The gender with which the respondents identified themselves was mostly female (98%), and the vast majority were born in Italy (92%). The majority of the sample (79%) was already receiving care within the psychiatric service (median = 12 years). Most of them had an education level beyond mandatory schooling (68%), were unemployed (72%), and resided with their parents (26%) or partners (30%). A considerable number fell in the lower income status (15,000 euros/year; 38%), and 18% were unaware of their annual income. More than half (66%) possessed a driver's license, but only 46% owned a car.

### *Pregnancies and motherhood*

As detailed in Table 2, 55% of the users had never been pregnant, and two were planning a pregnancy. Additionally, among the 46 who had been pregnant, 9 did not have children, suggesting the possibility of a history of abortion or miscarriage. The majority of women (57%) reported that they did not use any contraceptive method; if used, the male condom was the preferred choice. Among those with young children, they were responsible for the children's care in most cases.

**Table 1.** Characteristics of the women attending the CMHC and SerD in Ferrara randomly selected for the study (N = 100)

Information	Respondents	Missing	Information	Respondents	Missing
<b>Reported gender N (%)</b>			<b>Living situation N (%)</b>		5 (5)
Female	98 (98)		Rented	30 (32)	
Non-binary	1 (1)		Owned	56 (59)	
Prefer not to answer	1 (1)		Supported housing	6 (6)	
<b>Age, years</b>		3 (3)	Rehabilitation facility	2 (2)	
Mean (SD)	44 (10.89)		Other	1 (1)	
Median (range)	49 (19-75)		<b>Employment status N (%)</b>		1 (1)
<b>Nationality N (%)</b>		-	Employed	28 (28)	
Italian	92 (92)		Unemployed	71 (72)	
Other	8 (8)		<b>Disability pension N (%)</b>		2 (2)
<b>First access to the Services</b>	21 (21)	-	Yes	35 (36)	
<b>Access for follow-up visit</b>	79 (79)		Employed	15	
Duration of treatment (years), mean (SD)	12 (1.9)		No	63 (64)	
Median (years) (range)	8 (0-36)		Employed	12	
<b>Educational level N (%)</b>		-	<b>Annual income N (%)</b>		4 (4)
Elementary	1 (1)		No income	22 (23)	
Lower middle school	24 (24)		<15,000 euros	36 (38)	
High school	52 (52)		15,000-28,000 euros	16 (17)	
University degree	14 (14)		28,000-50,000 euros	4 (4)	
Postgraduate	2 (2)		>50,000 euros	1 (1)	
Other	7 (7)		Unknown	17 (18)	
<b>Housing situation N (%)</b>		2 (2)	<b>Transportation*, N (%)</b>		
Alone	29 (30)		Obtained a driving license (yes)	66 (66)	-
With partner	29 (30)		Owens a car (yes)	43 (46)	6
With parents	25 (26)		Owens other means of locomotion, e.g., bike (yes)	39 (44)	12 (12)
Alone with children	3 (3)		Use public transport (yes)	78 (89)	12 (12)
With partners and children	5 (5)		<b>Sports and leisure time*, N (%)</b>		
With friends/acquaintances	7 (7)		Sport (yes)	42 (42)	1 (1)
<b>Has a partner currently (yes) N (%)</b>	55 (63)	12 (12)	Has a group of friends (yes)	41 (41)	-
Partner has a full-time job	31 (56)		Attendance of clubs, associations, groups (yes)	15 (17)	12 (12)
Partner is unemployed	24 (44)		Presence of at least one close friend (yes)	69 (72)	4 (4)

Percentages have been computed on available data for that variable. \*The question allowed for multiple selections.

### Physical health and prevention

Only a minority of the sample (31%) had a gynecologist they can easily refer to, and just half (50%) had visited the community family-OBGY clinic at least once. As described in Table 3, the Papillomavirus vaccination cycle had been completed by 98% of the eligible sample. Only a small percentage of the sample (34%) had a regular menstrual cycle.

As detailed in Table 2, 88% were taking at least one psychotropic medication, 55% were taking at least two, 27% were prescribed at least one medication for a major physical illness. Among the side effects reported, weight

gain and sexual difficulties were the most frequent. In details, 46 women reported weight gain: half of them were in menopause, 25 were currently prescribed anti-psychotics, 4 were on birth control pills, and 4 were not prescribed any psychotropic medication. Among the 15 women using birth control (pill, IUD), 9 reported weight gain and 5 were taking antipsychotic medication. Of the 26 women who reported sexual side effects, difficulty achieving climax or a reduction in sexual desire were the symptoms more frequently reported. Most women reported not using alcohol (70%), with 3% consuming it more than four times a week. Less than half of the women (42%) engaged in regular physical activity.

**Table 2.** Description of the main dimensions explored in the questionnaire: summary of the findings regarding pregnancies, child care, physical health, preventative medicine, medication, and side effects

	Respondents	Missing		Respondents	Missing
<b>Pregnancies and maternity</b>			<b>Current drug therapy and side effects reported in the last year</b>		
<b>Number of pregnancies N (%)</b>		1 (1)	<b>Pharmacological category*, N (%)</b>		14 (14)
0	54 (55)		Psychotropic medications		
1	27 (27)		Antidepressants	40 (47)	
2	11 (11)		Antipsychotics	45 (52)	
3	5 (5)		Mood stabilizers	19 (22)	
4	2 (2)		Benzodiazepines	46 (53)	
<b>Has children (yes) N (%)</b>	35 (35)	-	Medication for physical illness		
<b>Child care responsibility N (%)</b> (open question)		5 (5)	Antihypertensive	8 (9)	
Mother	5 (17)		Cholesterol-lowering drugs	5 (6)	
Father	3 (10)		Gastrointestinal drugs (e.g., prokinetics)	8 (9)	
Foster family	2 (7)		Anti-inflammatory	2 (2)	
Independent children	20 (67)		Antidiabetic	1 (1)	
<b>Is breastfeeding N (%)</b>	0	2 (2)	Other (e.g., thyroid hormones)	34 (40)	
<b>Is planning a pregnancy N (%)</b>	2 (2)	1 (1)	1 psychiatric drug prescribed	23 (27)	
<b>Presence of trusted gynecologist (yes) N (%)</b>	31 (31)	1 (1)	2+ psychiatric drugs prescribed	47 (55)	
<b>Access to community family-OB GYN clinic (yes) N (%)</b>	49 (50)	2 (2)	1+ medication for physical illness prescribed	45 (52)	
<b>Contraceptive method used in the last 90 days*, N (%)</b>		6 (6)	<b>Medication side effects in the past 90 days*, N (%)</b>	96 (96)	4 (4)
None	54 (57)		Weight gain	42 (44)	
Male condom	20 (21)		Hair loss	15 (16)	
Contraceptive pill	10 (11)		Menstrual disorders	9 (9)	
Barrier method	5 (5)		Galactorrhea	0	
Intrauterine device	3 (3)		Feeling of swollen and sore breasts	8 (8)	
Long-acting reversible contraceptives	2 (2)		Reduced sexual desire	19 (20)	
Female condom	0		Anorgasmia	15 (16)	
Diaphragm	0		None	21 (22)	
Tubal ligation	0		Other	6 (6)	
Other	0		<b>Alcohol use N (%)</b>		3 (3)
<b>Preventative medicine*</b>			Yes	29 (30)	
<b>Regular menstrual cycle N (%)</b>	34 (34)	-	Once a month or less	6 (6)	
<b>Menopause N (%)</b>	43 (43)	-	2-4 times a month	13 (13)	
<b>Completed HPV vaccination N (%)</b> (eligible 93/95)	37 (39)	5 (5)	2-3 times a week	3 (3)	
<b>Screening tests for cervical cancer N (%)</b> (eligible 81/100)		-	4+ times a week	3 (3)	
Yes	71 (88)		Did not indicate frequency	4 (4)	
<b>Screening mammography for breast cancer N (%)</b> (eligible 66/99)		1 (1)	No	68 (70)	
Yes	63 (95)				
<b>Undergone breast ultrasound N (%)</b>		1 (1)			
Yes	46 (46)				

Percentages have been computed on available data for that variable.

\*The question allowed for multiple selections.

**Table 3.** Exposure to traumatic events and women's perceived barriers to accessing mental health services

	Respondents N (%)	Missing N (%)		Respondents N (%)	Missing N (%)
<b>Personal history of potentially traumatic events</b>			<b>Barriers accessing to mental health services</b>		
Respondents who have suffered a serious accident at work, in a car or somewhere else	24 (25)	4 (4)	Believing to have had difficulty accessing the service as a woman	5 (5)	1 (1)
Respondents who experienced a natural or man-made disaster in which they felt that their loved ones were in danger, or who saw people seriously injured or killed	39 (40)	3 (3)	Feeling to have been judged by their own family, society, or services because of their suffering	64 (65)	1 (1)
Respondents who have experienced harassment or non-consensual sexual intercourse	30 (32)	7 (7)	Feeling that one's symptoms have been underestimated (since they were too dramatic)	50 (51)	1 (1)
Respondents who have experienced some other stressful event not reported above	57 (59)	4 (4)	Believing that their suffering was underestimated because they seemed too well to have a mental disorder	70 (71)	1 (1)
Respondents who have not reported any stressful or traumatic life events	12 (12)	-	Considering not to have any of the above difficulties in accessing mental health services	14 (14)	-
			Percentages have been computed on available data for that variable.		

### Exposure to traumatic events

The vast majority (88%) reported having been the victim of a traumatic event, as detailed in Table 3. The most frequent traumatic event ( $n = 59$ ) was something other than sexual abuse (mostly the significant earthquake in Ferrara in 2012); additionally, 32 users reported experiencing a sexual trauma.

### Barriers in accessing mental health services

As reported in Table 3, 85 women reported at least one difficulty in accessing mental health services. Only a small percentage of women (5%) reported attributing this challenge to the fact they were women. Most women reported feeling judged predominantly by their family, husband, friends, or co-workers. In 51% of cases, they were called "overly dramatic" or were told that they were seeking attention, and these comments came mostly from family and colleagues. Finally, 71% women reported that their distress was underestimated because they were considered unlikely to have a severe psychiatric disorder at the present moment, being deemed "too high-functioning".

### Satisfaction with care received in the community psychiatric services

As shown in Figure 1, most users expressed having a positive experience, with a fair amount of time spent during the visit. They received clear explanations, infor-

mation, interest, and attentive listening from the providers. Users reported satisfaction with the staff's expertise and felt adequately supported regarding women's health problems. Less than 10% provided negative feedback regarding the perceived quality of care received.

Regarding the preference for a professional of a certain sex, a strong preference in one direction was not observed: for 54% of the sample, providers' female vs male sex was not relevant, while 43% said they feel more comfortable with female professionals.

Overall, on a scale of 1 to 10, the women gave an average satisfaction score of 8 for the services.

They also provided some suggestions for improving the quality of care: these included being on time with scheduled visits, offering more flexibility with times/dates of appointments, enhancing workforce, allowing the choice of a case manager, implementing additional group activities (both in frequency and types), increasing empathy and kindness by mental health operators, expanding telephone availability beyond established time slots, providing an on-call service during the weekends.

## Discussion

The project aimed to create and implement a structured questionnaire. The purpose of the proposed questionnaire is twofold: first, to investigate the socio-demographic characteristics of women accessing the services,

and second, to highlight potential challenges or barriers they may during their pathway to care. The questionnaire is part of a broader quality improvement initiative aiming to promote sex and gender-sensitive care for women. This involves increasing awareness among both users and providers regarding these issues.

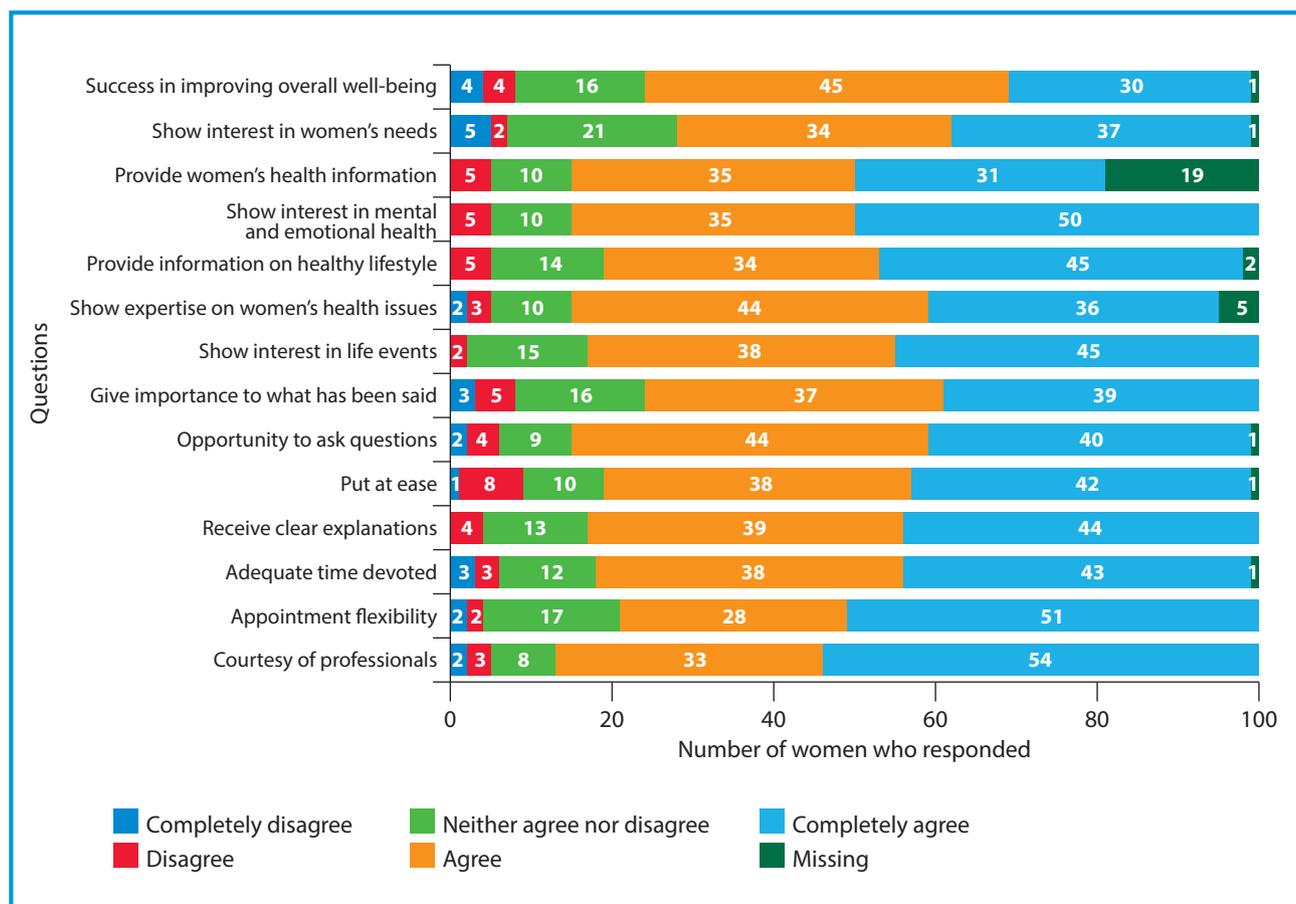
To the best of our knowledge, this is the first time a sex and gender sensitive tool has been created and tested in the real world. Its purpose is to describe the target population from a multidimensional perspective and formulate quality improvement initiatives tailored to women's health needs. Several novel aspects are provided by this tool.

The questionnaire could serve as a tool for patients to overcome self-stigma and encourage a potential coming out. Firstly, it normalizes non-binary gender identity, addressing a gap in standard health documentation that currently do not include alternatives besides binary sex at birth. Moreover, it becomes a tool to start a conversation or facilitate coming out regarding sexual orientation or gender identity. While society and governments make their own adjustments, mental health services should adopt a nonjudgmental and unprejudiced

attitude.<sup>36</sup> Additionally, the questionnaire proactively inquires about medications side effects by providing a list of the most common and underreported side effects, including those related to sexual dysfunctions (reported by 20% of our sample).

The questionnaire can be useful for coordinating with local agencies for preventative medicine. Considering that most severe psychiatric disorders occur during a woman's fertile age, some medications are teratogenic, and women with SMI often miss cancer screenings,<sup>26,37-43</sup> a comprehensive assessment of pregnancy planning and medical check-ups is crucial. In our sample, many individuals did not undergo regular screenings. It would also be appropriate to offer personalized support services to women planning a pregnancy (2% in our study) and to accompany them during the peripartum period.<sup>44</sup> Moreover, only a small proportion of our sample used contraceptive methods.<sup>45</sup> The designated clinician could act as a liaison agent with local services to assist the patient in scheduling regular visits, provide informational materials, and, if necessary, offer support on the day of the appointment.

The questionnaire can improve the monitoring of physical health and assist providers in profiling patients



**Figure 1.** Psychiatric Care Satisfaction Survey. The Y-axis displays the 14 questionnaire questions in abbreviated form, while the X-axis represents the number of users who selected scores on a Likert scale.

based on their cardiovascular risks. In our sample, 88% were taking psychotropic medications, and 52% were prescribed medications for physical health disorders. The clinician could collaborate with the patient to implement strategies, including adopting a healthier and less sedentary lifestyle, and negotiate with the provider for choosing the appropriate drug regimen.

The questionnaire could highlight socio-economic contributors to poor mental health. Most of the individuals in our sample were in a disadvantaged socio-economic condition. Even if the majority were not receiving a disability pension, this does not rule out some form of economic hardship, as the pension is guaranteed only to those who reach 75% of disability. It is possible, however, that women with higher education, and likely better socioeconomic status, have access to the private mental health sector. The implementation of programs for supported education and employment thus represents a priority.<sup>46</sup>

The questionnaire can also serve as a tool to investigate the presence of traumatic events in the users' personal history. Surprisingly, 32% of randomly interviewed women reported experiencing sexual harassment or abuse, while only 12% did not report any traumatic event in their lifetime. These findings are consistent with those found in Khalifeh's study, where 27% of women with SMI reported domestic violence and 10% sexual violence.<sup>31</sup> Moreover, in 2014, the Italian National Institute of Statistics reported that 31.5% of women between the ages of 16 and 70 had experienced some form of physical or sexual violence in their lifetime.<sup>47</sup> It might be worth considering to introduce a trauma survey into standard practice, especially with female users. An instrument like this questionnaire could serve this purpose.

The questionnaire can provide guidance to plan interventions toward personal recovery. Less than half of the surveyed women engaged in some kind of sporting activity, consistent with published literature.<sup>48</sup> This lack of physical activity exposes women to an increased risk of obesity, cardiovascular issues, and premature mortality, a risk that is already significant in women prescribed psychotropic medications. Engaging in regular physical activity can improve mental health, by facilitating positive social experiences, contributing to enhanced interpersonal relationships and self-esteem.<sup>49</sup> Women should be encouraged to join existing sports activities within the service or to create ad-hoc groups specifically for female users to overcome possible cultural barriers and concerns about body shaming.<sup>50</sup>

Finally, the questionnaire can highlight barriers along the pathway to care that may delay treatment. A significant proportion of women reported that their suffering was underestimated because they appeared too functional to suffer to experience mental disorders, con-

firmed other reports.<sup>51</sup> In this regard, it could be useful to implement sex and gender-sensitive mental health training for professionals in order to increase practitioners' awareness of unconscious biases related to roles and gender.<sup>52</sup>

The data collected shows that most of the sample did not perceive difficulties in accessing services because they were women. However, more than half of the women felt judged by their family due to their suffering. In addition to self-stigma, individuals with psychiatric problems are often affected by stigma, influenced by demographic characteristics such as age, gender, and ethnicity, among others. Some studies suggest, for example, that women internalize stigma to a greater extent than men,<sup>53</sup> and report significantly more "discrimination" (perceived hostility from others or missed opportunities due to prejudiced attitudes, negative reactions from other people) and marginally more stigma in relation to their mental health and disclosing information about their mental illness than men.<sup>54</sup>

It might also be useful to promote mental health awareness campaigns targeting the general population. Many events have been organized within local communities to raise awareness of mental health and reduce associated stigma. A few examples in Italy include M&M in Modena ([www.matmodena.it](http://www.matmodena.it)), Mental Health Week in Reggio Emilia (<https://www.ausl.re.it/settimana-della-salute-mentale-2023>), and Ro.Mens in Rome (<https://www.salutementale.net/romens-2023/>). These events are organized by mental health providers in collaboration with local services, users, families, caregivers, non-profit organizations, volunteering associations. They include free initiatives such as debates, conferences, and artistic and cultural events open to all the citizens. In addition, psychoeducation could be offered to family members.<sup>55,56</sup>

Psychoeducational tools delivered online by remote could also accommodate women with mobility problems or limited resources.<sup>24</sup> A positive initiative in this direction is freely available online material dedicated to parents with mental disorders to help them navigate their children's needs.<sup>57</sup>

In summary, this study has several strengths. First, the study offers a simultaneous, comprehensive overview of the various determinants of mental health in a random sample of women accessing the community mental health service, rather than focusing on specific sectors. Second, it underscores specific sex- and gender-related needs that these services must consider in the recovery process. These needs include, for example, trauma-oriented care, physical health, and economic independence. Third, the tools developed can be adapted for clinical practice to systematically investigate and monitor these specific areas.

## Limitations

The results of this study should be interpreted in light of some limitations. First, the questionnaires have not been validated against established assessment tools; the questionnaire has been conceptualized as guidance for collecting a more comprehensive personal history rather than a structured assessment tool.

Second, the questionnaires were administered to only 100 women, representing a small fraction of all the users accessing outpatient community psychiatric services. Therefore, the results may not be representative of the total population accessing such services. Additionally, the questionnaire was only administered for a short period of time and during the summer, when the attendance is reduced, affecting the number of approachable users. Moreover, in the present study, unintended selection biases may have been created, as the questionnaire might have been offered to women who appeared to be less symptomatic, more available, and perhaps even more satisfied with the service. There is a possibility that the questionnaires were given to those more fluent in Italian, or that foreign-born women refused them due to language or cultural barrier. Further bias in providing responses could have been created because the request to complete it originated from local providers; this bias has been mitigated by assuring anonymity and collecting the completed forms in a sealed box.

A formal revision of the text should be performed by a larger group of lived-experience users and providers to

make the forms more understandable and comprehensive. Additionally, the two questionnaires were created primarily for the population accessing the CMHC and may not fully capture the challenges and needs of women attending the SerD. Thus, it would be necessary to adapt them first by investigating all substances, second by inquiring about physical health given the high comorbidity with infectious and liver diseases. Finally, a parallel version dedicated to the male gender might also contribute to improving the quality of treatment provided to men.

## Conclusion

The implementation of a comprehensive women-oriented questionnaire proved to be a feasible tool for identifying sex-specific dimensions that could influence access to care and personal clinical outcomes. It also provided useful insights for implementing quality improvement actions with the involvement of key stakeholders.

Further studies are needed with larger and more diverse samples to enable sex and gender-tailored programming of community mental health services.

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### Key messages

- Women have sex and gender-specific needs for mental health.
- Women have role- and gender-specific risk factors for mental disorders.
- Specific tools that assess sex-specific health determinants are missing, and clinical services are rarely equipped to deliver sex and gender-tailored treatments.
- The comprehensive questionnaire proposed may represent a useful tool for investigating specific sex and gender aspects in women accessing mental health services and for implementing tailored treatments.
- This study confirms that women face socio-economic difficulties, a high frequency of traumatic histories, their disturbances are minimized even by family members, and there is non-optimal use of prevention in the area.

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*Ethical approval and informed consent.* As the project was classified as an audit of current practice and service evaluation, full ethical approval and written informed consent were not required. However, this study had been discussed with the local multi-disciplinary team, and approval by the head of the department (PC) was obtained locally. All data, collected anonymously, were handled in accordance with the General Data Protection Regulation (EU) 2016/679.

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