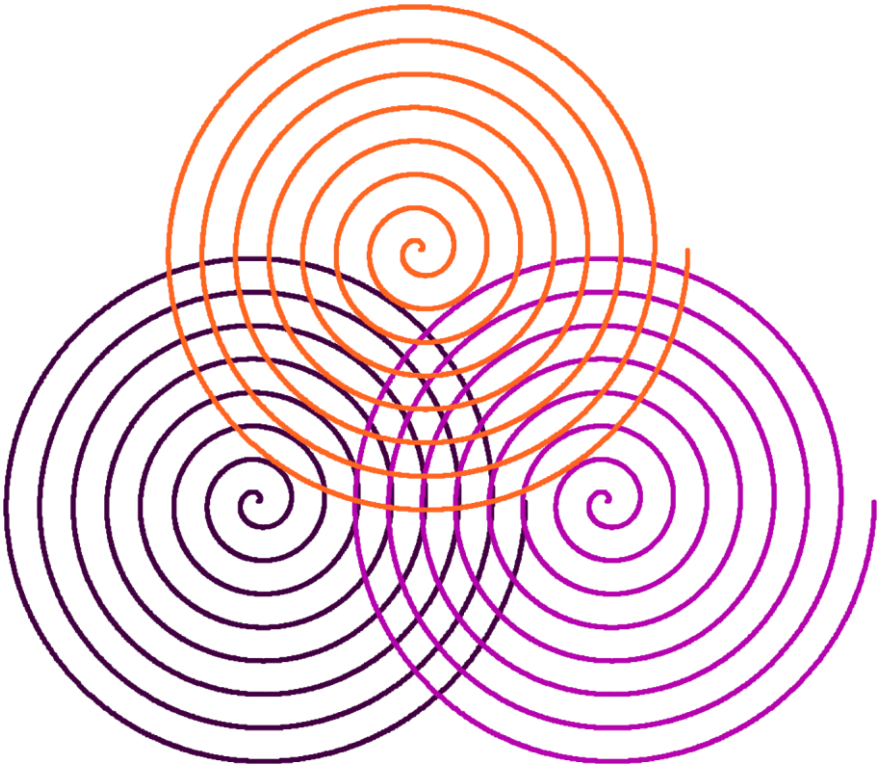
‘I AM MORE THAN ONE THING’:

A guiding paper by Imkaan, Positively UK and Rape Crisis England and Wales on women and mental health

May 2014



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INTRODUCTION

At least 'one in four people will experience a mental health problem at one point in their lives' (Department of Health 2011:8). Furthermore, women and girls, in increasing numbers, are almost twice as likely as boys and men to suffer from low level mental health problems, including depression, anxiety, eating disorders, low self-esteem, and self-harm (Women's Health & Equality Consortium 2013: 2). In addition the Department of Health's own *Mental Health Dashboard*, providing information on the overall progress on the government's mental health strategy, indicates that women are more likely than men to experience long-term mental health problems (Department of Health 2013:17) and are slightly more likely than men to have an additional long-term physical condition (Department of Health 2013:40).

This report builds on existing evidence to highlight women's experiences of poor mental health and wellbeing and their interactions with the mental health system. It also aims to identify support needs or barriers that women encounter in the process of seeking support across the voluntary and statutory sector. Whilst we are aware there are several factors that impact on women's mental health, specifically, this guiding paper focuses on women's mental wellbeing within the context of the effects of sexual violence.[1] as well as an assessment of different levels of social exclusion or marginalisation, that may be experienced by black and minority ethnic (BME) women, and women affected by HIV. The research is commissioned by the Women's Health & Equality Consortium (WHEC) and was delivered in partnership between Imkaan, Positively UK and Rape Crisis England & Wales (RCEW).

Overall, the findings highlight an inconsistent picture of how women's mental health and wellbeing is integrated within national and local policy processes and structures. For instance, national policies on mental health do not sufficiently consider the specific needs of women and girls. On a local level, a similar pattern emerges. Whilst the Joint Strategic Needs Assessments (JSNAs) reviewed prioritise mental health, they often failed to consider women and mental health as a specific strategic priority. Furthermore, there is a lack of consideration of how mental health may impact differently on specific groups of women, including women living with HIV, those experiencing sexual violence, or BME women. Whilst some local strategies and practice do reflect examples of promising practice, such as the inclusion of the mental health impact of domestic or sexual violence and the commissioning of a Rape Crisis Centre in one region, there is an over-reliance on limited data, for example, police statistics. Such data does not allow for an accurate or complete assessment of women's mental health support needs as a consequence of violence against women and girls (VAWG).[1] The lack of national and local recognition also creates a fragile relationship between commissioners and local women's voluntary sector support services who, despite playing a key role in prevention, early intervention and crisis-based responses, are not often

[1] Defined as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.' Adopted by the United Nations General Assembly, 23/2/94 (Resolution No. A/RES/48/104).

recognised as key delivery agencies in the health policy landscape. However, access to timely and appropriate support improves women's mental health. As highlighted by the women's organisations, holistic and targeted women-centred approaches that tackle women's experiences of inequality are very necessary. For example, there is a need to improve the response to asylum seeking women who have been trafficked, and the emotional impact on them when they receive negative decisions regarding their asylum claims, along with on-going trauma experienced as a result of being trafficked and exploited.

The findings of this report clearly demonstrate the need for and value of a consistent gender-specific approach in the commissioning and delivery of mental health services. The Department of Health's 2014 policy paper, *Closing the Gap*, which details priorities identified for essential changes in mental health services within the forthcoming two years, might well be an opportunity to close the gap between women's mental health needs and meeting these needs through appropriate service provision.

This guiding paper provides information to national policy leads, health commissioners, as well as women's voluntary and community services in reviewing their own policies, practice and service delivery.

Methods

The project involved the following:

1. Desktop research identifying relevant literature sources including key national policy documents and existing research data on mental health and women.
2. An assessment of local health policy and practice across three regional areas in England, across different themes (HIV; BME women; and sexual violence). This was conducted through desktop research and semi-structured interviews with local health commissioners, local voluntary sector specialists as well as focus group discussions with women in the different regions.
3. Identification of strategies and promising practice to improve women's mental health.

All of the face-to-face interviews and focus groups with women and girls were carried out by the individual partners and therefore took place at the projects where women and girls were accessing support to ensure safety and confidentially.

We have set out the findings of work as follows:

1. Literature review (including national policy context)
2. Women's views of support
3. Regional case studies

Parameters of the Work

This is a small scale project which focused on key issues arising across 3 regions of the country and therefore cannot be generalised to other areas of the country. It was delivered

within a short timescale. This meant that we were unable to explore in detail a number of emerging, or general issues in relation to the mental health of women, due to time and partly because of the scope of the project. However, we are aware that the causes and consequences and context of poor mental health have a much broader impact on women than we were able to convey within this report. We reviewed the most significant available national and local policy documents. Although the number of interviews and focus groups are small, the findings generated are rich in content and have identified pertinent issues to the development of more inclusive mental health strategies. Some areas identified would also benefit from further research and analysis.

Literature Review

Women experience a broad range of mental health issues, some that disproportionately affect women.. For example, women are more likely to experience depression; twice as likely as men to experience anxiety disorders; many more girls are likely to self-harm; two thirds of the population that suffer from dementia are women; eating disorders are more common in women than men; and worldwide more women are affected by post-traumatic stress disorder (Mental Health Foundation).[2] The Department of Health report that the days lost due to common mental health problems, as a proportion of overall sickness absence, has been consistently higher in women than men, with just below 13 per cent for women and just over 8 per cent of men (Department of Health 2013:18).

As the World Health Organisation comments, 'Gender determines the differential power and control men and women have over socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health risks'.[3] For instance, there are a range of socio-economic factors that can potentially impact on women's wellbeing and have a much wider impact on society, since not only can mental health problems be disruptive to women and girl's lives and health, the problems could have a knock-on effect on families, as women are more likely to have caring responsibilities (Women's Health & Equality Consortium 2013:3). Women are more likely to deal with the challenges of working whilst also having caring responsibilities for immediate as well as other dependent family members, experience poverty as a consequence of unemployment, or through insecure, irregular and poorly paid employment and are more likely to experience VAWG.[4] Women are more likely to become isolated from family and friends; in some cases leaving employment and /or use over-the-counter and prescription medication problematically (Platform 51, 2010: 8). A combination of events, triggers or experiences and the cumulative effect of these events, make it more difficult for women to cope with each new challenge (Platform 51, 2010: 7).

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[2] See for example, Mental Health Foundation: http://www.mentalhealth.org.uk/help-information/mental-health-a-z/W/women/; World Health Organisation: http://www.who.int/mental_health/prevention/genderwomen/en/ (accessed 28/3/14)

[3] See above footnote – the World Health Organisation link

[4] http://www.mentalhealth.org.uk/help-information/mental-health-a-z/W/women/ (accessed 31/1/14)

Women are also often subject to daily micro-aggressions, which over time can 'take its toll' on individual emotional and mental wellbeing.[5] Where women, such as black and minority ethnic women, lesbians, bisexual and transgender women, face multiple, intersecting oppression, the experience can be compounded. As this guiding paper explores women's mental wellbeing in the context of sexual violence, and women who may experience different levels of social exclusion or marginalisation, including BME women and women affected by HIV, much more focus has therefore been given to women in these particular circumstances.

Health impact of violence against women and girls

35 per cent of women globally have experienced some form of domestic and/or sexual violence in their lifetime; therefore violence against women is a major public health problem as well as a violation of women's human rights (World Health Organisation 2013). In 2013, the Ministry of Justice reported that approximately 85,000 women are raped on average in England and Wales every year and that 'around one in twenty females (aged 16 to 59) reported being a victim of the most serious sexual offence. It is also acknowledged that current figures are not an indication of prevalence given that women may not report for a variety of reasons, including not being believed and repercussions from reporting (Ward et al 2013: 240).

The link between violence against women and girls and mental health is well established in existing literature. For instance, the World Health Organisation (2002) has estimated that 60 per cent of women using mental health provision in the UK have experienced some form of sexual abuse, and that sexual violence can perpetuate further emotional, physical and social harms in the form of nightmares, depression, eating disorders, and self-harm, with consequences on parenting, employment, intimacy within future relationships (see Ward et al 2013: 240). Similarly, recent evidence, from NatCen's (2013) study on violence, abuse and mental health in England, which highlights violence against women and girls as the underlying problem of gender inequality within society, which then impacts on the long-term mental health of women.[6] For instance, women (84 per cent) were more likely than men to be in every group characterised by violence and abuse, particularly in the group marked by 'extensive physical and sexual' violence (2013:6). Further, individuals placed in the 'extensive physical and sexual' violence group were fifteen times more likely to have attempted suicide, with four per cent having attempted suicide in the last year (2013:11). Violence and abuse are also strongly associated with a wide range of health

[5] 'Microagressions' are 'brief, everyday exchanges that send denigrating messages to certain individuals because of their group membership' Sue, Derald Wing (2010) *Microaggressions In Everyday Life: Race, Gender and Sexual Orientation*; Hoboken, New Jersey and Canada: John Wiley & Sons, Inc.

[6] In looking at the socio-demographic profile of the abuse and violence experienced, NatCen's study gathered data on six groups of adults experiencing varying levels of violence: (1) little violence or abuse; (2) physical from partner; (3) extensive physical for partner; (4) sexual as child only; (5) sexual as adult; (6) extensive physical/ violence as child and adult. Data on the six groups of adults were collected in relation to gender; four different age groups (16-34, 35-54, 55-74, 75 plus); marital status; and four different ethnic group splits (White, Black, South Asian, Other/ mixed).

risk behaviours, including being more than twice as likely to be dependent on illegal drugs and smoking and 38 per cent of people in the 'extensive physical and sexual' group had a problematic pattern of alcohol consumption (2013:13).

Overlapping and intersecting areas of marginalisation

International research has identified a significant correlation between HIV and violence against women and girls in England and across the UK, yet, the link remains under-researched and relatively unacknowledged, and there is a need to investigate violence as a cause and consequence of HIV for women living in England (Sophia Forum 2012:4). Existing knowledge shows that where women are 'preoccupied with their personal safety', the health risks are likely to increase. For instance, women may be less attentive to HIV prevention messages, face challenges to disclosing their HIV status, implementing risk-reduction, engaging in other preventive health behaviours and adhering to HIV treatment' (World Health Organisation 2013:37). Furthermore, women with HIV experience high levels of stigma, such as being shunned, and discrimination, for example, forced evictions or refused treatment or care because of their HIV status, and other human rights abuses, which some studies define as a continuum of violence (WHO 2013: 8).

Similarly, very few studies have focused on the specific experiences and understandings of people from BME communities (Mental Health Foundation 2011:18). Yet, research shows that rates of admission as in-patients in mental health settings for women from African, Caribbean and South Asian groups (except Indian), were three to six times higher than average (Mental Health Foundation 2011:17). Specifically, in relation to the precise ethnicity of in-patients detained under the Mental Health Act 1983, the rates were higher than average for Other White, White/Black African Mixed, Other Mixed, Indian, Pakistani, Bangladeshi, Other Asian and Other Black groups, with two times higher than average rates for Black African, Chinese and 'Other' groups (Care Quality Commission 2011).

In addressing the mental health needs of BME women, other factors could have a major impact on how women access appropriate support within the mental health system. For example, women's wellbeing will be shaped by other socio-cultural and political factors, such as their asylum or immigration status, family circumstances, employment, education, marginalisation on the basis of ethnicity and/or culture both within communities and across society (Mental Health Foundation 2011:17). Part of the reason why BME people often first come into contact with mental health services at the acute stage of their condition is because of a range of issues, which include stigma and discrimination in the NHS (Mind 2013:19). When these associated issues are not addressed this is essentially 'failing to address a significant part of [BME women's] distress' (Mental Health Foundation 2011: 9).

In addition to factors that shape the experiences of both female and male refugees and asylum seekers, women in this group might also have been subjected to violence and rape, and as a result, are likely to have high mental health support needs 'in the context in which they may face questioning about their experiences, often before they are able and willing to talk about these [with mental health services]' (Keating et al 2003:23-4). Experiences of detention and prison can significantly exacerbate women's mental health problems,

particularly where there are pre-existing mental health concerns. A Women for Refugee Women report found that, of the women who were interviewed (n=46), 37 per cent responded that they had mental health problems, including psychosis, post-traumatic stress disorder, depression, insomnia and flashbacks. In addition, 30 per cent were on suicide watch during their detention, while 67 per cent described the healthcare in detention as 'bad' or 'very bad' and said that they did not trust the medical staff in detention. 89 per cent of the women found it difficult to sleep, while 70 per cent found it hard to eat the food (Girma et al 2014:4-5). Moreover, a report by Maternity Action and the Refugee Council found that there were extremely high rates of mental health problems among dispersed and relocated asylum seeking women who were pregnant – two out of the 20 women interviewed had attempted suicide during their pregnancies and more reported poor mental health (2013: 25; 48-50).

Whilst, Wish – a national, user-led charity working with women with mental health needs who are in prison, hospital and the community highlights an acute lack of appropriate support services. First, there has been a lack of funding for work to address the mental health needs of women through good quality women-centred preventative services that deal with mental health and other support needs. In addition, clearer leadership from the Ministry of Justice is needed to effectively address the needs of women offenders; and the impact of the continued lack of funding for women's centres and other voluntary sector services has meant that the needs of women offenders or those at risk of offending are still not sufficiently met.[7]

Gaps in statutory responses

Whilst the existing data highlights both the high prevalence of and specific factors that impact on women's mental health, there are gaps in the way in which statutory services respond. For example, violence and abuse is a relatively new issue for Mental Health Trusts to address in a systematic fashion (Holly et al 2012:6). Specialist support to victims of violence is lacking as well as staff that are tasked to lead in this area of work (Holly et al 2012:19). Furthermore, where therapeutic services were provided, only 14 per cent (n=6) delivered specific group-work for survivors of child sexual abuse, and seven per cent (n=3) offered specific work on domestic violence (Holly et al 2012:19). Therefore, it has been suggested that responses could improve if the Department of Health provide Mental Health Trusts with 'a template policy for responding to domestic violence and sexual violence'. In addition, further research is required to determine rates of routine enquiry on domestic violence within mental health services, and the joint funding of specialist workers who should be based within Mental Health Trusts (Holly et al 2012:21).

[7] http://www.womenatwish.org.uk/policy-campaigns/policy/consultations-2012/ See also, Clinks, Women's Resource Centre and Women in Prison's guidance paper on working with foreign national women offenders and ex-offenders, http://www.clinks.org/sites/default/files/basic/files-downloads/Guidance%20for%20working%20with%20Foreign%20National%20women.pdf (accessed 28/3/14)

Furthermore, whilst the value of integrated and holistic approaches are well established within the voluntary sector, this is not necessarily mirrored in the approach of statutory agencies. For instance, historical definitions of 'integrated care' are often based on a 'medical model' (Ward et al 2013: 239). Therefore, although some groups, such as those with long-term health conditions, are readily identified as needing support, victims of rape and sexual assault, are often not considered as having complex needs, or requiring access to 'person-centred, coordinated care' in the form of acute and long-term support to address the impact on their health (see Ward et al 2013: 239). Consequently, the lack of consideration of women experiencing rape and sexual assault not only leads to fragmented services but also to an escalation of women's health and wellbeing needs (Ward et al 2013 239).

For example, Coventry Rape and Sexual Abuse Centre (CRASAC) have developed pathways through dedicated counselling support and advocacy services including Independent Sexual Violence Advisors (ISVA), therefore not only can women access immediate support for recent incidents of sexual violence but they are also able to seek help 'many years after the initial abuse' (Ward et al 2013: 239). Due to the dedicated support offered, only two per cent drop out of the criminal justice process compared to a national rate of 80 per cent. However, there are concerns about how survivors of sexual violence will be prioritised and how dedicated services, like CRASAC will retain funding within the 'narrow, medicalised view of integrated care' particularly given current economic pressures (Ward et al 2013: 245). The difficulties that specialist women's services encounter in addressing their sustainability are further compounded by the fact that commissioners do not always understand the value or role of specialist women's services. In fact, they can be deemed as 'amateur charities' and 'not fully committed to or capable of providing services' to service users (Ward et al 2013: 244).

Given that women with HIV experience high levels of stigma, as well as experiencing violence rooted in gender inequality, there is clearly a need for integrated strategies which address violence against women and girls within the context of 'a national AIDS response' (World Health Organisation 2013:2). For instance, women can be reached with an integrated violence prevention approach through either HIV services or through services for abused women (World Health Organisation 2013: 37). In a report on responses to women living with HIV in the UK, the Sophia Forum suggest that current responses could potentially improve through closer partnership working between the HIV and violence against women and girls sectors. There is a need for the training of HIV professionals in identifying and supporting women with gendered-violence, including training in how to ask about women's experiences of gendered-violence and the use of appropriate pathways (2012:4). As part of this integrated approach, peer lead networks which promote awareness of the issues and understanding of rights entitlement for women experiencing violence and mental health problems in relation to HIV also need to be strengthened (Petretti et al 2012; Petretti and Ng abstract for forthcoming International AIDS Conference).

For BME women, an integrated care approach, to assist women with the recovery process, inevitably includes addressing the damaging effects of inequality and discrimination, including racism, sexism, other oppressions, or a combination of all of these issues. The

work of the Women and Girls Network (WGN) delivers, does exactly this, and includes clinical work that recognises 'the complex and intersecting impact of various forms of oppression and discrimination' that women experience (Thomas 2013:6). The Mental Health Foundation's 2011's report notes that not only have these inequalities not been eradicated, because they have a continued impact on BME women, there is a need to address these experiences, if a positive sense of self and identity is to be developed. Furthermore, women who were interviewed for the Mental Health Foundation's study felt that mental health services did not address their experiences of racism and other discrimination, nor were they capable of doing this, thereby failing to address a significant part BME women's distress (2011:38).[8] As highlighted earlier, integrated models of care exist in the voluntary sector and therefore provide opportunities for strengthening cross-sector working.

A key strand of the government's *No Health without Mental Health* approach to addressing mental health includes a commitment to investing about £400 million over four years to make a choice of psychological therapies available to those who need them in England (Department of Health 2011: para 5.13). There are already indications that work needs to be done to improve access to psychological therapies (IAPT). However, another concern relates to the application of IAPT to some groups. For example, although talking therapies on the whole, could help in preventing the deterioration of mental health, cognitive behavioural therapy[9] needs to be used cautiously in relation to any adult, young people or child survivor of childhood sexual abuse and/ or domestic violence (Itzen et al 2010: 39, 40, 46, 64). A major issue for the Itzen report was that the use of 'solution focussed, skill based and cognitive behavioural interventions may occur at the expense of longer term, "deeper" or effective therapies' (Itzen et al 2010: 39). Furthermore, despite the focus on different models of 'recovery' in *No Health Without Mental Health,* and the commitment to improving access to psychological therapies, 'a dilution of focus on the needs of specific groups of people, especially in terms of race equality' is problematic, and is likely to worsen with the austerity measures with BME groups being disproportionately affected by funding cuts (Mental Health Foundation 2011:11).

[8] See also http://www.helenbamber.org/http://www.helenbamber.org/ and the Helen Bamber Foundation's model of integrated care for survivors of human rights violations, which includes people who have been trafficked, and those who have experienced domestic or gendered-violence: 'We work 'here and now' to treat each person with dignity and help them with access to health care, legal advice and human rights. We adjust the care we give in accordance with changing circumstances and challenges clients face. We help our clients gradually establish a therapeutic relationship of trust, which can eventually enable them to form safe, restorative and stabilising relationships in the wider community. This is an intricate process, essential for survivors' safety, well-being, ability to re-build and move forward with their lives'.

[9] Cognitive Behaviour Therapy ' is a form of talking therapy that focuses on how you think things are going on in your life; thoughts, images, beliefs and attitudes; your cognitive processes, and how this impacts the way you behave and deal with emotional problems. It looks at how you can change negative patterns of thinking or behaviour that may be causing you difficulties, and in turn this can change the way you feel'. See www.mind.org.uk

National policy context

The coalition government's current priority on mental health, *No Health Without Mental Health*, seeks to place mental health needs 'on par with' physical health in recognition of the fact that these issues received less attention and that a wider perspective on health and wellbeing was required (Department of Health: 2011). Furthermore, the Department of Health, Public Health England, the Secretary of State, and the clinical commissioning groups at a local level have a specific duty to reduce health inequalities.

The current mental health policy was introduced during the inception of localism and the Big Society agenda, where power was shifted away from the Department of Health to local authority areas. A number of key changes were implemented. Nationally, for example, Public Health England included mental health as a key priority and a new national measure of wellbeing was developed as was taking a life course approach in order to prioritise interventions across all ages (Department of Health 2011: para 1.33; Department of Health 2012: 10). The focus also shifted to holding services to account 'for the outcomes they deliver, for example, through the public health, social care and NHS outcomes frameworks' (Department of Health 2011: para 1.27). Locally, *new* local bodies have been created under the *Health and Social Care Act 2012*, which included health and wellbeing boards, clinical commissioning groups. In addition, Directors of Public Health had new responsibilities for local populations' wellbeing, and were expected to treat mental health as a priority. Therefore, clinical commissioning groups and other local authority partners are required to consider evidence on the mental health and wellbeing of local populations as part of producing joint strategic needs assessments and health and wellbeing strategies.

Our critique of existing policy, that did not mention women, found that despite a strong policy commitment to mental health and a number of structural changes, a subsequent interim document, *Closing the Gap: Priorities for Essential Change in Mental Health*, needed to be produced early in 2014 in response to feedback from service users and carers about the continuing gaps in service provision and long waiting times (Department of Health 2014:9). The 2014 report includes a number of encouraging commitments. For example, 900,000 people will be assisted in accessing psychological therapies each year (Area 5). Furthermore, the Department of Health will be working with Monitor and NHS England to develop the payment system to enable commissioners to fund the most effective services based on quality of service delivery and outcomes. From April 2014, in helping commissioners of mental health services to hold providers to account, the Health and Social Care Information Centre will produce monthly reports for commissioners and providers, which will show how providers are achieving against a number of quality and outcome measures (Area 7). £3.8 billion has been allocated to help every health and wellbeing board in the country to develop its own plan for joined up mental health and physical health care (Area 13). While frontline health services will respond differently to people who self-harm (Area 14); the Department of Health will also publish a new national Crisis Care Concordat which will set out clearly the nature of support people experiencing a mental health crisis should receive (Area 15). Finally, anyone who is a victim of crime will be offered enhanced support (Area 22).

Moreover, even though the government has stated its commitment to promoting equality and access to services (Department of Health 2011: Section 6; Department of Health 2012: 8 and 10), a lack of a gendered analysis in relation to both the current mental health strategy and implementation framework has resulted in an inconsistent approach to meeting the mental health needs of women at a local level.

There has been an attempt to mainstream women and mental health. The 'whole systems approach' was an important first step and vital to addressing inequalities, improve public services and promote social inclusion (Department of Health 2003: 5, 11). A number of promising strategies and useful recommendations within the Implementation Guidance warrant consideration in the implementation of current local health and wellbeing strategies. For example, this includes appointing a key strategic lead in the then Primary Care Trusts with mental health trusts – now clinical commissioning groups, social services and all other stakeholders; establishing a women's advisory group to reflect user experiences; a review of existing provision within the statutory and voluntary sector to identify gaps in women-only provision as well as mapping the level of resources – both human and financial – allocated to women and mental health (Department of Health 2003: 13).

Yet, some of the concerns about the potential success of mainstreaming the mental health needs of women, raised at the time, are a useful reminder of action that needs to be taken in ensuring that the mental health needs of women are met. For example, how women's mental health problems are conceptualised and perceived affects the nature of service provision. Services 'approach women's mental health from an individual pathology perspective, whereas service users consistently ask for a more holistic view of their lives', a difference that could be summed up as follows: it was a difference between asking 'what is wrong with this woman?' as opposed to 'what has happened to this woman?' (Keating et al 2003:23). Specifically in relation to BME women, the policy consultation document itself continued the pattern of marginalising BME women, with only four substantive comments on the issues concerning BME women. A significant failure by the Department of Health at the time, was not cross-referencing *Into the Mainstream* with *Inside Outside*, the consultation document on BME mental health care, thereby reinforcing the divide and disconnection in debates on gender and 'race', as well as missing the opportunity to place the mental health needs of BME women firmly on the mental health agenda (Keating et al 2003:27). Finally, *Into the Mainstream* relied upon organisations addressing gender issues as a fundamental and integral part of their culture, and in the mainstream activity, not as an afterthought. An awareness of gender issues alone would not translate into gender-sensitive services. Organisations as a whole needed to begin to consider how they might develop a culture in which the gender inequalities that affect service users and staff are considered and addressed (Owen and Khalil 2004:11).

This report is being written at a time of widespread economic challenges and associated austerity measures. Our main concern about these measures, in this context, is that they could lead to further systematic failures to adequately address women's mental health needs. Within major cuts to public spending, it is questionable whether the wider determinants of population and individual health and wellbeing would always remain in focus for health and wellbeing boards and clinical commissioning groups, when

commissioning integrated care (Ward et al 2013: 239). The wider determinants are known to include lifestyle, feeling safe, education, employment, housing and belonging to a community, and as Marmot observed in 2010, these support individuals to take more control of their own and their families' lives in a positive way in relation to health and wellbeing. We are concerned that despite increased awareness amongst public health leads of the key factors that support health and wellbeing, austerity measures and increasing pressures on the health and social care system may lead to a de-prioritisation of this work within health and wellbeing boards and clinical commissioning groups (Ward et al 2013: 239). Furthermore, addressing the wider determinants of health requires a very specific understanding 'of the interplay between multiple processes of exclusion and discrimination operating across the labour market, education, housing and citizenship', particularly in terms of seeking effective socioeconomic interventions which would have a positive outcome on BME women, bearing in mind 'the structures and processes that perpetuate socioeconomic status among many minority ethnic people are themselves inherently racially patterned' (Salway et al 2014:5).

REGIONAL CASE STUDIES

Women's experiences of support services

Challenges and barriers to seeking help

During the interviews and focus groups women spoke both about the impact of the violence on their health whilst also sharing the challenges and positive elements of the support they received from support services. Women had experienced multiple and different forms of violence including domestic violence, forced marriage, sexual violence including rape and child sexual abuse, being exploited through prostitution and being trafficked for the purposes of sexual exploitation.

The impact of violence on women was also often exacerbated by their particular circumstances, and highlights a complex range of factors that have an impact on women's health. For example, facing prolonged imprisonment as a result of being trafficked, or having children abducted, had serious health consequences including acute anxiety, severe depression and extreme symptoms of post-traumatic stress disorder. BME women spoke about the insecurity of their immigration status and concerns about deportation and the subsequent problems around poverty, homelessness, debt, unemployment, and social isolation, which exacerbated their mental health problems. One woman told us, 'When I was in a desperate situation I couldn't get any help at all because I was locked up and terrified of the traffickers. I couldn't speak English, I didn't know how to get help and I was frightened of being deported if I did anything to anger the traffickers'.

Women living with HIV spoke about the difficulties in emotionally coping with the multiple stigma of being HIV positive, dealing with mental health issues and also being vulnerable to violence. For example, women talked about their reactions to being diagnosed with HIV which ranged from not feeling fully alert and a questioning state of mind: 'I feel like I want for somebody to get into my brain and dust off the cobwebs' to being suicidal, depressed, having low self-esteem, anger, with some of the anger being directed at having to take medication to control the HIV, while being constantly reminded of the illness at the same time.

Women who had experienced child sexual abuse spoke about the time it took to come to terms with what had happened to them, experiencing mental health problems for a number of years but without understanding what was happening to them and how it was linked to the abuse until they accessed appropriate support. This meant that they had not approached professionals until the symptoms became much more acute. Different types of mental and physical ill health issues were experienced, some of which had been clinically diagnosed and this was languaged by women in the following ways:

- Acute anxiety
- Severe depression / Bipolar disorder
- Post-traumatic stress disorder
- Self-harm

- Eating disorders
- Attempted suicide
- Low self-esteem
- Anorexia
- Phobias
- Panic attacks

Women also described factors impacting on their wellbeing:

- Fear, low-self-esteem, anxiety and other symptoms based on the impact of stigma and discrimination
- Being bullied
- Alcohol and drug dependency
- Truancy from school

All of the women we spoke to eventually sought help through specialist voluntary sector organisations, however women described different factors that impacted on their help-seeking processes. Some women spoke about the ways in which they had learnt to become self-sufficient as a way of coping, or in connection with what was expected of them and in this process women did not always recognise the impact of what was happening to them.

> 'For many years, I… thought I am supposed to be strong enough, I am supposed to be able to cope with everything. That was my learnt behaviour from since I was a kid. I grew up with some "example" of depression in my family but I didn't know what it was. I thought it was "normal". So it is weird when you don't label something that is negative as negative. Only when something else happens down the line that it is extremely negative you make the links. And realise how bad it was.'

Women also spoke about other barriers including:

- The emotional and physical consequences of violence prevented some women from leaving the house.
- Excessive physical restrictions and a policing of women by the perpetrator(s) prevented access to information and support services.
- Language barriers affected how confident women felt about disclosing and about how well they would be understood by external organisations.[10]

[10] The term language barrier should be viewed in the context of systematic exclusions rather than individual women's/community failures to 'integrate' i.e. where services are only available in English, they will not be accessible to women who speak little or no English. Women already engaged in services may also experience difficulty in speaking to workers about the violence they have experienced.

- Fear of potential violence from trafficker(s) and deportation if they sought help.
- Fear of being tracked down by the perpetrator(s) as a primary on-going concern after seeking help.
- Not knowing where or how to seek help in the first place, prevented some women from seeking assistance.
- A specific coping strategy for some women, particularly in terms of the trauma women had experienced in relation to child sexual abuse was to detach themselves from what had happened and therefore they had not sought help earlier.
- Women living with HIV spoke about direct discrimination of being HIV positive, which could lead to verbal and physical assault. Hence feeling safe then becomes an issue, which also affects whether women tell family members of their HIV status or whether it remains a secret, thereby leaving women feeling very isolated, and living 'a double life'.

Responses of professionals

Not feeling understood

Women described not feeling understood and that this was sometimes fuelled by the judgemental attitudes of some professionals. In addition, women found it difficult to continually relay painful events and stories repeatedly with different professionals in the same department. How women were treated by any professional the first time they sought help impacts on whether women feel able to ask for help and also prevented women from seeking help.

For other women, poor responses were directly linked to the health professional they had accessed not fully understanding or engaging with the full impact of sexual violence or how living with HIV has particular consequences for the safety and mental health of women. For example:

The following woman is a mother of two children, with a long history of childhood sexual abuse, which has left her estranged from her family. At the time of the focus group, she was currently waiting to see a psychiatrist for depression, self-harm, eating disorders, anxiety, and awaiting a diagnosis. She describes the limitations of current responses by stating:

> 'If you have these things – like I don't know, rape, sexual abuse, bi polar, transgender, PTSD – they don't want to know, they can't deal with it all. I am like an onion – I have eating disorders too – I am more than one thing… If I was just X with an eating disorder it would be fine, there's help with that and off I go but I have more than one thing.'

Whilst another woman states in connection to her experience of receiving non-specialised counselling:

> 'They didn't have the resources or knowledge to deal with sexual abuse'.

This was also a recurring theme for women who spoke about surviving sexual violence and subsequently seeking support for their mental health needs through a GP, who they all self-referred to and stated was their first access point.

A lack of understanding from health professionals also emerged as a strong theme for women living with HIV. Women frequently have to deal with the dual stigma of coping with a mental health condition before being diagnosed as HIV positive or experiencing mental health problems as a result of having the long-term illness. This means that staying emotionally balanced was vital. Yet, for some women who have tried to access talking therapy,[11] they have had to deal with medical practitioners who are not making the link between mental ill health and women's HIV status. As one woman told us,

> 'A whole more education needs to be done around the symptoms and how it impacts even low-level anxiety. I talk to women and the classic example is not disclosing their status and the burden of carrying that secret, and you explore what is going on in their minds and many do not realize how that is affecting your mental health. And subsequently your physical being. And women just accept it because it has been going on for so long'.

GP intervention

Seeing a male GP meant that women were not comfortable in fully discussing their situation and support needs. Being listened to by the GP and taking action was important to women. In one example, despite requests, a woman was not referred for counselling by her GP. She told us: 'I asked for counselling but I wasn't given any and I don't know why'.

Being on a GP practice's waiting list for counselling models, which include various talk and behavioural therapies, is a difficult period for women to cope with, especially when feeling low. It is important that interim measures are in place whilst women are waiting to access counselling services and that part of this may involve a direct referral to a women's organisation.

For women who have a long-term illness, adherence to medication was defined as a struggle, particularly when experiencing low levels of motivation or periods of depression: 'If you feel flat you can't be bothered, or you can't motivate yourself', and another commented 'Or you may just forget', 'Or you just get to a point where you just don't care'.

Poor communication by the mental health service and/ or not maintaining contact is a barrier.

[11] Talking therapy 'can be referred to as 'talking treatments' and more commonly known as counselling, psychotherapy, and therapy. Is practised by trained mental health professionals such as counsellor, psychotherapist, psychologist or psychiatrist'. See www.mind.org.uk

Lack of continuity of care

Women spoke about feeling unsupported. For example, being discharged before they were ready by the health practitioner, or the difficulty in engaging with health professionals where the practitioner moves on, or where they had to see a different consultant each time. For example, a young woman, who is now aged 18, but had been receiving support from a Child and Adolescent Mental Health Service (CAMHS) since aged 14, having suffered from childhood sexual abuse, was being treated for anxiety, depression, post-traumatic stress disorder, anorexia and for bi-polar disorder. She had made suicide attempts in the past, and yet, had seldom seen the same psychiatrist twice. Another woman, who was a survivor of domestic and sexual abuse, facing painful separation from her children after they were abducted by her ex-husband, told us that when her psychiatrist left, she was referred to another psychiatrist who saw her for 12 sessions,

> 'He helped me to show me good ways to cope with my "ghosts" and nightmares… At the end of the 12 sessions he said he couldn't see me for any more sessions and he advised that I should see someone else. But my [mental health] social worker discharged me… That was a month ago. I was upset as I am still suffering very badly and I need to talk to someone. The social worker said she would send me to relaxation group, but she hasn't done anything yet.'

Falling through the gap in service provision

Seamless therapeutic services are needed to support women living with HIV, as well as any mental health and wellbeing issues that may be linked to their HIV status, such as post-traumatic stress disorder. It is also important for services to respond to any form of VAWG that would contribute towards women's general health and wellbeing. For example, one woman received talking therapy via her HIV psychologist, however, the same psychologist could not work with her in terms of the post-traumatic stress she also had. Instead, her HIV psychologist had to refer to her GP for support with the post-traumatic stress disorder, yet the woman's GP informed her that she did not meet the criteria to receive support.

Furthermore, where voluntary sector organisations are subject to cuts, this often means that services are severely restricted or forced to close, which impacts on women's continuity of care, and consequently her health and wellbeing.

Being housed in National Asylum Support Service (NASS) accommodation

For women who had claimed asylum, the experience of being moved from a specialist refuge into NASS accommodation was not only unsettling but also had a negative impact on any progress that was made to improve women's emotional health whilst in the refuge. One woman talked about the transition between refuge provision to NASS accommodation as one that made her feel unsafe, anxious and fearful. She described a range of symptoms, such as, 'nightmares, flashbacks, headaches, and pains all over my body'. She was frightened, and could not talk about her horrendous experiences of being trafficked and being sexually exploited when she first arrived at the refuge. However, after settling into the refuge, she was forced to leave, 'which upset me a lot… I can't feel safe because my asylum situation is very bad'.

Multiple instabilities such as housing and asylum status compound women's experiences of anxiety and feeling unsafe. The impact on women's mental health becomes more significant when women have to leave safe supported refuge accommodation, and are placed in housing where there is a lack of specialist support and intervention because of immigration restrictions.

Women's suggestions for improving support

Women made a number of suggestions on how services could be improved including:

- Women-only support

  Access to specialist women support services was a strong theme in supporting women in their recovery. Women valued service responses that are tailored to women's individual circumstances and support needs, for example:

  - BME women's services

    On-going casework support from a specialist BME women's support worker was highly valued. A number of women spoke about feeling safe and understood and the importance of these types of services in managing their health and wellbeing.

  - Specialist sexual violence advocacy and support services

    Women also appreciated the value of specialist women's services that support women who have experienced sexual violence. Women survivors of sexual violence shared their experience of non-specialist counsellors being afraid to deal with the topic of sexual abuse. Women felt more confident in receiving help from specialist sexual violence counselling and advocacy services, and also spoke of consistency in approach including services and therapies that are highly specialist, build trust and recognise and adopt a whole person approach.

  - Access to different types of therapeutic support

    Women stated that medication partially helped them to manage their emotional health and also spoke about the value of having access to talking therapy in the first place. Cognitive Behavioural Therapy helped one woman with HIV, who needed some help with moving on from issues in her life that 'makes me feel down about myself'. Women who had accessed counselling on the whole described this as positive. Women felt more comfortable with therapists using a discussion-based approach, rather than relying solely on the woman to speak.

    In addition, women wanted improved access to other types of therapeutic activities including group-work, exercise, and social activities to combat social isolation and strengthen their overall sense of wellbeing. Women gave examples of activities that were particularly helpful, such as a women's gardening project, where women grow fruit and vegetables and cook together and do other activities. Access to financial assistance to help with

transport costs to attend activities was considered vital to women being able to engage. Other activities that helped women include: attending women-only workshops about living with HIV, complementary therapies, such as massage, acupuncture, yoga and access to the gym, including attending a fitness programme for people with HIV.

- Peer support

  In addition to complementary therapies, women spoke about the value of peer support programmes.

Responses from professionals

- GP intervention: For women who were receiving medication, such as anti-depressants and anxiety reducing medication, where the GP was proactive in reviewing and reducing medication was helpful, especially for women whose medication impacts on their ability to function on a daily basis.
- Access to GP services that have developed specialism: A GP surgery that specialises in supporting asylum seekers was described as very helpful as it enables women to access and be referred to other types of relevant services more quickly.
- Seamless and continuity of support: Women wanted consistent support so that they did not have to continually re-engage with different health professionals. A seamless service means that health practitioners treating women with a long-term illness are also alert to other practical needs she might have, and at least be able to directly refer women to appropriate services. This addresses the situation where some women feel they are not able to ask for help, particularly when they are feeling more vulnerable at a time they have to manage their long-term illness/s.
- Informed and proactive professionals: Social workers, NHS counsellors, GPs and other health professionals need to be more informed and proactive in supporting referrals to specialist women's support services. They also need to access on-going training in recognising and responding to indicators of violence against women and girls.
- Geographically unrestricted funding: Women spoke about the need for expanding the scope of existing services. For example, women living with HIV found it difficult to access services/support when needed because of the geographical restrictions related to funding. Access to cross-borough provision outside of women's locality is specifically important because of the stigma and fear women experience when peer, family and community networks.

Local policy context

In order to assess the extent to which women and mental health is prioritised in each area including any specific initiatives or work to address the needs of BME women, women who have experienced sexual violence, and women living with HIV, we assessed the local Joint Strategic Needs Assessment (JSNA), and conducted interviews with local commissioners and local voluntary sector specialists, to establish both the barriers and factors that would

improve current policy and service responses to women and mental health. Below is a summary of key issues that emerged across each of the three areas; Coventry & Warwickshire, London (Islington) and Sheffield.

COVENTRY & WARWICKSHIRE

Gendered analysis?

Gendered nature of violence against women and girls acknowledged (Coventry JSNA:26)

Need for assessment and early treatment for post-natal depression in relation to pregnant women and new mothers(Warwickshire JSNA)

Inclusion of sexual violence and child sexual abuse (including other forms of violence against women and girls), BME women and women living with HIV?

- Domestic and sexual violence included (Coventry Health and Wellbeing Strategy – 'Healthy Communities'; JSNA: 3).
- Mental health impact of violence against women and girls linked to poorer health outcomes.
- Health funding towards local rape crisis centre (Coventry Rape and Sexual Abuse Centre) and Sexual Assault Referral Centre – highlighted as primary sources of support.
- No specific focus on BME women or women living with HIV.

Commissioner perspective

- Existing data on women in the JSNA and mental health is considered too 'basic' and the need to improve Coventry data on women and mental health has been identified.
- Not common practice to commission specific women-only projects or organisations; any service access issues would be identified through the equality impact assessment. Financial challenges on a local level mean that there can be a reliance on third sector women's organisations to deliver 'bespoke and dedicated support'.
- Current IAPT provision was identified as a route for addressing needs of women.
- Focus of commissioning is on 'achieving good outcomes for the population as a whole'.
- Changes are required to improve the way evidence is currently used to inform commissioning processes.

Gendered analysis?

Have developed a separate women's strategy (Camden & Islington NHS Foundation Trust Women's Strategy 2012). Examples of actions within the strategy include the development of Drayton Park Women's Crisis House for women experiencing mental distress, training of health staff; awareness-raising to recognise the particular mental health risks to women seeking asylum.

Inclusion of sexual violence and child sexual abuse (including other forms of violence against women and girls), BME women and women living with HIV?

- Focus more on BME community as a whole (Islington Factsheet on Mental Health 2013:1).
- HIV is included with an acknowledgement of the health impact, stigma and discrimination. Recognition that there are higher rates of mental health conditions amongst people living with HIV. However, there is a lack of focus on the particular mental health impact and risks for women living with HIV (Islington JSNA:10).
- Domestic violence and child sexual abuse are highlighted as risk factors in relation to mental health (Islington Factsheet on Mental Health 2013:2).
- The Joint Health and Wellbeing Strategy acknowledges that women from some BME communities are over-represented in secondary care services and on primary care registers for serious mental illness, and there is a need to improve mental health and wellbeing in accordance to gender, ethnicity and age, and that mental health needs are influenced by family, social and environment determinants (Islington Joint Health and Wellbeing Strategy: 15).
- Suggestions for improving access primarily relate to maternal and parental wellbeing, making mental health services and pathways more accessible, especially in relation to postnatal depression and in addressing stigma and discrimination associated with postnatal depression including referral routes into iCope (Islington's IAPT) service (Joint Health and Wellbeing Strategy: 7). A commitment to increasing the number of people who receive Islington's IAPT service, iCope, targeting 'hard to reach' groups, as well as focus on improving recovery rates (Islington Adult Joint Commissioning Strategy 2012-2017: 11-13).

Commissioner perspective

Islington recognises the different needs of women by commissioning a range of services. Other than commissioning bed spaces in acute mental health wards, and a post-traumatic stress disorder clinic – accessed by women who have experienced sexual violence, with half of the referrals being refugees and asylum seekers – the Clinical Commissioning Group commissions three women-only services including:

- (1) Drayton Park Women's Crisis Service, an alternative to hospital admission for women with mental health problems (Islington and Camden). This has been developed in recognition of a need for a safe women-only environment and provides support on a range of issues including childhood sexual abuse. Women have access to BME or LBT workers, and peer support workers. The service is valued by GPs, as well as being an example of excellent practice. They also commission (2) a perinatal mental health service and (3) the Women's Therapy Centre, run by women for women which provides specialist individual and group psychotherapy support to women, many of which have experienced sexual violence and/ or childhood sexual abuse.
- The Clinical Commissioning Group is currently working with the public health lead and clinical lead for IAPT to scope service provision for women experiencing domestic and sexual violence, as a gap has been identified in this area for a women-only service. There is recognition that women who have a history of sexual violence are over-represented in terms of having a personality disorder, along with substance misuse, and the Clinical Commissioning Group is currently looking at how to help women to move on, cope and self-manage, the focus being to tackle the issues earlier, which would then reduce cost.

Gendered analysis?

The JSNA recognises that **domestic violence** can have a significant, as well as negative impact on people's health and wellbeing and as a result, considerable implications for services. Within Sheffield itself, 50 per cent of those accessing domestic violence services reported having mental health problems (Sheffield JSNA 2013 Position Statement: Para 1.36).

In the main, there is a lack of focus on the specific mental health needs of women in both the JSNA and Joint Health and Wellbeing Strategy.

Inclusion of sexual violence and child sexual abuse (including other forms of violence against women and girls), BME women and women living with HIV

- While the JSNA itself did not present disaggregated data on the number of women experiencing domestic violence who also reported having mental health problems, there was recognition that groups of people most at risk of mental ill health, include, amongst others, new and expectant mothers and survivors of abuse (Sheffield JSNA 2013 Position Statement: Para 2.40).
- BME communities and 'victims of domestic and sexual abuse', among many others, are given recognition as two of the groups that are reported nationally to have below average health. For example, although disaggregated data has not been provided the JSNA refers to people from some BME communities as being twice as likely to be admitted to in-patient mental health services, and up to five times more likely to be compulsorily admitted under the Mental Health Act (Sheffield JSNA 2013 Position Statement: Para 2.46).
- A recognition that local data on 'communities of interest' have not been collated consistently, as some BME communities, survivors of domestic violence and sexual abuse do not fall within the inequality data already being collated (Sheffield JSNA 2013 Position Statement: Para 3.3).

Evidence within the Sheffield JSNA suggests that the demand for medium to longer-term community based counselling and therapy is increasing significantly 'at a time when both public and voluntary sector provision are experiencing difficulties' (Sheffield JSNA 2013 Position Statement: Para 2.47).

Commissioner perspective

- Mental health services commissioned by NHS Sheffield Clinical Commissioning Group offer services to both men and women, ensuring that the requirements within the Equality Act are met, with the exception of the following two services. (1) A perinatal mental health service is commissioned from Sheffield's main provider. This is a specialist mental health service that delivers specialist assessment, early intervention and effective treatment for women with mental health problems around the time of childbirth. (2) A Sheffield women's counselling and therapy service 'is commissioned from a VCF provider to offer women who have suffered sexual abuse an opportunity to explore their feelings and experiences in a safe, supportive women-only setting which is unavailable to them elsewhere'.
- The commissioner felt that 'there is never sufficient data available to fully inform need'. However, various analyses of mental health in Sheffield have been considered within the JSNA, covering adult mental health, child and adolescent mental health, dementia and, more recently, wellbeing. Data about mental health by sex, age, ethnicity, and so on, are also analysed.
- The overall message was that the services commissioned are intended to meet the needs of the entire population in Sheffield, including the needs of BME women, women with HIV, and women who have experienced sexual violence.

Women's sector perspectives

A lack of statutory service understanding of the impact of violence on women's mental health:

- Statutory mental health services had a very different understanding of risk compared to the specialist providers, often underestimating the impact of violence on women's mental health, and not understanding violence unless it is framed within a clinical context.
- Although the needs of women have been identified, there is an insufficient awareness of their mental health experiences, with a focus on 'quick-fix' and short-term solutions. There is a greater pre-occupation with physical illnesses, than ensuring that services are linked, so that mental health needs are taken into account when someone is experiencing a long-term physical illness.
- Violence against women and girls and its impact on women's mental health is not sufficiently understood or prioritised across policy and service delivery. For example, women's behaviour can be questioned and/or pathologised by some mainstream health professionals rather than being viewed as the normative impact of the violence they have experienced. For instance, women's parenting capabilities may be questioned.

A lack of gendered analysis in local mental health policies

- The lack of integration of women-centred provision within mental health commissioning frameworks makes it exceptionally difficult for specialist women's providers to further develop existing services. An impact of the lack of women-centred provision, is that women's organisations that deliver a range of interventions to support women's emotional wellbeing are frequently not recognised as legitimate providers of therapeutic services by some policy makers.

Specific gaps in mainstream understanding of mental health support needs for particular vulnerable groups

- The mental health impact of women living with HIV is still not part of mainstream thinking and awareness, therefore policy and practice does not synchronise with the work undertaken by specialist HIV support services for women.
- A number of barriers prevent women living with HIV from openly discussing the impact this is having on their lives or from feeling equipped and safe to disclose their HIV status or ask for help about a mental health issue. Agencies described women experiencing 'double discrimination', and therefore a key reason women were fearful of disclosing is connected to the significant levels of stigma they experience associated with being HIV affected and the nature of discrimination women experience from some agencies and from wider society.
- There is a need for a more effective and nuanced understanding of how BME women and girls experience mental health issues and how this may differ within and between different groups. Mental health issues may be languaged in different ways.

For instance, Eurocentric terms such as 'despair' or 'depression' would not necessarily be recognised in some contexts.

- There is still a significant stigma attached to seeking help to deal with complex emotional problems. This may be more acute where the individual woman's family/community context is one where mental health issues are not discussed openly: 'Stigma [is] attached to seeking help. It is harder for women from certain communities, and certain BME women and their understanding of mental health is different'.
- There are strong concerns about the lack of appropriate mental health support services for trafficked women. There needs to be improved understanding in the range of ways that women experience coercive control by the perpetrators including the misuse of and impact of different spiritual belief systems and how this can have a damaging impact on women's emotional health. Some of the problems women experience also stems from the nature of government systems which do not address the need for mental health support, or consider the emotional impact on women, along with on-going trauma experienced in being trafficked when they receive negative trafficking decisions. For instance, emotional support needs of women are not adequately integrated within the government's National Referral Mechanism programme of support, 'We have to work with women who experience a huge amount of trauma. The Ministry of Justice think women can recover from the trauma of trafficking within 45 days. If women get a negative trafficking decision, they then have 48 hours within which to leave'.

Restrictive thresholds for accessing appropriate support

- Thresholds for accessing mental health support are too restrictive and often leave women vulnerable to deteriorating mental health because of the emphasis on clinical diagnosis. For example, women who have experienced rape or other forms of violence who have high levels of trauma and mental distress but are rarely considered eligible for additional mental health support services unless they have received a clinical diagnosis.
- A further concern relates to existing support systems not being available to respond to the specificity of trafficked women's experiences: 'There is a need for crisis intervention, that does not exist within statutory provision or the service available is not appropriate or cannot be accessed unless diagnosed … I supported a woman recently who was trafficked, along with her husband and there was domestic violence. The woman experienced severe trauma, she ran in front of a bus. Had two mental health assessments, diagnosed as not having a mental health issue. She was traumatised AND needed help but was not ready for counselling, and could not just be given a service to help with this'.

Lack of consistent care

- The lack of continuity of care and inconsistency of support within statutory mental health services have a very debilitating impact on women. Examples of concerns include not being able to access a mental health social worker or an advocate in a

timely way, leading to women receiving an inadequate level of support; some cases being closed prematurely or women being discharged before they are ready leads to a 'revolving door' situation.

- There is a pressure to deliver short-term interventions which may not be appropriate or effective for all. 'Recovery' is still largely thought of in terms of short-term interventions rather what is required to support the individual's good mental health and wellbeing. Furthermore, there are concerns about the growing trend and pressure to deliver 'catch-all' mental health services that are intended to meet the needs of all, yet often fail to engage with women because of a lack of expertise and specificity around their approach.

A lack of policy level recognition of women's services as key to improving mental health

- Specialist women's services are not sufficiently acknowledged as key service providers within the mental health policy landscape. Statutory mental health services and commissioners need to work more closely with specialist women's providers, such as local Rape Crisis Centres, as they frequently play a pivotal role in providing immediate emotional support that prevents the onset of more chronic mental health conditions and therefore avoid the need for more intensive statutory mental health interventions. As highlighted by one interviewee, 'We try to keep women out of statutory services. We work with many women with undiagnosed personality disorders, and we do this work very well'.

Concerns about funding and commissioning processes

- Local women's organisations are seeing an increase in referrals with a 'mental health' component including referrals from the existing IAPT providers – however this has not led to a parallel increase in funding.

- The lack of focus on women living with HIV in relation to potential mental health issues arising has consequently led to fragmented levels of commissioning and tendering in local areas, therefore women's access to appropriate support services is highly variable. For instance, although Positively UK provides pan-London services some boroughs have only allocated £1,000 towards support services yet Positively UK data shows that over '600 people report being in isolation' and at least '100 people are turned away' because of a lack of funding. Support available to women in some areas is still very much a postcode lottery.

Suggestions for improving current practice

- Voluntary women's sector professionals strongly felt that the success of mental health interventions and outcomes lay in the gendered specialism and flexibility of services to adapt to the individual circumstances of women, whether this is through long or short-term support interventions.

- Voluntary specialist women's services need to be sustained in order to be able to survive on a long-term basis, so that better outcomes are achieved for the longer-term health needs of women, since 'quick-fix' and short-term solutions may not be appropriate or effective for all.

- Thresholds for accessing mental health support should not be restricted to clinical diagnosis since this leaves many women vulnerable to deteriorating mental health. Statutory services should recognise but also better utilise the existing expertise of specialist services, such as Rape Crisis Centres, BME and other voluntary sector women's organisations who often have a critical role in prevention work by providing women with immediate emotional support. However, statutory services would need to resolve the tension in an over-reliance on specialist providers based on their expertise, but without resourcing this specialist support.
- More leadership at a national level on these issues would ensure that HIV is prioritised within mental health strategic frameworks.
- There is a need for better co-ordinated multi-agency policy and service responses to ensure that support for women is more accessible but also that mental health professionals are better equipped to understand and respond appropriately to women living with HIV who will be experiencing mental health issues and who also may experience domestic, sexual and other forms of violence.

Key issues emerging from local interviews and focus groups

The feedback from interviews indicates that whilst local areas are recognising to some extent the links between sexual and domestic violence and the mental health impact on women, Joint Strategic Needs Assessments are developed inconsistently and often without data from the women's sector. Commissioners are aware that they have insufficient evidence or knowledge or they are not using the evidence that they have effectively. A lack of disaggregated data often makes it more difficult to understand levels of need and how services can be structured to meet the different needs of women. The understanding of issues in relation to BME women, as well as women living with HIV and women who have experienced childhood sexual abuse and/ or sexual violence, lacks integration across the different strategies. However, Islington clearly offers an example of promising practice given the development of a separate strategy on women and mental health and provides a useful template for other authorities to consider.

The focus groups and interviews with women about their individual challenges in managing their mental health and different factors that impacted on their help-seeking processes clearly highlighted the need for more consistent and integrated service responses. Not only does the impact of the violence itself have a negative health impact this then becomes more acute in the context of situational factors including homelessness, concerns around deportation and immigration status, poverty, social isolation. A specific coping strategy for some women, particularly in terms of the trauma experienced in relation to child sexual abuse, was to detach themselves from what had happened and therefore they had not sought help earlier.

The stigma of having a health mental problem, as well as the discrimination that arose from being HIV positive often compounded their health problems. Decisions to seek support were often undermined when women felt that they were not always understood by professionals, felt judged, were discharged from care before they were ready or were not accessing the type of support they valued consistently enough. Women spoke about the

importance of women-centred on-going and specialist support services which did not purely rely on more clinical forms of intervention. Whilst women's sector professionals felt that violence against women and girls and its impact on women's mental health is not sufficiently understood or prioritised across policy and service delivery. Furthermore, that the thresholds for accessing mental health support should not be restricted to clinical diagnosis alone, since this leaves many women vulnerable to deteriorating mental health. In addition, the mental health needs of women who are seeking asylum need to be addressed, while their application is being processed.

The lack of consistent and in-depth consideration of women and mental health also leads to fragmented local health-based commissioning. Responses to women are considered too generic with a focus on 'quick-fix' and short-term solutions which may not be appropriate or effective for all. Therefore, there is a tendency not to consider the vital role of or fund women's organisations that specialise in providing a range of therapeutic interventions to assist women who have experienced domestic or sexual violence, or provide bespoke services for BME women and women living with HIV. These services often deliver a range of wellbeing outcomes and prevent the need for more costly mental health interventions. Statutory services could better utilise the existing expertise of specialist services, such as Rape Crisis Centres or other women's organisations. However, statutory services would need to resolve the tension in an over-reliance on specialist providers, based on their expertise, but without resourcing this specialist support.

Nationally, leadership is required to ensure that current strategies on mental health are gender-proofed and that this is used to influence policy and practice on a local level.

CONCLUDING COMMENTS AND RECOMENDATIONS

Apart from understanding, identifying and responding to the specific health needs of women, it is vital to recognise that women:

> 'Hold different assets, resources and play different roles in the community… [Women] are more likely to live in poverty, but may have developed effective self-help strategies and resilience… often at neighbourhood level. However there are barriers to their participation in the development of health strategies – many women don't have a voice in decision-making' (Women's Health & Equality Consortium 2013a: 3).

Having an understanding of this gendered analysis would ensure that Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies will successfully identify the needs of the entire community, including those in vulnerable groups who experience inequalities. In a 2013 report, we suggested a five-step process could be followed in ensuring that there is a gendered analysis (Women's Health & Equality Consortium 2013a: 12-14). Furthermore, use of the refreshed 2013 NHS Equality Delivery System (EDS2) creates an opportunity for commissioners to support a more diverse community and patient involvement, as well as being able to generate more evidence based and outcome focussed equality and diversity work (Salway et al 2014:8). This would also ensure that the protected characteristics of people within various communities are taken into account, and their needs met. For example, transgender women, who have been sectioned, may be held in male-only in-patient units because they have been labelled male at birth. This may have a further negative impact on a transgender woman's mental and emotional wellbeing. It is therefore important that the perspectives of transgender women, and of agencies with expertise around the range of needs of transgender women, is sought in order to develop more appropriate responses and services.

The recent Clinical Commissioning Group Outcomes Indicator set for 2014-15 has mental health outcomes (NHS 2013). Within this context, being aware of, and commissioning services that women value, would ensure that women's mental health needs are met. Some of the services that women value include the following: women-only violence against women and girls specialist support services, BME violence against women and girls support services, dedicated advocacy and support services for young women, therapeutic support, including counselling and group work (Imkaan 2013: 20-28). We would encourage commissioners to organise women-only meetings locally in order find out which services women value, if this information is not already available. Furthermore, we suggest that commissioners consider ensuring better access to women-only mental health inpatient units, particularly for women who have been sectioned.

Prevention measures are cost effective when seen within the context that about 50 per cent of women who use mental health services have experienced violence and abuse. For example, better health outcomes could be achieved through the return on investment in prevention; low-cost community-based support services, such as refuges, rape crisis

centres, that can reduce the demand on local GP services, A&E and admissions to hospitals (Women's Health & Equality Consortium 2013a: 9).

In terms of health equality issues, the All Party Parliamentary Group on Mental Health launched in January 2014, to carry out a six-month enquiry into the government's progress in implementing its commitment to 'parity of esteem' for mental and physical health in the NHS. At the time of the launch, there were already concerns from the voluntary sector about the reality of equality for mental and physical health.[12] Yet, there are opportunities for commissioners to ensure that women's mental health needs are met, and we have provided examples of organisations carrying out promising practice work within the regional case studies. For example, Coventry Rape and Sexual Assault Centre's integrated care for women who have experienced sexual violence; Positively UK's peer support for women living with HIV, and Ashiana Sheffield's service for BME women who have experienced domestic and related forms of violence.

Finally, to ensure that underlying gender inequality issues are addressed effectively, it is vital for gender-based work to be carried out, with organisations needing to address gender and other equality issues as a fundamental and integral part of their culture, and in their mainstream activity, not as an afterthought. If they have not done so already, organisations as a whole need to begin to consider how they might develop a culture in which the gender inequalities that affect service users and staff are considered and addressed. Without a 'whole-system' approach, the existence of social inequality means that women's needs continue to be marginalised, leading to longer-term financial and other costs on society.

Recommendations

- The Minister of State for Care and Support and the Parliamentary Under-Secretary of State for Public Health can use the findings of this report and engage with the women's sector to consider how mental health provision can be improved for women and girls as part of their on-going engagement with the voluntary sector, to ensure effective implementation of the Government's Mental Health Strategy, taking into account duties and responsibilities within the *Equalities Act 2010*, the *Human Rights Act 1998* and the NHS Constitution.
- NHS England to work with the Health and Social Care Information Centre to ensure that all data has been disaggregated on the basis of gender and on all the protected characteristics groups. This data should be published and used to shape the thinking and development of service responses.

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[12] See http://www.mentalhealthtoday.co.uk/inquiry_launched_into_governments_commitment_to_parity_of_esteem_for_mental_and_physical_health_25769806829.aspx (accessed 5/1/14). The concerns raised by the voluntary sector are not new. A core working group on parity of esteem between mental and physical health was established and met in 2012. This group included voluntary sector organisations. The report, *Whole-person Care: from Rhetoric to Reality. Achieving parity between Mental and Physical Health*, was subsequently published, which included contributions from the Mental Health Foundation, http://www.rcpsych.ac.uk/pdf/OP88summary.pdf (accessed 30/4/14).

- **The Department of Health** to give guidance on promising practice and approaches to meeting the mental health needs of women, drawing on the lessons learned from *Into the Mainstream*.
- **Healthwatch England** to ensure that women and mental health is a priority theme within local monitoring and consultations and across national health and care agencies, taking into consideration guidance from NSUN's Mental Health Handbook, which would provide some useful models which could be used to address women and their mental health needs.
- **The Home Office**
  - To ensure that immigration and asylum cases are processed with an understanding and sensitivity to any mental health issues, in addition to case owners having an awareness of and understanding of the Gender Guidance.
  - With the UK Human Trafficking Centre and Ministry of Justice, to urgently review current interview tools, frameworks and processes, such as the National Referral Mechanism, to ensure that first responders/ UKVI (UK Visas &Immigration) Case Officers appropriately and adequately interview women seeking asylum, who have been trafficked into, within, and out of the UK, and who have experienced or are experiencing trauma as a result of trafficking; and that staff are mindful of the negative impact of experiences of violence on women's emotional and mental health.
- **Women's sector organisations** to:
  - Be involved with the local Healthwatch.
  - Approach their local joint strategic needs assessment lead to offer support with collating gendered data.
  - Approach their local health and wellbeing board as well as clinical commissioning group and suggest how they can help with local service planning and design.
- **Local health and wellbeing boards to**:
  - Address health inequalities by using the refreshed NHS Equality Delivery System (EDS2), to ensure that equality and diversity values are embedded in the work.
  - Under the core outcome of improving mental health & wellbeing (Joint Health & Wellbeing Strategies) develop a separate strategy and actions to address women and mental health.
  - Involve local third sector specialists delivering mental health support services to women and girls in local service planning and tendering processes.

- Map local voluntary sector women's services that deliver mental health services, if they have not done so already, and identify a lead on the board to build a meaningful working relationship with the women's sector.
- Together with clinical commissioning groups collate information on a regular basis through surveys and meetings held with women who have mental health illness who are being supported by third sector specialist women's services.
- Together with clinical commissioning groups, to identify and improve the responsiveness of services to address the mental health needs of refugee and asylum seeking women.
- Commission women-only mental health services from the voluntary sector in recognition of the need for safe, women-led and women-only provision including organisations that hold specific specialisms.
- Appoint a local champion on women and mental health to better co-ordinate local strategies, services and outcomes on women and mental health, including prevention and understanding of the causes of poor mental health.

- Statutory mental health services, GPs and other health practitioners need to:
  - Look at the effectiveness of IRIS (Identification and Referral to Improve Safety) model on domestic violence to identify lessons learned and consider ways of improving processes of identification, referral and support, as well as consider how models can be developed and targeted to address women and mental health. Collaboration with organisations working with women who have experienced sexual violence, women living with HIV and BME women would be required to consider the specific needs of particular groups.
  - Work in partnership with local voluntary specialised women's sector experts to co-deliver training and awareness-raising initiatives targeted at addressing women's mental health.

Promising practice example of a third sector women's specialist service that provides emotional support to women

With over 30 years of experience, Ashiana Sheffield provides emotional and practical support to BME women who have experienced domestic violence, including forced marriage and 'honour-based' violence, as well as women who have been trafficked into the UK for the purposes of sexual exploitation. Services delivered include advocacy, floating support, outreach and training. Ashiana Sheffield has a particular model of working with women with mental health needs, which has been particularly effective to addressing their immediate mental wellbeing holistically. Often, they provide space and support to women so they feel safe and supported while they build trust. For example, they state:

'We try to place women at the centre of services; we empower women and enable them to access their rights and entitlement… We will work with agencies, mental health experts,

and with women… so they feel safe'. In working with women, Ashiana 'try to establish a good, solid boundaried experience, we try to be respectful (of women's experiences), women's trauma might lead to behaviour that is challenging… We must be aware of not causing harm… to be boundaried, explain our role; what it is and isn't, to be careful not to foster and create dependency… We can listen and are skilled enough until she is ready for counselling… We consolidate, we observe, model and shadow and are encouraging. We try to address imbalance of power between worker and, for example, trafficked women with insecure immigration status, where they are left powerless… We create a relationship of trust so that women are not further traumatised…'

Promising practice example of a specialist sexual violence service

Coventry Rape and Sexual Abuse Centre has been delivering specialised support services for survivors of rape and sexual abuse for the last 32 years and support nearly 5,000 women, men and children through their services every year providing crisis and long-term specialist counselling, support and advocacy.

CRASAC offers specialist support to women and girls who have experienced any childhood sexual abuse and/ or sexual violence. CRASAC offers an Independent Sexual Violence Advisor Service, which provides support to women and girls who have experienced sexual violence recently or in the past. An advocacy service assists women and girls to access mental health services; the advocates would attend appointments, meetings and GP appointments. There are weekly individual counselling for those who have been identified as having a high anxiety level, and group work sessions. Group work includes a life-skills group for women; a youth participation group focusing on confidence building; skills development; interview panels; build self-esteem; and empower to give voice on how services are run.

Promising practice example of a peer support project

Positively UK provides practical and emotional support, which also extends to 'the person's physical and social wellbeing'. Peer support workers are able to assist by applying for funding when someone is experiencing financial hardship. 'We provide support, space to feel welcome, safe [space] because it is peer-led support. People come, knowing we don't just prescribe. We know what they are going through, we feel that they can open up eventually, somehow, If not now then later. All frontline staff and volunteers at Positively UK have HIV and have been diagnosed for two years, which means that not only are staff and volunteers able to deal with their own circumstances, they are also able to offer support. Positively UK can help with an HIV diagnosis; sexual health; relationships; starting a family; Social Services; HIV treatment and adherence; disclosure; finance and benefits; immigration; housing. Regular support groups provide a safe and comfortable space for women to meet. In 2012-13 Positively UK supported 296 new people, an increase of 20 per cent from the previous year.

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