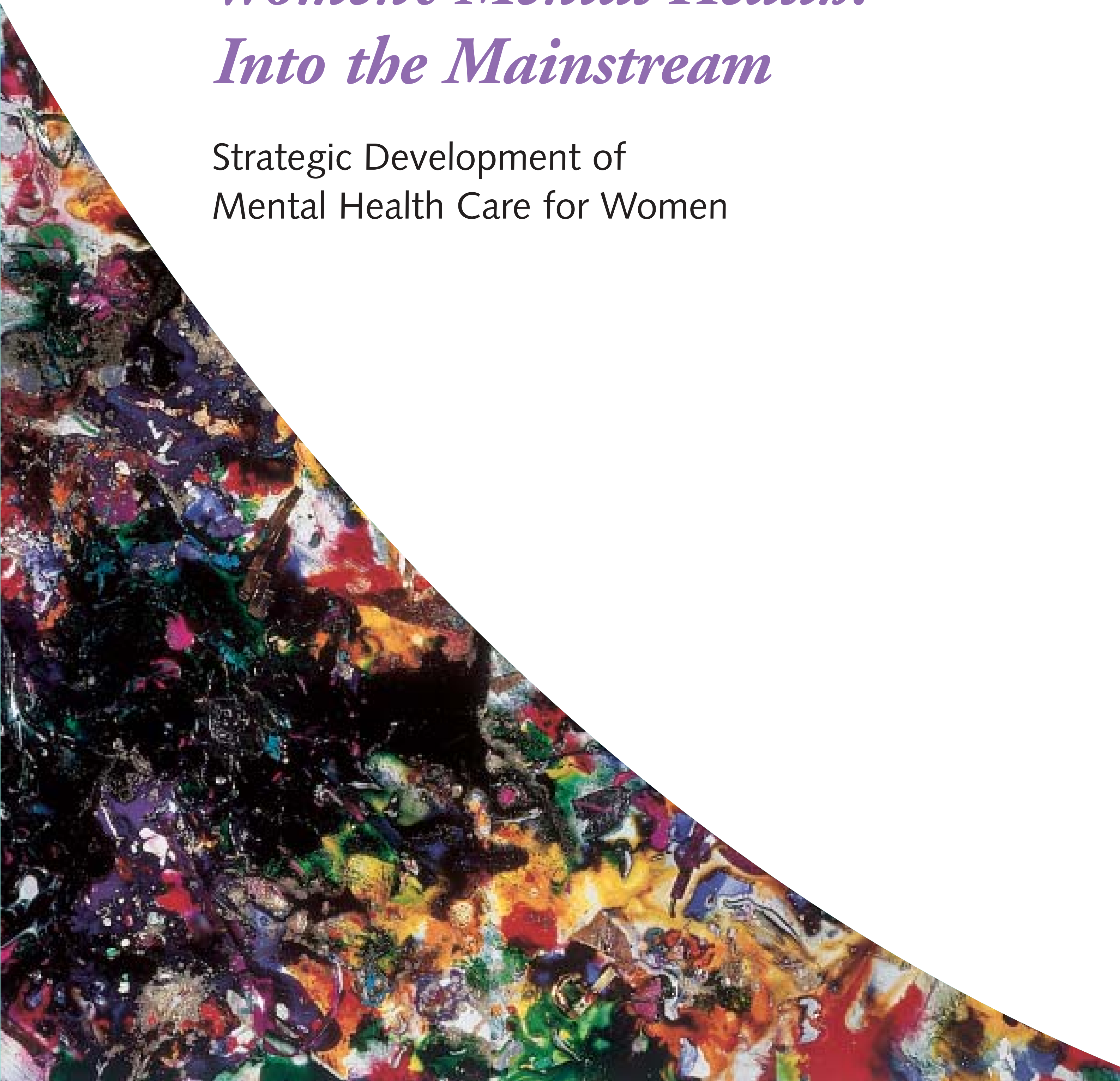
Department of Health

Women's Mental Health: Into the Mainstream

Strategic Development of Mental Health Care for Women



Flower to earth
by Christine Daddy

Art is how I express myself and this picture is in memory of a friend who suffered with mental health problems. It is a celebration of her life.

Christine Daddy's work was featured in Art Works in Mental Health, an exciting National Exhibition of original work created by people who have been directly or indirectly affected by mental ill health. Covering a spectrum of painting, drawing, photography, writing, sculpture, pottery and ceramics, the exhibition was designed to enhance and promote understanding of mental health issues that affect us all in some way.

To view all the art works submitted visit www.artworksinmentalhealth.co.uk

Women's Mental Health: Into the Mainstream

Strategic Development of Mental Health Care for Women

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Foreword

The needs of women are central to the government's programme of reform and investment in public services and to our commitment to addressing discrimination and inequality. Modernising mental health services is one of our core national priorities.

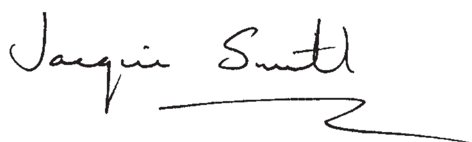
There are differences in the family and social context of women's and men's lives, the experience and impact of life events, the presentation and character of their mental ill health and consequently their care and treatment needs. These differences must be understood by policy makers and those planning and delivering services. Mental health care must be responsive to these differences.

Women's Mental Health: Into the Mainstream highlights that women make up over half of the general population, play a significant role in the workforce and assume the major responsibility for home making and for the caring of our children and other dependent family members. At the same time, many women experience low social status and value. Social isolation and poverty are much more common in women, as is the experience of child sexual abuse, domestic violence and sexual violence. The complex interplay of all these factors can have a major impact on women's mental health and have wider repercussions as a result of the multiple roles that women adopt in our diverse communities.

Women's Mental Health: Into the Mainstream emphasises the importance of listening to women. Their voice is highlighted throughout the document together with examples of services across the country that are genuinely empowering women and responding to their needs.

We must take heed of what women are saying. They want to be listened to, their experiences validated, and most of all to be kept safe while they recover from mental ill health. They want importance placed on the underlying causes and context of their distress in addition to their symptoms, support in their mothering role and their potential for recovery recognised.

The implementation of the Mental Health National Service Framework enshrines these principles in that the expertise and experience of service users should be at the heart of planning and delivering mental health services, with holistic assessment and care planning and an emphasis on hope and recovery. Gaining more insight into the needs of women will contribute greatly to closing the gaps between national mental health policy and local implementation.



Jacqui Smith
Minister for Mental Health

Section 1
Mainstreaming women's mental health

Women make up over half of the general population, play a significant role in the workforce and provide the majority of the care for our children and other dependent family members. The consequences of women's mental ill health affect more than the individual, reflecting these multiple roles. Mental ill health in women, as in men, is common. It differs however in both presentation and character. Currently, much mental health care is not organised to be responsive to gender differences and women's needs consequently may be poorly met. It is for these reasons that a strategic approach to the development of mental health care for women is necessary. This consultation document forms the foundations for this work.

The changes needed to develop mental health care that is genuinely sensitive to gender will have to be systematic and sustainable. This will require both generating greater understanding of the issues and further commitment to the development of user-focused services. It will be best achieved by gender becoming integral to existing systems, such as those for service planning, delivery and evaluation. That is, by becoming a mainstream issue.

The aim of this consultation document is to provide information, to generate discussion, and to outline a direction to help achieve a mainstream approach to gender in mental health service organisation and delivery. It covers services for adults of working age, in line with the *Mental Health National Service Framework* (MHNSF)[1]. Many of the principles, however, are relevant to all age groups and to men as well as women.

This document has been developed:

- with advice and support from two expert advisory groups, comprised of practitioners, managers, policy staff and service user representatives (see appendix 1 for terms of reference and membership);
- building on the work undertaken to produce the report *Secure Futures for Women: Making a Difference*[2], which was informed by a series of listening panels across the country;
- through visiting and meeting a range of services and individuals – examples of ways of working positively with women are included throughout the document;
- using quotes by women themselves, to help bring alive the issues as they see them – these were derived from a number of sources, including a service user listening event, a consultation exercise with women in secure services and a survey of views on women's mental health services;
- by holding a working conference on the development of secure care for women, which was attended by a wide range of stakeholders.

The overall remit of the expert advisory groups was to help produce *"a framework for the delivery of comprehensive, high quality, mental health services that meet the needs of individual women"*. This should:

- acknowledge and address the links between the social and economic context of women's lives, their mental health and support/treatment needs;
- address specific issues related to gender, race, age, class, disability and sexual orientation;

- ensure women's safety, privacy and dignity;
- engage with women service users on a partnership basis;
- tackle the impact of organisational culture on the delivery of high quality services.

This consultation document is comprised of the following sections:

- Section 1 introduces the document and the policy context in which mental health services are being developed;
- Section 2 outlines specific issues for women's mental health, including the links between poverty, child sexual abuse, domestic violence and the impact of caring and mothering on mental health;
- Section 3 describes what is known about mental health care for women, including what women think of services;
- Sections 4, 5, 6 and 7 introduce the ideas and actions needed to achieve change in services to make them more sensitive to gender and the needs of women in particular, covering underpinning principles, organisational development, planning, research and development;
- Sections 8, 9, 10 and 11 describe the development of gender sensitivity in the delivery of mental health care for women, in particular secure care and community day services, areas in which the government has already made specific commitments;
- Section 12 describes mental health provision for specific groups of women.

Key issues and consultation points are summarised at the end of each section.

We acknowledge that there is some duplication of information between sections, but have tried to create sections that are self-contained, so that the reader can use them individually without too much cross-referencing.

Further copies of this document and/or the summary version can be obtained either from the internet at www.doh.gov.uk/mentalhealth or free of charge from the Department of Health, P.O. Box 777, London SE1 6XH, tel 08701 555 455, fax 01623 724524, email doh@prolog.uk.com.

1.1 Consultation

The publication of this document, which will be circulated to a wide range of stakeholders, will be followed by a three-month formal consultation period. Written comments are invited (see appendix 2) and a number of consultation events will be held around the country. These events will involve service users, carers, practitioners, managers, commissioners and policy makers.

Following consultation, service specifications for women-only community day services and women's secure care will be published in the *Mental Health Policy Implementation Guide*. A strategic implementation plan will also be developed outlining key actions, with indicators against which improvements will be measured, in priority areas identified during the consultation period. However it is envisaged that this detailed consultation document will have a long term use as a valuable resource for commissioners and providers in planning and delivering appropriate mental health services for women.

1.2 The policy context

Modernising Mental Health Services[3] and the *Mental Health National Service Framework* describe how mental health care in general should improve and develop. The *NHS Plan*[4] makes the commitment to reduce inequalities and develop a comprehensive health service designed around the needs and preferences of individual patients, their families and carers, which will respond to the different needs of different populations. Women are one such population.

In March 2001, the then Minister for Mental Health, John Hutton, announced the development of a strategy for women that would:

> "pull together issues of concern for women across the Mental Health Framework and NHS Plan and link with work of other government departments; ensure that women are listened to and their views translated into real change; and value the contribution made by the voluntary sector, who currently provide valuable services for women in crisis ...."

This would build on the existing commitments to mental health services for women:

- mixed-sex accommodation to have been removed in 95% of NHS trusts by 2002;[5]
- women-only community day services developed in every health authority by 2004 (*NHS Plan*);
- development of a strategy for women's secure care, with women being a high priority for moving out of high secure care into more appropriate services.[6]

The development of this strategy sits within an overall commitment to address inequalities in the delivery of mental health services and to tackle discrimination and disadvantage. Other strands of positive action include the development of a strategy to address the needs of people from black and minority ethnic groups and a strategy for people who are deaf.[7]

The National Institute for Mental Health in England (NIMHE) has been created to assist frontline health and social care staff implement policy and improve outcomes for people using mental health services. NIMHE's equality programme *"will develop to embrace the implementation of specific actions from the strategies for black and minority ethnic communities and for women"*.[8]

The ultimate aim of modernising mental health care is to ensure that the needs of the individual are addressed with respect and an understanding of diversity,* and that inequalities are tackled.

1.3 The wider government agenda

Meeting the needs of women is central to the government's programme of reform and investment in public services. In 1999, the government launched a unique *Listening to Women*[9] exercise. A series of road shows, a postcard campaign and meetings with women's groups heard from over 30,000 women. Physical and mental well-being was identified as the most important issue facing the country. Women said that they wanted quality health care and reliable information about health for themselves and the people they care for. The delivery of health and education services appropriate to women's needs is a key priority for the Government.

* ie. gender, race, culture, religion, age, disability and sexual orientation

Violence was also identified as a key issue in *Listening to Women*. The publication *Living without Fear*[10] provides information and guidance on tackling violence against women. It set goals for reducing violence, providing a better environment for a healthy family life and encouraging the development of multi-agency partnerships to improve support to women who experience violence.

The Government is developing and implementing preventative strategies to reduce domestic violence and repeat victimisation, to provide support for victims and their children and to ensure that the criminal justice system's response to domestic violence is appropriately robust. This is an ongoing programme of work, which is working towards a focused national strategy to address domestic violence. Five priority areas for action have been identified:

- early intervention in the cycle of violence and abuse by health practitioners (Department of Health);
- enhanced civil and criminal justice interface when dealing with cases where violence is alleged (Lord Chancellor's Department);
- increasing safe accommodation choices for women and children fleeing domestic violence (the Office of the Deputy Prime Minister);
- education and awareness raising on the prevalence and social unacceptability of domestic violence (Cabinet Office and Department for Education and Skills);
- ensuring appropriate police and Crown Prosecution Service (CPS) response to all incidents of domestic violence (Home Office and CPS).

The Government has also made a commitment to reduce offending by women. *The Strategy for Women Offenders*[11] was published for consultation in 2000 and the results of that consultation were published in a report in September 2001[12]. The key messages from the *Consultation Report* are being fed into the development of the *Women's Offending Reduction Programme*, a Home Office-led initiative which is being launched towards the end of 2002.

The *Women's Offending Reduction Programme* promotes an holistic response to the range of factors that impact on women's offending including mental and physical health, housing, experience of abuse, caring responsibilities, education and employment. The aim is to strengthen links between the various departments, agencies and organisations that are responsible for these areas, to ensure that integrated policies, programmes and spending partnerships are developed to meet the specific needs and characteristics of women offenders. There is a clear need to establish links between the *Women's Mental Health Strategy* and *Women's Offending Reduction Programme* (see section 12.7 on services for women offenders with mental ill health).

The Department of Health and Prison Service *Strategy for Developing and Modernising Mental Health Services in Prisons*[13] outlines how mental health care for prisoners should be improved and monitored.

Maternal health will be addressed in the *National Service Framework for Children*. The aim of this framework will be to ensure that childbearing women, children and young people develop healthy lifestyles and have opportunities to achieve optimum health and well-being, within the context of high quality preventative and treatment services.

A new integrated policy and funding framework for support services and accommodation will be introduced in 2003, outlined in *Supporting People*.[14] This will place the funding and development of supported housing for vulnerable groups, including people with mental ill health and victims of domestic violence, on a more secure and co-ordinated basis. It will also encourage the delivery of support in ordinary housing as well as in specialist schemes.

The government has undertaken a cross cutting review of the role of the voluntary sector in service delivery. The Review makes a series of recommendations to strengthen the working relationship between government and the voluntary and community sector in pursuit of world class public services.[15] The voluntary sector plays a key role in providing mental health support for women.

Section 2
Understanding women's mental health

Understanding the nature and causes of mental ill health in women is essential to the development of mental health care sensitive to their needs. This section describes:

- the major differences in the occurrence of mental ill health between women and men;
- the factors that are thought to be important in the causation of mental ill health and those that may be protective;
- groups of women who may be vulnerable to mental ill health.

2.1 Mental ill health in the general population

Studies in the general population suggest that the overall prevalence* of mental illness does not differ significantly between women and men. For specific disorders, however, clear gender differences emerge. Anxiety, depression and eating disorders are more common in women, substance misuse and anti-social personality disorders are more common in men.[16] There are also gender differences in the way in which women and men present with mental ill health.

Most studies suggest that depression and anxiety are at least one and half to two times more common in women.[17] In contrast, mental illnesses, such as schizophrenia and bipolar affective disorder, do not show such clear gender differences in incidence† and prevalence.[18] Rates for probable psychosis in the UK general population are estimated at 0.5% for women and 0.6% for men.[19] There is some indication that schizophrenia may have an earlier onset and a more disabling course in men.[20,21] A significant proportion of women experience post-natal depression and some post-partum psychosis (see section 12.5 on perinatal mental ill health).

2.2 Risk and protective factors for mental health

There are various risk factors known to relate to mental ill health. These include socio-economic, physiological and psychological factors. In addition, women's mental health is affected by experiences of child sexual abuse, domestic violence, sexual violence and rape. The interplay of these factors and their interactions are complex and not yet fully understood.

Research into the impact of protective factors that mitigate exposure to risk is in its infancy. The role of family ties, positive parenting experiences, social networks, self-esteem, environmental factors (such as housing and having meaningful ways in which to occupy time) are all likely to play a part.

It is clear however that gender, like socio-economic status, shapes individual opportunities and experiences across life and consequently creates differences in exposure to risk and protective factors.[22]

* Prevalence: the total number of cases of a disorder in a group of people at a point in time, or if specified, over a period in time.

† Incidence: the number of new cases of a disorder in a group of people at a point in time or, if specified, over a period of time.

2.2.1 Socio-economic factors

Deprivation and poverty are strongly linked to the prevalence of mental ill health in communities. Psychosocial health in women seems to be particularly strongly related to socio-economic status. This suggests that the impact of inequalities in health between socio-economic groups may be different for women and men and that consequently gender specific policies are needed to address them.[23]

Poverty

Gender inequalities in income and wealth, in combination with women's role as mothers and carers, make them particularly susceptible to poverty. It has been estimated that two thirds of adults living in the poorest households are women. A similar percentage of adults dependent on income support are also women.[24] Women are much more likely than men to live in poverty, particularly if lone parents or in later life. Poverty is associated with mental ill health.

Employment

Nearly twice as many women (30%) than men (16%) of working age are economically inactive, and nearly twice as many men (60%) than women (35%) are in full-time paid employment.[25] The majority of women in paid employment are employed part time, half are in the low paid clerical, retail and personnel sectors. This contributes to women's vulnerability to poverty.

Unemployment is associated with mental ill health. The impact of unemployment on women and men seems to be different, some studies showing a less negative effect on women. This may reflect gender differences in expectation of work and the role of women within the family.

Women's work in the family

Women provide the majority of care for children and other family dependents. In some cases, women's work in the family is their reason for being categorised as 'economically inactive'. Studies have found that women who work, whether part time or full time, generally also undertake the majority of the housework and childcare.[26] The tension and stress inherent in having competing, and often unsupported, multiple roles and responsibilities as mothers, homemakers, carers and partners may have an adverse effect on women's mental health. The low societal status and value placed on women's roles in the family and workforce and the potential negative impact on a woman's sense of self-worth may also contribute to mental ill health.

2.2.2 Physiological factors

Increased prevalence of depression in women may be in part explained by the impact of hormonal and reproductive changes. Hormone levels are known to influence mood, at its most extreme seen in pre-menstrual dysphoric disorder.* Women are also vulnerable to developing mood disorder during pregnancy and in the postnatal period. Mental disorder is a significant cause of maternal mortality[27] (see section 12.5 on services for women with perinatal mental ill health).

Physical ill health

Physical ill health is known to be associated with mental ill health. In women and men, emotional well-being is a strong predictor of physical health.[28] People with chronic physical ill health are more at risk of mental ill health, particularly depression. People with mental illness are more likely to have physical illnesses such as cardiovascular disease and respiratory complaints.[29]

* Pre-menstrual dysphoric disorder: a mental disorder in which there are marked changes in mood associated with the menstrual cycle.

One of the symptoms of mental illness can be 'somatisation'. This is a process by which psychological problems are expressed as bodily or physical complaints. Somatic complaints are two to three times more common in women. There may also be cultural differences in presentation of psychological problems. Consequently, it is important to be aware of the possible physical manifestations of psychological disorders as well as the effects on physical health of psychological problems (eg stress, muscular tension and headaches).

2.2.3 Psychological factors

Life events

There is a well-described association between major life events and mental ill health.[30] It seems that certain types of events are more likely to be associated with specific disorders: events involving loss, such as bereavement, being associated with depression and events associated with threat, associated with anxiety. Although generalisations can be made about specific types of events, it is the meaning of those events for the individual, and their psychological resilience, that is likely to be important in determining whether mental ill health ensues. Moreover, the meaning of events may differ for an individual at different points in their life. It may be repetition of certain types of events, for instance of violence and abuse, which is of particular importance or the association of certain events with other types of adversity.

Social isolation

Social isolation is associated with mental ill health. Women are more vulnerable to social isolation than men because of:

- higher levels of poverty;
- lone parenthood;
- lack of mobility – women are more likely than men to be dependent on public transport, they are less likely to be able to drive or to own a car;[31]
- longer life expectancy, women are more likely to live alone and in poverty in their later years than men;[32]
- fear, many women in cities are afraid to go out alone at night.[33]

Findings of research presented to the Royal College of Psychiatrists annual conference in 2002 illustrates the relationship between these factors and their association with mental illness in women bringing up children on their own.[34] This study found that lone mothers are three times more likely to be depressed than any other group of women. There was a correlation between mental illness and high rates of material disadvantage: most of these women were not employed, the majority lived in rented housing and two thirds had no access to a car.

It is important to note that there are also protective factors for women in that they tend to have better social networks than men. Positive views on one's social networks and/or having confiding relationships can counteract social isolation and protect mental health.

Emerging work on the concept of social capital* may help to link these issues. A gendered view of social capital will help to address long standing gender inequalities and gender blind policy making. These can systematically disadvantage women and erode the limited social capital available to them, thus compromising their mental health.[35]

* Social capital is a broad term that embraces the level of trust, reciprocal relationships, community and civic participation in a particular locality.

2.2.4 Experiences of violence and abuse*

Women are at a greater risk of violence and abuse than are men. This applies both in childhood and as adults. There is a substantial body of research which links women's experience of child sexual abuse and domestic violence with long term mental illness and also with physical and sexual health problems.[36,37] Important issues are that violence and abuse against girls and women:

- are more common than is generally realised;
- can have a significant impact on physical and mental health;
- are often not disclosed (especially in the case of women who are young, disabled, old and some minority ethnic groups).

The high levels of child sexual abuse and domestic violence suggest that these may relate to the high prevalence of depression in women (see section 2.1 on mental ill health in the general population, section 9.1 on assessment and care planning and section 12.1 on services for women who experience violence and abuse).

Child sexual abuse

Prevalence rates for child sexual abuse vary in community studies depending on the definitions used i.e. penetration, any sexualised physical contact or non-contact, inappropriate sexual behaviour. There is a consensus amongst researchers that there is substantial under-reporting. This will have an impact on the rates reported for boys as well as girls.[38]

Studies suggest that child sexual abuse is relatively common. Estimates from across the international literature suggests that 7–30% of girls and 3–13% of boys may be affected.[39,40] Higher rates are reported in some studies, particularly if non-contact abuse is included.[41,42] Most studies suggest that women are up to 3 times more likely to have been abused than men are. Intra-familial abuse is more common amongst girls. Research is consistent in identifying men as the abusers in about 95% of cases regardless of whether the victim is female or male.[43,44]

Not all people who experience child sexual abuse report later problems, however there are many studies that report an association with an increased risk of mental disorder and psychological problems such as self-harm, depression, anxiety, somatisation, difficulties in inter-personal relationships, eating disorders, drug/alcohol abuse and problems with parenting.[45,46,47] Women in contact with mental health services have experienced significantly higher rates of child sexual abuse than other women and than men (see section 9.1 on assessment and care planning). Child sexual abuse may be associated with a range of other childhood adversity, including physical and emotional abuse and domestic violence. Further research is needed to help in identifying those who will be at greatest risk of later problems.[48]

Domestic violence

Domestic violence has been defined by the Crown Prosecution Service:

> "The term domestic violence shall be understood to mean any violence between current or former partners in an intimate relationship, wherever and whenever the violence occurs. The violence includes physical, sexual, emotional or financial abuse."

Accurate rates are difficult to ascertain, given the extent of under-reporting. Research suggests that between 18 and 30% of women experience domestic violence during their lifetime. Most research has focused on violence perpetrated by men on women, which is estimated to account for 80 to 95% of domestic violence. Domestic violence occurs in same sex relationships and can also be perpetrated by women.[49,50,51] It accounts for 25% of all violent crime and two out of five murders of women in

* Throughout the document, the term 'violence and abuse' refers to child sexual abuse, domestic violence, sexual violence and rape.

England and Wales are by partners/ex-partners.[52] The majority of women with experience of domestic violence do not report it to anyone. It is estimated that women on average experience 35 episodes before seeking help. Survivors frequently turn to non-statutory agencies such as Women's Aid, Victim Support and other voluntary sector service providers. Although all women face difficulties getting help, these difficulties may be greater for some groups of women, particularly black and Asian women, older women, lesbian women and those with a disability.[53]

Women have twice the risk of experiencing domestic violence whilst they are pregnant.[54] The experience of domestic violence was disclosed voluntarily to a health professional in 12% of maternal deaths in the UK.[55] This is likely to be an underestimate, as violence is not routinely asked about.

Women who experience domestic violence report more depressive symptoms, are at greater risk of suicide and make greater use of mental health services than women in the general population.

At least 750,000 children a year witness domestic violence. Nearly three quarters of children on the "at risk" register live in households where domestic violence occurs. It is thought that children are most vulnerable to abuse and long-term adverse effects when domestic violence co-exists with parental mental illness or problem alcohol/drug use.[56]

Sexual violence and rape

Large-scale studies on rape and sexual assault are rare and definitions for inclusion vary. The research that does exist shows that, in developed countries, between 14–40% of women have experience of sexual violence. Many of the perpetrators are known to the woman.

Findings of the 2000 British Crime Survey[57] on the extent of sexual victimisation of women, since the age of 16, indicates that around 1 in 10 women have experienced some form of sexual victimisation, including rape, and approximately three quarters of a million women have been raped on at least one occasion (highlighting that these figures are likely to be under estimates). 'Strangers' are only responsible for 8% of rapes. Women are most likely to be:

- sexually attacked by men they know in some way (partners 32% and acquaintances 22%);
- raped by 'current partners' (45%).

Research suggests that there is a link between the experience of sexual violence and mental ill health in both women and men.[58]

2.3 Groups of women who may be vulnerable to mental ill health

An understanding of the risk factors associated with mental ill health allows identification of groups of women who may be vulnerable to mental ill health. Whilst most women within such groups will not suffer mental ill health, the recognition of vulnerability to illness is one step towards increasing the chances of detecting and managing it effectively and appropriately (see section 9.1 on assessment and care planning).

2.3.1 Women who are mothers and/or carers

The vast majority of the running of households, i.e. cooking, shopping etc. and of caring for children and dependent adults is carried out by women.[59] Forty percent of women spend over 50 hours a week caring for someone living with them.[60] This, in conjunction with women's position in the labour market, means that they are more likely than men to live more home and community based lives.

Women with children

The *Health and Lifestyle Survey* suggested that the most important factor associated with the mental well-being of married women was the age of their youngest child.[61] Women with children under five were particularly likely to have poor mental health, especially if a lone parent.

It is likely that the interaction of socio-economic factors, in conjunction with being at home with children, puts low-income women at greater risk of mental ill health than those better off. Lone parents are likely to have low income or to be reliant on state benefits; most lone parents are women.[62] Lone mothers, however, appear to have poor psychosocial health even after controlling for income, employment status and occupation.[63] In the *UK Psychiatric Morbidity Survey* a lone parent mother was three times as likely as a lone parent father to have non-psychotic mental illness.[64] Women with generalised anxiety disorder* were particularly likely to be lone parents.

Young women who are mothers are at risk of socio-economic disadvantage and consequently mental ill health. Teenage mothers have an increased risk of adverse outcomes for themselves and their children.[65] Estimates suggest that one in seven girls leaving local authority care are either pregnant or already mothers.[66] Looked after children are generally at an increased risk of developing mental ill health in later life.[67] This will relate to the experiences of abuse and neglect that brought them into the care of local authorities as well as, for some, negative experiences while being looked after.

Research suggests that parental mental ill health can have a major impact on children. Some estimates suggest a third to two thirds of children will be adversely affected.[68]

Other caring responsibilities

There are around 6 million carers in the UK, over half of these are women, the majority in the 45–64 age range.[69] Caring for dependent adults or disabled children can have a significant impact on mental health.

Carers of people with dementia show high levels of mental ill health, particularly those that feel burdened, such as younger carers, those not receiving regular help and if the person with dementia has behavioural problems.[70]

Caring for a person with learning disabilities can place considerable strain on carers and families having an impact on emotional well being, financial resources and relationships.[71] The majority of people with learning disabilities and many of their families are poor. Carers of adults with learning disabilities report 40% more health limiting problems than the general population.[72] This is of particular importance as the number of elderly carers increases.

Carers providing substantial amounts of care face financial hardships. They find it difficult to combine the care they provide with paid employment.[73]

2.3.2 Older women

Social isolation and poverty are more common in older women than in men. Women are more likely than men to be reliant on state pensions: less than half the numbers of elderly women than men have personal or occupational pensions.[74] Women are more likely to experience bereavement in old age, their partners dying earlier than they do. Their increased life expectancy also means that they are more likely to experience institutional care with its attendant loss of independence and role.

* Generalised anxiety disorder: an anxiety disorder in which the person experiences unrealistic or excessive worries which last over long periods of time, months or years. (In distinction to panic attacks where the feelings are short lived).

Overall, even allowing for the increasing prevalence of dementia with age, mental ill health is more common in older age groups. This is particularly true for depression.[75] Depression is more common among older people with physically disabling conditions.[76] Women are more likely than men to suffer from disability resulting from restriction in mobility and self-care.[77] It is not unusual for depression to be missed in older people, the ageing process being blamed for changes in mood or social functioning.

2.3.3 Women from black and minority ethnic groups

The interrelationship between gender, culture and ethnicity is poorly researched in terms of its impact on mental health and well being. The interplay between gender and power is made more complex when taken in conjunction with culturally traditional gender roles, particularly for young women from minority ethnic groups growing up in a westernised society. In addition, racism, the impact of immigration with potential loss of family and social networks, language barriers, uncertainty over the future and social isolation can all have a detrimental impact on mental well being. Many individuals from minority ethnic groups have these negative experiences alongside socio-economic adversity such as poor housing, poverty and unemployment.

Despite the research limitations there are indications of important differences in mental health and illness between different ethnic groups.[78,79] Of particular concern with respect to women are:

- suicide, self-harm and eating disorders amongst Asian adolescent girls;[80,81]
- post-traumatic stress disorder and other mental illness, together with experience of torture/abuse, in some groups of refugees and asylum seekers.[82]

2.3.4 Lesbian and bisexual women

There are few studies that report prevalence figures for either the size of the population of women who define themselves as lesbian or bisexual or that look specifically at their mental health. Estimates are likely to be low given that lack of understanding, prejudice and discrimination mean that many would prefer to keep their sexual preferences hidden. Estimates of prevalence of same sex relationships vary from 2–12%. Women's pathways and choices concerning their sexuality are influenced by many factors in their lives.

Women who do not define themselves as heterosexual may have added stressors in their lives given the degree of stigma prevalent in society. These experiences may contribute to poorer mental health. Studies suggest that there are higher rates of mental ill health amongst the non-heterosexual community including anxiety, depression, and substance misuse.[83,84]

2.3.5 Transsexual women

The prevalence of transsexuality* in the general population is not accurately known. Published figures are likely to be underestimates for reasons of prejudice and lack of understanding. Current estimates of biological men with gender identity disorder (1:10–12,000) far exceed the number of biological women (1:40,000–50,000).[85] Transsexual women and men experience stigma and discrimination that may contribute to poorer mental health.

* Transsexualism, also know as gender dysphoria, is an overwhelming desire to live and be accepted as a member of the opposite sex to that allocated at birth. The condition is usually accompanied by a sense of discomfort with one's physical body and a wish to go through a process known as transition, in which hormonal treatment and surgery align the body with the sense of gender identity experienced by the brain. Gender dysphoria is a recognised medical condition for which NHS and private treatment is available.

2.3.6 Women involved in prostitution

Women involved in prostitution have experienced high levels of violence and abuse as children and as prostitutes. Many misuse drugs/alcohol, have little or no access to primary care and may experience homelessness. They also either live in fear of losing custody of their children or have to deal with the loss of their children. Subject to severe discrimination, research suggests high levels of mental ill health.[86,87,88]

2.3.7 Women offenders

The relationship between mental ill health and offending is complex. It is clear however that women in prison have high levels of mental ill health, some women using mental health services have histories of offending behaviour and women's offending patterns differ substantially from those of men.

Broad differences between women and men's offending include:[89]

- men commit more crime than women; less than 5% of the prison population are women;
- men start their criminal careers at an earlier age than women (8% of women and 34% of men have a criminal record by the age of 40) and are more likely than women to have lengthy criminal careers (>10 years – 3% of women and 25% of men);
- women are more likely than men to commit acquisitive crimes e.g. shoplifting, fraud (60% women prisoners, just over 30% men) and are less likely to commit arson, violent or sexual offences;
- women are more likely than men to say that financial hardship, particularly in relation to children, contributed to their crime (41% v 25%);[90]
- there has been a dramatic increase in the number of women in prison compared to men which continues to rise, particularly for drug and acquisitive offences (between 1993 and 2000, the average women's population increased by 111.5% compared to a 42% increase for men);
- women in prison have experience of high levels of violence and abuse as children and as adults.[91,92]

The offending profiles of women and men in secure mental health services also differ from each other and from the broad differences outlined above (see section 11.3 on secure/forensic services).

Mental ill health in prisoners

Exact prevalence figures are difficult to ascertain given the differences in reported rates between the two major research studies in UK prison populations (which used different research methodologies).[93,94] It is clear that mental ill health is common, often co-exists with substance misuse and that remand prisoners have higher levels of mental ill health than those in the sentenced population.

Overall, the following differences between women and men are reported. Women are:

- twice as likely as men to have received help for a mental/emotional problem in the 12 months before entering prison (40% v 20%);
- less likely than men to receive a diagnosis of anti-social personality disorder, although more likely than men to have a diagnosis of borderline personality disorder;
- more likely to have severe mental illness;
- twice as likely as men to have symptoms associated with post-traumatic stress disorder;
- more likely than men to have a history of self-harm, particularly in those with high scores for probable mental disorder.

Although further research is needed, it is likely that mental ill health makes a substantial contribution to offending behaviour in women.[95,96,97]

2.3.8 Women with learning disabilities

In all age groups of people with learning disabilities, there is an increased prevalence of psychiatric disorder and behavioural disturbance over that found in the general population. In many cases mental ill health remains undetected owing to lack of understanding on the part of carers and professionals, together with potential difficulties in communication. Concurrent physical ill health may make diagnosis more difficult and the effects of medication may obscure the clinical presentation of mental illness.

Many risk factors, known to contribute to the development of mental illness, occur more frequently in people with learning disabilities. These include sensory impairments, communication difficulties, low self-esteem, stigma, abuse, low levels of social support, poor coping skills and chronic ill health.

Estimates of co-existing mental illness and/or behavioural disorder in adults with learning disabilities vary from 14.3 to 67.3%. If challenging behaviours are excluded then rates found fall dramatically.[98] The pattern of ill health is somewhat different to the general population. Higher rates of substance misuse and affective (or mood) disorders are found in the general population.[99]

People with learning disabilities suffer high levels of sexual, physical and emotional abuse. This applies to those living in their own homes and to those in residential care.[100] It has been estimated that 1,400 adults with learning disabilities are reported as victims of sexual abuse in the UK each year. This is likely to be an underestimate of the actual number of cases.[101]

2.3.9 Women who misuse alcohol and/or drugs

There are known gender differences in alcohol and substance misuse. In the general population men are more likely to misuse both. There seems however to be greater social stigma attached to women misusing substances, particularly alcohol. This may lead to women's problems being missed or ignored, with consequent difficulties in accessing services. In addition, as women are more likely to be lone parents, fear of loss of custody of children may also mean that their substance misuse problems remain hidden for longer and therefore present later.

Both women and men who misuse alcohol or drugs are at a high risk of having mental disorders. The nature of the relationship between the two conditions is complex and may take any of the following forms:

- mental illness precipitating or leading to substance misuse;
- substance misuse worsening or altering the course of mental illness;
- substance misuse leading to psychological symptoms;
- substance withdrawal leading to mental ill health.

Examination of the gender differences in the nature of these relationships is limited and most research comes from the US. Women in touch with substance misuse services are significantly more likely than men to have experience of the following:[102,103,104,105]

- violence and abuse;
- poor physical and psychological health, particularly anxiety and depression;
- suicidal thoughts and attempts.

Key Messages

- Mental ill health is common in women and men.
- There are significant gender differences in type and presentation of mental disorder and in the prevalence of risk and protective factors.
- Understanding the nature and causes of mental ill health in women, and how these differ from those of men, is essential to the development of mental health care that is responsive to women's needs.
- An understanding of the risk factors associated with mental ill health allows the identification of groups of women who may be vulnerable to mental ill health e.g. women who have experience of violence and abuse, women with caring responsibilities and women offenders.

Consultation Question

- Are there other groups of women who should be considered as particularly vulnerable to mental ill health?

Section 3
Mental health care for women

3.1 What is provided now

This section describes what we know about mental health care for women. This information is derived from a variety of sources including surveys of mental health services, evaluations of specific models of provision and research that asks women what they think about services.

The majority of mental health care for women is provided by generic, mixed-sex services. Some services provide women-only sessions or specific activities for women and others provide dedicated women-only services. We currently do not have a comprehensive picture of the levels and types of services that are specifically for women. The Department of Health's comprehensive mapping of mental health services (website www.dur.ac.uk/service.mapping_2001_02.pdf) asked some specific questions about women-only provision. The 2001 survey suggests that there is tremendous variability across the country. Current information suggests that:

- approximately a fifth of day hospitals and a quarter of day centres provide women-only sessions – in some local implementation team (LIT) areas all these facilities provide women-only sessions, in others none do;
- a few areas provide women-only acute in-patient and/or secure services – the majority of acute units provide single-sex sleeping accommodation, toilet and bathing facilities;
- few employment schemes have women-only sessions.

As is often the case, it is likely that such variation is as much determined by historical factors as specific differences in the need of the population served.

An earlier UK survey of women and mental health services received over 500 nominations of projects demonstrating good practice.[106] The majority of these were not exclusively for women and many were in the voluntary sector. A wide range of needs were addressed including counselling services, supported accommodation, services for women with experience of violence and abuse or for those who self-harm.

The voluntary sector provides the vast majority of women-only community day centre or day services. These services may not always be described as mental health services (by commissioners, the women using them, or the wider community), however they address many of the mental health care needs of women who use them (see section 10.3 on community day services).

3.2 Models of care

Published research comparing different models of care that specifically address women's needs is limited. It is therefore difficult to be sure which model/s of provision provide the most effective or appropriate mental health care for women.[107,108] There have been serious criticisms of some aspects of mixed gender care, particularly acute in-patient, community residential and secure care.[109,110,111,112,113] Concerns often relate to safety, women patients being vulnerable to intimidation, coercion, violence and abuse by other patients, visitors, intruders or members of staff.

"I and a number of women I know have had very bad experiences on mixed wards. A friend of mine was raped and I was harassed to death by men and the staff never intervened. The staff think that women being there will make the men behave better and that if men behave badly it's the fault of the women. I would have thought that if you see a seriously ill woman being harassed, you ought to stop it…. Now when I feel very depressed, I stay with a friend. The situation in the hospital was so awful, I'd never go back there – you can't be ill in peace."

Studies suggest that it may be having a choice between mixed-sex and single-sex provision that is important to women.[114,115] Research on the effects on women of mixed-sex acute in-patient care is limited.

3.3 What women say

There are few large-scale surveys that ask women specifically what they think of, or want from, mental health care. There is, however, a significant body of small scale research which collectively repeats consistent and compelling themes expressed by women service users, survivors and carers.[116,117,118] This evidence should be given equal consideration alongside more formalised research/data as it emerges. To emphasise the importance of involving and listening to women, service user views are incorporated throughout this document in the form of italic quotes.

Generally women say, when asked, that they experience women-only services as safe services and more attuned and responsive to their needs. In addition to their fundamental right to be 'kept safe', women say they want services that:

Promote empowerment, choice and self-determination
Women express an overwhelming sense of 'not being listened to', that their life experiences, views and needs are not validated or responded to.

"Women are thought unreliable witnesses of their own lives and experiences."

"There's a 'there, there, dear' attitude. People don't take us as being credible – you've got the double bind of being women and 'mentally ill'."

"I am fed up with everyone running my life for me, doing my thinking for me, giving me their opinions about who I am."

Women say medication is often the only option on offer with little information about side effects. They want greater access to 'talking treatments', complementary therapies, learning new strategies, developing new skills and alternatives to hospital admission when they are acutely ill.

Women say it is important to them to choose the gender of their key worker (doctor and therapist) which is often denied them, and the opportunity to develop *'sensitive, appropriate relationships'* with staff committed to partnership.

Place importance on the underlying causes and context of women's distress in addition to their symptoms
Women say they want recognition that their psychological vulnerability is not rooted in their 'biology' but in the context of their lives: their sense of powerlessness, lack of social status/value and life experiences of violence and abuse that they have survived or are surviving.

"Psychiatry on the whole demonstrates limited understanding of the social impact of poverty, sexism, racism, parenting issues, sexual abuse and violence on women's lives … All account for much mental distress but a sticking plaster approach never addressed the issues so distress just recurs."

Address important issues relating to women's role as mothers, and the need for accommodation and work

Women want staff to be sensitive and responsive in supporting them to care for their children, recognise their fear of 'losing' children due to their mental distress or their potential desire to have children if they are not already mothers.

"Women's needs often get ignored because of the mantra 'the needs of children are paramount'. In practice, this seems to mean that the woman herself doesn't matter. I think these services desperately need to become more 'woman' friendly, with the idea that women are entitled to support to keep their children. This is likely to be a more effective way of helping children in the long run."

Women express concern over the lack of childcare facilities in all settings, and of friendly visiting areas within residential settings that would help them to maintain contact with their children.

Women want access to a range of safe accommodation options and welcome services that support and enable them to start, retain or return to meaningful employment.

Value women's strengths and abilities and potential for recovery

Women say that too much attention is focused on their problems and difficulties and not enough importance placed on the positive aspects of their lives, and their ability to survive painful experiences.

"To get services, you need to provide a worst case scenario. Rather they should say 'how can we help you benefit from this service. What do we need to do to support this woman to be independent, to meet her potential and to enable her to participate and get support in the wider community'."

Mental Health Media has produced a video (funded by the Department of Health) – **What Women Want, Mainstreaming Women's Mental Health** to dovetail with the National Women's Mental Health Strategy process. It features a number of women service users talking about their mental health problems and experiences with positive reference to specific mental health settings that they feel have been truly responsive to their needs and why. A training booklet accompanies the video.

Purchase price incl. pp: £74.95 (standard price)
£44.95 organisations with 10 or fewer fulltime employees

Contact Mental Health Media, telephone 020 7700 8171, email info@media.com, www/mhmedia.com

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Key Messages

- Most mental health care for women is provided in mixed-sex environments.
- There is significant variation across the country in the provision of women-only sessions/services.
- The voluntary sector is the leading provider of women-only community day services.
- There has been serious criticism of mixed-sex in-patient care in relation to women's safety from violence and abuse.
- Women who have used women-only services speak highly of them.
- Women express an overwhelming sense of 'not being listened to'.
- Research evidence for the effectiveness of women-only versus mixed-sex service provision is lacking.

Consultation Questions

- What information, if any, should be collected on the provision of women-only/women focused services?
- How should good practice in the provision of mental health care for women be disseminated?

Section 4
Developing gender sensitive mental health care

Mental health policy has increasingly emphasised the centrality of service users – their needs, their experiences and choices – and has encouraged working in partnership with them in order to deliver appropriate services. Key issues that influence individuals' experience of the world – gender, race, religion, culture, class, sexuality, disability, age – must therefore be incorporated into service planning, delivery and evaluation. Turning these aspirations into action is challenging, as organisational and individual values and behaviours will need to be addressed and changed.

Gender describes those characteristics of women and men that are socially determined, as opposed to sex, which is genetically and biologically determined. The Beijing Platform for Action (1995) gave this definition:

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

Gender is thus fundamental to our sense of who we are, the roles we adopt, the way in which we perceive others and in which they perceive us.

4.1 Gender sensitivity

The development of gender sensitive services is described in the following sections:

- underpinning values and principles (section 5);
- organisational development (section 6);
- planning, research and development (section 7);
- services – general principles, delivery and organisation (section 8, 9, 10 and 11);
- services for specific groups of women (section 12).

The issues outlined should be considered by all organisations involved in planning, delivering and evaluating mental health care to ensure that they are sensitive to gender and the needs of women. Addressing gender should be an integral activity and not an afterthought. It will not be possible to address the needs of women and men equitably, appropriately and effectively if gender is not considered.

Within this it is of course important to continue to recognise the important differences between individual women:

> "Each woman is different. Each woman's pain has its own history, its own roots – and its own solution… We must stop treating women as an homogeneous group, expecting one solution for all, one analysis for all. We do not need either to celebrate or deny difference, whether between women, or between women and men. We share a lot as women, but as individuals we cannot be subsumed under some category, some all-encompassing label that predicts that our experiences will all be the same. Each woman's experience is still unique to her."[119]

It should always be the individual that is seen, but within a view that is informed by an understanding of diversity issues, such as gender, race and culture. There are experiences that will be common to many women and some that will only be shared by those from specific groups, such as women from a particular minority ethnic group or lesbian women.

4.1.1 Gender specific services

One aspect of ensuring that service planning and delivery is sensitive to gender is to understand that there is a need to provide gender specific, or single-sex, services in some instances. Some services will by their nature be entirely, or predominantly, women-only such as perinatal mental ill health and eating disorder services.

When a women-only service is developed the reasons should be explicit and criteria for its usage developed. Reasons for women-only developments include:

- the expressed preferences of women to ensure choice is available;
- specific gender, cultural or religious needs;
- the generation of a safe environment which has particular relevance for specific groups of women, such as those with experience of male violence and abuse, those with sexually disinhibited behaviour, older women or lesbian women.

In services that are women-only, in particular in-patient and other residential services, explicit decisions about the appropriateness, or not, of mixed-sex activities should be made (see section 11.2 on in-patient services and section 11.3 on secure/forensic services). These decisions should be dictated by the needs of the women, their stage in recovery and their capacity to make informed decisions about their safety and welfare (see section 9.1.7 on risk assessment and section 11.3 on secure/forensic services).

Key Messages

- Gender is a key issue that influences an individual's experience of the world and therefore gender issues should be incorporated into research, service planning, delivery and evaluation.
- To turn these aspirations into action, organisational and individual values and behaviours need to be addressed and challenged.
- It is also important to continue to recognise the uniqueness of the individual.
- To ensure that service planning and delivery are sensitive to gender, there is a need to provide single-sex services in some instances.

Section 5
Gender sensitivity: Underpinning values and principles

The *Mental Health National Service Framework* makes a clear statement of the principles that should inform the planning and delivery of mental health services across all settings (Figure 1). Many of these principles fit in with the increasing emphasis on a recovery-based model of mental health care. Recovery is about mental health care creating an optimistic and positive environment for all people who use it, enabling them to take an active role in improving their lives, increasing their independence and taking their full place in society.

Figure 1: Mental Health National Service Framework Principles

- involve service users and their carers in planning and delivery of care;
- deliver high quality treatment and care which is known to be effective and acceptable;
- be well suited to those who use them and non-discriminatory;
- be accessible so that help can be obtained when and where it is needed;
- promote their safety and that of their carers, staff and the wider public;
- offer choices which promote independence;
- be well co-ordinated between all staff and agencies;
- deliver continuity of care for as long as this is needed;
- empower and support their staff;
- be properly accountable to the public, service users and carers.

As generic principles these are equally relevant to women and men, in mixed and in single-sex settings. It is in their application that gender issues should be addressed. This requires gender awareness and understanding across organisations and service settings, in conjunction with consulting and listening to women. Ways in which organisational awareness and understanding can be encouraged are described in this and the following sections.

5.1 Involving and listening to women

The process of involving and listening to women should be fundamental to all service planning, delivery and evaluation. Policy development, service planning, individual care, commissioning and audit all need to include the voice of women themselves.

A broad spectrum of women need to be included, from all parts of the community, as well as those who are existing service users or carers. There is inevitably a wide range of mechanisms through which consultation and involvement can be encouraged. It is only through using a range of techniques that representativeness will be gained. Specific consultation exercises for hard to reach groups, such as women from rural areas or some black and minority ethnic groups who live very home-based lives, may

be necessary. Practical issues also need to be considered e.g. the provision of childcare, the timing of meetings and the safety and accessibility of meeting venues. Making use of existing meetings and venues, such as those for parent and toddler groups may be helpful.

It may also be necessary to provide information, interpreting or training to help women be involved in processes that may be unfamiliar or daunting for them.

The establishment of patient advice and liaison services (PALS) in every NHS trust and primary care trust will help to provide new ways for women to influence decision making. They will be a source of information and feedback to NHS staff and have the potential to be a powerful lever for organisational and cultural change.

Key Messages

- Gender issues should be addressed in the application of the principles enshrined in the *Mental Health National Service Framework*.
- Involving and listening to women should be fundamental to all service planning, delivery and evaluation.

Section 6
Gender sensitivity: Organisational development

It is unlikely that genuinely gender sensitive services can be planned or delivered by organisations that have not acknowledged and addressed gender issues as a fundamental part of their organisational culture. An understanding of the essential inter-relationship between the organisation, the practitioner and the service user and the impact of gender is needed.

The way in which mental health care will be experienced by women will reflect the structures and processes involved in planning services, as well as their actual experience at the point of delivery. It is important therefore that gender is addressed in both commissioning and provider organisations.

The government's modernisation agenda is underpinned by recognition of the need for changes in organisational culture and delivery of care. Critical areas include:

- partnership working and a reduction in hierarchy;
- choice and autonomy for service users and carers;
- transparency – both for service planning and clinical care;
- valuing evidence-based services;
- focusing on outcomes, as opposed to inputs and outputs;
- increase in integrated and mainstream services and reduced specialisation and service insularity;
- valuing information systems;
- supporting the workforce, both clinical and management;
- valuing non-professional and volunteer staff;
- involvement of staff groups in major redevelopment;
- meaningful service user and carer involvement and inclusion in service planning.

Addressing these issues will help to generate user-focused services and increase staff engagement with service planning and evaluation. Acknowledging, analysing and also addressing inequalities in power relationships within organisational structures and processes will facilitate gender sensitivity:

- acknowledging the ways in which power can be abused to the detriment of women service users and staff and the potential role of the organisation in retraumatisation of the service user;*
- analysing organisational issues, such as untoward incidents, with an understanding of the dynamics of power and gender;

* Retraumatisation: This refers to the reawakening and re-experiencing of previous negative life experiences, such as child sexual abuse. This can occur in response to a variety of stimuli or events, including those that may be well intended. Organisational, and even therapeutic processes, that are experienced as oppressive can act in this way, such as restraint procedures or close quarters constant nursing observation A related phenomenon is re-victimisation where the experience of past abuse can produce the tendency for a sufferer to develop/seek out inappropriate or further abusive situations/relationships.

- applying the same values and principles to the organisation as to the delivery of patient care, ensuring that gender, alongside other inequality issues, is addressed in all organisational structures and processes e.g. harassment policies should apply equally to interactions between patients, between staff and between staff and patients.

Organisational principles such as these are thought to help generate a culture for evidence-based practice: valuing people, being service user centred, having continuing education, clear role delineation for staff, effective teamwork, clear leadership, routine use of audit and regular peer review.[120] These will help to create organisations that develop knowledge about what constitutes best practice and effective mental health care for women.

6.1 Workforce development

An aware, informed and competent workforce is essential if gender sensitive services are to be provided. An understanding of the following issues is therefore necessary for all staff involved in planning, delivering and evaluating services – policy makers, clinicians, managers and researchers:

- the economic and social context of women and men's lives;
- the interplay between gender and other inequality issues such as race, culture, ethnicity and age;
- differences in the prevalence of risk and protective factors for mental health between women and men;
- differences between women and men in presentation and pathways into services and differences in treatment needs and responses;
- the relationship between gender and power inequalities and how this may affect individual patients, staff and the organisations in which they work or are cared for.

The level of detail required will differ depending on the roles and responsibilities of the individual employee, however all staff need a general understanding of these issues and therefore they should be addressed in all core training in mental health.

6.1.1 Leadership

Leadership within organisations should make a clear commitment to addressing gender issues. Modelling gender sensitive behaviours and relationships will be essential. Managerial and clinical practice styles need to demonstrate that staff, as well as patients, are valued. Practical ways of leading by example and addressing gender include:

- collaborative/partnership working styles, particularly between clinicians and managers, across professional and organisational boundaries and with service users;
- devolution and transparency of decision making;
- family friendly employment policies including job shares, carers leave, term-time contracts, child care facilities, generous maternity and paternity leave entitlements;
- being seen to value roles traditionally taken by women, such as secretarial and administrative support or catering;
- helping employees to have an appropriate work/life balance;[121]
- not tolerating bullying, sexual or racial harassment and by having robust policies for dealing with these issues.

6.2 Governance

Clinical Governance: Quality in the new NHS sets out the Government's programme of modernisation and achievement for the NHS.[122] Clinical governance provides a *"framework within which local organisations can work to improve and assure the quality of clinical services for patients"*. In mental health care, given the necessity of multi-professional, multi-agency input into service planning and delivery, it is particularly important that governance and quality issues are addressed across health and social care and in conjunction with other agencies such as housing and the criminal justice system (see section 7.3.1 on service evaluation).

Governance arrangements should formally include gender and other inequalities. Some of the ways in which this can be achieved are:

- ensuring women's involvement in all aspects of service planning, delivery and evaluation;
- including gender and other dimensions of inequality in training programmes;
- developing a culture of evidence-based practice with respect to gender;
- developing quality and monitoring standards that refer to gender, such as choice of key workers and treatment interventions;
- addressing gender and diversity in annual clinical governance reports.

Positive practice example

North West Region Secure Commissioning Team has produced a comprehensive set of **Standards for Women in Secure Services**. These standards cover policy and practice development and are linked to clinical governance indicators. The values that underpin these service standards are described by the Commissioning Team as *'sensitivity to gender, race and culture and the empowerment of women patients'*. Many of the issues addressed are pertinent to non-secure service settings. Local providers have been asked to identify five key areas from the standards for initial development. Networking, participatory workshops and positive practice directories are supporting this process.

Contact Pat Edwards/Carol Elford, telephone 0151 920 5056, email carol.elford@southsefton-pct.nhs.uk

Key Messages

To provide gender sensitive services:

- Gender issues should be acknowledged and addressed as a fundamental part of organisational culture and the inter-relationship between the organisation, the practitioner and the service user.
- An aware and informed workforce is essential.
- Leadership in organisations should make a clear commitment to address gender issues.
- Clinical governance arrangements should include gender and other inequalities.

Section 7
Gender sensitivity: Planning, research and development

The principle from the *Mental Health National Service Framework* that *"all mental health services must be planned and implemented in partnership with local communities and involve service users and carers"* should underpin service planning.

The new arrangements under *Shifting the Balance of Power*[123] give primary care trusts (PCTs) the lead in assessing need and commissioning health services. NHS trusts will continue to provide services, working within delivery agreements with PCTs.

Local councils have been required, since April 2000, to develop Best Value performance plans. These plans offer a framework to help councils improve the way they deliver services and implement the Government's modernisation agenda.

Positive practice example

North Staffordshire Combined Healthcare Trust has undertaken a **radical reconfiguring of specialist mental health services:** nearly 50% of acute in-patient beds relocated into community based mental health resource centres and a new build for hospital based services. The process of strategic change was informed by a service user focus (with equitable gender balance) with service user monitoring groups in each aspect of the service now that it is fully operational. A joint process was established between the Trust, Community Health Council and service users to monitor implementation of the Safety, Privacy and Dignity Guidance. A Women's Forum is also being developed to involve key staff and managers, voluntary sector representation and service users in joint monitoring of service provision in relation to the needs of women.

Contact Jenny Crisp, telephone 01782 275135, email jennifera.crisp@nsch-tr.wmids.nhs.uk

7.1 Assessment of need

The assessment of need is a starting point for service planning and should be part of a dynamic set of processes, not an isolated piece of work. Need is not static, it may change over time, projections of future need should also be assessed.[124] Other essential processes related to needs assessment include:

- Resource mapping: A picture of the services providing mental health care for women (structures, staff, skills) and how much is spent on them is needed. In order that information collected is comparable across different areas, clear definitions of services and interventions are also needed;
- Determination of unmet need/gaps in services for women and the linking of this information to service planning.

Four approaches to needs assessment are described.

7.1.1 Epidemiological research

Epidemiology describes the occurrence of illness/disease in a population and can provide an estimate of the likely numbers in need. Information can be gathered by:

- applying the results of research to a local population, allowing for relevant differences between the research and local populations, for example in ethnicity or deprivation;
- local surveys may be useful for certain groups such as women refugees, where there is relatively little published research.

7.1.2 Key informants

The views of a variety of individuals/groups can help define need and benefits of services. This includes clinicians and service planners as well as women service users and carers (see section 3.3 on what women say and section 5.1 on involving and listening to women). Views can be obtained through, for example, individual or group interviews using structured or semi-structured questionnaires or focus groups.

7.1.3 Analysis of service usage

Data is collected on aspects of service usage that is considered a proxy for need. The information can be compared with data from other services, particularly those that cover similar populations. This makes it is essential to collect service usage data by gender, ethnicity etc. This can help to identify groups who are not in touch with services such as homeless women, women in rural areas, or women from certain minority ethnic groups.

7.1.4 Aggregating data from the direct determination of need in individuals

If standardised measures are used, then aggregate data from individuals can produce an overall picture of need. Similarly, if care plans are detailed and robust enough, aspects of their information can be collated to provide a picture of local need.

7.2 Commissioning

When assessing need and planning services all aspects of service provision should be seen within the context of the whole system, so that a comprehensive system of care can be developed. Inevitably the need for any one component e.g. in-patient beds or day-care will be a function of levels of need and the available range of services. For example, high levels of in-patient bed usage reflects the need for more beds only if the patients occupying those beds are all considered to be appropriately placed.

With the move to primary care trust commissioning, it will be important to maintain robust arrangements for commissioning specialist services such as secure care or in-patient eating disorder services, ensuring appropriate population size and commissioning expertise. PCTs will be expected to act collaboratively to ensure that the right level and quality of service is available to their populations. Strategic health authorities will have a role in ensuring that this happens.

A group, led by the National Director for Mental Health, has been set up to encourage the development of specialised mental health services and to ensure that they become increasingly available to the whole population.

7.2.1 The voluntary sector

The voluntary sector can bring many strengths to service delivery:

- a close understanding of, and working relations with, client groups or communities;
- a greater likelihood of engaging hard to reach groups;
- an ability to adapt to the changing needs of client groups;
- an ability to deliver on health and social care objectives.

Despite this it has been acknowledged that, whilst the work of the voluntary sector in mental health services is clearly of immense value, individual organisations find medium or long term planning difficult because of the uncertain nature of the funding system. In some cases a lack of year-on-year support has led to valuable services folding or reducing provision.[125]

In addition, evidence from Best Value reviews suggests that this sector is often overlooked.[126] As the voluntary sector plays a significant role in providing women's mental health care, health and local authorities will need to enter into longer-term contractual agreements and apply the same principle to their voluntary sector service agreements as they are required to do in their NHS and social care agreements. An emphasis on partnership working will place increasing demands on the voluntary sector and stretch their capacity to deliver. Commissioners should recognise this, and allow sufficient additional resources to meet these demands.

7.3 Research and development

There are similarities in the health care needs of all women as well as important differences between the sexes and between individual women and men. There is some evidence to suggest that there is gender bias in research; women may be excluded from studies for inappropriate reasons.[127] It is essential that gender is a key study variable if a better understanding of the differences in the mental ill health of women and men, and the effectiveness of different interventions, is to be gained.

There are many unanswered questions. Broad areas for future research include:

- differences between women and men of the impact of risk and protective factors in the generation of mental illness and disorder;
- interaction of gender with other factors such as race, ethnicity and culture and the impact on mental health and illness;
- looking at the way in which social capital may be linked to mental health and illness in women and men;
- clearer understanding of the differences in help-seeking behaviour of women and men and how these differences impact on the determination of rates of mental ill health;
- testing whether current research instruments, particularly risk assessment tools, are equally appropriate in both women and men;
- determining the effectiveness of treatment interventions in both women and men;
- studying in more depth the differences in the way in which the criminal justice system, health and social services treat mentally disordered women and men;
- determining whether there are advantages across a broad range of outcomes, both clinical and service user defined, in delivering mental health care in women or men-only environments.

The Mental Health Research Network, under the auspices of NIMHE (National Institute for Mental Health in England) will provide the infrastructure to support high quality mental health and social care research that places the needs of service users, families and other carers at the centre of research.

7.3.1 Service evaluation

Given the general lack of information about gender and mental health care, service planners and providers need to ensure that all service evaluation takes account of gender. This means that:

- in all settings service monitoring, audit and research data should be collected, analysed and presented by gender;
- local audit is carried out of issues where gender is considered a concern e.g. serious incidents, observation practice, prescribing eg of benzodiazepines, use of electro-convulsive treatment (ECT), seclusion and control and restraint;
- where single-sex environments are established their impact should be evaluated. Evaluations should include service user views and whether there are demonstrable differences between mixed and single-sex environments in objective measures of mental health.

Key Messages

- Local service planning should be informed by needs assessment processes that involve a range of women.
- Information from a number of different sources and approaches to needs assessment should be used.
- The importance of the voluntary sector in provision of mental health care for women should be reflected in robust commissioning arrangements that ensure the financial sustainability of voluntary sector services.
- Service evaluation and research should incorporate gender as a key variable in analysis and presentation.

Consultation Questions

- Are there examples of good practice with respect to gender sensitive/gender specific service planning, commissioning or evaluation?
- Are there specific research questions relating to gender and mental ill health that should be considered?

Section 8
Gender sensitivity: Services – general principles

The way in which services are organised and delivered has a direct effect on the service user's experience. This section discusses general principles and is followed by sections on service delivery (the process of care) and on service organisation (the structural components of care).

The following principles should apply across all service settings:

- access to a same sex member of staff;
- access to a female doctor for physical healthcare;
- physical examinations to be undertaken by a female member of staff or with a female chaperone present;
- a female member of staff present if restraint is used;
- access to women-only therapy groups, particularly for issues such as violence and abuse;
- access to women-only social activities;
- acknowledgement of caring responsibilities through provision of childcare facilities, transport and flexible appointment times for example.

Adapted from *Safety, Privacy and Dignity Guidance*[128]

Applying these principles gives women greater choice and addresses safety issues.

8.1 Workforce issues

Service users and carers should be engaged throughout the whole process of workforce planning, education, training and recruitment. A user-centred approach is fundamental to the work being taken forward by the Mental Health Care Group Workforce Team, in response to the Government's Workforce Action Team Report on workforce issues for mental health services. The following sections build on the general workforce issues outlined under organisational development (refer page 30). More specific gender sensitive training and staff support for mental health care practitioners is described.

8.1.1 Training

The fundamental gender issues that need to be incorporated into training programmes have already been outlined (refer page 31). In addition to these, training for mental health practitioners should address the following in order to foster positive, user-focused and consequently gender sensitive working practices:

- listening skills;
- being non-judgmental, empathic and respectful;
- understanding and managing people with complex problems, who may be difficult to engage and constantly test boundaries, not treating them as a nuisance or using labels, such as personality disorder, to exclude them from services;

- the importance of consistency and continuity of care from staff and staff as role models, particularly when dealing with patients who may have had few positive role models in their lives;
- risk assessment processes underpinned by a clear understanding of the gender differences in risk to self and others;
- a range of risk management skills including de-escalation techniques, the use of therapeutic relationships to create security, appropriate use of time-out and safe restraint procedures.

To create a gender aware workforce these issues will need to be thoroughly integrated into the qualifying and post-qualifying training of all mental health practitioners.

Core competencies with respect to gender in secure care have been developed, as has a training course for practitioners working with women in secure environments (see below).[129]

Positive practice example

The **Gender Training Initiative** (a joint initiative between the University of Liverpool and WISH), funded by the Department of Health, was established to develop gender awareness training for multi-disciplinary staff working with women patients in secure mental health settings. The principal aim of the training is to develop staff understanding of issues involved in working with women patients in secure settings and thereby contributing to the overall improvement in provision. The course is administered by the Tizard Centre, University of Kent, Canterbury and is available for multi-disciplinary staff teams working with women in secure settings, prisons and adolescent secure units.

Contact Carey Sellwood, telephone 01227 827863, email c.sellwood@ukc.ac.uk

8.1.2 Staff support

All workforce development plans should include the structures and processes for providing staff support. For these to be sensitive to gender the following should be acknowledged:

- a majority of the workforce will be women;
- many of the life experiences of women patients are common and are therefore likely to be shared by a significant number of the workforce e.g. violence and abuse or bereavement;
- similarly disorders such as depression, substance misuse and eating disorders, because they are common in the general population, will also be/have been experienced by a significant number of the workforce;
- if these issues are unaddressed/unresolved they can cause stress for the practitioner, have a negative impact on the development of therapeutic relationships or, at worst, a detrimental impact on the service user's chances of recovery.

Ways of providing staff support include:

- access to regular, systematic supervision;
- opportunities for reflective practice to acknowledge the tension between understanding and putting limits on extreme behaviours e.g. self-harm and to help practitioners to deal with personal rejection and refusal of care;
- out-of-hours crisis support and confidential counselling services;
- regular staff appraisal to identify both high achievers and those who need additional development and support.

Key Messages

- Access to women staff, women-only interventions and an acknowledgement of women's caring responsibilites, need to be addressed in all settings providing mental health care.
- Training for mental health practitioners should be informed by an understanding of gender issues and address specific issues such as violence and abuse and self-harm.
- Staff support programmes should be underpinned by the understanding that mental ill health and other experiences may be shared by practitioner and patient, and they should address the potential impact this may have.

Consultation Questions

- How should gender and other dimensions of inequality be addressed in training for mental health practitioners?
- Are there examples of good practice in the provision of training or staff support processes that address gender and other dimensions of inequality?

Section 9
Gender sensitivity: Service delivery

This section covers issues related to the way in which services are delivered and includes assessment and care planning, care and treatment interventions, consultation and liaison and advocacy. It does not attempt to provide a comprehensive overview, but to highlight issues that specifically relate to gender.

9.1 Individual assessment and care planning

Assessment and care planning take place in all settings, whether a GPs surgery, a day centre or an in-patient ward, although the terms are more often associated with specialist mental health provision. Fundamental to user-focused delivery of mental health care is a whole person, individual assessment of need and the development, in partnership with the service user, of a care plan to address those needs. This process is formalised as the Care Programme Approach (CPA) in specialist mental health services. Recent care co-ordination guidance makes explicit that the service user's needs must be central and that gender should be taken into consideration:[130]

> "Care plans should focus on *users' strengths and seek to promote their recovery*. Recognising, reinforcing and promoting service user strengths at an individual, family and social level should be an explicit aspect of the care plan. Care plans should recognise the diverse needs of service users, reflecting their *cultural and ethnic background as well as their gender and sexuality*, and should include action and outcomes in all the aspects of an individual's life where support is required, e.g. psychological, physical and social functioning."

The focus on service users' needs and own recovery goals is reiterated in *The Journey to Recovery*.[131] Care plans should incorporate what service users say works for them, such as support networks of friends and families.[132]

> *"To regain control over our lives we need to be active, assertive and strong. Our concern is that, all too often, treatments encourage inactivity, passivity and compliance."*

The following should be key components of assessment and care planning:

- experience of violence and abuse;
- caring responsibilities;
- social and economic support;
- physical health;
- ethnicity and culture;
- dual diagnosis with substance misuse;
- risk assessment and management.

Care planning should address factors that cause social exclusion, as well as those that improve mental health. Inevitably the two are intimately linked.

9.1.1 Experience of violence and abuse

> "Clinicians generally ask patients about abuse experiences if they have some reason to suspect abuse … research underscores the discrepancy between the alarming numbers of people who are physically and sexually abused and the relative lack of attention that is given to these topics in taking routine psychiatric histories."[133]

> "The links between mental ill health and previous experience of sexual abuse are well known but persistent findings suggest that the issue of sexual abuse receives little attention in mental health services; indeed, it is common for coping mechanisms to be misinterpreted as symptoms of pathology, and assessments are often made which ignore the context of abuse, thereby perpetuating the problem."[134]

Research suggests that women using mental health services often have histories of violence and abuse in child and/or adulthood. Although many of the studies are small, figures of over 50% are not unusual.[135,136,137] In secure settings this figure is even higher.[138]

The level of awareness of violence and abuse appears low amongst mental health professionals, women are rarely asked about such histories.[139,140] Where survivors of violence and abuse have been asked about their feelings with respect to disclosure, they say they want to be asked/wished they had been.[141,142]

By not initiating exploration of abuse staff may:

- confirm a person's belief in the need to deny the reality of their experiences;
- leave unexplored a significant factor affecting an individual's mental health, thus compromising the capacity for recovery;
- unwittingly engage in a process of retraumatisation (see page 30 for definition).

There are of course many reasons why staff may not address issues of violence and abuse, not least that they may have been subject to abuse themselves (see section 8.1.2 on staff support) or do not know what to do if it is disclosed (see section 12.1 on services for women with experience of violence and abuse).

9.1.2 Parenting and caring responsibilities

Women's parenting and caring responsibilities deserve specific consideration for the following reasons:

- The impact of the loss, or threat of loss, of a woman's caring role, particularly with respect to her children, may lead to women not seeking help, not reporting abuse or underplaying symptoms. This may result in their self-esteem being undermined or in the generation of mental ill health.[143] Women need sensitivity and support *"to care for their children rather than pathologising/judging them negatively"*;
- At least 30% of adults in touch with mental health services have dependent children and the majority of women service users. The consequences to the children of interventions/ treatments should be considered;[144]
- Approximately a quarter to a third of parents whose children are known to children's services may experience mental ill health;
- Some women with mental ill health are cared for by their children.

There is an important inter-agency component to the assessment of children and families in need, including the education and criminal justice systems, as well as health and social care. Government guidance highlights the impact of parental ill health on families and an assessment framework for working with children and families in need has been published.[145,146]

By taking a family or systems approach to mental health the following understandings will be facilitated:

- parental mental illness affects children;
- mental illness can affect parenting and parent-child relationships;
- parenthood can precipitate and influence mental illness.

Women as carers for people with mental ill health must also be considered in assessment and care planning. This is highlighted in care co-ordination guidance:

> "The process of the CPA is clearly intended to deliver care to meet the individual needs of service users. However, those needs often relate not just to their own lives, but also to the lives of their wider family. The CPA should take account of this, in particular the needs of children and carers of people with mental health problems, and must comply with the Carers (Recognition & Services) Act 1995 and the National Service Framework standard on caring for carers." [147]

9.1.3 Social and economic support

A commonly mentioned barrier to recovery is the benefits trap and low income.[148]

For those on enhanced CPA, the written care plan must show the action needed to secure accommodation, employment/education/training or other occupation and appropriate entitlement to welfare benefits. This should be in place by March 2002 and be extended to all those on CPA by 2004.

All assessment and care planning should take into consideration the individual's socio-economic situation. It has been shown that addressing housing for example, is a prerequisite for engagement of some service users in services. Housing need for women may be hidden; they may be staying with family/friends or be trapped in accommodation with abusive partners.

Care plans should also include daytime activity addressing service users' needs and wants rather than gender stereotypes. There is some evidence to suggest that women may be expected to improve self-care and domestic skills, whereas men are expected to find employment.[149]

> *"Work, leisure pursuits and education were not considered as important for women as for men and were rarely accorded the same priority in women's care plans."*

9.1.4 Physical health

The *Mental Health National Service Framework* highlights the need for improvement in physical health care for people with mental illness. This needs to be addressed across health care settings, in both primary care and specialist mental health services.[150,151] Health promotion interventions are not well provided for those with mental illness.[152] This is despite high rates of smoking, obesity, poor diet and lack of exercise in those with mental ill health.[153,154] Women who have experienced violence and abuse may not participate in health screening programmes.[155] The risk of sexually transmitted disease and unintended pregnancy should also be considered.[156,157,158]

> *"Our physical healthcare needs are important and should not be subsumed under our mental health label."*

Assessment and care planning should therefore include:

- GP details (attempts to find one if not registered) and attendance at other primary care services;
- cervical smear and mammography history;

- appropriate questions for asylum seekers and refugees to determine immunisation status and presence of other diseases e.g. TB;
- need for dental care;
- details of last menstrual period and contraception (and pregnancy test if indicated). Oral contraceptives and pregnancy will have an impact on choice of medication, if required. Women should be counselled, or directed for counselling, about appropriate contraception and the potential risks of medication on pregnancy.

The care plan should address physical health issues, even if it is limited to providing help/support to enable the woman to access mainstream services.

Positive Practice Example

In the Bolton, Salford and Trafford MH Partnership practice nurses, working in the Edenfield Centre and the high dependency unit on the Prestwich site, offer **general and specific health services** to patients. On admission patients are given a 'health' history interview including current acute and chronic health problems. These are incorporated into care plans, alongside advice on a healthier lifestyle, in conjunction with the patient and their primary nurse. Practice nurses also liaise with general hospitals in the event of planned or emergency treatment. Specialist health care includes pre-treatment counselling for patients commencing Clozapine, continuing support and monitoring of side effects through a weekly 'Clozapine Clinic'.

Contact Ian Maule, telephone 0161 772 3597, email imaule@edenfield.bstmhp.nhs.uk

9.1.5 Ethnicity and culture

Assessment and care planning must recognise that for some minority ethnic groups negative experiences with respect to their race or culture are common. The experience of racism was said to be a significant barrier to recovery by a quarter of respondents in a recent MIND survey.[159] Services are not always sensitive to cultural needs: food, language, personal hygiene and spiritual needs are not always understood. This, in addition to potential racial abuse by other service users or staff, can exacerbate mental ill health.

"An Asian woman was scolded by staff for not bathing… The woman didn't wish to use a bath while she was menstruating because of her beliefs but nobody took the time to realise or educate themselves that this was the reason and help her to find and use a shower."

In situations where a woman does not speak English care should be taken if family members are used as interpreters. Issues such as domestic violence may remain hidden if an independent person is not used.

9.1.6 Substance misuse

Substance misuse and mental ill health commonly occur together, women may hide their addiction, due to social stigma and/or fear of loss of children, and are more likely than men to abuse prescription drugs. These issues should be taken into consideration in assessments (see section 2.3.9 on women who misuse alcohol and/or drugs and section 12.4 on services for women with dual diagnosis).

9.1.7 Risk assessment

Risk assessment for women and men will have much in common, but should acknowledge gender difference. Research on risk assessment and management often does not include gender analysis. As yet there is no clear research evidence to determine whether current risk assessment instruments are appropriate for women or whether gender specific ones should be developed.[160] In general, it is important to assess offending/ dangerous behaviours within the family and social context of a service user's life in order to make a judgement about dangerousness to the public, staff and/or other service users. Also important, particularly for women, is the differentiation between active suicidal intent and other acts of self-harm (see section 12.2 on services for women who self-harm).

The vulnerability of a patient to abuse should also be part of risk assessment and management. Similarly, an assessment of the potential for a patient to act as an abuser should be made. This is of particular relevance in mixed-sex settings/activities or to assessments of those in single-sex settings when deciding about the appropriateness of mixed-sex activities.

9.1.8 Sexuality

It is important that mental health practitioners do not make assumptions or value judgements regarding women's sexual identity, sexual behaviour and/or the choices they make regarding their sexuality. Women may feel that their sexuality is ignored, denied or frowned upon. They may be subject to frank abuse.

> *"We are judged by our sexual behaviour – we are asked about our sexual behaviour when it clearly doesn't relate to anything. There is the pathologising – if you are a lesbian you are pathologised, if you are having a lot of sex that is pathologised, or if you are not having sex that is also pathologised. To lesbians: 'Are you sure you are a lesbian?'."*

Irrespective of a woman's sexual orientation, respect and sensitivity should be accorded at all times. The Royal College of Nursing has produced guidance *"to develop and promote good nursing practice in mental health by assisting nurses to meet the needs of all who identify themselves as lesbian, gay or bisexual"*.[161]

Addressing the needs of transsexual women appropriately may present particular challenges for services. Individuals should be treated in the gender role in which they present and addressed appropriately ie she/her. If a transsexual woman passes convincingly in her chosen role there may be few difficulties but if she is, perhaps, early on in transition and still has male physical characteristics, this could be distressing for other patients. Equally, female to male transsexuals may feel at risk in male wards. In such circumstances alternatives to admission to hospital or sensitive provision in the in-patient setting should be considered.

Positive practice example

North Warwickshire Primary Care Trust has developed a Mental Health Services **Equality Initiative** to improve the sensitivity of existing services for service users who are gay, lesbian, bisexual or transgendered. The project offers both one-to-one and group work for service users (in conjunction with a service user's key worker), advice and training for staff and a group for gay and lesbian staff to provide support and identify issues that the Trust needs to address e.g. harassment, homophobia. The project also works closely with non-health organisations such as the police and education.

Contact Christine Trethowan, telephone 024 7664 2200, email christine.trethowan@nw-pct.nhs.uk

9.2 Care and treatment

Services should provide a range of services to respond to individuals diverse needs: social, therapeutic and creative activities, self-help, practical support, medication and psychological interventions. In a recent survey, nearly half the people who said they felt recovered or were coping, said support from mental health services first helped their recovery; 42% said support from family and friends first helped, 42% said psychiatric drugs, 38% said talking treatments, 31% said GP services, 20% said spirituality/ religion and 11% said alternative therapies. Over a third of respondents, however, said that mental health professionals and a lack of choice in treatments had hindered their recovery.[162]

This section does not attempt to be a comprehensive overview of approaches to care and treatment, but to highlight some important issues with respect to women.

9.2.1 Medication

There is good evidence for the effectiveness of a range of medication in the treatment of mental illness. User research, however, often highlights a perceived over reliance on medication.

> *"There is a limited supply of 'talking therapies' available in the NHS. High dependence of GPs and psychiatrists on prescription medication that is ineffective on its own without other support or life style changes … Doctors education in more holistic practice should be increased …Help women reclaim the immense wealth of intuitive health knowledge they have got from each other."*

For women there are some specific issues that should be considered with respect to prescribing:[163]

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

9.2.2. Psychological therapies

A wide range of psychological therapies is available and there is evidence for the effectiveness of some.[164] Within the NHS, psychological therapies are provided by different professional disciplines. Some therapists have generic roles providing therapy as an integral part of care programmes within mental health teams, and others provide stand alone services. Psychological therapies are also provided by the voluntary sector e.g. community based therapy centres, day services. Women service users clearly want more access to a range of 'talking therapies' and less reliance on medication.

The Department of Health recommendations on treatment choice in psychotherapy and counselling[165] include the following:

- Psychological therapy should be routinely considered as an option when assessing mental health problems. Medication may be the treatment of choice in an individual case but it should not be the only option considered;
- Patient preference should inform treatment choice, particularly where research evidence does not indicate a clear choice of therapy;
- Effectiveness of all types of therapy depends on the patient and the therapist forming a good relationship.

When psychological therapies are provided, gender inequalities in society which impact on women's mental health needs should be acknowledged, particularly those aspects of women's lives that can create dependence and powerlessness (see section 2 on understanding women's mental health). Therapeutic interventions therefore need to be based on the principles of empowerment, partnership and giving women a sense of control over the pace and movement of the therapeutic process.

There is an acknowledged shortfall in the availability of a range of psychological therapies. Planned developments in primary care aim to address some of this (see section 10.2 on primary care). Work being taken forward by the Mental Health Care Group Workforce Team will examine issues relating to the delivery of psychological therapies across the whole system of mental health care.

Positive practice example

The Women's Therapy Centre in Islington, London is a major voluntary sector provider of both individual and group psychoanalytic **psychotherapy for vulnerable women**. Women present with a multiplicity of problems including experiences of child sexual abuse, domestic violence, eating problems, substance misuse, bereavement/loss, depression and psychosis. Over 50% are from black and minority ethnic communities and therapy is provided in several languages. Clients are seen on a self-referral basis with a sliding scale of fees.

Contact Ann Byrne, telephone 0207 263 7860, email a.byrne@womenstherapycentre.co.uk

9.2.3 Complementary therapies

Complementary therapies, such as aromatherapy and reflexology, are often highly valued by women service users and are increasingly available, alongside more traditional approaches. Formal evaluation of effectiveness is often lacking. Some effectiveness evidence is available for hypericum or St John's Wort, exercise and meditation.[166,167,168] More research with larger study numbers over longer periods of time is needed.

9.3 Consultation/liaison

Specific work is needed to ensure that, at a population level, there are no gaps in service provision and that consultation and liaison about individual clients can occur with relative ease. There are a number of mechanisms that may help achieve this:

- agreed process for referrals;
- agreed standards for referral;

- named responsibility at both clinical and managerial levels for ensuring development and review of consultation and liaison structures and processes;
- development of information systems shared across agencies.

Formal agreements between specialist mental health service providers and the following may be of benefit.

- Primary/secondary care providers: shared care issues e.g. prescribing costs, drug monitoring, physical health screening and monitoring, family planning, the relative roles of primary and secondary care in management of severe mental illness and less severe disorders;
- Non-statutory services e.g. residential homes, level of service provided to them, training provided etc;
- Sub-specialities within mental health services – defined responsibilities are particularly important at the boundaries of services. The following are groups that merit specific consideration: people with learning disabilities, early onset dementia, brain injury, personality disorder and substance misuse, and 16–19 year olds;
- Obstetrics and gynaecology: prevention, detection and management of perinatal mental ill health, psychosexual and other gynaecological disorders which may have a significant psychological component;
- Medical and surgical specialities: the organisation of hospital liaison psychiatry services and the management of somatisation;
- Accident and emergency departments: management of crisis, particularly self-harm.

9.4 Advocacy

Gender and other dimensions of inequality should be taken into consideration when advocacy services are established.

The White Paper *Reforming the Mental Health Act*[169] made a commitment that people subject to the new mental health legislation will have a right of access to specialist mental health advocacy. The Department of Health commissioned the University of Durham to undertake a study of mental health advocacy services to assist it in developing and implementing this proposal for new mental health legislation. Their report: *Independent Specialist Advocacy in England and Wales: Recommendations for Good Practice*, has how been presented to the Department of Health and has been published with a series of questions. The report can be accessed at www.doh.gov.uk/mentalhealth/advocacy.

Positive practice example

The North West Secure Commissioners commissioned WISH (Women in Secure Hospitals) to provide and evaluate a pioneering, **gender specific advocacy service** for women patients detained at Ashworth Hospital, Merseyside that aims to protect vulnerable women, give them a stronger voice and promote their rights. This requires *'an awareness that women have been rendered silent over long periods of time and finding a voice is not easy'*. To ensure maximum access, the service is provided flexibly and in response to the needs identified jointly by the women and advocacy workers. Initial types of advocacy offered are the encouragement of self-advocacy, 'one to one' representation, group advocacy and support to ward based community meetings.

Contact Kate Noble, telephone 0151 471 2639, email wishnw@freenet.co.uk

Key Messages

- Individual assessment and care plans should address gender difference and include the following: experience of violence and abuse, caring responsibilities, social and economic situation, physical healthcare, ethnicity and culture; dual diagnosis with substance misuse, risk assessment and management.
- It is important that mental health practitioners accord women respect and sensitivity at all times with regard to their sexuality.
- Practitioners need to be aware of and address gender in all care and treatment ie social, therapeutic and creative activities, self-help, practical support, medication, psychological therapies and complementary therapies.

Consultation Question

- Are there other aspects of service delivery that should be considered to ensure that gender, and women's needs in particular, are addressed?

Section 10
Gender sensitivity: Service organisation – non-specialist mental health services

10.1 Health promotion programmes

Mental health promotion programmes are a vital part of local planning.[170] Issues pertinent to women include:

- Improving the health of women of childbearing age may also improve the physical and mental health of the next generation.[171] Providing support to women with young children, through parenting programmes or schemes such as Sure Start, can have a beneficial effect on maternal and child mental health and child development;
- A number of groups of women are at high risk of mental ill health (see section 2 on understanding women's mental health) and should therefore be specifically considered in local health promotion plans. These should include women with experience of violence and abuse;
- Reducing social isolation and poverty. This will have an impact on women and men, however programmes should take into account gender difference, such as women's need for improved public transport and childcare facilities.

Positive practice example

The **Mothering Project** at The Maya Centre, Islington works holistically to improve the quality of parenting for children whose mothers are living with multiple deprivation, may have experienced violence, sexual abuse, abandonment or neglect in childhood and who are unlikely to approach traditional mental health services. A six-month programme of support may include individual counselling, group work, parenting skills training and dance/movement therapy.

Contact The Maya Centre, telephone 0207 281 2673, email maya.centre@virgin.net

10.2 Primary care

Most mental ill health, mainly depression and anxiety, will be seen and managed in primary care.

10.2.1 General practice

Studies suggest that, on average, GPs detect about half of the people with mental illness (according to screening questionnaire) that present to them.[172] What in actuality 'detection' represents is complex and relates to both GP and patient factors. There is also considerable variation between individual doctors. There is relatively less research on detection by other primary care practitioners.[173,174] Detection is affected by the way in which patients present their problems. Generally, the combination of physical complaints and mental ill health, common in women, impedes recognition of the latter.[175]

Specific issues for women (see also section 9.1 on assessment and care planning) include:

- recognition and appropriate treatment of depression (including postnatal depression), anxiety and eating disorders, such as increased availability of psychological treatments and appropriate use of antidepressants/anxiolytics;
- detection and management of issues/conditions that often remain hidden – self-harm, substance misuse and experience of violence and abuse;
- review of long-term prescribing, particularly of benzodiazepines;
- access support services, such as benefits or housing advice.

Specific work is underway which will help to achieve improvement in these areas. New graduate primary care workers will have a role in the provision of brief interventions, mental health promotion and providing information about other services. The development of 'Gateway' workers will help to improve the interface between primary and secondary care. Further information can be obtained from the website: www.doh.gov.uk/fastforward.

Positive practice example

In response to a growing number of patients with depression, the Regis Primary Care Group in West Sussex collaborated with a voluntary sector partner, United Response, to develop an initial **pilot mental health project**. It is based in two GP practices which serve diverse communities. A skilled mental health support worker is employed by United Response. She provides patients, predominantly women, with a practice-based intervention. She talks to patients about their symptoms, works with them on identifying individual coping strategies, monitors medication and acts as a link between patients and GPs. The aim is to enable individuals to maintain normal activities of daily living and access community support e.g. local self-help groups.

Contact Mary Doran, telephone 01243 837906, email Mary.Doran@united-response.co.uk

10.2.2 NHS Direct

In 2001/02, NHS Direct received a total of approximately 7 million calls and between 6 to 8% were logged as mental health calls. Many calls are about children (approximately 40% of the total calls received). NHS Direct provides a non-stigmatising way for women to access mental health information and, at the same time, to raise any physical healthcare needs. This is an opportunity which could be further developed.

A partnership has been developed with voluntary sector mental health helplines. Gender and other diversity issues are being addressed as part of this process.

10.3 Women-only community day services

The listening panels that contributed to *Secure Futures*[176] identified the need for on-going community support, including access to self-help groups, for women mental health service users. The panels heard that women "dip into services" to get help while trying to hold the family together. The document highlights evidence of how crucial community support is, not only for existing service users, but also for women recovering from mental ill health and in helping to promote mental health and well-being.

Women-only services are highly valued by the women that use them. They can provide a non-stigmatising source of support and inspiration for a wide range of women. Some women speak of the sense of social isolation that they feel when they are at home with families, especially if they are struggling with mental ill health. Many acknowledge the value of meeting with other women to share

concerns and experiences. By encouraging creativity, participation, learning and relaxation these services can help women increase their self-esteem and develop individual coping and protective strategies.

"I'm struggling to leave the house – the staff and women at the Day Centre understand. If I make it down on my own, they make me feel good. If I can't make it some days they come round for me. It's helping."

"Safe spaces for women to meet and share, give and receive support, learning groups, activity groups, creative expression groups, information and skills exchange."

"It makes you realise that it's not you alone – there are others who have it as bad if not worse and they are getting through. It gives me hope."

10.3.1 NHS Plan commitment

To help develop community support for women's mental health and well-being the NHS Plan made a commitment that *"by 2004, services will be redesigned to ensure there are women-only day centres in every health authority"*.

However, it has become clear that concentrating on women-only day centres, in their conventional sense, would not provide sufficient flexibility to allow local services to address the differing needs of women in different locations. So the emphasis of the *NHS Plan* target has been changed from day centres to day *services*.

Local health and social care communities should develop services to ensure that a range or network of women-only community day services is available to meet the local needs of women. The way in which these services will develop is likely to be different across the country, depending on existing local provision and need. For example there may be a need for different approaches in rural settings, and for the provision of "outreach" or out-posted services to reach socially isolated women

Currently the majority of women-only day centres are provided by the voluntary sector.*

They provide a range of support that address women's mental well-being. However, many of them are not perceived as mental health services by the services themselves or by the women who use them. They are used by a variety of women, including those with mental ill health. Service development should build on these services, where they exist.

An outline service specification for women-only community day services is described on page 54. Voluntary sector day centre services will form part of this provision, but should not be the sole focus. The final service model for women-only community day services will be described in the *Mental Health Policy Implementation Guidance.*

10.3.2 What will these services do?

The aim of service development should be to promote mental health and to help prevent mental ill health or relapse by supporting women in their own homes and communities.

The services should be non-stigmatising and allow open access. They should provide a range of services/activities dictated by local needs, such as counselling, drop-in facilities, educational opportunities e.g. parenting/health promotion, self-help groups, complementary therapies, information and advice services. They may be provided in a range of settings.

* Women@Centre Network directory, available from Keighley Women's Centre, 01535 681316.

"To women seeking help, a source both directly and indirectly of opportunities in their communities that could benefit their health … information, opportunity, support, effective treatments for body, mind and spirit … to teach women directly about health and opportunities to improve theirs."

10.3.3 Who will use these services?

These services have the potential to help a range of women:

- those with existing mental illness who receive support from mental health services;
- women recovering from mental ill health;
- survivors of difficult or abusive experiences, who would benefit from on-going support;
- women in the community who would benefit from advice and support to maintain good mental health (links should be made to the development of local mental health promotion strategies)[177].

"We have a laugh, share our troubles. I don't know what I'd do without my friends and the staff at the Centre."

In particular, returning to home and the community after being in hospital can be a difficult time – adjusting to "normal" living, and resuming caring responsibilities and parenting roles. Support at this time is crucial and guidance on the Care Programme Approach (CPA), *Effective Care Co-Ordination*, emphasises that care co-ordination should facilitate access for individual service users to the full range of community supports. CPA plans must ensure continuity of care and should foster good links between community care and support services for patients while in hospital.

Women-only services may also be particularly appropriate for women who are reluctant to access mainstream services as they find them inaccessible, culturally inappropriate, frightening or in other ways not appropriate to their needs. Similarly there are some women who feel that mainstream services have "failed" them.

10.3.4 Planning, commissioning and provision of services

Commissioners and planners need to build on existing provision identified through service mapping, and develop and support women-only community day services services to meet the needs of women in their communities. This will involve:

- understanding, uncovering and addressing the "hidden"needs of women in needs-based planning and commissioning systems (see section 7.1 on assessment of need);
- consulting with local women and organisations;
- building on good practice and existing women-focused services;
- strengthening partnerships with voluntary sector organisations (including provision such as women's refuges, etc) in planning and delivering services;
- acknowledging the contribution to women-only provision made by the voluntary sector and put in place longer term funding arrangements to ensure stablility and sustainability of such service provision;
- addressing training needs at all levels to ensure that service commissioners and providers are aware of issues around gender.

In considering levels of funding and contractual arrangements with voluntary organisations, commissioners and planners should also address the need for:

- robust systems for internal and external supervision;
- management systems that sustain and support staff working with complex client groups;
- the evaluation of effectiveness of services – with the use of outcome measures and feedback from women using these services.

Positive practice examples

The **"Staying Out" Project**, developed by Sefton Women's Advisory Network (SWAN) provides specific support for women who have experience of repeated admission to acute in-patient care. Commended by the North West Health Challenge Awards 2001, the project is designed to minimise the effects of mental ill health, maximise the potential for self-worth and positive achievement and reduce social isolation. Established in September 1999, the project is funded by the Health Action Zone until September 2002.

Contact: Ann Crotty, telephone 0151 933 3292, email swan-centre@3tc4u.net

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Dosti (friendship) is a **multi-faith women's support project**, based at Stockhills Day Centre in Leeds, run by and for Asian women of all ages. It provides a crèche and transport. Women have access to counselling, advice, advocacy and support (including at times of crisis) in their first language and can take part in a range of activities e.g. creative sessions, complementary therapies and cultural events. Dosti focuses on issues that impact on Asian women's mental health including extended family and family pressures, domestic violence, arranged and forced marriages, socio-economic problems, bereavement and postnatal depression. At Dosti *'we are promoting good mental health, challenging barriers that prevent women getting help and bring women together to share experiences and gain strength from each other'*.

Contact Manjula Prasad, telephone 0113 279 3836

Calderdale **Well Woman Centre** has provided a service *'run by women, for women'* since 1985 which comprises support, information, advice and opportunities on an open access basis. The underlying philosophy is holistic *'that acknowledges the effects of deprivation, loss, abuse or discrimination on our overall mental and physical well being'*. The Centre strongly encourages and supports women to become involved at all levels within the organisation.

Contact Clare Hyde, telephone 01422 360397, email wellwoman@tesco.net

Outline service specification for women only community day services
This specification should be considered in conjunction with the sections describing the development of gender sensitive services (see sections 5 to 11).

Service design principles
Women-only community day services should:

- be staffed by women
- aim to promote self-esteem and empowerment
- be flexible and responsive – to the range of women's needs and at times that are convenient for them
- be safe and confidential
- allow open access
- be supportive and welcoming
- have an holistic approach to health and well-being
- use appropriately trained staff and volunteers, with mental health focused training programmes for volunteers and paid workers
- take account of women's parenting responsibilities, e.g. consider the need for crèche or childcare facilities
- be accessible to all women by taking account of diverse needs of race, culture, religion, age, disability, sexual orientation, where they live and their caring responsibilities
- maintain strong links with primary care, community mental health teams and other voluntary/statutory agencies

Who is the service for?
This policy initiative aims to provide community support for women who have a range of experiences and needs with an emphasis on those who:

- are mothers living with a serious mental illness
- are suffering from postnatal depression
- self-harm
- are surviving abuse and violence
- need a women-only setting (particularly for cultural reasons)

Flexibility at local level is essential to ensure that individual community day services reflect the specific needs of local women e.g. who are socially isolated, are experiencing depression and anxiety.

What will the services provide?
A range of provision, for instance:

- educational programmes
- therapeutic interventions and activities (individual and group)
- self-help groups
- crisis support
- information
- workshops and activities
- complementary therapies

How will the services be accessed?
By a number of means, which may include:

- open access
- drop-in
- outreach services for those women for whom access to services is problematic
- referral from primary care or mental health services

10.4 Employment services

A range of employment opportunities should be provided to ensure that the needs of service users for daytime activity are met. The Department of Health has commissioned the Institute for Applied Health and Social Care Policy to undertake a project to:

- map and evaluate existing employment schemes nationally;
- highlight examples of good practice;
- make recommendations on how mental health services can best engage with employers;
- consider development of standards for mental health services.

Currently, few schemes are specifically for women. Schemes need to address gender differences in educational backgrounds, employment histories and childcare requirements.

Positive practice examples

Milton Keynes MIND provides a **Supported Training and Employment Placement Scheme** (STEPS) for around 100 new service users per annum. A training officer leads on the needs of women service users and the ratio of women to men on the STEPs scheme is approximately 50:50. Around 40% of service users move on each year to take up formal training or employment opportunities. A parallel project is based on a local housing estate with vulnerable young mothers – a toy library has been established jointly with the group and provides valuable work experience (a need identified by the women).

Contact Phil Green, telephone 01908 630939, email STEPS@mindsteps.freeserve.co.uk

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As part of Pentreath Industries based in Cornwall, Now 2, provides intensive support to women who have or who are recovering from mental ill health. It gives trainees the chance to receive individually focused **training and employment** support in a safe and empowering environment. Now 2 responds to many women's preference for women-only training as they experience low self-esteem and self-confidence following traumatic life events. It works on the premise that meaningful activity is central to community development and, by raising public awareness, issues of stigma and discrimination can be tackled.

Contact Louise Knox, telephone 01727 850565, email louise@pentreath.co.uk

10.5 Supported housing

Addressing accommodation needs is a key part of assessment and care planning. The development of a range of supported housing options in the community should be part of the development of comprehensive services. A shortfall in accommodation options can cause delays in discharge from hospital and discharge to placements at higher levels of security than needed (see section 11.3 on secure/forensic services).

Local strategic planning should address the need for women-only safe, supported housing for women who have experience of violence and abuse and accommodation that will accept children.

One of the primary factors in enabling women to leave violent men is the availability of crisis housing. Violence and the fear of violence add an extra dimension to a woman's housing needs. In many cases not only are they losing their family home, but they also have to deal with all the emotional, financial and legal issues involved in disentangling from a relationship. These issues are likely to be even more difficult to cope with where there are children involved or the person fleeing violence has special needs. In addition those fleeing violence do so suddenly, their departure precipitated by a crisis. For all these reasons, many women fleeing violence need not only safe and secure accommodation but also focused and appropriate support to help them rebuild their lives.

> "What most distinguishes the violence women experience compared to that experienced by men, is the likelihood of the violence being perpetrated by someone they know and, usually, someone they should be able to trust. If the idea of having a home encompasses living in a place that affords physical and psychological security, then a child or a women experiencing violence in her own home is in a very real sense, homeless."
>
> Jill Astbury, University of Melbourne,
> "Gender and Mental Health"

The Department of Environment, in co-operation with the Department of Health and the Women and Equality Unit has commissioned research into the provision of accommodation and support for households experiencing domestic violence in England.

Positive practice examples

Stonham Housing Association is committed to reducing the impact of homelessness and social disadvantage through provision of **specialist supportive housing**. One example is Watershed in Cheltenham that provides a safe environment for women with mental health difficulties and who have the capacity to live communally: 'Swindon' for six single women and 'Prestbury' accommodating four single women and their children (to enable them to retain their parental rights) Women stay *'as long as they need to'*, progressing towards independent living in the community.

Contact Ros Payne, telephone 01242 522544

Missing Link Housing Association based in Bristol provides a range of safe and **supported accommodation** for single women with mental health needs. Short term shared housing, permanent tenancies in self-contained flats with extensive floating support, a resettlement service for rough sleepers, a counselling outreach scheme for vulnerable homeless women and drop-in for all women who use Missing Link services. Hallmarks of the service are personalised support, women's empowerment, service user involvement in the setting of service standards and an holistic approach to meeting women's needs.

Contact Carol Metters, telephone 0117 925 1811, email mlink@globalnet.co.uk

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AZADEH Community Network (formerly Petrus) provides **self-contained flats** with permanent tenancies for women with a long history of mental health problems to enable them to sustain independent living and reduce their admission to acute in-patient care. Typically women have experienced institutionalised care, removal of their children, child sexual abuse, domestic violence and received a borderline personality disorder diagnosis. AZADEH adopts a multi-agency approach to providing each woman with an integrated package of support including a 12-hour daily drop-in facility and on-call home based support.

Contact Emnet Araya, telephone 0151 728 7272, email Emnet.Araya@novas.org

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Queen Mary's Hostel in central London, provides accommodation for 57 **homeless women**, aged 18–93, mainly those with enduring mental health problems, some with a dual diagnosis and a few younger women with a borderline personality diagnosis. Severe life disruptions are common including abuse/violence, family breakdown and the loss of children. The staff team operates a key worker system in addressing residents' mental ill health (including appropriate referral to specialist mental health services), physical healthcare needs, practical concerns and encouraging their involvement in local activities. The ethos is characterised by *"a strong recognition of the women's strength to survive, a great sense of compassion for the women and wanting them 'here' "*.

Contact Lorraine Miller, telephone 0207 976 6338, email lmiller@echg.co.uk

Key Messages

- Mental health promotion is a vital part of local planning and should address specific issues for women.
- Primary care services will see the majority of mental ill health in women.
- Practitioners, and the services they provide, need to have access to appropriate training, support and a range of interventions to ensure that depression, anxiety, eating disorders, self-harm, substance misuse and experience of violence and abuse are detected and appropriately dealt with.
- Women-only community day services should be developed, building on existing good practice, to ensure that a range of provision is available locally.
- Local strategic planning processes need to address the need for women-only safe and supported housing that can also accommodate women's children.

Consultation Questions

- Are there models of good practice with respect to the provision of primary care services for women?
- Is the model of provision for community day services described in this document sufficiently coherent to allow services to be developed?

Section 11
Gender sensitivity: Service organisation – specialist mental health services

The *Mental Health National Service Framework* describes a range of services that are needed to deliver effective and appropriate mental health care. The spectrum of care needed is the same for women and men, but all services should consider how they address gender and identify the need for single-sex provision. This section does not cover all aspects of specialist mental health care, it concentrates on residential and in-patient care, including secure care, where consideration of women's specific needs are particularly important.

11.1 Community services

Resources have been allocated to increase the number of assertive outreach teams, crisis resolution/home treatment teams and establish early intervention in psychosis services in order to increase the number of community-based settings. *The Mental Health Policy Implementation Guide*[178] states that these services should be sensitive to the needs of both women and men.

Positive practice examples

Turning Point's Gwydir Project in Cambridge provides intensive and tailored **community support to people with severe mental illness** on a referral basis from community mental health teams. By operating a co-working system, the team has sufficient flexibility to offer clients a range of open-ended interventions depending on their needs. The emphasis is on relationship building, developing clients' community/social networks and enabling them to access other relevant services. On average, the team works with 2:3 women:men clients.

Contact Chris Rowlands, telephone 01223 516511, email gwydir.project@dial.pipex.com

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Oakley Square in central London is one of the few **women-only hostels** nationally for women with mental ill health. It accommodates eight women providing a service for women who have been discharged from secure care and women using local mental health services who are at risk of becoming 'revolving door' service users. The hostel provides 24-hour supported care with a minimum of two staff day and evening and one overnight. It aims to provide a stepping stone towards greater independence and to support women in developing requisite life skills. Residents are actively encouraged to participate in community-based activities, educational courses and voluntary work as well as 'community life' at the hostel.

Contact Gerdy Grafendorf, telephone 0207 388 1112, email admin@oakley.equinoxcare.org.uk

Positive practice example

The Ashcroft Project in Norfolk provides a **high support community service** for women with long-term mental health needs. The service includes a:

– residential unit for ten women in the main house, plus four bungalows as move on facilities;
– housing scheme comprising six flats supported on a daily basis by two support workers;
– day service for women living in the community as well as for Ashcroft residents.

The three principles underpinning the Project are trust (providing a safe environment in which trusting, non-judgmental relationships can develop), healing (enabling women to get in touch with their painful feelings and work on healthier ways of coping) and independence (building women's self-confidence and making links with the outside world).

Contact Heather Robinson, telephone 01953 605191, email theashcroftproject@care4free.net

11.2 In-patient and other residential settings

Current guidance on *Safety, Privacy and Dignity* states that residential settings should provide single-sex accommodation, toilet and bathing/washing facilities, a women-only lounge in 'new build' mental health units and, wherever possible, in existing units. It also suggests that access to single-sex secure outside space would be beneficial and that women should have access to women-only therapy groups and social activities. To facilitate implementation, the Guidance states that *"an officer at a senior level within the Trust is appointed to have responsibility for women's safety"*.[179]

Given what is known about acute in-patient care and the needs of women patients in particular, acute services *"should provide a self-contained women-only in-patient unit"* as outlined in the *Mental Health Policy Implementation Guide, Adult Acute In-patient Care Provision.* (Also see section 4.1.1 on gender specific services.) In secure settings, single-sex units should be the norm (see section 11.3 on secure/forensic services).

In women-only residential/in-patient environments, the gender mix of staff should be specifically addressed. Some women value an environment with all women staff and others value contact with male staff who maintain professional boundaries and do not impinge on their privacy and dignity. The potential for male staff to provide positive role models for patients is important.

"Male nurses and doctors using touch without asking, even just a touch on the arm can be totally unacceptable if you have been abused."

"Even though there are female-only areas – male nurses are still able to go in there – 2/3 of us were talking about being raped earlier in our lives and the idea of any man being in your sleeping, living, washing area is very intimidating and threatening."

Many services adopt a policy of having no more than 30% male nursing staff. It may be more difficult to achieve a similar gender balance for other professions; offering a choice of the gender of key workers should be the norm.

In all residential settings appropriate facilities for family visiting should be developed. Ideally, this should be provided:

- in an area that is off the ward/main patient area, so that family members, in particular children, do not have to go through this space;
- in a homely space with appropriate toys/books for a range of ages of children;
- with access to tea/coffee, toilet and baby changing facilities away from patient areas.

Examples of reconfigured acute in-patient services

Two years ago, Linfield Mount Hospital, Bradford reviewed its acute in-patient care services which was compliant, at that time, with the guidance on Safety, Privacy and Dignity. The acute in-patient care service was reconfigured to provide **four self-contained single-sex units** (two for men and two for women), together with single-sex external areas, as it was considered the only means of guaranteeing the safety and protection of women patients. A visitor's recreation centre within the service enables patients to mix, receive their visitors and spend time with their children.

Contact Des Crowley, telephone 01274 363164, email des.crowley@bcht.northy.nhs.uk

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At South Staffs Healthcare NHS Trust, their 50 bed acute service includes a self-contained three bed **women-only unit** that also enables women on the mixed-sex units to access a women-only lounge and smoking room.

Contact Chris Holley, telephone 01785 257888, email chris.holley@ssh-tr.nhs.uk

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In London, both the Homerton Hospital in Hackney and the Royal Free Hospital, Hampstead have acute services comprising two mixed-sex units and one self-contained women-only unit and, in both services, demand exceeds the capacity of the **women-only units**.

Contact Stephanie Boag, Helen Boyle Ward, Royal Free Hospital, telephone 0207 830 2739
Contact Brigid Redmond, Mermaid Ward, Homerton Hospital, telephone 0208 510 8998/8214

Women-only crisis houses
The *Mental Health National Service Framework* refers to the development of crisis houses as a possible alternative to admission. The models that exist are varied, some are women-only, and there is little comparative research. However recent evaluations indicate that women-only crisis houses are highly valued by many women residents because they feel safer and more comfortable in an all-women environment than on mixed hospital wards. Women also said that staff were readily available, easy to talk to and supportive and that they derived valuable support from other residents.[180,181]

Positive practice example

Anam Cara **Crisis House** in Birmingham was set up in 1997, in conjunction with the local Home Treatment Service, to provide an alternative to hospital admission for women and men (in practice working primarily with women) and a 'sister' women-only crisis house, Celine, opened in 2001. Both houses work on a *'hope and recovery model'* and use a range of complementary therapies. The ethos is resident-led and staff are regarded as 'recovery guides' who use their experience of mental health problems and recovery to help residents to recover.

Contact Helen Glover, telephone 0121 686 1592, email helenglover@bigpond.com

Positive practice example

The Women's House in Croydon aims to provide a safe, supportive and therapeutic environment for eight women with enduring mental health problems who are in acute crisis. It offers 24-hour care and support to women who might otherwise be offered an informal admission to hospital or to pre-empt the need for hospital admission. The staff team comprises women nurses and care assistants plus input from a woman psychiatrist. The service philosophy enshrines a commitment to working in ways that demonstrate respect, sensitivity and valuing difference amongst women residents and staff.

Contact Penny Cutting, telephone 0208 660 8676

We came in with our soul
Trapped, discouraged, alone
Pain, sadness and sorrow
But we the women of courage
Will leave this house with
Love, understanding and friendship
But most of all hope to reach
For the moon, the stars and
That which is life

"My gratitude is impossible to verbalise, I found a place of sanctuary and peace."

Residents, Women's House

Positive practice example

Drayton Park in Islington provides an **alternative to hospital admission** for up to twelve women and four children. The service is informed by the views and experiences of women service users and the staff working with them. The House offers women a stay of up to four weeks, 24-hour support and a range of service options/treatments. The service works closely with local services to ensure continuity of support after women leave. Women residents assume full parental responsibility for their children. The staff team aims to be as supportive as possible and sessional crèche workers are available up to six times per week.

Beacon Service

Contact Shirley McNicholas, telephone 0207 607 2777

"I think the fact that Drayton Park is women only is really, really important because a lot of women have had problems with men in the past being beaten up or whatever, and then to have to go into an environment where you're around nutty men, it is ridiculous, that's why I think Drayton Park is really important."

"It's just a much nicer environment in which to cope with any kind of crisis. Going into hospital is just such an undignified and degrading, horrible feeling. And in many cases it makes it worse and took me a lot longer to recover."

Residents, Drayton Park

11.3 Secure/forensic services

There are significant differences in the presentation of mental disorder, social and offending profiles between women and men in secure care. As a consequence, women's needs are poorly met by being the minority in a system of secure care primarily designed for men. Women are often placed in levels of physical security greater than their needs: they are generally less of a risk to the public, are less likely to abscond and are more likely than men to have been transferred from other NHS facilities, than from the criminal justice system (often owing to their self-harming or assaultative behaviour towards staff). Lack of appropriate facilities for women may be one of the reasons that they are more likely than men to be readmitted to medium security and often have longer lengths of stay (in medium and high secure care).[182]

Most studies of gender difference in secure care are of patients in high and medium security, there is relatively little research on those using low secure care. The major differences between women and men in secure care are outlined below. Women are much more likely to:

- have been transferred from other NHS facilities;
- have a history of fire setting or criminal damage, but less likely to have committed a violent or sexual offence;
- have a history of abuse and/or self-harm. Estimates suggest that at least 70% of women in high secure care may have histories of child sexual abuse and over 90% self-harm;
- have physical ill health, 25% of those in high secure care have significant physical health needs;
- be admitted after behaviours for which they were not charged or convicted and be detained under civil sections of the Mental Health Act;
- have a diagnosis of personality disorder, particularly borderline personality disorder.

Women are always in the minority. 14% of the high secure population and approximately 16% of the medium secure population.[183]

Current provision

There has been regular, criticism of current secure care provision for women, including by the Mental Health Act Commission, the Health Select Committee, WISH and NACRO.

Women in secure care have also raised significant issues with respect to the limitations of current care:

"There's sixteen of them and they dominate. I'm always having to stand up for myself and then I explode. The staff then say I'm violent and threatening." (about medium secure care)

"No-one has ever discussed why I did my crime, to try and understand why I did it. I'd like someone to talk to."

"Men get away with it. If women do something they get a harder time."

"I was severely abused as a child so I do not want to go and talk to a sixty year old man."

The conclusion of an in-depth patient consultation exercise with women, predominantly in high secure care, stated that:

"Their stories revealed a shared belief that the dream of discharge could best be achieved by toeing the line rather than fully addressing the causes of their distress. With little responsibility or choice over their daily lives or futures:

We're expected to behave like adults but we get treated like children."[184]

There are few NHS secure services dedicated to women, although their number is increasing. A survey in 2000 estimated that only 3% of medium secure NHS beds and 26% of independent sector beds were designated women-only.[185]

Needs assessment exercises across all levels of in-patient care show significant levels of inappropriate placement.

> "There is currently a significant mismatch of mental health services and mental health needs. There are too few medium secure and intensive care beds and a shortfall in supported accommodation in the community, including those staffed 24 hours per day."[186]

This is particularly true in secure care, especially in high security.

> "Surveys in secure units indicate patients placed inappropriately in levels of security which are higher than needed. There are gaps in medium secure provision, especially long stay medium secure provision, in local intensive care provision, in long stay low secure accommodation and in a number of supported community places, including day-care. These shortfalls result in delayed discharge and transfer, put extra pressure on local in-patient services, and hinder the effective use of resources."[187]

Moreover, not only is it clinically inappropriate for many women to be cared for in the level of security that they currently find themselves in, this also raises significant concerns about human rights and resource wastage:

> "We regard it as inappropriate, both from a civil liberties and efficient use of resources viewpoint, for patients who can safely be accommodated in less secure conditions to remain in a high security setting for lengthy periods."[188]

Research estimates for the proportion of women inappropriately placed in secure care vary and can be difficult to interpret given the lack of appropriate discharge placements. There are significant gaps in provision of longer-term low secure and high support community residential facilities for women.

This led to the Government's commitment to women being a high priority group for movement out of high secure hospitals under the *NHS Plan* and to the commitment to develop a strategic approach to women's secure services.

Money, made available for the accelerated discharge of high secure patients subsequent to the publication of the *Tilt Report*, has been allocated to the development of new secure services for women across the country. This will allow an additional group of women to move out of high secure care over the coming years.

Definitions of security

Secure in-patient services are provided in a number of different settings and commonly divided into high, medium and low secure care. Until now, high secure care for women patients has been provided by all three specialist hospitals, Broadmoor, Ashworth and Rampton. However, when category B perimeter security becomes synonymous with high secure care, the facility at Ashworth will no longer be suitable for this purpose and will close in 2004.

Given this, it is probably unhelpful to think about developing services within the confines of non-existent definitions of levels of security. It is perhaps more helpful to think about security with respect to the needs of the client group and specific aspects of the built environment, organisational processes and staffing; environmental, procedural and relational security.

- *Environmental security:*
  Perimeter security: the nature and height of perimeter fences i.e. measures to prevent absconcion.

- *Internal security:*
  The design and lay out of the care environment, some of which hinder escape e.g. air-lock entry systems, secure windows and alarms and others which reduce the potential for injury e.g. safety glass, secured furniture, absence of ligature points and materials that could be used for self-harm.

- *Procedural security:*
  Organisational polices and processes that help:
  - maintain a safe and therapeutic environment e.g. limiting use of lighters and policy on cutlery use/kitchen use and possessions;
  - contribute to preventing absconcion;
  - prevent entry/possession of contraband and such as weapons, alcohol and drugs. e.g. entry procedures for visitors and mail checks.

- *Relational security:*
  This is a function of the nature and quality of the therapeutic relationships between patients and staff. It partly reflects the staff/patient ratio, partly specific policies relating to staff/patient interaction (such as the way in which increased observation is managed) and partly the training of, and interventions provided by, the staff group.

It is accepted that in order to provide a secure, therapeutic environment, in which staff, public and patient safety is addressed, women generally need high levels of skilled relational and procedural, rather than environmental, security.

11.3.1 A model for the development of women's secure services

This section describes an approach to the development of services to more appropriately meet the needs of women, given what is known about the current limitations of women's secure provision. In keeping with the development of all mental health care, a systems approach to development should be taken. This is essential as the provision of high quality, comprehensive care is as much about the processes of care as it is about settings. The dynamics of the system will determine the nature and quantity of the service elements required.

For example the lack of appropriate care for women at lower levels of security has led to inappropriate placements in high secure hospitals. Similarly, if community staff are not skilled in dealing with issues such as abuse, self-harm or in providing psychosocial interventions, hospital admissions are more likely. The need for any one part of a system of care will be determined by the capacity of other parts, in particular the capacity for working at the interfaces between services, settings and agencies. This can help to prevent admission to secure care e.g. early intervention services or consultation/ liaison services from secure care to other services.

An outline service specification for women's secure services is described on page 69.

The future of high secure care
The size of the population of women in high secure care has reduced. It is likely that it will reduce further over the coming years:

- as women's services at lower levels of security are developed, women will be transferred out of high secure care;

- the development of women's services at lower levels of security should reduce the demand for new admissions into high secure care;
- there are only a very small number of women who need category B security.

As numbers reduce it becomes unfeasible to continue to provide women's high secure services on three sites. From 2002 women's high secure services will be provided from two of the three high security hospitals only.

The following section describes the development of women-only secure services that provide for a range of security needs outside category B high secure services. The principles outlined will, however, apply equally to the high secure hospitals as to other levels of secure care.

A dedicated, integrated secure service

Women's therapeutic and safety needs are unlikely to be met in mixed wards. Women's secure services should be provided in single-sex units, alongside the development of women specific programmes of care. Given women's needs for security are predominantly for relational and procedural security, making a distinction between medium and low secure care, particularly for longer-term care is probably unnecessary. (This does not apply to local short-term psychiatric intensive care.) This approach is likely to create a critical mass of patients which will facilitate the development of:

- women-only therapeutic, occupational, educational, social and leisure interventions/ facilities;
- women-only secure outside space;
- a range of in-patient settings for a range of needs e.g. intensive care, challenging behaviour, remand assessment, rehabilitation and personality disorder;
- a dedicated, appropriately skilled staff group with capacity for cross-cover and development of specialist skills;
- a stable staff group which will encourage consistency in practice and the development of therapeutic relationships;
- easier movement of patients across levels of security;
- the ability to move staff/patients, if conflict between individuals makes this a useful option;
- improved links between high secure care and lower levels of security, through shared posts, for example.

The physical design of the unit/s should take into account the primary need for relational security:

- wherever possible environmental security should be provided by the built environment, rather than perimeter fences;
- unit lay out should be such that zonal observation is a realistic alternative to high levels of one to one, or more, nursing;
- crisis suite/s i.e. bedroom, day and bathroom areas that are separate, or can be separated off as an alternative to a seclusion room;
- quiet area/s;
- child/family visiting areas (see page 60);
- small unit size, probably no more than 12 beds.

Services will however probably need to be large enough to support at least two multi-disciplinary teams, to allow adequate numbers of staff to provide specialist cover for times of additional need/holidays etc.

The development of integrated women's secure services is likely to benefit from being in proximity to other mental health services. This would help to ensure a range of facilities, adequate open space and the potential back up of extra staff in times of additional need. It also would allow mixed-sex activities, if and when appropriate.

Clear policies on mixing between women and men patients should be developed. These should cover relationships between patients, social events and the relative numbers of women and men to ensure that, as a rule, women are not always in the minority. Women-only activities should be the norm, with the capacity for mixed-sex activities as part of a recovery/ rehabilitative process. Decisions about the appropriateness of mixed activities should be made on an individual basis. They should be dictated by a woman's capacity to make safe, informed decisions about their welfare and risk assessment as to which men patients would be safe and appropriate for inclusion in mixed-sex activity.

In-patient beds will need to be supported by multi-disciplinary/multi-agency community teams. These teams should provide consultation and liaison services and ensure links with the criminal justice system, prisons, courts and probation (see service specification).

The policies and procedures, staff training and support for units will need to acknowledge the multiple needs of many of the women patients such as their high levels of self-harm, eating disorders, substance misuse, abuse and specific offending profiles e.g. fire setting.

Service planning should include the needs of women within the prison service given their high levels of psychiatric morbidity.

Services for women with very challenging behaviours
Whilst it is clear that there are few women who require category B security there are a group of women with very challenging behaviours who are currently in high secure care. These women require levels of relational and procedural security that not usually provided at lower levels of security. To provide for these women outside category B high secure care new types of services will need to be developed. It is likely that this will require commissioners to work together as the number of women is small. In some areas, work to identify and plan for this group has started.

Services for women with learning disabilities
As the number of women will be small, collaborative work between commissioners and providers is also needed to ensure that women with learning disabilities, who need secure/forensic care, have access to dedicated facilities/care packages at appropriate levels of security.

Evaluation
Published research on women in secure care tends to be descriptive. A recent review of the literature suggests a lack of systematic information on current service models and therapeutic interventions.[189]
All new services should be evaluated.

Service development next steps

- Following the establishment of two providers of category B high secure women's services, namely Broadmoor and Rampton, consideration will be given to the future appropriate siting of the reducing high secure women patient population. This should include careful monitoring of admissions to ensure their appropriateness;

- Ongoing work between secure providers and commissioners, the criminal justice system and the Home Office to further develop integrated, women-only secure services to provide for the needs of all women who do not need category B security, including those with very challenging behaviour, those with learning disabilities and those within the prison system;
- Ongoing work between commissioners and the high secure hospitals to plan for the very small group of women who may need category B high secure care in the future.

Positive practice examples

The Longhirst Unit, Northgate Hospital in Northumberland provides in-patient care for **women with learning disability** and mental illness/personality disorder. Many of the women have committed serious fire setting and/or violent offences. The unit has low physical security and high levels of relational security, with a staff:patient ratio of at least 1:2. The service comprises two nine-bed areas and a four-bed rehabilitation bungalow. Therapeutic groupwork includes 'surviving abuse'; anger management and addressing fire setting. Staff work jointly with women on a individual, needs led basis in addressing their self-harming behaviours. Staff supervision and training are a high priority and the Unit maintains a high level of staff retention.

Contact Jean Callender, telephone 01670 394000

The Gaskell Unit, at Newton Lodge in Wakefield, is a medium secure, ten bed **self-contained women-only unit**. It has its own multi-disciplinary team, including four clinical nurse specialists in substance misuse, anger management, self-harm and surviving trauma/abuse. The staff:patient ratio is at least 1:2, with a high proportion of qualified staff. They provide a needs led service with women actively involved in the philosophy and operation of the unit e.g. through regular community meetings and a independently facilitated women user group. A wide range of activities take place on the unit that are open to women patients in other parts of the service.

Contact Sue Threadgold, telephone 01924 328651

St. Andrews Hospital, a national charity based in Northampton, is developing a **discrete pathway of care for women patients** with safety and security needs within a mixed hospital environment. Current components are: 14 bed secure admission unit for the assessment and treatment of women presenting with complex and severe emotional, psychiatric and behavioural difficulties; 15 bed secure unit for women with a diagnosis of borderline personality disorder who engage, for a minimum of one year, in dialectical behavioural therapy; six bed 'step down' facility for women in need for continuing care and rehabilitation. It is also anticipated that one of the hostels in the hospital grounds will be designated women-only.

Contact Fiona Mason/David Nevason-Andrews (DBT), telephone 01604 616000

Outline service specification for integrated, dedicated secure care services for women
This specification should be considered in conjunction with the sections describing the development of gender sensitive services (see sections 5 to 11).

Client group
Women with complex mental health care needs. Women in this group often have: more than one mental disorder including mental illness, substance misuse, learning disabilities, eating or personality disorders, particularly borderline personality disorder; have a history of severe prolonged abuse and significant experience of separation and loss, including that of their children; experience intense feelings of powerlessness and vulnerability with difficulties in forming trusting relationships; present with self-harm, offending behaviours, pervasive anger, depression, mood instability, dissociation and/or anxiety; are managed in conditions of physical security greater than their needs, having been transferred from conditions of lower security.

Structures
Secure in-patient services
A range of provision will be needed to create an integrated, dedicated system of secure care for women. This system will need to provide:

- short assessment and longer-term placements;
- a range of settings that can cater for the range of needs, including intensive care, challenging behaviour, remand assessment, rehabilitation, personality disorder and learning disabilities;
- services for the small number of women, currently in high secure care, who have committed severe offences or who have very challenging behaviours who could not be catered for within existing medium secure care, but who do not need Category B high secure care;
- multi-disciplinary, multi-agency teams to support in-patient services;

Physical design
- wherever possible environmental security should be provided by the built environment rather than perimeter fences and specifically address maintaining an environment that reduces as far as possible the capacity for self-harm (see Internal security, page 65);
- ward lay out should be such that zonal observation is a realistic alternative to high levels of one to one, or more, nursing;
- crisis suite/s i.e. bedroom, day and bathroom area/s that are separate, or can be separated off, should be considered as an alternative to a seclusion room;
- child/family visiting areas should be provided;
- women-only secure outside space should be available;
- wards should have no more than 12 beds;
- quiet/low stimulus area/s should be provided.

Other related in-patient/residential services will be needed. This includes non-secure general in-patient assessment and treatment services that will accept women with challenging/offending or self-harming behaviours and high support community residential placements.

Primary health care
In-patient services should have dedicated primary care input including, well-woman sessions, dentistry and general practice. Health promotion services should be provided.

Forensic community teams
These should be multi-disciplinary and include input from the following disciplines: psychiatry, psychology, psychotherapy, social work, occupational therapy and nursing. Sessional input from other services/disciplines, such as substance misuse and eating disorders may be required. It may be appropriate to arrange secondments from learning disabilities/rehabilitation/probation services, to increase the range of experience, the likelihood of recruitment and the capacity for interagency liaison.

Functions to be provided by the service
Consultation and liaison
Support to:

- criminal justice system: probation service (including bail and probation hostels), courts and prisons;
- local adult and child and adolescent mental health and learning disabilities services, giving advice on how women may be managed without admission to secure beds;
- private sector/out-of-area placements.

Assessment and care planning
- assessment should inform a formal care planning process under CPA;
- should be multi-disciplinary, holistic and comprehensive including issues of abuse, self-harm, substance misuse, sexuality and gender sensitive assessment of risk;
- will need to take place in a variety of settings including the community, family and residential homes, and distant secure placements including prisons, high secure hospitals and the independent sector;
- the link with local court/police diversion and liaison services should be explicitly agreed.

Treatment and continuing care
Teams should provide the following:

- Community follow-up of those discharged from secure care, those who do not require secure placement, but whose behaviours are too unusual/severe to be contained by local general mental health teams and those with established forensic/offending problems and mental illness/personality disorder;
- A range of out-patient and in-patient interventions including: a range of psychological therapies including family, systemic, cognitive/behavioural approaches in group and individual sessions; interventions to deal with substance misuse, anger management/impulse control, self-harm, eating disorders, offending behaviours (including fire-setting) and experience of sexual/physical abuse; ECT; medication;
- Daytime activity programmes including: education (including basic numeracy/literacy) and occupational programmes, development of coping, social and parenting skills, complementary therapies, social/leisure opportunities. Links with community based organisations should be made.

Policies and procedures
Policies and procedures should address access to mixed-sex activities, if and when, clinically appropriate and observation policies sensitive to women's need for privacy and least restrictive care, such as zonal observation and additional support plans.

Policies and procedures for dealing with self-harm will also need to be agreed, including agreements with local emergency care providers.

Workforce
Development of:

- a dedicated, appropriately skilled staff group with capacity for cross-cover and development of specialist skills;
- a stable staff group which will help consistency in practice and the development of therapeutic relationships;
- an appropriate gender mix of staff (existing women-only services often use a minimum of 70% female nursing staff with access to women staff at all times).

Training
The service will need to be able to provide training to other organisations and professionals as well as appropriate training for its own staff group.

Staff support
This should be an integral to the organisation of services and include supervision and space for reflective practice.

Management
Multi-disciplinary/multi-agency management teams to help create gender sensitive organisational culture, policies and practice.

Research
Sufficient funding should be available to ensure that the service is established with a culture of research and audit. Formal links to an academic base should be made.

Key Messages

- Acute in-patient services should provide a self-contained, women-only unit to ensure choice is available for acute admissions.
- In secure settings, single-sex units should be the norm.
- Following the establishment of two providers of Category B high secure women's services, namely Broadmoor and Rampton, consideration will be given to the future appropriate siting of the reducing high secure women patient population.
- Providers and commissioners should work together to ensure that all women who do not need Category B high secure care have access to more appropriate accommodation in dedicated, women-only secure services or other facility as their needs require.
- Women's secure/forensic services should be developed as part of a system of care providing for a range of security and treatment needs.
- Women's secure/forensic services should be developed alongside other facilities to provide an effective pathway of care, such as access to high support community placements, and with formal links with the criminal justice system and generic mental health services.
- Development of new women's secure care services should provide for the needs of a range of women, including those with personality disorder, highly challenging behaviours and learning disabilities.

Consultation Questions

- Are there other issues that should be considered to ensure that acute in-patient facilities are safe for, and responsive to the needs of, women service users?
- Is there a need to further develop women only crisis houses?
- Are there specific issues with respect to the development of secure/forensic care for women that should also be incorporated into a service specification?

Section 12
Services for specific groups of women

12.1 Services for women with experience of violence and abuse

Child sexual abuse, domestic violence and sexual violence are common amongst women, often hidden and generally poorly provided for in all settings. Organisations need to:

- Address the lack of staff awareness, understanding and training;
- Provide specific support/treatment interventions;
- Recognise the need for staff support, particularly for those who may be survivors of abuse themselves.

To generate local expertise and ensure that the impact of violence and abuse is addressed as a core mental health issue, a lead person should be identified in every NHS Trust to:

- facilitate appropriate interagency working;
- ensure access to appropriate staff training;
- monitor assessment and care planning processes to ensure that abuse is sensitively addressed;
- develop the provision of specific support/appropriate treatment interventions;
- develop staff support processes;
- help the organisation address issues that may lead to retraumatisation of survivors (see footnote page 30 for definition).

12.1.1 Child sexual abuse

Service development
The importance of including sexual abuse in assessment and care planning has already been highlighted. These processes need be developed alongside training to increase awareness and skills in the sensitive exploration of abuse issues, developing appropriate interventions, ensuring staff support is provided and generating interagency working that addresses sexual abuse.

Positive practice examples

Within the Devon Partnership Trust, based in Exeter, a multi-disciplinary team of women mental health workers offers **group work** for women with mental health difficulties who have suffered child sexual abuse, based on a psychological empowerment model of trauma recovery. Each group is evaluated through qualitative feedback and pre- and post-group measures of trauma, depression and self worth. There are consistently positive outcomes. At a review following each group, access to other services (eg safe, supported housing, health information, psychological and creative therapies) is arranged if necessary.

"Responsibility is replaced on the perpetrators of abuse and on the social context that perpetuates inequalities of power. Within the presence and support of other survivors, women are enabled to speak what has previously been unspeakable."

Contact Gilli Watson, telephone 01392 403170, email giwatson@plymouth.ac.uk

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In 1993, South Staffordshire Healthcare NHS Trust appointed a **Sexual Abuse Team** to highlight child sexual abuse as a core mental health issue and work in partnership with a voluntary service, Emerge (for survivors of sexual abuse). The team, based at St. Georges Hospital in Stafford, provides advice, support, training and supervision for mental health professionals working with adult survivors of child sexual abuse and direct therapeutic input. The Team also facilitates a Sexual Abuse Forum and runs support groups for adult survivors and partners/friends of survivors jointly with Emerge.

Contact Chris Holley, telephone 01785 257888 Ext. 5715, email chris.holley@ssh-tr.nhs.uk

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A multi-agency and multi-professional group in Sheffield, in consultation with staff working in adult mental health services and survivors, compiled a handbook – **Breaking the Silence** – covering important issues in understanding child sexual abuse and its consequences and good practice guidelines for clients and staff. The Handbook stresses however that there is no adequate substitute for the thorough, ongoing training and supervision of staff working with survivors in mental health services.

Available from: Pavilion Publishing Customer Services, telephone 01273 623222

12.1.2 Domestic violence

Multi-agency working

The importance of multi-agency work in addressing the needs of this group of women has been identified in Department of Health guidance.[190] This guidance provides a valuable resource for health care professionals, including those in mental health services. Managers and health professionals in primary and secondary mental health services need to be jointly involved in establishing and implementing domestic violence policies and protocols to reflect local need.

A number of forums exist in which the needs of this group of women should be addressed:

- Health Improvement Programmes;
- Health Action Zones;
- Sure Start programmes;

- Crime and Disorder Partnerships;
- Domestic Violence Forums (where generally to date heath care professionals have only played a small part);[191]
- Mental health promotion programmes;
- Area Child Protection Committees.

> "Ultimately, changes in community responses to domestic violence, to woman abuse, will be measured not by the number of multi-agency forums that are established, nor by the number of public pronouncements by government and statutory bodies as to the seriousness of the issue, but by the quality and sensitivity of services that are (or are not) available to women and children who are at risk from violence from men who they know or with whom they live."
> Nicola Harwin, Director Women's Aid Federation of England

Service development

To ensure that mental health services are actively engaged with service development for domestic violence, local implementation teams should liaise with local domestic violence forums and ensure that protocols are established for making links between refuges and other organisations providing crisis or temporary accommodation and appropriate mental health services support.

Positive practice examples

Apna Haq, working within the Asian community in Rotherham, South Yorkshire, supports families in crisis and provides support for **women and children facing domestic violence**. They provide community awareness raising and training events, training for professionals, individual support for women and group work for young people.

Contact Zlakha Ahmed, telephone 01709 552121

Refuge is developing a cost-effective blueprint model to address the **psychological impact of domestic violence**, funded by the Department of Health, with three objectives: to establish a straightforward, comprehensive assessment measure, to identify the most appropriate and effective support strategies to enable women to regain control over their lives and to disseminate assessment methods and intervention techniques to practitioners working with women experiencing, or escaping from, domestic violence.

Contact Roxanne Agnew Davies, telephone 0207 395 7700, email info@refuge.org.uk

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Gateshead primary care mental health team are developing links with the Safer Families Project, that works with **women (and their children) who have experienced domestic violence** and male perpetrators, with the aim of future joint work e.g. community mental health team referrals. There has also been sharing of good practice in developing service evaluation tools. The Domestic Violence Forum also has an active practitioners network.

Contact Caris Vardy telephone 0191 443 7061 email, Caris.Vardy@exchange.gatesh-tr.northy.nhs.uk

Key Messages

- Women experience violence and abuse more commonly than often thought.
- It can play a contributing factor in the development of mental ill health. Histories of violence and abuse are common amongst women in touch with mental health services.
- Violence and abuse are often not asked about/detected by mental health or other practitioners.
- Interventions/services are poorly developed to help support women with experience of violence and abuse.
- A lead person should be identified in every NHS trust to ensure that the impact of violence and abuse is addressed as a core mental health issue.

Consultation Question

- What do practitioners/services require to help them develop appropriate responses for this group of women?

12.2 Services for women who self-harm

Self-harm is defined by the National Institute for Clinical Excellence as:

> "Intentional self-poisoning or self injury, irrespective of the apparent purpose of the act." [192]

The term covers a wide range of behaviours including cutting, overdose, burning with cigarettes or caustic agents, self-strangulation and inserting/ingesting sharp or other harmful objects. Much of the available research evidence relates to self-poisoning, which is more likely to present acutely to services, particularly accident and emergency services.

The prevalence of self-harm is difficult to ascertain. Studies are likely to produce under-estimates; many individuals hide their self-harm and/or it may not be severe enough to need attention from health services. It is estimated that 4–5/1000 per annum of the population self-harm. This results in at least 140,000 hospital referrals and 85,000 hospital admissions per year in England and Wales.[193,194] Generally, studies suggest rates 2–3 times higher in women than in men, although the gap in sex specific rates may be closing.[195,196]

12.2.1 Repeated self-harm

The majority of people who self-harm repeatedly are women, some of whom meet the criteria for borderline personality disorder. Many of these women have histories of multiple deprivation and violence and abuse as a child or adult.[197,198] Self-harm is particularly common in women in prison and in secure mental health services.

Self-harm, particularly acts such as cutting or burning, may be a means of releasing negative feelings, coping with psychological distress, increasing a sense of reality or of self-punishment.

"It is widely accepted that self injury is an expression of distress, a way of coping with emotional pain and that injuring can release, relieve or express acute feelings of self-hatred, anger or anxiety. People who self-harm frequently report feeling relief immediately after injuring. The relief may be short-lived, particularly if the source of distress is not being addressed. The injuring itself may bring a range of difficult feelings including shame, stigma, isolation." [199]

The reasons women give for self-harm are very individual:

"I'm sad about all my scars but they are also really important. I can look at them and know I'm not mad and I'm not making it all up."

"It's like there's a child inside me screaming most of the time. I see her as bad."

"Hurting myself stops the screaming, then I can cry, see the child's wounds, feel compassion and look after her."

"When I've seen the blood run I've felt relieved and purged, the stress recedes and I've felt as though I am back in control of my mind. Once more I have defeated those emotions and painful memories."

"Cutting was my only release from the unbearable chaos inside me."

12.2.2 Self-harm and suicide

The distinction between self-harm with and without suicidal intent and the overlap between the groups is a complex area. Many women who self-harm make a clear distinction:

"There is no hazy line. If I'm suicidal, I want to die. I have lost all hope. When I'm self-harming, I want to relieve the emotional pain and keep on living. Suicide is a permanent exit. Self-harm helps me get through the moment."

For health and other practitioners, making this distinction in individual cases may be difficult and generate considerable anxiety. However, this should form an integral part of the assessment process (see Section 12.2.4 on Service development).

A clear association between self-harm and completed suicide (usually by self-poisoning, sometimes cutting and less common self-ligation) has been shown in research studies. About half of those who commit suicide have a history of self-harm and 20–25% of all suicides attend a general hospital after a non-fatal act of self-harm in the 12 months before they die.[200] At least 1% of patients presenting to general hospitals after an episode of self-harm kill themselves within the year, 3–5% kill themselves within 5–10 years. A history of multiple episodes of self-harm is a particular risk factor for completed suicide.[201] It is however often difficult to predict exactly who this will be or when it will occur, hence the potential difficulties in risk assessment and management (see Section 12.2.4 on Service development).

12.2.3 Effectiveness of interventions

Systematic review of randomised controlled trials, using further episodes of self-harm as the outcome measure, suggests:[202]

- problem solving therapy produces lower rates of repetition of self-harm during follow-up periods, although effect sizes are small;
- dialectical behaviour therapy (DBT) in cases of borderline personality disorder can reduce self-harm (see borderline personality disorder section);
- no apparent benefit from anti-depressants (unless depression is also present);

- assertive outreach can help to keep patients in treatment.

Limitations of the studies include: most were of self-poisoning, used subjects recruited from general hospital samples and many were too small to have the power to detect significant differences. Considerable uncertainty therefore remains. A randomised controlled trial of interpersonal therapy after deliberate self-poisoning has also shown positive outcomes.[203] Further research looking at outcomes for individuals who self-harm regularly is needed.

12.2.4 Service development

Local services need policies and training to assess and manage women who self-harm. Local accident and emergency departments may have a policy on assessment and management that includes the local mental health service, but many mental health settings do not.

Policies, training and staff support should:

- recognise the importance of the woman's view of the event;
- understand that staff may behave in a punitive or dismissive way, which may exacerbate patients' negative feelings about themselves or the care provided for them;
- understand that staff may find dealing with repeated or serious episodes of self-harm frightening and/or rejecting;
- understand that some women describe constant observation to prevent self-harm as intrusive and inappropriate, alternative approaches to maintaining a safe environment should be explored e.g. zonal observation, additional support plans and crisis suites;
- address the development of therapeutic interventions to help to provide alternative mechanisms of coping.

Overall, the aim of training and policy development should be to develop a balance between:

- understanding that some women use self-harm as a coping mechanism or survival strategy;
- an active concern for the individual's safety; and
- therapeutic approaches that help women to address underlying causes and move towards other, more positive, means of coping and expressing themselves.

The National Institute for Clinical Excellence (NICE) is preparing a guideline on the *"short term physical and psychological management and secondary prevention of self-harm in primary and secondary care"* regardless of whether the behaviour is accompanied by a mental illness. It will apply to all people over the age of eight. (Publication date 2004)

Positive practice examples

The Crisis Recovery Unit is a **unique national specialist service**, primarily working with women, who persistently harm themselves, providing an in-patient facility at the Royal Bethlehem Hospital in Kent and an out-patient unit at the Maudesley Hospital, South London. In-patient service users typically have received a borderline personality diagnosis, have other difficulties such as substance misuse and eating disorders and survived abusive experiences, particularly sexual abuse. The service offers a six month care package, including one-to-one therapy and group based work to maximise residents personal responsibility and their long term safety.

'It is mixed, but rarely has men there. The service there was amazing compared to what I had experienced before. I was respected – there was lots of time to talk and explore things both in groups and in one-to-ones … It was very structured, groups were held at set times … there were counselling sessions that were planned in advance and 'safety planning' times as many times as you wanted'

Contact Jane Bunclarke, telephone 0208 776 4102

Bristol Crisis Service for Women is a charity set up in 1986 to respond to the needs of women in emotional distress with **a particular focus on self-injury**. They provide a national confidential helpline (around 50% of calls relate to self-injury), support self-help groups and publish self-help booklets, undertake user focused research/evaluation, organise conferences, provide training for staff and have produced good practice guidelines for working with people who self-injure.

Contact Hilary Lindsay, telephone 0117 925 1119, email bcsw@womens-crisis-service.freeserve.co.uk

Positive practice examples

The National Self-Harm Network is a **survivor-led organisation** that campaigns for the rights and understanding of people who self-harm. They undertake training workshops for staff, work with services to establish good practice models, organise user-led national conferences and have recently published two resources for those living with self-harm: 'Cutting the Risk' and the 'Hurt Yourself Less Workbook'.

Contact National Self-harm Networks, P.O. Box 16190, London NW1 3WW

The Mental Health Care Group, based in Denbighshire, provides residential community based services, including women-only provision, within the independent sector. They have developed a detailed policy and procedural manual on **working with self-injury**, informed by service user experience. It covers all aspects of working with residents who self-injure from principles, procedures, risk response through to staff support, training and competencies.

Contact Sue Hope-Borland, telephone 01824 790600, email suehope-borland@mental-health-care.co.uk

Key Messages

- Self-harm is relatively common and covers a range of behaviours including self-poisoning and cutting. It is particularly common amongst women in prison and women in secure mental health services.
- There is an overlap between acts of self-harm and attempted suicide, making the distinction can be challenging for practitioners.
- Local services need policies to assess and manage women who self-harm.
- Practitioners need training and support to provide appropriate assessment and interventions.
- However, evidence of the effectiveness of interventions is currently limited.

Consultation Question

- What do practitioners/services require to help them develop appropriate responses for this group of women?

12.3 Services for women with personality disorder

Personality disorder has been defined as an enduring pattern of inner experience and behaviour that deviates markedly from the expectation of the individual's culture, is pervasive and inflexible, has onset in adolescence, is stable over time, and leads to distress or impairment [204]

At least eight different personality disorders are described, depending on which classification system is used. Although these disorders are clearly described there remains considerable controversy over their construct and use, particularly as a significant proportion of individuals will fit the criteria of more than one category of personality disorder. This, in conjunction with concerns about treatability, has led to poor and patchy provision of services. This is despite the fact that personality disorder is common, both as a diagnosis in isolation, but also in conjunction with other mental disorders and interventions do exist that produce good outcomes (at least in some people).

There is a significant gender difference in reported prevalence of personality disorder, both in overall prevalence, but also in specific disorders: men are more likely to be diagnosed with anti-social personality disorder and women are more likely to be diagnosed as having a borderline personality disorder (BPD).[205,206,207]

A strategy for the development of NHS personality disorder services will be published in 2002. This section only addresses borderline personality disorder.

12.3.1 Borderline personality disorder

> "the essential features of borderline personality disorder are a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts." [208]

The diagnosis of borderline personality disorder, in common with other personality disorders, is for many a stigmatising label that leads to victim blaming and accusations of attention seeking/manipulative behaviour. This, in conjunction, with general fears about treatability have led to poor service provision and marginalisation in service planning.

"Having that diagnosis resulted in my getting treated exactly the way I was treated home. The minute I got that diagnosis people stopped treating me as though what I was doing had a reason. All that psychiatric treatment was just as destructive as what happened before."

"Denying the reality of my experience – that was the most harmful. Not being able to trust anyone was the most serious effect … I know I acted in ways that were despicable. But I wasn't crazy. Some people go around acting like that because they feel hopeless. Finally, I found a few people along the way who have been able to feel okay about me even though I had severe problems. Good therapists were those who really validated my experience."[209]

Borderline personality disorder commonly occurs with other conditions, particularly substance misuse, major depression, anti-social personality disorder, self-harm and episodes of psychosis.[210,211] Studies suggest that between 26–71% of individuals with borderline personality disorder have histories of child sexual abuse.[212] As significant histories of abuse are common in other diagnostic groups, some have suggested that it is the presence of severe, repetitive abuse, involving multiple traumas that is important in the development of borderline personality disorder.

In recent years there has been increasing work on links between complex post traumatic stress disorder (PTSD) and borderline personality disorder. Many clinicians now see borderline personality disorder as a variant of complex PTSD.[213] There is increasing evidence to suggest that these two disorders can be at least partly understood through failure to develop secure attachments during childhood.[214] Neuro-physiological studies suggest that in PTSD brain function may be affected giving a physiological, as well psychological, component to the disorder.[215,216] This is further supported by ideas of self-medication through re-traumatisation (see footnote page 30 for definition). Individuals may achieve this through repetition-compulsion in abusive relationships, self-harm or binge eating: activities that may alter the production of endogenous, or natural, opiates i.e. provide self-medication. These understandings have led to the development of therapeutic models based on concepts of trauma and recovery.[217]

The co-existence of borderline personality disorder with other disorders has been associated with poor outcomes.[218] Other variables associated with poor outcomes include histories of parental cruelty, child neglect and sexual abuse.[219,220]

12.3.2 Effective service interventions

Specific interventions that have been evaluated include the following.

- **Psychodynamic psychotherapy**
  One randomised study has shown that psychoanalytically-orientated psychotherapy and partial hospitalisation can produce significant improvement in acts of self-harm, the number and duration of in-patient admissions, the use of psychotropic medication, and self-report measures of mental health over standard psychiatric care.[221] Improvement was maintained at 18-month follow-up.[222]
- **Cognitive therapies**
  Cognitive behavioural therapy has been shown to be effective in small trials, including a small randomised trial.[223] Small, non-randomised trial suggest that cognitive analytic approaches may also be of help in some patients.[224]

  Dialectic behaviour therapy, a special adaptation of cognitive therapy, has been shown in small randomised trials to reduce episodes of self-harm, at least at six month follow-up. It is less clear whether it is effective in treating other aspects of borderline personality disorder.[225]

* 'Typical' refers to traditional anti-psychotic drugs (eg chlorpromizine, haloperidol) and 'atypical' (or novel) anti-psychotic drugs are those that have come on to the market relatively more recently (eg clozapine, olanzapine).

- **Therapeutic community treatment**
  A recent meta-analysis concluded that therapeutic communities could provide effective treatment for personality disorder. However, there are a number of models and approaches and work is required to gain an understanding of which approaches are most effective with particular client groups. A recent study suggested the importance of specialist follow-up for those with borderline personality disorder.[226] There was significantly greater improvement on global assessment of mental health and in social adjustment at twelve months, after a short in-patient admission and outreach, than with no specialist aftercare.

- **Drug treatment**
  Although drugs are widely used in the treatment of personality disorder, particularly anti-psychotic drugs, there is considerable confusion about their value.[227] There is some evidence that both typical and atypical* antipsychotics may be of help to some patients with borderline personality disorder.[228,229,230] Tricyclic antidepressants and selective serotonin reuptake inhibitors are also suggested to be of help.[231]

  The mood stabilisers lithium, carbamazepine and sodium valproate have all been used to treat borderline personality disorder, although current evidence for their effectiveness is limited.[232]

12.3.3 Service development

Although there is much to learn about which individuals may benefit from which type of intervention, there is evidence to suggest that effective interventions do exist. Key issues in service development will be to ensure adequate and accurate assessment, consistency and adequate in-patient support. Restricting the people involved in care to those whose roles and tasks are clear reduces the chances of creating inconsistency

Models of care include one-person taking all treatment and care responsibility, an experienced practitioner or a specialist team approach. There is currently no research evidence to recommend one over the other.

At a local service level both community mental health teams and primary care staff need training, supervision and support to assess and manage this group of women. Specialist psychological therapy services could provide training and outreach to help support other practitioners, as well as providing secondary treatment services. A range of psychological therapies will be required.

Positive practice examples

The Cassel in Richmond, Surrey provides three inter-linked **residential services** for single adults, adolescents and parents (with their children) with severe borderline personality disorders and profound difficulties in their relationships with others. The patient group is predominantly women. Group and individual psychoanalytic psychotherapy and psychosocial nursing approaches are provided within a therapeutic community ethos. Typically patients return home at weekends and are encouraged to build links within their community. The outreach teams undertake direct work with patients, prior to and after their Cassel stay, in liaison with local services for whom they provide support and training.

Contact Kevin Healy, telephone 0208 237 2922, email K.healy.Cassel@btinternet.coms

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The Pele Tower is an innovative **supported housing project** for people, primarily women, with a diagnosis of borderline personality disorder. Initiated by Newcastle's Regional Department of Psychotherapy, the project addresses the difficulties of accessing suitable accommodation for clients with this diagnosis. Pele offers a high level of support to residents within a psychodynamic ethos, including in-house group work and community meetings and works closely with referring agencies in providing a seamless service between therapy and community support.

Contact Julia Mundy, telephone 0191 565 8111, email peletower@btconnect.com

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The Traumatic Stress Service, Maudesley Hospital in London is an out-patient service run by a multi-disciplinary team specialising in the treatment of individuals who suffer from both simple and complex **post traumatic stress disorder**, many of whom are women with a history of childhood trauma and who have received a diagnosis of borderline personality disorder. After a thorough assessment, based on an attachment model of development and a systemic understanding of their social context, patients are offered an individualised treatment package involving one or more therapeutic approaches. The Service's work is reviewed and audited quarterly and based on the latest research developments on attachment, PTSD and dissociation.

Contact Felicity de Zueleta, telephone 0207 919 2969, email f.dezulueta@iop.kcl.ac.uk

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Halliwick Psychotherapy Unit at St. Ann's Hospital, Haringey, London provides an evidence-based, **integrated psychotherapeutic approach** to working with people with a diagnosis of personality disorder.

Approximately 60% of patients are women, primarily with a borderline personality disorder. A package of group and individual treatment is offered (within a day hospital over five days or on an out-patient basis three sessions per week). Assertive outreach is provided as an integral part of the engagement process. Patients also have access to a self-booking psychiatric clinic to discuss medication *Beacon status*

Contact the Unit on telephone 0208 442 6528, email halliwick.therapy@beh-mht.nhs.uk

Key Messages

- Services for personality disorder are patchily provided across the country.
- Effective interventions do exist, for at least a proportion of people with personality disorder, particularly women with borderline personality disorder.
- Specialist psychotherapeutic services can help to provide effective interventions and advice and training to general mental health services/other sectors to help to provide services for this group.

Consultation Question

- What do practitioners/services require to help them develop appropriate responses for this group of women?

12.4 Services for women with dual diagnosis with substance misuse

Research suggests that substance misuse among patients with mental disorder should be considered as usual rather than exceptional. Service provision for this group is however poorly developed. The *Department of Health Dual Diagnosis Good Practice Guide*[233] emphasises the need for mainstream mental health services to provide appropriate interventions.

Local services should ensure that the general and specific needs of women with dual diagnosis are met. For women this means ensuring that alcohol/substance misuse is asked about in assessments, as it may remain hidden, providing for the abuse of prescription medication, monitoring the prescription of benzodiazepines, providing for child-care needs and addressing violence and abuse. It is likely that ongoing training and skills development for mainstream staff will be required, alongside support, supervision from specialist workers or teams.

Key Messages

- A dual diagnosis of mental illness and substance misuse is common.
- There may be added stigma attached to women substance misusers, especially alcohol.
- Women may hide their substance misuse and not access services.
- General mental health service practitioners will need training and support to provide for this group. Local specialist practitioners/teams could help provide this.

Consultation Question

- What do practitioners/services require to help them develop appropriate responses for this group of women?

12.5 Services for women with perinatal mental ill health

The occurrence of mental ill health at or around childbirth is common. The months surrounding the birth of a baby carry the greatest life time risk of developing mental illness for women.[234] The adjustments necessary at birth affect a woman's physiological, social and psychological world, and no matter how positive the emotional response to a baby's birth, it is a highly stressful time. The impact of perinatal mental ill health can be widespread. The effect on child development is of particular importance. If mother-infant attachment is upset, social, cognitive and intellectual development may all suffer. This is thought to be particularly true for boys.[235]

Any type of disorder may occur postnatally and about twenty are described.[236] The most common is postnatal depression and the most serious puerperal psychosis. Psychiatric illness is implicated in about 10% of maternal deaths.[237]

"It wasn't a life, it was an existence."

"I was so afraid … so scared … I couldn't relax."

"They are mine … I should look after them …
they're not going to be babies for long."

"It kills me, I can't move, I feel like screaming."

12.5.1 Baby blues and postnatal depression

It is important to distinguish between the relatively normal occurrence of the 'baby blues' and postnatal depression. Baby blues usually occur shortly after childbirth, tend to be self-limiting, short-lived and mild in nature, although potentially very distressing to the mother and her family. Estimates of prevalence range from 26–85%, depending on how the condition is assessed.[238] Postnatal depression on the other hand usually begins in the first 12 weeks after birth, although it can emerge anytime in the first year. Quoted prevalence rates vary between 10 and 15%, 3 to 5% meet the criteria for moderate to severe depression.[239] There is debate as to high much depression is present in the antenatal period.

12.5.2 Puerperal psychosis

This is a serious disorder in which depression or mania occurs in the first six weeks after birth; onset is often in the first week postpartum. There is pronounced disturbance of mood, which can be either consistently low or high or fluctuate unpredictably between the two extremes. Irritation, delusions and hallucinations may also be present. About 2 per 1000 women delivered are admitted to hospital with the condition.[240] (A further 2 per 1000 deliveries are admitted with non-psychotic conditions). There is risk of recurrence of puerperal psychosis. Women who have non-puerperal relapses, have a greater risk of a second puerperal episode. Psychotic relapses may also occur postpartum in women who have existing psychotic illness, such as schizophrenia. Estimates suggest 2 per 1000 of women delivered will be suffering from severe, chronic or enduring mental illness.[241]

12.5.3 Specific groups

Women from black or minority ethnic groups

Race and culture may have a significant impact on perinatal mental health. It may "*predispose, precipitate or perpetuate*" mental illness and thus cultural differences should be acknowledged.[242] This may be because of a variety of factors such as tensions in the extended family or cultural attitudes to the desirability of male offspring.[243] Family support may not always exist and problems can be further exacerbated by isolation, particularly in rural areas, language and communication difficulties, experiences of racism and indifference from NHS and other statutory services

Positive practice example

A collaborative programme between Sheffield Primary Care Trust, Sure Start and the University of Sheffield has developed a **culturally sensitive interview instrument**. This is to screen Punjabi speaking women to identify psychological distress after childbirth and enable appropriate support and care to be provided.

Contact Abi Sobowale telephone 0114 237 5476/Raiza Bhatti-Ali telephone 01274 228855

Teenage mothers
Young women may present during pregnancy and post delivery with a range of mental health problems. Many Health Action Zones and Sure Start initiatives include projects to promote mental health in teenage mothers.

Women with substance misuse
Substance misuse can complicate both pregnancy and childbirth. This has been highlighted in the *Confidential Inquiry into Maternal Deaths.*[244]

Women with learning disabilities
Women with mild to moderate learning disability may face special problems in their adjustment to motherhood and meeting the needs of their developing child. Primary care, maternity services and specialist mental health services undertake joint assessment and management where appropriate.

Bereavement
Women, who suffer bereavement either through a miscarriage, still birth, perinatal death or in some cases post-abortion can develop mental ill health, usually depression.

12.5.4 Effectiveness of interventions

Baby Blues
Baby blues are usually self-limiting and respond to simple reassurance from general practitioners; practice nurses, health visitors, midwives or family and friends. Adequate preparation for childbirth and child-rearing may help in preventing and/or alleviating distress.

Postnatal depression
Prevention: There is some evidence to suggest that parenting and antenatal support may be effective in preventing the development of postnatal depression in vulnerable mothers

Screening: Health visitors in Britain are in a good position to detect psychological problems and illness in newly delivered mothers. Detection can be improved significantly through the use of screening questionnaires. The most widely used is the Edinburgh Postnatal Depression Scale. This is well validated within caucasian populations in English, but not within black and minority ethnic groups.

Psychological interventions: Such as 'listening visits' and interpersonal and cognitive behavioural therapy have been shown to be effective.[245] Postnatal therapeutic groups run by health visitors and mental health nurses have also proved to be effective.

Antidepressants: May be required in more severe cases.

Puerperal psychosis

For the most seriously ill mothers who are suffering puerperal psychosis, they generally respond well to anti-depressants, supported by psychological treatments sometimes for both the mother and the family. Antipsychotic medication, mood stabilisers and sometimes electro-convulsive treatment may be needed.

12.5.5 Service development

The *Mental Health National Service Framework* requires health authorities to develop protocols for the management of postnatal depression. These protocols should span early identification of postnatal illness and its management in primary care through to more specialist treatment in secondary care.

It is likely that having a mental health practitioner in each specialist mental health service with an interest in perinatal mental health will lead to the improvement of local service provision, both at primary and specialist level. They could help to develop a community-based multi-disciplinary/ multi-agency perinatal mental health service, working in partnership with local communities to build capacity for early identification, support and treatment. This could be underpinned by a care pathway approach for all pregnant women from the booking-in phase, covering mental health promotion, early intervention for vulnerable mothers and follow-up. Care plans for mothers in contact with specialist mental health services should specifically address needs related to their pregnancy.

Nationally, the provision of specialist perinatal mental health services is patchy and unco-ordinated. There are at least 10 specialist mother and baby units.[246] It is however more usual for acute in-patient services to offer in-patient care. Generally, the mother and baby (sometimes mother without baby) share facilities and an environment with other patients with differing needs and demands. Local appropriate, dedicated, in-patient provision needs to be commissioned across a number of primary care trusts.

Local education and training programmes need to develop local knowledge and skills in assessment and intervention.

Positive practice examples

The **Mother and Baby Service** at the Queen Elizabeth Psychiatric Hospital comprises a nine bed in-patient unit, day hospital/day service and a community nursing function dealing with 600 referrals pa. The Service is for mothers suffering from a range of mental health problems during pregnancy and in the first year post-partum e.g. difficulties in adjusting psychologically to motherhood, mild depression/anxiety and puerperal psychosis. They also support women with pre-existing serious mental illness who give birth. They liaise with local obstetric and primary care services and provide an education programme for health visitors in identifying vulnerable women.

Contact Dr Gill Wainscott, telephone 0121 678 2000/2195

The Charles Street **Parent and Baby Unit** in Stoke, Staffordshire provides preconceptual counselling for women at risk of perinatal mental health problems and antenatal and postnatal assessment, treatment and support for women (and their families) for up to twelve months after the birth of a child. Service delivery encompasses an open referral system, daycare (with creche), out-patients, outreach and obstetric liaison. The multi-disciplinary team provides training for allied practitioners e.g. health visitors, midwives. An active 'Mum's Group' of previous service users is involved in service management and offers buddy support for new users. Active liaison with local maternity services and Sure Start projects increases the profile of services for young parents and their children including vulnerable families from minority ethnic, asylum seeker and refugee communities.

Contact Janice Gerrard, telephone 01782 425090, email JaniceE.Gerrard@buckmail.nsch-tr.wmids.nhs.uk

Key Messages

- The development of mental ill health in the period of time after a baby is born is significant (10–15% of women develop postnatal depression) and can have a negative effect on the child, as well as the mother.
- Perinatal mental illness is a significant, and potentially preventable, cause of maternal mortality.
- Vulnerable mothers can be identified at antenatal stage; early intervention may be effective.
- Local specialist perinatal mental health services need to be developed. Formal agreements between maternity, primary care (including health visitors) and specialist mental health services are needed to ensure that a range of provision, training and support is available.

Consultation Question

- What do practitioners/services require to help them develop appropriate responses for this group of women?

12.6 Services for women with eating disorders

Eating disorders are far more prevalent in girls and women, and include bulimia nervosa, anorexia nervosa and binge eating disorder. Obesity alone is not included in psychiatric diagnostic systems. At any one point in time up to 10% of girls and women may have an eating disorder. Eating disorders can be mild, self-limiting and amenable to self-help, but for some the illness can be severely debilitating and have a significant mortality rate. Anorexia has the highest mortality rate of any single psychiatric illness, if deaths from medical complications, starvation and suicide are combined

Most cases of anorexia and bulimia are in women with a typical age of onset during teenage. Approximately 1–3% of women, or over 5% if partial syndromes are included, are affected by bulimia.[247,248,249] Anorexia affects about 0.1–1% of young women (about 4000 new cases every year).[250,251] They are both more prevalent in occupations where slimness is valued e.g. dancers and models.

Other psychiatric disorders are often associated with eating disorders. In bulimia 36–70% of women have a lifetime risk of major depression, anxiety is similarly common.[252] Approximately 30% of those with bulimia have a history of post-traumatic stress disorder.[253] Similar proportions have a history of anorexia. Depression is found in approximately 50% of women with anorexia. Co-morbidity is more common in clinical than in community samples, with personality disorder, substance misuse and self-harm commonly found.[254]

12.6.1 Effectiveness of interventions

Key findings are:

- Compliance with any treatment may be low, with high drop-out rates, particularly for medication and some in-patient regimes;
- Some of the most severely affected may be excluded from treatment trials;
- As with other mental ill health, detection in primary care is low, many cases of bulimia in particular are not detected;

- For bulimia cognitive behavioural therapy is best evaluated and most widely used.[255] A usual course consists of between sixteen to twenty sessions. At completion 40–60% of patients are symptom free.[256] Self-help, with some therapist support, has been found to be equally effective.[257] Interpersonal therapy has been shown to be as effective as cognitive behavioural therapy. Anti-depressants seem to have a variable response rate;[258]
- There are few randomised control trials to assess effectiveness of anorexia treatments. The age of the patient and the severity of disorder will determine the treatment that is most appropriate. Brief focused out-patient psychotherapy can be effective and prevent relapse for those less severely affected.[259] The involvement of the family in therapy is recommended in those with young onset. In-patient care is necessary for those with severe weight loss. Day-care also shows promising results. A small randomised trial of intensive in-patient treatment versus day-care with cognitive behavioural therapy showed fewer relapses, more stable weight and fewer admissions in the day-care group.[260] Specialist care seems more effective than non-specialist;
- Early intervention is recommended.

Evidence of service user perspectives on services and on cost effectiveness is lacking.

12.6.2 Service development

Large areas of the country have no access to NHS dedicated services.[261,262] This is reflected in significant private sector provision.

Different models of service provision have been recommended such as a comprehensive specialist service co-ordinated centrally with service elements based in a range of district localities. Others argue that not all services should be comprehensive, given the range of services needed, and that specialisation is required for a few patients. Therefore specialist treatment centres are recommended. There is as yet no research to guide decisions on the most appropriate model.

Given this, there needs to be at least:

- improved detection in primary care and access to simple psychological therapies, including self-help approaches for less severe cases;
- access to specialist dedicated eating disorder services for more severe cases. These should be able to provide assessment, consultation, liaison and treatment services.

Services for people with eating disorders have been defined as specialist mental health services. This means that primary care trusts will be expected to act collaboratively to ensure that the right level and quality of service is available to their populations. Strategic health authorities also have a role in ensuring that this happens.

Positive practice examples

The **Eating Disorders Unit**, South London & Maudsley NHS Trust, offers a service across the spectrum of severity of eating disorders for patients of all ages, providing seamless care from child to adulthood. The Unit serves a population of two million in South London plus national referrals. Care packages range from self-help, more complex psychological therapies through to day and in-patient care for the most severely ill. Aftercare is provided in close collaboration with a Richmond Fellowship hostel. Carers are actively encouraged to participate in treatment. The team is committed to an evidence-based stepped care approach to treatment and the quality of care is assessed with a comprehensive outcome monitoring system. The Unit's research portfolio aims to increase knowledge of causation and to develop better treatments for sufferers.

Contact Dr Ulrike Schmidt, telephone 0207 919 3180, email ulrike.schmidt@slam-tr.nhs.uk

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The **Eating Disorders Association** is a national charity providing information, help and support for anyone over eight years of age affected by anorexia nervosa, bulimia or related eating disorders. This includes people with personal experience of eating disorders, carers, families, friends and professionals. Their services include telephone helplines, a UK wide network of self-help and support groups, a website with help and information, a comprehensive range of information including leaflets for young people and lists of treatments available around the country.

Contact Eating Disorders Association, telephone 01603 619090, email info@dauk.com

Key Messages

- Eating disorders affect a significant proportion of young women. Severe anorexia is associated with a significant mortality rate.
- Most cases of eating disorders will be seen in primary care and will not require specialist mental health service interventions.
- Appropriate assessment and interventions in primary care are required.
- Consultation/liaison services are also required to ensure adequate advice, training and support for primary care and specialist intervention for the most severe cases.

Consultation Question

- What do practitioners/services require to help them develop appropriate responses for this group of women?

12.7 Services for women offenders with mental ill health

The prison mental health strategy, *Changing the Outlook*, and the *NHS Plan* make clear the commitment to improving mental health care for offenders. The Government's *Strategy for Women Offenders*[263] highlights the specific needs of women with mental ill health. Service planning and delivery needs to specifically address this group given the considerable morbidity experienced by women in touch with the criminal justice system (see section 1.3 on the wider government agenda and section 2.3.7 on women offenders).

12.7.1 Service development

Changing the Outlook requires all prisons to examine critically the services they provide and develop action plans to ensure that they meet the identified needs of their particular population.

Currently three women's prisons are involved in the NHS funded project to develop mental health inreach services in prisons. A further three women's prisons will join the project during the course of 2002/03. As with the development of secure care for women, mental health inreach will need to develop assessment and interventions that address abuse, dual diagnosis with substance misuse, self-harm and personality disorder. It is likely that this will require training, support and supervision of prison health care staff, as well as the provision of specialist mental health service interventions.

Local service planning should include the prison population as part of its community. This requires an understanding of the local prison population (should the primary care trust/strategic health authority include one), the need for primary and generic specialist mental health provision and also the need for specialist secure/forensic provision for both local women and those in more distant prisons who require transfer to the NHS. A crucial issue for both mental health services and criminal justice agencies is to examine ways of improving women's community based mental health care and access to it by women in the criminal justice system.

Availability of and confidence in community alternatives need to be improved if the female prison population is to be reduced. The female prison population has been increasing dramatically over recent years, at a far greater rate than the male population, and almost twice as many women prisoners suffer from mental ill health than male prisoners (see section 2.3.7 on women offenders).

Perhaps the most compelling justification for a distinct response to women's offending, including the provision of women-specific services and interventions, is the fact that women's offending carries a higher individual and social cost than men's offending. For example, the separation of children from their mothers whilst they are serving a prison sentence has a detrimental knock-on effect in terms of transmitted disadvantage and social exclusion. It is all the more importanty, therefore, when dealing with women offenders to ensure that custody is only used as a last resort for the most serious offences and where it is necessary for the protection of the public.

Many of the factors that affect women's mental health, e.g. poor housing, lone parenthood, experience of abuse, social exclusion, are often the same factors that impact on their risk of offending, It is often the way these factors combine that has the greatest impact on whether a woman is likely to offend. The Department of Health and the Home Office are therefore working together to consider how the *Women's Mental Health Strategy* and the *Women's Offending Reduction Programme* (see section 1.3 on the wider government agenda) could link up to tackle these factors. The aim is to promote a co-ordinated approach so that women with a range of problems and needs can feel assured that the departments and agencies responsible for providing help and support respond to their needs as a whole, rather than in isolation. Relevant agencies and organisations will be invited to contribute ideas on how the two initiatives could best be linked.

Positive practice examples

Adelaide House is a **women-only bail hostel** in Liverpool providing a safe environment for 20 women, over age 17, who are either awaiting their court appearance, on licence following release or serving an alternative sentence to custody. The all female staff team provide 24-hour cover. In fulfilling it's aims of protecting the public and reducing offending, the hostel facilitates the women's access to all relevant services in meeting their diverse needs. These include physical healthcare, housing, maintaining contact with their children, addressing drug misuse, counselling (a high percentage of residents have experienced violence and abuse), education, training and employment opportunities.

Contact Cathy Earlam, telephone 0151 263 1290

Revolving Doors Agency's **assertive outreach team** based in Islington works with people who have had contact with the criminal justice system, are vulnerable to mental ill health and have multiple needs. In addition to the police, courts and solicitors, they take referrals from the community mental health team based in HMP Holloway. The service aims to provide long-term continuity from first contact at the police station, through remand and sentencing to resettlement in the community. They act as a link between client and relevant services with respect to physical healthcare, drug misuse, specialist mental health needs, benefits and accommodation.

Contact Amy Moore, telephone 0207 5278200

Key Messages

- Local service planning and delivery should specifically address the mental health care needs of women offenders.
- Availability and confidence in community alternatives must be improved if the female prison population is to be reduced.
- Women's offending carries a higher individual and social cost than men's offending.
- Many of the factors that affect women's mental health are often the same factors that impact on their risk of offending.

Consultation Question

- What examples are there of existing joint initiatives for women offenders between mental health services and criminal justice agencies, and how successful are they?
- What more is needed to provide adequate community provision specifically for women offenders with mental ill health?
- What could be done to improve links between mental health services and criminal justice agencies to ensure that women's mental health care needs are identified and addressed as early as possible?

Appendix 1
Terms of reference and membership of advisory groups

The overall aim of the Strategy is to produce a framework for the delivery of comprehensive, high quality, mental health services that meet the needs of individual women. Within this overall aim the Strategy will seek to:

- acknowledge and address the links between the social and economic context of women's lives, their mental health and support/treatment needs;
- address specific issues related to gender, race, age, disability and sexual orientation;
- ensure women's safety, privacy and dignity;
- engage with women users on a partnership basis;
- tackle the impact of organisational culture on the delivery of high quality services.

Membership and Terms of Reference of Advisory Groups for the Women's Mental Strategy

Two advisory groups are working in parallel as follows:

1. Overarching Advisory Group

Terms of Reference

- To provide guidance and direction to the Government's mainstream mental health agenda to ensure that both policy and practice are gender sensitive and meet the specific needs of women;
- To describe a service framework/service model for women's mental health services with particular reference to the Government's commitment to developing women-only community day services;
- To undertake specific projects to address the aim and objectives of the Strategy as agreed with Project Managers.

Kathryn Abel	Senior Lecturer, Women's Mental Health, University of Manchester
Cheryl Adams	Professional Officer, Community Practitioners and Health Visitors Association (CPHVA)
Kathy Billington	Secretariat, Mental Health Services Branch, DH
Cathy Borowy	Deputy Branch Head, Mental Health Services Branch, DH
Jenny Bywaters	Deputy Branch Head, Mental Health Services Branch, DH
Anne Cremona	Consultant Psychiatrist, Royal College of Psychiatrists
Janet Davies	Chair, Mental Health Services Branch, DH
David Fordham	Mental Health Strategy Manager, East Sussex, Brighton and Hove Health Authority
Helen Hally	Director of Nursing, Haringey Primary Care Trust; Professor of Nursing Policy, Middlesex University

Dora Kohen	Consultant Psychiatrist, Royal College of Psychiatrists, Prof. of Women and Mental Health to the Lancashire Postgraduate School of Medicine and Health
Cath Laverty	Central Manchester Joint Commissioning Consortium
Ruth Lesirge	Director, Mental Health Foundation
Liz Mayne	Mental Health Services Branch, DH
Carolyn Merry	Mental Health Lead, Trent Social Care Region
Abina Parshad-Griffin	Disability Rights Commissioner; User/Chair of Mental Health Action Group
Sally Prescott	Mental Health Lead, Northern and Yorkshire NHS Region
Sian Rees	Mental Health Services Branch, DH
Kay Sheldon	Mindlink National Advisory Panel (member)
Fenella Trevillion	Association of Directors of Social Services, Greenwich Health Authority
Margaret Unwin	Threshold, Brighton
Jennie Williams	Senior Lecturer in Mental Health, Tizzard Centre, University of Kent
Melba Wilson	Policy Director, MIND

2. Advisory Group focusing on issues relating to secure services and services for women with a history of abuse and/or self-harm

Defined Client Group
Women who have complex needs, including offending behaviours and learning disabilities. Women in this group often: have more than one mental disorder including mental illness, substance misuse, eating or personality disorders, particularly borderline personality disorder; have a history of severe prolonged abuse and significant experience of separation and loss, including that of their children; experience intense feelings of powerlessness and vulnerability with difficulties in forming trusting relationships; present with self-harm, pervasive anger, depression, mood instability, dissociation and/or anxiety; are managed in conditions of physical security greater than their needs due to a lack of appropriate services.

Terms of Reference
To provide advice relating to the development of high quality mental health care for the defined client group. This should include consideration of the following issues:

- Health promotion;
- The effectiveness of interventions, particularly for self-harm and dealing with histories of abuse;
- Models of care and practice;
- Training and staff support;
- Organisational development;
- Research and development.

Anne Aiyegbusi	Nurse Consultant, Women's Directorate, Broadmoor Hospital
Diana Baderin	Director, National Probation Service
Cathy Borowy	Deputy Branch Head, Mental Health Services Branch, DH
Andrea Campbell	Director of Community Care, Sefton Health Authority

Sue Clarke	Clinical Psychologist, Head of Intensive Psychological Therapies Service, Dorset Healthcare Trust
Anne Crump	National Self-harm Network; Service User
Sarah Davenport	Lead Consultant Psychiatrist, Women's Services, Ashworth Hospital
Felicity de Zulueta	Consultant Psychotherapist, Traumatic Stress Service, Maudesley Hospital
Liz Dewsbury	Director, WISH (Women in Secure Hospitals)
Sheila Foley	Chair, Prison Healthcare Task Force, DH
Tony Maden	Professor in Forensic Psychiatry, West London Mental Health Trust
Liz Mayne	Mental Health Services Branch, DH
Jennifer Morris	Mental Health Unit, Home Office
Debbie Murdock	Manager, Women's Services, Rampton Hospital
Sian Rees	Mental Health Services Branch, DH
Cynthia Robinson	Co-Founder, Ashcroft Project, Norfolk
Sara Scott	Manager, Gender Training Initiative
Penny Stafford	Mental health service user
Sue Threadgold	Clinical Lead, Women's Services, Gaskell Unit, Wakefield
Anita Wadhawan	Secretariat, Mental Health Services Branch, DH
Christine Whalley	Assistant Chief Executive, Calderstones NHS Trust

We would also wish to acknowledge input from a wide range of other contributors – too many to name individually here.

Appendix 2
Women' Mental Health: Into the Mainstream

Strategic Development of Mental Health Care for Women

Consultation questionnaire

This consultation process follows the Cabinet Office Guidelines on written public consultations www.cabinet-office.gov.uk/servicefirst/2000/consult/code/consultationcode.htm

Comments from: ______________________________
(your name)

Organisation: ______________________________
(if applicable)

Address: ______________________________

____

____

Perspective ______________________________
(e.g. CPN, Carer, GP, service user etc. – as many as are applicable)

Any comments received will be treated in confidence

1. Overall

Does this consultation document cover areas that you expected/would have wished to have seen covered? Yes ☐ No ☐

If not what are the gaps or concerns that have not been addressed?

2. Service specifications

Please provide comments on the service specification for the:

- women-only community day service;

- women's secure services;

Are the specifications sufficiently:

- clear to enable services to develop them?

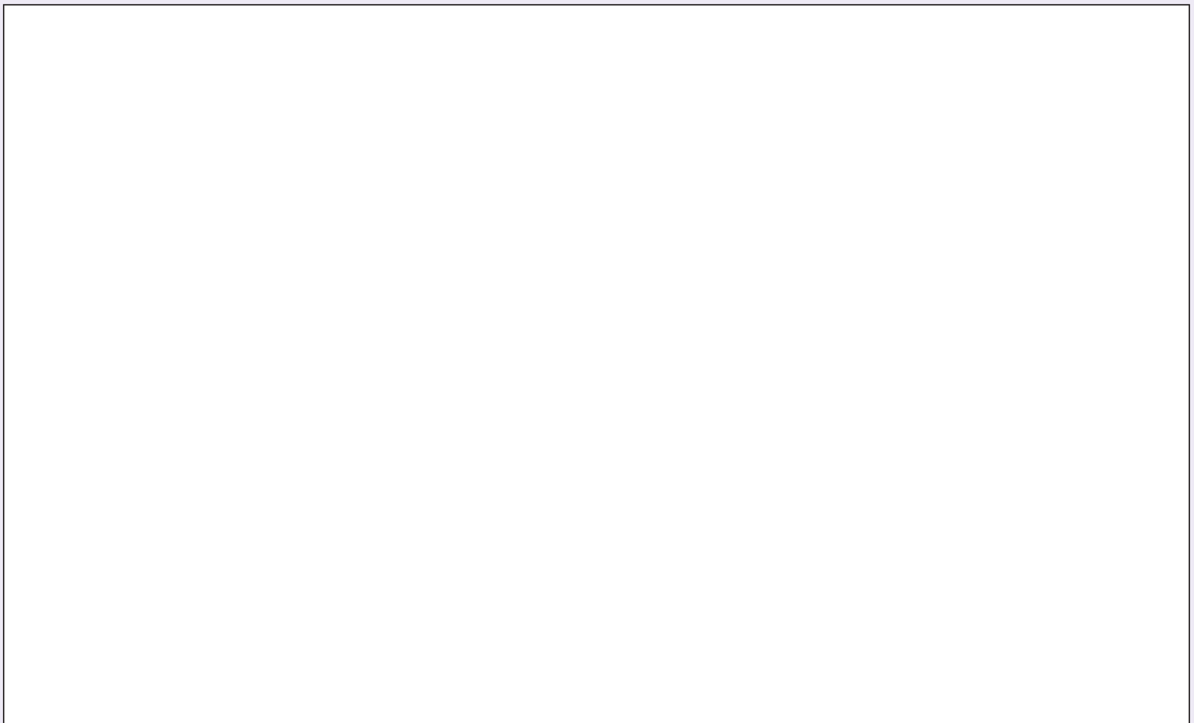
- challenging to make progress, but realistic enough to be achievable in timescales set out?

3. Implementation

What are the key priority areas for implementation and how should improvements be measured?

4. Other comments

Any other comments or views on the specific issues highlighted throughout the document?



Please return by 31st December 2002

To: Kathy Billington, Policy Manager, Department of Health, Mental Health Services, Room 311, Wellington House, 133–155 Waterloo Road, London SE1 8UG.
e-mail: Kathy.billington@doh.gsi.gov.uk

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