

# **TAKING A FORWARD VIEW ON WOMEN AND MENTAL HEALTH**

## **KEY MESSAGES FOR GOVERNMENT**

### **JUNE 2017**



# ACKNOWLEDGEMENTS

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# INTRODUCTION

Over the course of the past nine years the partners of the Women's Health and Equality Consortium (WHEC), which comprise Imkaan, Forward UK, Maternity Action, Positively UK, Women's Resource Centre and Rape Crisis England & Wales, have been documenting the voices of survivors of violence against women and girls (VAWG), and practitioners working with them, in regards to their experiences of mental health and helpseeking. Alongside this, WHEC have produced several policy guidance documents aimed at policy makers and commissioners with the view of improving health sector responses to women. The briefings have contributed to the ever increasing evidence base for the associations between sexual and domestic violence and abuse and mental health and the service responses valued by women. For example, greater severity of abuse is associated with greater negative impacts on mental health and increased likelihood of developing drug and alcohol problems (Natcen 2013, Rees et al 2011). This means that every day specialist women's organisations work with women who are displaying a myriad of mental health symptoms ranging from depression, anxiety to complex post-traumatic stress and psychosis. Women have described that group activities, peer support and specialist one to one counselling, offered over the long term by professionals who understand the correlation with interpersonal trauma, HIV, discrimination and mental health, are crucial to their recovery (Imkaan, Rape Crisis England & Wales and Positively UK 2016).

Last year NHS England and the Home Office published three strategic documents which have the potential to catalyse much needed change; the Implementation Plan to realise the recommendations in the Five Year Forward View on Mental Health, a VAWG commissioning toolkit and the National Statement of Expectations (NSE) for the local commissioning of VAWG services. The Government also announced a £15M 3-year VAWG transformation fund (Home Office 2016d) to assist local areas to deliver on the VAWG priorities outlined within both the NSE and the VAWG commissioning toolkit. However, these frameworks follow decades of previous policy recommendations and commitments within the NHS and across government to improve service provision on women's mental health and wellbeing which have not been realised, despite considerable effort from victims and survivors, advocates from within the women's voluntary sector, academics and champions in the statutory sector.

It therefore seems timely to take a step back and review advances within the policy landscape in terms of women's mental health and the attempts at implementing change over the past fifteen years. It is hoped that critical learning identified from this rapid review will provide some additional contextual impetus and renew strong recommendations for ensuring future commissioning within the health sector takes a fully gendered approach leading to appropriate sustained funding for specialist women's organisations.

Before continuing, a note regarding gendered responses within service provision. A substantive approach to equality acknowledges that equal treatment of men and women doesn't result in equal outcomes for women. Moreover when thinking about women and girls at risk, understanding gender inequality is absolutely essential – but alone it is not enough (McNeish & Scott 2014). Therefore, a fully gendered response must acknowledge the intersections of numerous inequalities that women face and which may increase their risks of psychological distress and/or access to appropriate health provision. For example, looked-after children and care leavers are between four and five times more likely to self-harm in adulthood (DH 2012) and girls from disadvantaged backgrounds<sup>1</sup> are almost twice as likely to be recipients of physical partner violence in their relationships as other girls. Half of the disadvantaged girls in one study reported they had experienced some form of sexual violence (Wood, Barter & Berridge, 2011). Women in custody are five times more likely to have a mental health concern than women in the general population and report disproportionately high levels of childhood abuse, partner violence and experiences of care (WIP 2016). A study in one inner city hospital found that half of women living with HIV had experienced violence at the hands of their partner (Dhairyawar, Tariq, Scourse & Coyne 2012) and other research has found that violence and abuse intensified in frequency, extent and nature when gender and disability intersect (Dowse et al 2013). Women who experience physical violence from a partner (without having suffered other abuse in their lives) are much more vulnerable to anxiety and depression if they are also dealing with poverty than if they are not (McManus & Scott, 2016).

Therefore, a fully gendered response must meaningfully incorporate the intersections of gender with race, class, poverty, disability, age and sexual orientation, as par for the course, rather than as an afterthought or a tokenistic consideration of the equalities agenda. The consequences of not taking such an approach are highlighted in the findings of this report and could go part way to explaining the low take up of statutory psychological services by some women. For example, the most rigorous data we have on mental health and wellbeing in England has shown that mental health treatment use is highest among White British women aged 35-54 years. This is despite the fact that common mental health problems such as anxiety and depression, as well as post-traumatic stress, are more prevalent most notably among Black and Black British women, and self-harm is now at unprecedented levels among young women (McManus et al 2016).

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<sup>1</sup> The definition of disadvantaged used in the research. Any young person who had experienced a particularly complex or disrupted childhood which may have disadvantaged their welfare.

# THE ROLE OF SPECIALIST VOLUNTARY SECTOR ORGANISATIONS

Specialist voluntary sector organisations are providing significant mental health care to women facing multiple and intersecting disadvantages, which is highly valued. This role is increasingly acknowledged in key policy and commissioning documents. However, in practice this role is not being realised in health funding budgets.

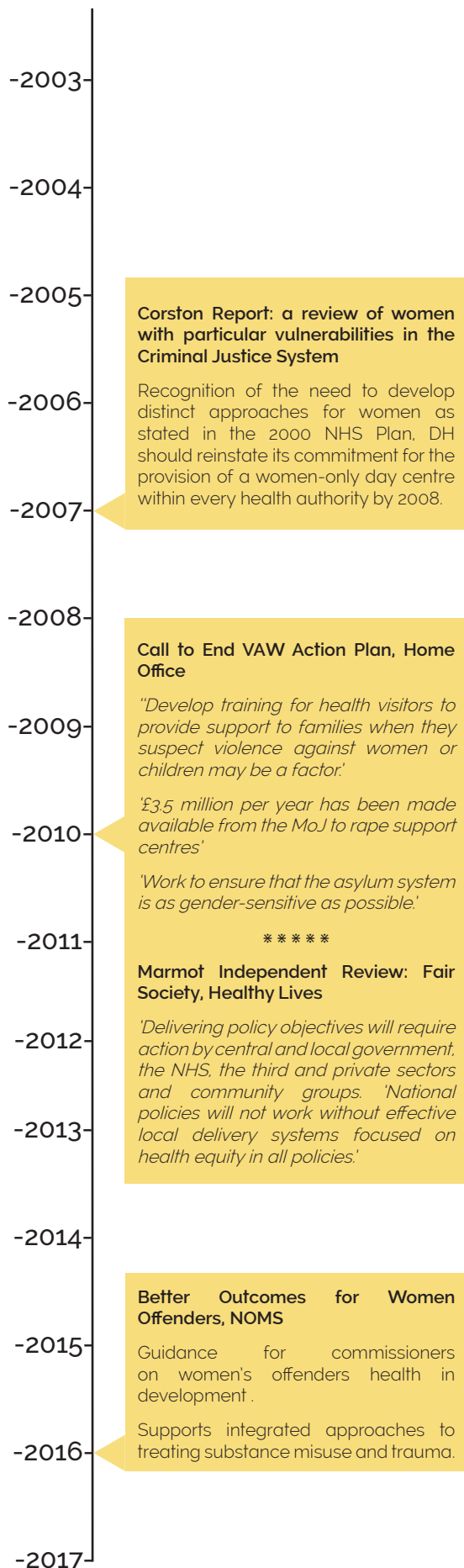
## Continued reliance and relevance of women's services, which are valued by women

- A national online survey of over 400 adult survivors of childhood sexual abuse found that among survivors who had used both sectors, over 70 per cent were more satisfied with voluntary sector services than with statutory services. Counselling and psychotherapy services, often provided through sexual abuse and rape support services, represented the provision which respondents found most satisfying (Smith et al 2015).
- 'Women's Mental Health - Into the Mainstream' (DH, 2002/3), a critical document on women's mental health published by the Department of Health, made women's centres a priority service recommendation but their implementation has not been forthcoming. This model of service was also recommended within the Corston Report (2007) in order to cater to the needs of women involved or at risk of being involved in the criminal justice system. Subsequent evaluation has evidenced their effectiveness (NEF 2012, Radcliffe et al 2013). Women's centres, most often provided by the specialist sector, offer practical, emotional, and therapeutic support to their clients in tailor-made packages which aim to address a range of underlying issues. Seventy-one percent (n=34) said they provided psychological therapies, comprising on average 3-4 types of therapies (BACP 2013).
- Women interviewed for a recent WHEC report highlighted the role of women's services in providing specialist counselling or key-working sessions with much shorter waiting times than could be provided by

**Women's Mental Health: Into the Mainstream + Implementing guidance, Department of Health**

*Build on existing positive practice and existing women-only day services (many provided by the voluntary sector)*

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statutory services. Not only are women's services lessening the burden on NHS services but they are also acting as valuable prevention services (Imkaan, Rape Crisis England & Wales and Positively UK 2016).

- NHS cost savings from the women's sector amount to half a billion per annum at a minimum and this does not include wider savings e.g. social care. (Women's Resource Centre & Women's Health and Equality Consortium, 2017).
- Rape Crisis organisations frequently report receiving referrals from mental health services who are unable to support survivors because of the severity of their symptoms, which may have led or lead to medication and/or hospitalisation (Rape Crisis England and Wales 2015).
- The report of the Independent Mental Health Taskforce to NHS England entitled the Five Year Forward View on Mental Health (2016) stated that *'More widely, we heard that community and voluntary sector providers play a critical role in supporting groups that are currently poorly served by services, such as BAME communities, children and young people, older people, lesbian, gay, bisexual and transgender people, and people with multiple needs.'*
- Eighty-nine percent of women accessing a BME-led 'by and for ' ending VAWG organisation reported improvements in their mental health and well-being (Imkaan, 2012). Ninety-nine percent of women responding to a research study in London with survivors of violence said that the Black and Minority Ethnic (BME) led women's organisations made them feel safe and protected. Women pointed to the understanding held by specialist workers in regards to the intersecting impact of interpersonal and structural forms of violence, their language, cultural context, racism and immigration issues (Imkaan 2013).
- A report on the experiences of women living with HIV in the UK highlighted the importance of peer support and its complementary role in clinical care particularly around promoting adherence to treatment and reducing isolation and stigma (Positively UK 2015).



**Valued as key collaborators and partners to the NHS, the important role of the women's sector has consistently been acknowledged in key Department of Health policy and cross government strategies**

- The implementation guidance for Into the Mainstream (DH 2003) makes a recommendation to 'Build on existing positive practice and existing women-only day services (many provided by the voluntary sector).'
- Commissioning Services for Women and Children who are Victims of Violence and Abuse (DH 2011) highlights to commissioners the important role of voluntary and community organisations in supporting survivors and the importance of partnership working and collaboration with people from a variety of backgrounds to ensure their needs are met in service delivery.
- Call to End VAW Action Plan (HO 2010) lays out plans to 'Support local authorities and specialist organisations...to work together to provide local support for women and girls affected by abuse.'
- No Health Without Mental Health (HM Government 2011) aims to 'Increase the number of rape crisis centres and put them on a sustainable footing' and 'Implement recommendations of Call to End Violence Against Women and Girls.'
- Female Genital Mutilation (FGM) Guidance for Healthcare Staff (DH 2015) states that provision should include: "A multi-disciplinary team with access to psychological support for the child and her family whether or not FGM is confirmed and signposting to available local community based voluntary and community sector support."
- The refreshed End to Violence Against Women and Girls Strategy 2016-20 (HO 2016) stipulates an 'Expectation that local NHS should increase the amount they spend on mental health' and that 'Clinical Commissioning Groups to play a vital role in local commissioning of services to address VAWG including mental health.'
- The National Statement of Expectations for Violence Against Women and Girls Services (HO 2016a) states that local commissioners should '*have sufficient local*

**Commissioning Services for Women and Children who are Victims of Violence or Abuse – A Guide for Health Commissioners, DH**

Highlights important role of commissioners, voluntary and community organisations in supporting victims/survivors and the importance of partnership working/collaboration with people from a variety of backgrounds to ensure service needs are met.

**A guide to working with women involved in prostitution/sexual exploitation and victims of domestic abuse (NOMS) noting that:**

*"The best available evidence from service evaluations and research with women at risk supports a model of integrated, holistic, women-centred services as effective in promoting and sustaining engagement and being highly valued by women at risk."*

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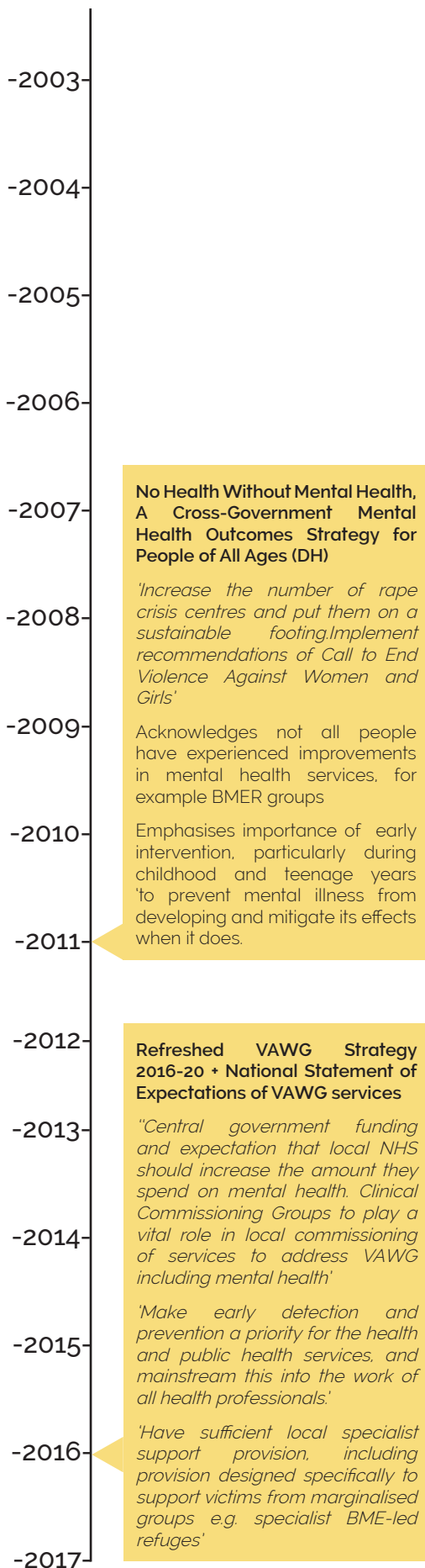
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*specialist support provision, including provision designed specifically to support victims from marginalised groups e.g. Specialist BME-led refugees'.*

### **Despite this, the devastating underfunding continues particularly for BME specialist services**

- A ten year review of Into the Mainstream found that "The third sector remains the main provider of women-only day services. There are concerns about the sustainability of this financially vulnerable provision... Voluntary sector community groups continue to play a central role in provision for BME women, but cannot be expected to fill this gap without secure funding." (National Mental Health Development Unit, 2010).
- Evidence provided from a snap shot survey of Rape Crisis organisations in Sep 2014 (25 services) pointed out that less than 50% of Rape Crisis Centres received any significant funding from health or health commissioned services. Seventy nine percent of organisations said they felt funding allocated to sexual violence in their area disproportionately prioritised Sexual Assault Referral Centres (SARCs) and services aligned with the Criminal Justice System. This was met with alarm by an enquiry of the All Party Parliamentary Group on domestic and sexual violence: *'The current model for funding specialist domestic and sexual violence services is not fit for purpose. Many services are under huge financial pressure and are drawing upon reserve funding just to survive, whilst some have already been forced to close. More will be lost over the coming years if they continue to be funded on a hand to mouth basis. We recommend that the government introduces a sustainable and secure funding model that will ring-fence funds for specialist services. This will ideally require cross party support to ensure consistency and continuity of service provision.'* (All Party Parliamentary Group for Domestic and Sexual Violence, Women's Aid, Rape Crisis England & Wales 2015)
- Cuts continue to have a disproportionate impact on BME-led ending VAWG organisations. 'This APPG has noted that a considerable number of BME services have been absorbed into non-BME services or are experiencing disproportionate funding cuts.' Reports

from some Imkaan members highlight that in some areas BME women's organisations have lost over 40 per cent of their refuge funding, while in other areas, the local authority cut provision by choosing not to include specialist BME-led provision in their contracts (All Party Parliamentary Group for Domestic and Sexual Violence, Women's Aid, Rape Crisis England & Wales 2015).

- The London Assembly has also expressed concern regarding the funding crisis facing the specialist voluntary sector and have prioritised VAWG as one of their top 5 target areas in their Police and Crime plan (MOPAC 2017).
- Findings of the National Perinatal Mental Health Project focused on BME women have also suggested that more needs to be done to improve the links between primary and secondary care and between statutory and voluntary sectors (Edge 2011).



## PROMISING EXAMPLES

- Birmingham and Solihull Mental Health Trust in partnership with Anawim Women's Centre successfully sought funding from the NHS England West Midlands Clinical Strategic Clinical Network to fund a clinical psychologist to deliver integrated trauma and substance use groups over the course of two years. This followed years of successful partnership working (supported by funding) between the Trust and Anawim to deliver psychological services onsite at the Women's Centre.
- Brighton and Hove CCG are funding the provision of psychological services to survivors of domestic and sexual violence based at RISE, Survivors' Network, Mankind and Threshold as part of their trauma pathway. This involves close collaboration with Sussex Partnership NHS Foundation Trust which provides mental health services.
- Bradford Rape Crisis & Sexual Abuse Survivors Service (SASS) have been commissioned by the CCGs in Bradford District (NHS Airedale, Wharfedale and Craven, Bradford City and Bradford Districts CCGs Collaboration) to provide specialist sexual violence services for women and girls since April 2013 when they took responsibility from the PCT. Since April 2014 the value of the commission has stayed the same at £83,930 per year and been awarded on a 12 month basis each year. Moreover, Bradford District Council and the CCGs recognise that services need stability and have agreed to work together to jointly commission sexual violence services on longer term contracts, offering 2-3 year joint funding whilst they establish their future commissioning arrangements. This is important because the nature of short term contracts creates instability and uncertainty within service delivery at the end/beginning of each financial year, requiring use of reserves until the new contracts are confirmed.

# FRAGMENTED STATUTORY APPROACH TO WOMEN AND GIRLS

Responses from the statutory health sector in England are patchy in relation to the provision of gendered care which addresses the realities of women's lives.

## Gender specific and safe mental health provision by the statutory sector is lacking

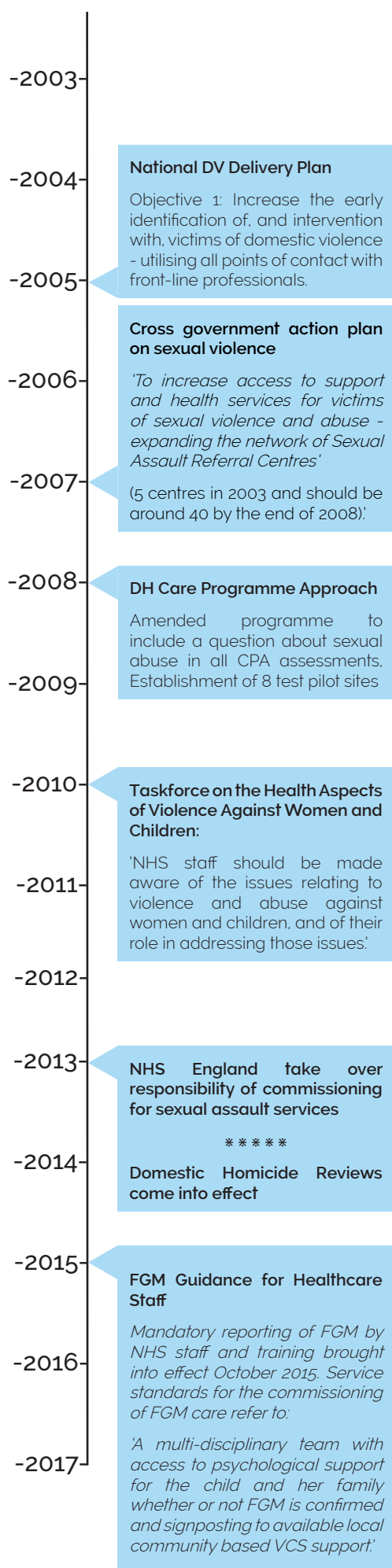
- The Five Year Forward View on Mental Health (DH 2016) revealed that fewer than 15 per cent of localities provide effective specialist community perinatal services for women with severe or complex mental health conditions, and more than 40% provide no service at all.
- In 2011 a Royal College of Psychiatry report described wards as overcrowded and understaffed, with 15 per cent lacking segregated sleeping accommodation and fewer than 60 per cent having separate lounges for men and women (Kings Fund 2015).
- Patients and carers reporting to the Commission on Acute Adult Psychiatric Care in 2015 stated that many acute wards are not always safe, therapeutic or conducive to recovery and in some cases could have a negative effect on an inpatient's wellbeing and mental health (Kings Fund 2015).
- The 10 year review of Into the Mainstream, illustrated that there has not been widespread development of crisis houses for women. Whilst the development of Crisis Resolution Home Treatment will have benefited women, there is a need to research whether these teams are applying gendered understandings of crisis to their work (National Mental Health Development Unit, 2010).
- Research with women from a rich variety of backgrounds (n=49) has shown that women are

**Women's Mental Health: Into the Mainstream + Implementing guidance, Department of Health**

*'Build on existing positive practice and existing women-only day services (many provided by the voluntary sector)'*

**Also on page 4**

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still falling through the gap of current service provision for mental health. Thresholds for statutory services are too high with long waiting lists and there is a GP over-reliance on medication. Language barriers, lack of understanding about trauma and abuse among mental health professionals and its particular impacts on marginalised/vulnerable populations, and HIV stigma create obstacles for service access (Imkaan, Rape Crisis England & Wales and Positively UK 2016).

**On-going policy commitments spanning the past 10 years have included pledges to introduce routine enquiry for domestic and sexual violence, supported by training.**

- Into the Mainstream (DH 2003)
- National DV Delivery Plan (HO 2005)
- Alberti Review (2010) recommends that the 'NHS commissioners should assess local needs and local services for victims of sexual violence and/or sexual abuse and ensure that appropriate commissioning arrangements are in place.'
- Care Programme Approach<sup>2</sup> amended the programme in 2008 so as to include a question about sexual abuse in all CPA assessments, with the establishment of 8 pilot sites to test this.
- Closing the Gap (DH 2014) recommends that 'Staff need to be supported so that they can appropriately explore with women whether they have had experience of sexual violence.'
- National Institute for Health and Care Excellence Domestic Violence Guidelines (NICE 2014) require that 'People presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion.'
- FGM Guidance for Healthcare Staff (DH 2015). Mandatory reporting of FGM by NHS staff was brought into effect in October 2015.

<sup>2</sup> The Care Programme Approach (CPA) is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs.

- Future in Mind: Children and Young People's Mental Health and Wellbeing (DH 2015) commits to 'Ensuring those who have been sexually abused and/or exploited receive a comprehensive assessment and referral to the services that they need, including specialist mental health services.'

**However, in reality, enquiry about sexual and domestic violence and abuse within mental health settings remains patchy**

- A substantive literature review concluded that while professionals acknowledged the importance of enquiry, there was little evidence of widespread routine enquiry occurring during mental health assessments (Hepworth and McGowan, 2013).
- HSCIC data revealed that in 2014/15, of the 335,727 people on the Care Programme Approach in England, there was a record of the question about sexual abuse being asked in only 17% of cases. Freedom of Information requests revealed that: only 66% of staff were trained to 'ask the question' and only five out of 53 Trusts audited whether the question was asked (Brooker et al 2016).
- A survey of 68 mental health professionals working nationwide, of which 74% were NHS based, revealed that only 28% had attended training on sexual violence in the past 2 years (2010-2012) with 64% stipulating a need for more training (AVA 2013).
- Freedom of Information requests to 57 Mental Health Trusts in April 2016 received replies from 35 Trusts. Only one had a specific women's strategy and 14 had a policy on routine enquiry for violence and abuse. Five services had a policy on pro-actively offering a female care worker but generally there was a lack of pro-active care for those disclosing abuse (Agenda 2016).
- A review of Domestic Homicide Reviews (DHRs) showed that, of the 21 DHRs involving perpetrators with mental health issues, the majority of perpetrators (n=16) were known to

NICE. Domestic violence and abuse: multi-agency working. London: National Institute for Health and Care Excellence + NICE domestic violence Quality Standards

*aimed at all health professionals including mental health. All should be trained to be able to provide Level 1 or 2 responses.*

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Five Year Forward View for Mental Health: A report from the Independent Mental Health Taskforce to the NHS in England

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Better Outcomes for Women Offenders, NOMS

See page 5

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Drug Misuse and Dependence: UK Guidelines On Clinical Management: consultation, Department of Health

*Promotes development trauma-informed care for addressing intimate partner violence among perpetrators and victims.*

Government's response to the Five Year Forward View for Mental Health

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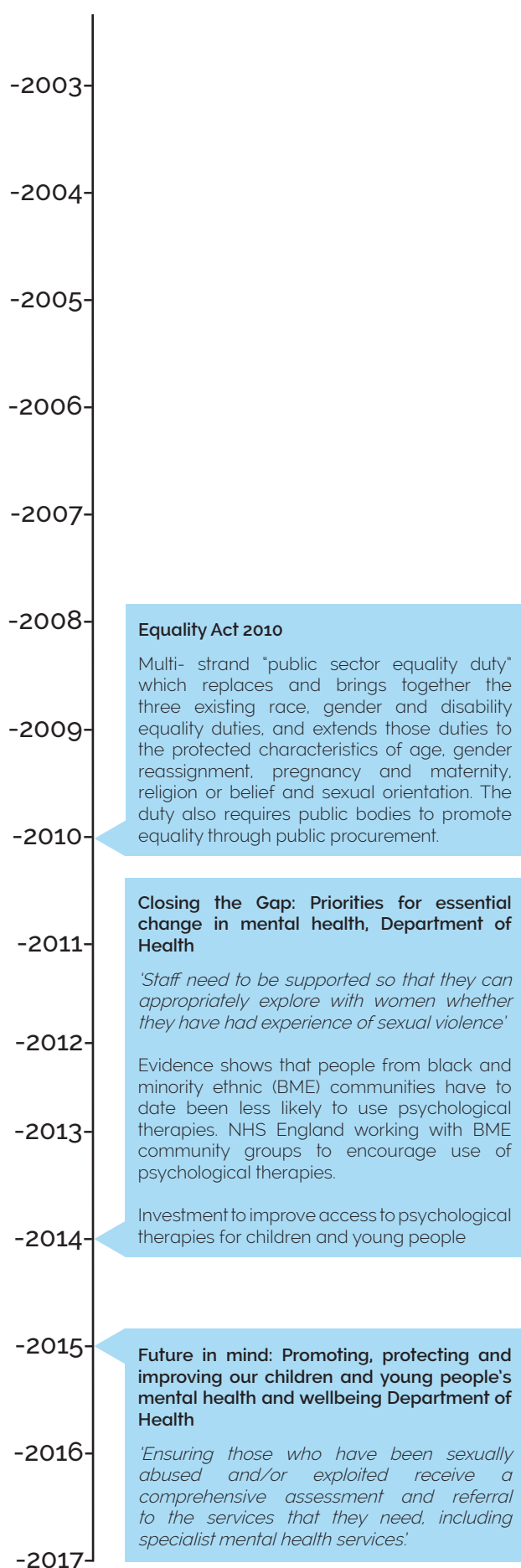
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health professionals. Of the 10 DHRs involving victims with mental health issues, all were known to health services. Health sector services were the most prominently mentioned in regards to poor record keeping (particularly GP records), risk assessment, victims and perpetrators presenting with possible signs of domestic violence but not being recognised or explored further, information sharing, multi-agency working (most notably Multi-Agency Risk Assessment Conferences) and training. On the other hand, in 12 DHRs the health sector was mentioned in relation to good practice (HO 2016b).



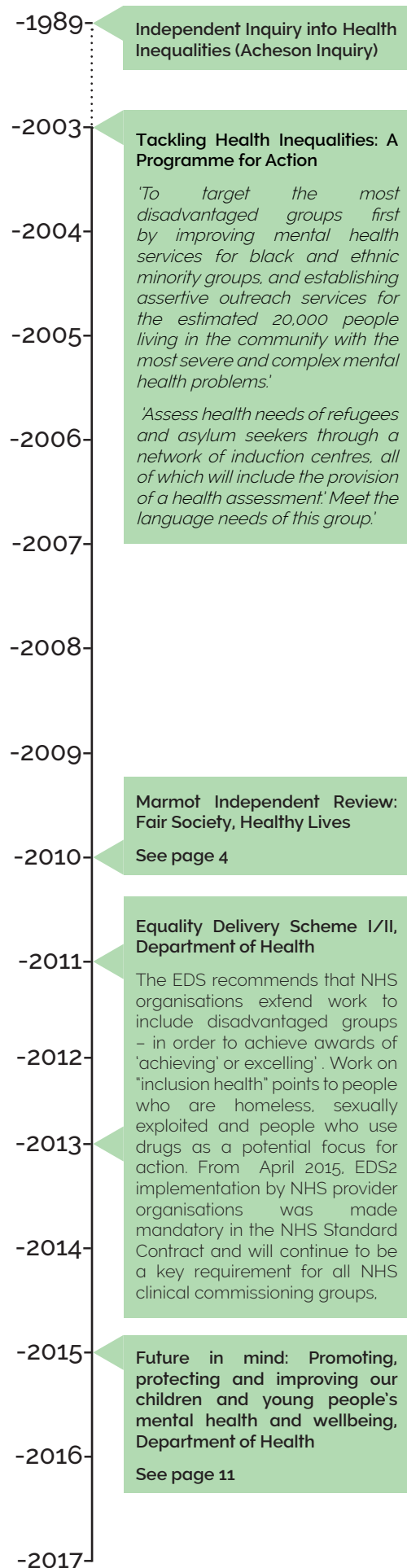


## PROMISING EXAMPLES

- Tees, Esk and Wear Valleys NHS Foundation Trust has been embarking on a program to develop trauma-informed services throughout its adult division. This has involved appointing a lead for trauma informed care among its clinical team. The pilot project on an acute adult mental health ward included all staff from senior medics to health care assistants. Ward staff reported feeling empowered to have meaningful discussions about trauma which informed the formulation of care plans. Staff were also able to implement some core skills in grounding and emotion regulation, which resulted in a reduction in the use of medication (Sweeney et al 2016).
- Camden and Islington NHS Foundation Trust selected a Quality and Innovation (CQUIN) target<sup>3</sup> in 2014/15 to ensure that 20% of the 1,726 frontline staff were trained to recognise the indicators of domestic violence and abuse and to ask relevant questions to help people disclose their past or current experiences of such violence or abuse, in line with NICE Guidance. This was highlighted in evaluation as a key driver for ensuring staff were trained as part of its Promoting Recovery in Mental Health collaboration with Against Violence and Abuse (Oram et al 2016).
- Four Trusts were presented as case studies in the evaluation of a two year project to implement and sustain routine enquiry into mental health services. Overall strategic leadership, the use of champions (mostly trainers) and team managers who kept routine enquiry on the agenda, accompanied by staff training were highlighted as key to effective implementation. As a result of this work, twelve month data in one Trust showed that in 83% of assessments it had been recorded whether service users were known to have experienced violence or abuse (Scott and McNeish 2008).

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<sup>3</sup>CQUINs enable commissioners to reward excellence, by linking a proportion of service providers' income to the achievement of national and local quality improvement goals.



## PERSISTING INEQUITIES

Despite the growing attention paid to health inequities over the past 15 years, access to mental health care, particularly for BME people persists, exacerbated by cuts to specialist women's services.

**Government policy documents have consistently acknowledged the health inequities among people from different communities particularly around access to mental health services**

- Tackling Health Inequalities: A Programme for Action (DH 2003a) highlighted a number of priority actions for BME and refugee communities: (1) *'To target the most disadvantaged groups first by improving mental health services for black and ethnic minority groups, and establishing assertive outreach services for the estimated 20,000 people living in the community with the most severe and complex mental health problems'* and (2) *'To assess the health needs of refugees and asylum seekers through a network of induction centres, all of which will include the provision of a health assessment.'*
- The National Suicide Prevention Strategy (DH 2012) recognised the urgency of meeting the needs of BME and refugee groups, children and young people, Lesbian, Gay, Bi and Trans (LGBT) people, survivors of sexual abuse, untreated depression, and people experiencing problematic drug and alcohol use.
- No Health Without Mental Health Cross Government Strategy on Mental Health for People of All Ages (HM Government 2011) highlighted how access to services is uneven, and acknowledged that not all people have benefitted equally from improvements in mental health services - for example many people from BME and refugee groups. The document also illustrates the need to improve monitoring of sexual orientation, in order to improve access to services for LGBT people, as well as the need for early intervention with children and young people: *'By promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help to prevent mental illness from developing and mitigate its effects when it does.'*

- A review of access to the NHS for 'foreign nationals' was undertaken in 2011 and free secondary healthcare provision was widened to include refused asylum seekers receiving UKBA section 4 support.
- The NHS Equality Delivery Scheme (EDS) 1 (2013) & 2 (2016) stipulates that '*Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities.*' Furthermore, in April 2015, EDS2 implementation by NHS provider organisations was made mandatory in the NHS Standard Contract and will continue to be a key requirement for all NHS clinical commissioning groups.
- Statutory guidance (DH 2013) highlights the duties and powers for CCGs and local authorities as partners working through Health and Wellbeing Boards, to formulate and implement Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. These are locally owned evidence-based processes of 'strategic assessment and planning' to 'improve the public's health and reduce inequalities.'
- Closing the Gap: priorities for essential change in mental health (DH 2014) highlights the inequities in access to psychological therapies, particularly for people from BME communities, children and young people and older people.

**However despite these on-going policy commitments, service responses from health care sector are still inadequate exacerbated by funding cuts and a non-gender sensitive asylum policy.**

- The Five Year Forward View on Mental Health (2016) found that "There has been no improvement in race inequalities relating to mental health care since the end of the 5-year Delivering Race Equality programme in 2010. Inequalities in access to early intervention and crisis care, rates of detentions under the Mental Health Act 1983 and lengths of stay in secure services persist.
- Whilst targets for better engaging BME communities through the Improving Access to Psychological Therapies (IAPT) programme are important, this can deflect from discussions about the appropriateness of the model for all women. For example, the model

**InsideOutside: Improving Mental Health Services for Black and Minority Ethnic Communities in England (National Institute for Mental Health)**

Acknowledging institutional racism within the NHS recommending:

*'...reform inside the mental health system must take place in tandem with investment and development outside in order to be successful.'*

**Review of access to the NHS of foreign nationals, Department of Health**

*Free secondary healthcare provision was widened to include refused asylum seekers receiving UKBA section 4 support.*

**Closing the Gap: Priorities for essential change in mental health, Department of Health**

See page 11

**Five Year Forward View for Mental Health: A report from the Independent Mental Health Taskforce to the NHS in England**

**Government's response to the Five Year Forward View for Mental Health**

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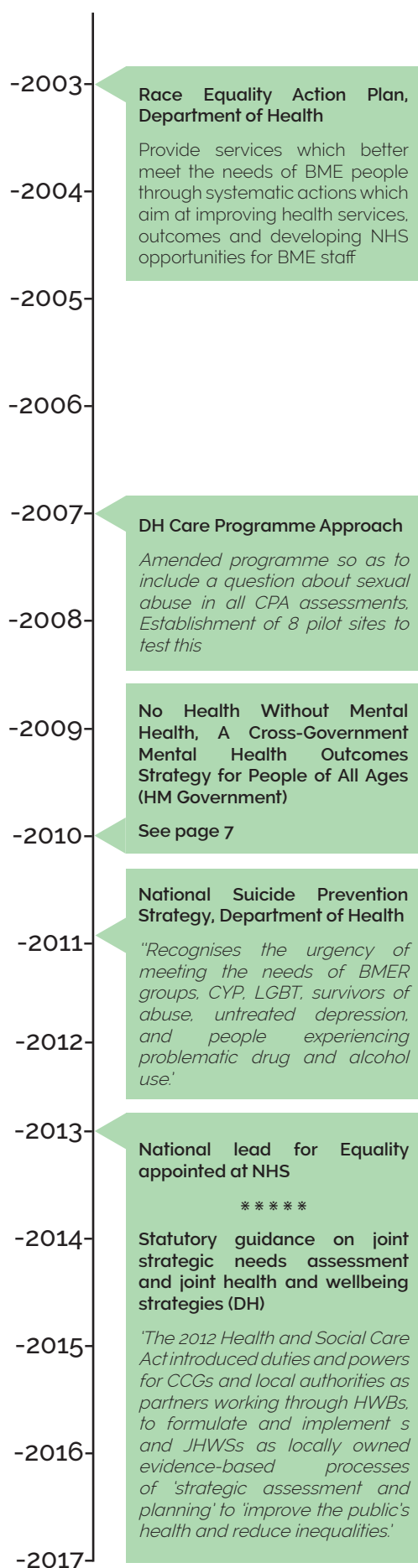
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has been deemed by some as too Euro-centric in terms of an approach which does not embrace other 'cultural' narratives, nuances and histories, with a tendency to approach understandings of recovery which depoliticise experience (Fitzpatrick et al 2014). This is important because research has highlighted how women *'felt that mental health services and recovery frameworks did not account for their experiences of racism and other discrimination, essentially failing to address a significant part of their distress.'* (Kalathill 2011).

- Freedom of Information requests found that 74 out of 96 NHS Clinical Commissioning Groups have frozen or cut their Children and Adolescent Mental Health (CAMHS) budgets between 2014/2015 and 2013/2014 (Young Minds 2014).
- 1 in 5 children and young people referred to CAMHS services by the GP are rejected for treatment, many of these will have experienced abuse (NSPCC 2015).
- Professionals participating in a study into the healthcare responses to victims of trafficking within one large inner city mental health trust recorded concerns that the social and legal instability had a negative impact on their patient's mental health. Patients' unstable immigration status often impacted on their eligibility for other support services, hindering professionals' efforts to improve patients' situations (Domoney et al 2015).
- Evidence from 21 interviews with pregnant women seeking asylum suggests that 'dispersal not only exacerbates problems of mental health of pregnant asylum seeking women, but also, at worst prevents, and at best, impedes the provision of appropriate care that could mitigate such problems and reduce their effects on the woman, her family and development of the foetus or child.' (Maternity Action and Refugee Council 2013).
- 67% of BME "by and for" ending VAWG organisations report feeling uncertain about their sustainability in the current climate and that there is an unequal playing field in accessing funding (Imkaan 2016).

## PROMISING EXAMPLES

- London Black Women's Project (LBWP) is incorporated into the East London Foundation Trust and CCG commissioning framework and funded to provide adult therapeutic and counselling for domestic and sexual violence, forced marriage and FGM. The organisation forms part of the local specialist IAPT pathway for psychological services for survivors of domestic violence. At the point of triage assessment within the IAPT services, if a BME woman is identified as experiencing domestic violence they are signposted to LBWP who provide specialist psychological therapy. This model of provision helps the CCGs to achieve national targets around improving equity to access of mental health care for disadvantaged groups and responding to some of shortfalls in IAPT models in terms of meeting the needs of BME groups.<sup>4</sup> LBWP's provision of therapy is based on humanistic approaches from diverse schools of thoughts including unconscious union and nature in recovery (the idea of the interconnected self), self-conscious reflection, story-telling, and knowing and value (understanding one's existence in universe and nature). This approach aligns itself to cosmology (understanding interconnected self to nature and vice versa). This approach is particularly useful for addressing the numerous and intersectional experiences of BME women as attention is paid to shifting stigma, and creating participatory spaces and equality between practitioner and service user. Boundaries are maintained, however language and space are transformed through engagement.

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<sup>4</sup>For example, see CQUIN guidance for 2016/17 <https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17/>



# TRAUMA INFORMED CARE

- There has been a growing interest in the development of trauma informed care in the UK over the past few years, which has been particularly visible among the women's prison estate. This approach is also expected to appear in the refreshed UK Guidelines for the management of substance misuse (PHE 2016) due to be published later this year. Principles of trauma awareness, safety, choice and collaboration, trustworthiness, strength and skills building underpin a trauma informed approach (Elliot et al 2005). This is particularly important to enact within a mental health system which can be re-traumatising in itself through its operating principles based on coercion and control. As others have argued, the system has also traditionally contributed to historical and cultural trauma by recasting responses to racism as individual pathology, classifying women's resistance to societal control as hysteria and recasting homosexuality as sexual deviance to be addressed in therapy (Sweeney et al 2016).
- The trauma-informed approach provides a framework for recognising the wider socio-political historical influences in women's lives (Urquhart & Jaisura 2012). In North America this framework has been used to try to implement an intersectional approach to improving women's mental health particularly around addressing the inter-generational trauma resulting from racism and colonial practices (Menzies 2012). It may therefore prove a useful framework for improving services for women here in the UK and addressing some of the concerns highlighted in this report about recovery frameworks which fail to take account of the impact of historical and structural discrimination faced by many women. It is critical to recognise that these approaches should be delivered by practitioners that have a track record and expertise of an intersectional approach to trauma informed interventions e.g. A BME-led ending VAWG organisation who provides a safe space across a wide range of interventions, which contribute towards women's recovery.
- Scotland's Mental Health Strategy 2012-2015 includes psychological trauma as a key priority (Scottish Government, 2012). The strategy states that 'General services should be Trauma Aware', and aims to improve recognition and awareness of trauma in primary care and mental health services, encourage staff to make appropriate referrals for trauma survivors, and roll out trauma training.

## FUTURE DIRECTIONS – POLICY LEVERS

### NICE Domestic Violence Guidance

- Given the highlighted inadequacies in health sector responses to domestic violence identified by the Home Office analysis of Domestic Homicide Reviews, there is an urgent need to ensure the implementation of the NICE domestic violence guidelines (2014) and monitoring of the accompanying four NICE service quality standards (2016) undertaken in all health bodies.
- Recommendation 12 requires that health commissioners '*Provide specialist advice, advocacy and support as part of a comprehensive referral pathway.*' As part of this commissioners should '*Ensure practitioners are aware of how discrimination, prejudice and other issues, such as insecure immigration status, may have affected the risk that people using their services face.*'
- NICE are publishing new guidelines in September 2017 to help people working with children and

young people recognise and stop child abuse and neglect (NICE 2017). This will also require collaborative partnership working between the statutory health sector and specialist women's organisations in order to ensure appropriate therapeutic responses are provided.

### **The National Statement of Expectations (NSE) for VAWG services (Home Office 2016a)**

- This document contains some promising actions and commitments around health responses. For example, the document states that local commissioners should:
  - (1) Make early detection and prevention a priority for the health and public health services, and mainstream this into the work of all health professionals.
  - (2) Assess and build in access to mental health service provision for victims of all types of VAWG, effectively linking up such services with, for example, health services, Rape Crisis Centres, specialist BME women's services or support for adult survivors of child sexual abuse.
  - (3) Have access to a broad diversity of provision, considering how services will be accessible to BME, disabled, LGBTQQI and older victims and survivors, and those from isolated or marginalised communities.
  - (4) Consider whether an individual may have complex needs or suffer from multiple disadvantage and, if so, the services in place to manage these. Women and girls with learning disabilities, mental health problems, drug/alcohol dependency and those facing homelessness are disproportionately subject to domestic and sexual violence.
- A commissioning toolkit (HO 2016c) has been produced to support the NSE and demonstrate how commissioning services to tackle VAWG can be done to meet needs effectively. This includes information on the advantages of pooling budgets across Police and Crime Commissioners (PCCs), Health and Local Authorities to align services against a common set of outcomes and co-production with survivors and specialist service providers for women and girls in order to get the right services delivered.

**The NSE is supposed to act as a blueprint for all local areas to follow and set out core expectations. However, there are concerns as to what mechanisms are in place to ensure these commitments get delivered.**

- Detailed implementation guidance should also be provided, for example, along the lines of that produced in the Five Year Forward View on Mental Health. Greater consideration should be given to how the NSE is to be aligned with local Sustainability and Transformation Plans and within the work of Health and Wellbeing Boards.
- The Home Office should convene a discussion (via the VAWG stakeholder group) with the specialist ending-VAWG sector to review the areas highlighted in this report. In light of the NSE, it would be useful to map and monitor (on an ongoing basis) the local implementation of the NSE in terms of local commissioning approaches, care pathways, barriers and gaps as well as promising approaches to addressing the mental health support needs of girls/women.
- The Department of Health (DH) should make dedicated funding available to support specialist, voluntary sector women's organisations to deliver support services to support the health and wellbeing of women and girls.

## Five Year Forward View for Mental Health (2016)

The Government has accepted all recommendations in the Five Year Forward View for Mental Health. Those most relevant to this report are:

- Rec 1: build on Children and Young People's Local Transformation Plans which must include helping 70,000 more children and young people to access high quality mental health care when they need it.
- Rec 2: national programme to support local authority plans to integrate mental health, substance use, housing and parenting needs.
- Rec 14: investments in psychological treatments for depression, bi-polar and personality disorder.
- Rec 15: to improve access to mental health care during the peri-natal period.
- Rec 17: access to 24/7 community based mental health crisis care.
- Rec 22: to substantially reduce Mental Health Act detentions and targeted work to reduce the current significant over- representation of BME and any other disadvantaged groups within detention rates.
- Rec 48: NHS England should disaggregate the inequalities adjustment from the baseline funding allocation for CCGs and primary care, making the value of this adjustment more visible and requiring areas to publicly report on how they are addressing unmet mental health need and inequalities in access and outcomes.
- The Implementation plan (NHS England 2016) published last year also outlines concrete steps for how the recommendations will be implemented.
- WHEC recommends that in addition to the collection of disaggregated data to monitor equity of access to mental health services there is also a need for research into how both a gendered and intersectional understanding of mental health is being delivered by mental health professionals within the statutory sector.
- In line with promising practice highlighted in this report, commissioning of IAPT services should also include specialist VAWG services as part of the pathway for women disclosing experiences of sexual and domestic violence and abuse, FGM and trafficking.
- To help achieve this WHEC recommends that local commissioners specify and monitor the inclusion of smaller or specialist providers to deliver services for marginalised groups. This would encourage larger, generic organisations to partner with or enter into sub-contracting arrangements with local, specialist organisations (Women's Resource Centre and Women's Health and Equality Consortium 2017).
- CCGs should also invest more in their grants programme, as recommended by NHS England (NHS 2015) to create a better mechanism to procure services from smaller and BME or specialist providers where it is shown to be the most effective way of providing those services, in particular to those who are most marginalized (Women's Resource Centre and Women's Health and Equality Consortium 2017).

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The Women's Health and Equality Consortium (WHEC) is a partnership of women's charity organisations who share common goals of health and equality for girls and women. WHEC aims to ensure that health policy addresses the real needs of girls and women. It therefore pools the expertise of member organisations to better influence decision-makers and government. WHEC works to improve engagement and sustainability of the women's and girls' health and social care sector and to support women's and girls' organisations to tackle health inequalities.

WHEC partners are: FORWARD, Imkaan, Maternity Action, Positively UK, Rape Crisis (England and Wales) and Women's Resource Centre.

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