Working towards Women’s Well-being: Unfinished business
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<tr>
<td>Author</td>
<td>National Mental Health Development Unit</td>
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<tr>
<td>Publication Date</td>
<td>24 Feb 2010</td>
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<td>Target Audience</td>
<td>Regional Equality Leads</td>
</tr>
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<td>Circulation List</td>
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<td>Working Towards Women's Well-being is a progress report measuring the extent of policy and mental health organisational progress since the publication of 'Into the Mainstream', women's mental health strategy in 2002 and implementation guide 'Mainstreaming Gender and Women's Mental Health' in 2003.</td>
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<td>For Recipient's Use</td>
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If only you had listened... I asked for help.
If only you looked into my eyes...
and seen the darkness in my soul.
If only you had looked beyond my aggression...
and acknowledged my distress.
If only you had dismissed my verbal abuse...
and acknowledged my pain.
If only you had... seen me...

I tried to share with you... but it fell on deaf ears.
I tried to show you... my desperation...
I tried to stay... but felt invisible...
I tried... by God I tried...

Why did you not embrace me...
Why did you not empathise with me...
Why did you not engage with me...
Why did you not bother with me...

It could have been so different...
It could have given me hope...
It could have made a difference...
It could have changed my mind...
But it compounded my fears...
But it made my life more fractious...
But it destroyed my desire for the future...
But I tried... God I tried...

Next time... always give hope...
Next time... always give compassion...
Next time... always give your humanity...
Next time... always give your understanding...

Otherwise, there won’t be a next time...

Tracey Hayes © 2007
Foreword

I am pleased to present Working towards Women's Well-being. This report has been developed by the Gender Equality team within Mental Health Equalities, one of the six strands of activity undertaken by the National Mental Health Development Unit (NMHDU).

Working towards Women's Well-being reflects and contributes to the New Horizons framework that was launched in late 2009 to build on the 1999 National Service Framework for Mental Health (NSF).

Creating a new framework for mental health delivery offers a real opportunity to create a framework that has as its cornerstone equality and fairness. Establishing a framework in which equality is embedded will make a big difference to service users, reducing the level of unjustifiable inequalities. One of many ways that this can be achieved is by listening to others, be it at the individual and/or the organisational level, and learning from experiences.

At the national level, the Equality Bill signals the government's commitment to ensure a more unified and uniformly accessible approach to service delivery. Women will be beneficiaries of this commitment.

Working towards Women's Well-being presents clear evidence that some progress has been made in providing gender-specific and gender-sensitive mental health services to meet the needs of women. The report brings together an account of progress on implementation of the recommendations in the 2002 Department of Health report Women’s Mental Health: Into the Mainstream with examples of best practice on the ground to demonstrate this progress. These will have relevance to commissioners, service providers, service users, their carers and advocates.

Locally within the voluntary sector, women’s projects play their part too in redressing the balance to provide equality of service provision for women. However, while some progress has been made at national, departmental and local levels, there are still wide gaps in women's experiences when it comes to retaining and maintaining their well-being. Sections in Working towards Women's Well-being highlight where these gaps still exist in ensuring gender-specific and gender-sensitive service development to meet women’s unique needs.

In summary, Working towards Women's Well-being provides a clear view of the past and present, and a vision of a future towards which we can all contribute, to ensure that women’s well-being is assured through the provision of gender-specific and gender-sensitive services.

I commend Working towards Women’s Well-being to the policy maker, the commissioner and the service provider as a contribution to making real change to the landscape of equality and mental health.

Louis Appleby CBE National Director for Mental Health
Executive summary

*Working towards Women’s Well-being* reflects and contributes to the government-wide commitment to ensure fairness and equity for all women, of all ages and all backgrounds.

Women’s Mental Health: Into the Mainstream, published in 2002 by the Department of Health, described in detail the mental health needs of women and, with its companion report Mainstreaming Gender and Women’s Mental Health: Implementation Guidance (2003), set out the necessary steps to improve services to meet their distinct needs.

Underpinning these recommendations was the principle that gender-awareness should be integrated or mainstreamed into all planning, commissioning, developing, delivering and evaluating of mental health services.

This report examines the evidence for progress on the recommendations of Into the Mainstream and the implementation guidance. It draws on two national surveys (in 2006 and 2007) of mental health trusts, a wide range of relevant government and national reports and evaluations, and evidence and observations from service users and third sector organisations.

**Learning and development**

Some learning and development initiatives have been developed, most commonly on prevention of violence and abuse, perinatal mental health and self-harm.

However, evidence of training in gender equality was variable: half of Trusts in the 2006 survey had no specific plans for equalities learning and development activities.

The new advanced module on gender equality commissioned by the Gender Equality Programme should improve access to this training.

**Governance**

Some Trusts in the 2006 survey had adopted governance arrangements that included gender. These arrangements have been strengthened further by the corporate focus on equalities, as a consequence of equalities legislation.

However, only a minority of Trusts reported that they disaggregated assessment, care and outcomes data by gender and a limited number had set up gender-sensitive service evaluation and monitoring processes. The introduction of the Public Sector Gender Duty in 2007 and associated equalities legislation will have stimulated more Trusts to undertake this activity.

**Leadership**

A significant percentage of Trusts have appointed management leads with responsibility for gender, but there is considerable variation in their roles, ranging from executive director to clinician or practitioner level.
Fewer Trusts have appointed an identified clinical lead. Where this role exists, the individual holding it is likely also to be the managerial lead.

National organisational changes to the regional structure of NIMHE in April 2009 have led to wide variation in how the regions are delivering gender equality. In many cases, gender equality and gender equality leadership has been incorporated into the wider equality agenda.

Gender-specific provision

Developments in gender-specific service provision remain patchy, variable and vulnerable, although some significant advances have been made in recognising women’s special needs.

• The third sector remains the main provider of women-only day services. There are concerns about the sustainability of this financially vulnerable provision.

Reports from some areas suggest that the restructuring of mental health day service provision has included consideration of appropriate gender-specific services. However, there is no clear evidence that this has occurred routinely.

Local voluntary sector women’s centres have a clear and important role in engaging women and fostering well-being, particularly women who are marginalised.

• There has not been widespread development of crisis houses for women. It seems likely that commissioners and providers have been focusing on the development of Crisis Resolution Home Treatment (CRHT) services to meet national requirements. These will have benefited women, but there is a need to research whether these teams are applying gendered understandings of crisis to their work.

• Single-sex inpatient accommodation remains a focus for service development. Progress appears to have been slow.

There are some excellent examples where Trusts have adopted a whole-system approach to create a therapeutic environment that is physically and emotionally safe for women so that healing from mental trauma and distress can take place. Joint work combining improvements to acute care with a gender equality perspective will provide the most effective way to achieve high quality, appropriate services.

• Secure services for women have been rationalised since Into the Mainstream, with the concentration of women’s high secure services at Rampton and development of new gender-specific services in medium and low secure provision. However, women remain a minority within the secure services, meaning their specialised needs may be overlooked. Further work is needed as a matter of urgency to move towards the provision of genuinely personalised, tailored secure services for women as close to home as possible, and greater availability of ‘step down’ services.

Gender-sensitive provision is also variable. Welcome developments have occurred in policy and practice since Into the Mainstream, but there remains considerable scope for improvement to ensure women’s needs are not overlooked.

• Mental health promotion is a critical area for activity if the causes of women’s distress are to be tackled and women at risk of developing mental health problems are to be identified and helped at an early stage. Local Area Agreements and Local Strategic Partnerships (LSPs) provide a mechanism for ensuring the needs of women are recognised at commissioning and service planning levels.

In 2009 the government launched a cross-government strategy, Together We Can End Violence Against Women and Girls. The Department of Health has also set up a task force to review how the NHS identifies and should respond to violence against women and girls. There is a clear and urgent need to continue and build on these initiatives to tackle violence and abuse.

• Women are at higher risk of common mental health problems and more likely than men to seek help in primary care. Developments such as graduate mental health workers, the
Improving Access to Psychological Therapies (IAPT) programme and training for health visitors and midwives have made a major contribution to building capacity within primary care to respond to common mental health problems. Data from the early IAPT pilot sites show that more than half of referrals are women, consistent with prevalence of common mental disorders in the population.

• In 2007 less than a third of Trusts reported steps to include gender issues in **assessment and care planning** and the CPA process. Only one in ten Trusts said that women were offered a choice of female care co-ordinator and that experience of abuse and violence was routinely explored and women were involved in making decisions about their care. Nearly one third reported availability of gender-sensitive services, including women-only groups and facilities, but only four per cent made culturally appropriate provision.

This picture may have changed with the 2008 review of the CPA, but inclusion of gender issues in care planning and assessment is evidently far from routine. More work is needed to promote understanding of what this entails among practitioners and professionals.

• The 2007 survey found improved access to **talking treatments** nationally, with 92 per cent of Trusts reporting new psychological services from which women would benefit. Approximately half also reported specific initiatives for women. A limited amount of staff training was mentioned, and there was some reference to the contribution of equality impact assessments in highlighting the gender issues that should be considered in service design and provision.

• There has been increasing attention to the management of **self-harm**, in particular in relation to young people and women in prison.

NICE is revisiting this topic and aims to develop guidance that focuses on the longer-term management/response to individuals who self-harm, for publication in 2011.

There have been a number of initiatives nationally and locally to promote a harm minimisation approach in relation to self-injury. Further work is needed to address concerns about the duty of care in relation to different types of self-harm and the harm minimisation approach.

• The 2006 and 2007 surveys indicated that initiatives to tackle **violence and abuse** were being actively developed. Most commonly these included multi-agency working with local refuges, the voluntary sector, police and drug and alcohol teams; service developments such as single-sex wards, Sexual Assault and Referral Centres and women-only medium secure units, and specific group and individual services and therapies, including survivors groups.

In 2009 the national roll-out of the Mental Health Trust Collaboration Project (MHTCP) began. This aims to include as routine the assessment of experiences of violence and abuse of all people admitted to adult mental health services. At national level, the launch in 2009 of **Together We Can End Violence against Women and Girls** should create a catalyst for continued development of this work.

The third sector and women’s centres play an essential role in responding to the effects of childhood sexual abuse and domestic violence, both as service providers and in training staff in statutory services. This has to be recognised by commissioners and service planners.

• Nearly half of Trusts in the surveys reported significant developments in process to review and develop **perinatal mental health services**, including mother and baby units and dedicated multi-disciplinary teams.

Responses from primary care also indicated service developments, including training for health visitors and midwives. However, there was little evidence of a whole-system approach
to perinatal mental health services within Trusts. Improvements seemed often to be championed by a few committed individuals.

- Significant gaps in **personalised services** continue to exist, in particular for women from Black and minority ethnic (BME) communities, women with children, and women in contact with the criminal justice system.

  - The 2006 and 2007 surveys found little mention of initiatives to meet the needs of **women from BME communities**. However, a number of community projects for BME women have been developed through the Delivering Race Equality (DRE) programme. 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. DRE’s five-year programme ended in 2009, but its vision continues to be a priority for the Equalities and New Horizons programmes.

  - The new CPA guidance places particular emphasis on assessing and meeting the parenting support needs of people with mental health problems, and their children and families. This, and the introduction of Family Intervention Projects, should improve recognition of and responses to the needs of **women as mothers and carers**.

  - Awareness of the mental health needs of **women in contact with the Criminal Justice System** has been raised by several high profile government reports and initiatives. Positive progress has been made within prisons, with Primary Care Trusts (PCTs) taking over responsibility for health care since April 2006. Prison mental health in-reach teams and the guidance on the transfer of prisoners to psychiatric care have also improved provision. However, a whole-system approach to women in contact with the CJS is needed, built on the recognition that issues that lead to offending are often intertwined with mental health issues.

Moving forward

The next five years must see further progress to build on and sustain the achievements to date and ensure that women-only services become the norm within an integrated care pathway and are routinely and regularly reviewed to inform further development and improvement. Essential elements in this process are:

- strong leadership
- building coherent multi-agency workforce development
- ensuring the development of integrated care pathways
- improved response to diverse needs
- maintaining and extending action to tackle violence and abuse, as a priority.

The introduction of the Public Sector Gender Duty and the forthcoming Equality Act will have a major impact on mainstreaming the women’s mental health agenda. Gender impact assessments provide an opportunity to influence the implementation of gender-specific and gender-sensitive services for women. Awareness of the different mental health needs of women, men and transgender people is improving, although it has been hindered by the absence of disaggregated data and consideration of gender as a key variable in service outcomes. There is no stronger persuader than the evidence base; monitoring, evaluation and research is essential.

Leadership at a senior level, mechanisms for accountability, strong partnership working between the statutory and voluntary sector, and the involvement of women with experience of mental health problems emerge as critical factors in mainstreaming action to tackle gender inequality in mental health services.

The launch of the Department of Health’s new ten-year mental health strategy and programme of action, *New Horizons*, offers an exciting opportunity for this work to be taken forward. Women’s safety, within mental health services and in the community at large, must be a constant theme within all this work, and a continuing priority.
Introduction

‘To provide equity of service to all, gender differences in women and men need to be equally recognised and addressed across research, planning, commissioning, service organisation and delivery.’

Into the Mainstream

A fair society may seem a universally accepted goal but conclusions over the last two years from myriad reports, including the final reports of the Equalities Review and the Darzi Review and the Equality Bill 2009 show we are not there yet.

Working towards Women’s Well-being reflects the government-wide approach to ensure fairness and equity for women, of all ages and all backgrounds. Its focus is women’s mental health – the issues, the challenges and the possible solutions.

But why consider mental health in gender-specific terms?

It is an established and oft-repeated fact that there are gender-related differences between women and men. Women’s life experiences, socio-economic realities, expressions of mental distress, pathways into services and their treatment needs and responses differ greatly from those of men (see Table 1).

This report coincides with the publication by the Department of Health of New Horizons: towards a shared vision for mental health. New Horizons builds on the successes of the National Service Framework for mental health, and sets out a new framework for improving and maintaining the mental health and well-being of the whole population, including those with diagnosed mental health problems. It supports the local development of higher quality, more personalised services and builds a cross-government, multi-agency alliance to tackle the root causes of poor mental health.

Gender Equality and Women’s Mental Health

The authors of Working towards Women’s Well-being are from the Gender Equality team within the Mental Health Equalities programme in the National Mental Health Development Unit (NMHDU). The NMHDU is funded by the Department of Health to provide a centre of mental health expertise for the implementation of health policy in England, including identifying relevant mental health-related research and providing evidence in the form of case studies to support the roll out of the New Horizons programme of action.

The Gender Equality Programme, formerly the Gender Equality and Women’s Mental Health Programme, was originally established in 2004 by the National Institute of Mental Health in England (NIMHE), the predecessor of NMHDU. The Gender Equality Programme’s role continues to be the implementation of the recommendations of Into the Mainstream to improve women’s mental health and well-being. The programme does this within a wider Gender Equality perspective.
Table 1: Overview of gender differences in relation to mental health

<table>
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<tr>
<th>Life experiences</th>
<th>Female</th>
<th>Male</th>
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<tr>
<td></td>
<td>Sexual, physical abuse&lt;br&gt;Domestic violence&lt;br&gt;Caring and domestic responsibilities&lt;br&gt;Single parents&lt;br&gt;Live alone in old age</td>
<td>Pressure to adhere to ‘traditional’ male values, eg. not express emotion&lt;br&gt;Fighting&lt;br&gt;Expectations of strength/protect others&lt;br&gt;Bullying</td>
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<td>Socio-economic realities</td>
<td>Poverty/state benefit or pension only&lt;br&gt;Unequal pay/part-time employment/low paid jobs/prostitution&lt;br&gt;Unemployment (education, caring duties)&lt;br&gt;Lack of mobility/non car driver or owner&lt;br&gt;Fewer achievements in further education&lt;br&gt;Less likely to be in leadership position&lt;br&gt;Competing, often unsupported multiple roles&lt;br&gt;Low societal status and values placed on women's roles</td>
<td>Greater risk of being distant from children&lt;br&gt;Stress in workplace&lt;br&gt;Full-time employment&lt;br&gt;Burden of responsibility&lt;br&gt;Unemployment&lt;br&gt;Retirement</td>
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<td>Expressions of mental distress</td>
<td>Depression (loss and bereavement)&lt;br&gt;Anxiety/Phobias (threat)&lt;br&gt;Obsessive compulsive disorder&lt;br&gt;Self-harm/low self-esteem&lt;br&gt;Eating disorders&lt;br&gt;Perinatal mental health problems</td>
<td>Suicide&lt;br&gt;Early onset psychosis&lt;br&gt;Drug and alcohol related problems&lt;br&gt;Anti-social behaviour&lt;br&gt;Anger attacks&lt;br&gt;Acting out generally&lt;br&gt;Go missing&lt;br&gt;Rough sleepers</td>
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<td>Pathways into services</td>
<td>Primary care&lt;br&gt;Community services&lt;br&gt;Maternity services</td>
<td>A&amp;E&lt;br&gt;Criminal justice system&lt;br&gt;Substance misuse services</td>
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<tr>
<td>Treatment needs and responses</td>
<td>Physical and relational safety&lt;br&gt;Tackling underlying issue&lt;br&gt;Talking therapies&lt;br&gt;Expertise in responding to history of sexual abuse&lt;br&gt;Role of voluntary sector/informal settings&lt;br&gt;Flexible access to recognise caring responsibilities&lt;br&gt;Holistic approach&lt;br&gt;Women-only facilities, community and inpatient</td>
<td>Mental health promotion focused on physical health, eg. nutrition, exercise&lt;br&gt;Language – ‘well-being’ rather than mental health&lt;br&gt;Dedicated advice (not help) lines&lt;br&gt;Proactive outreach via generic community rather than NHS services&lt;br&gt;Work-friendly primary care hours&lt;br&gt;Men-only group therapy&lt;br&gt;Assertive outreach/early intervention</td>
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A Partnership Approach across Government

The government’s overall commitment to fairness and equity for women is well established with the appointment of Harriet Harman MP (Leader of the House of Commons) as Minister for Women. That commitment has been reinforced with *A Framework for a Fairer Future*, The Equality Bill introduced into the House of Commons in April 2009. The Bill is expected to complete its passage through both Houses of Parliament by the summer of 2010.

Table 2 summarises the relevant women’s policy responsibilities for each of the relevant government departments.

Moving Forward

The Equality Bill should bring increased profile and activity around women’s needs within statutory and non-statutory organisations. When enacted, the Bill will strengthen protection, advance equality and bring together into one Act the many pieces of equality legislation that have been enacted over the last four decades.

Within the arenas of health and social care provision, positive seeds have been sown by a raft of policy developments. Key themes are: voice, choice and control; the shift of focus to well-being and health promotion; equality of access to services, and personalisation. These, with the increased focus on social inclusion, are all key potential drivers that will bring benefits for the most vulnerable. Significant also is the acknowledgement of the need for additional support to ensure well-being for the most vulnerable.

<table>
<thead>
<tr>
<th>PRIORITY AREA</th>
<th>Women’s health and Well-being</th>
<th>Supporting women in their roles as mothers, carers, employees and students</th>
<th>Women’s safety and freedom from threat of abuse and violence</th>
<th>Justice and fairness for women who come into contact with the criminal justice system</th>
<th>Women’s participation, particularly empowering women from BME communities</th>
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<tr>
<td>Cabinet Office</td>
<td>Equalities Review: fairness and freedom</td>
<td>Public Sector Gender Equality Duty</td>
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<td>1) Department for Constitutional Affairs</td>
<td>1) Review of the implementation of Human Rights Act</td>
<td>1) &amp; 2) Parental Separation: children’s needs and parents’ responsibilities</td>
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<td>2) Reducing Re-Offending through Skills and Employment</td>
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<td>2) Department for Education and Skills</td>
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<td>Department for Communities and Local Government</td>
<td>Improving Opportunity, Strengthening Society: the government’s strategy to increase race equality and community cohesion</td>
<td>Homelessness Prevention: a guide to good practice Safer Places: the planning system and crime prevention</td>
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<td>Strong and Prosperous Communities Managing the Impact of Migration: a cross-government approach</td>
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Table 2: Overview of policy developments relevant to women’s mental health
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<tr>
<th>PRIORITY AREA</th>
<th>GOVERNMENT DEPARTMENTS</th>
<th>Women’s health and Well-being</th>
<th>Supporting women in their roles as mothers, carers, employees and students</th>
<th>Women’s safety and freedom from threat of abuse and violence</th>
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<th>Women’s participation, particularly empowering women from BME communities</th>
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<td></td>
<td>Department for Children, Schools and Families</td>
<td>Teenage Parents Next Steps: guidance for local authorities and primary care trusts</td>
<td>Every Child Matters</td>
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<td>The Treasury</td>
<td>Our Health, Our Care, Our Say: World Class Commissioning Public Service Agreement 18 Promote better health and well-being + Public Service Agreement 19 Ensure better care for all</td>
<td>Caring about Carers: a national strategy for carers (including young carers) Public Sector Agreement 10 Raise educational achievement of children and young people</td>
<td>Public Sector Agreement 15 Address disadvantage through gender, race, disability, age, sexual orientation, religion or belief</td>
<td>Improving Health, Supporting Justice Public Sector Agreement 16 Socially excluded adults in settled accommodation</td>
<td>Delivering Race Equality Public Sector Agreement 21 Build more cohesive, empowered and active communities</td>
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Chapter 1
Responding to New Challenges

‘Everyone has a stake in creating a fair society because fairness is the foundation for individual rights, a prosperous economy and a peaceful society. Fairness and equality are the hallmarks of a modern and confident society.’

Harriet Harman MP, A Fairer Future

Working towards Women’s Well-being is not only timely for the New Horizons strategy; it is also useful for organisations seeking to embed the Public Sector Gender Equality Duty within their governance and operation.

Public Sector Gender Equality Duty

The public sector Equality Duty will, when it comes into effect in 2011, bring together the three existing race, disability and gender duties on public services and extend the duty to include gender reassignment, age, sexual orientation and religion and belief. The duties mean public bodies have to develop and deliver services that meet the needs of all those people using public services. They also provide a means to tackle entrenched disadvantage and equality gaps in all public service provision, including health, social care, education, criminal justice and local citizenship and participation. They also increase accountability, as people can use the duties to challenge public bodies about the services they provide.

For mental health services, this will require services to be sensitive to women’s particular needs and to ensure that all members of the community have equal access to equal levels and standards of service provision, with due regard to their differing needs. One size will not be enough to fit all.

See www.equalityhumanrights.com for further information.

A Fairer and More Equitable Society

With all challenges also come opportunities. Creating a mental health service that puts the needs of individuals who use the service first also requires practical and affordable solutions for mental health commissioners and service providers.

Creating a mental health service where one size is not expected to fit all is a big challenge and an even bigger opportunity to redress the balance of service delivery to meet the needs of women. Working towards Women’s Well-being can help commissioners and providers meet this challenge by its case examples demonstrating innovative good practice in the delivery of women’s mental health services.

A Three Pronged Approach

Working towards Women’s Well-being identifies the necessary actions to improve the mental well-being of women. It has three specific objectives:

- to capture what has been learned from the implementation of Into the Mainstream
- to set out a strategic direction for the next five years, building on achievements to date, so that gender-specific pathways are firmly embedded in mental health services
to offer case studies and point to resources that can help turn ideas into concrete action and improvements.

**Whose Business Is It?**

Improving women’s mental health is everyone’s business. That is why *Working towards Women’s Well-being* is addressed to a wide audience.

*Working towards Women’s Well-being* is aimed at those committed to establishing and developing services that help women to achieve well-being – specifically:

- Strategic Health Authorities
- Regional Offices
- commissioners
- statutory service providers
- voluntary sector providers
- service users
- families of service users
- carers
- advocates for service users.

*Working towards Women’s Well-being* provides Strategic Health Authorities and Regional Offices in England a base from which to develop and strengthen their strategic plans for tackling gender based inequalities.

It provides commissioners and service providers of mental and physical health services for women with practical support through the case studies set out in its Practical Solutions case examples. These Practical Solutions demonstrate how regional and local priorities can be developed and put into effect through public health Local Area Agreements (LAAs) and Local Strategic Plans (LSPs).
Chapter 2
Fairness for Women

‘Mainstreaming...is a long term strategy to frame problems in terms of the realities of people's daily lives and to change organisational cultures and structures. It puts people and their diverse needs and experiences at the heart of policy making.’

Mainstreaming Gender and Women’s Mental Health

Positive mental health is essential to everyone's well-being. Inequality, oppression and discrimination are root causes of mental ill health. Yet there is a plethora of evidence4 to show that mental health services today are still often experienced both by women service users and by professionals alike as unfair, insensitive and inappropriate to women's needs.

Into the Mainstream4 and its companion implementation guidance Mainstreaming Gender and Women’s Mental Health6 provided a watershed in the understanding of women’s mental health needs and identification of actions to address them.

The documents outline the substantive and sustainable changes required to improve the quality of mental health services for women. They have helped generate a greater understanding of how women’s lived experiences contribute to their mental health difficulties. Key to that understanding is the knowledge that gender-awareness should be integrated or mainstreamed into mental health services: that is, an awareness of women’s (and men’s) distinct needs and life experiences should be incorporated into all planning, commissioning, developing, delivering and evaluation of mental health services.

A gendered perspective, set within the wider contexts of personalisation and user-focused services, then becomes part of the organisation’s culture, permeating throughout workforce development, service user assessment and care plans and the full range of interventions.

Five Key Areas of Activity

Within the cross-government agenda to achieve fairness and equity for women, there are five key areas where actions can make a clear difference in supporting improved mental well-being for women. These are:

1. developing specific services that focus on women’s health and well-being
2. creating support tailored to their unique life stages as students, mothers, carers, employees
3. ensuring their safety and freedom from the threat of abuse and violence
4. ensuring that the Criminal Justice System treats women fairly and equitably
5. empowering women through their participation as service users or potential service users in policy development, with particular attention to the participation and empowerment of women from Black and minority ethnic groups.
Chapter 3
Fairness for Women

‘...women want services that promote empowerment, choice and self-determination...place importance on the underlying causes and context of their distress in addition to their symptoms...address important issues relating to their role as mothers, the need for safe accommodation and access to education, training and work opportunities...value their strengths, abilities and potential for recovery.’

This chapter provides an overview of progress in implementing gender-specific and gender-sensitive services for women. It draws on information from a range of sources, as detailed in Figure 1 on page 16.

The chapter provides a general overview of progress, followed by a more detailed look at the key areas identified in Into the Mainstream and subsequently prioritised by the National Programme for Gender Equality and Women’s Mental Health (see Table 3).

Reviewing Progress

The Gender Equality Programme has assessed the extent to which gender-specific and gender-sensitive services have become part of mainstream mental health provision.

This assessment is based on a number of surveys and reports. It draws on two national surveys: a survey of mental health trusts conducted by the Gender and Equality Programme with the Mental Health Network of the NHS Confederation in 2006 and a benchmarking study, conducted in 2007 to measure progress against the national priorities of Into the Mainstream. In addition, relevant national reports and evaluations have been reviewed to draw out key themes (see Figure 1 on page 16). The Gender Equality Programme has also considered evidence and observations from service users and third sector organisations.

The two key outputs from this are:

- good practice examples (Practical Solutions) offering systemic and sustainable solutions for gender-specific and gender-sensitive services
- a review of progress highlighting gaps that continue to exist.

This will:

- enable the Gender Equality team to identify priority areas in order to inform its strategic focus
- inform the New Horizons programme by providing a gender-specific dimension
- provide guidance for commissioners and service providers on ways to improve service design and delivery
- inform service users, carers and advocates to enable them to contribute to improving the mental health system for women.
Figure 1: Working towards Women’s Well-being – key policy drivers and reports

Policy Drivers

National reports:
- National Service Framework for Mental Health – Five Years On. A review of the progress on implementation of the seven NSF standards and their underpinning programmes
- New Horizons
- The Corston review of women with particular vulnerabilities in the criminal justice system.
- CSIP, NIMHE, SCIE and SPN reports relevant to women’s mental health, including conference reports and newsletters.

Specific evaluation of progress
- Joint survey of mental health member Trusts
- Benchmarking progress against national programme priorities
- Evaluation of Women-only Secure Provision
- Evaluation of high support women-only pilots
- Evaluation of implementing NHS for mental health

Information from:
- Primary Care Trusts, NHS Trusts, local authorities & third sector organisations on strategies and activities to implement recommendations from Into the Mainstream.

Individuals and Groups
- Reports and feedback from service user groups and women’s groups including personal narrative and poems.

Practical Examples
- Practical solutions – examples of good practice from policy development

Priority areas
- Outcomes for women’s mental health and well-being

Foundations for Moving Forward

Strategic Leadership

‘The leadership in organisations should make a clear commitment to addressing gender issues. Management and clinical practice styles need to demonstrate that staff, as well as patients are valued.’

Into the Mainstream

The 2006 survey and 2007 benchmarking study provided information about the organisational strategies put in place to support Into the Mainstream. These ranged from multi-organisational, city-wide strategies to strategic planning work undertaken by NSF Local Implementation Teams (see Practical Solution 1 on page 18).
### Table 3: Priorities for the National Programme for Gender Equality and Women’s Mental Health 2006-08

<table>
<thead>
<tr>
<th>Priority area</th>
<th>Key outcome</th>
<th>Key policy drivers</th>
</tr>
</thead>
</table>
| Mainstreaming gender equality                         | Increased volume and coherence of gender appropriate services                  | • Equality Act 2006 Part 4  
• Public Sector Gender Equality Duty (April 2007)  
• EOC guidance  
• DTI Code of Practice  
• Creating a Gender Equality Scheme – Department of Health  
• Equality and Human Rights in the NHS                  |
| Gender equality in mental health services:            | Improved sexual safety and experience of acute in-patient care.                | • With Safety in Mind: mental health services and patient safety – NPSA  
• No secrets – Department of Health  
• Acute inpatient services review – Healthcare Commission  
• Social Exclusion and Mental Health report – SEU  
• Commissioning guidance on day services for people with mental health problems and women-only community day services – NSIP/DH  
• CPA review                                             |
| - safety in acute inpatient wards                      | Explore potential for harm reduction approach.                                |                                                                                                                                                   |
| - self-injury                                          | Develope appropriate day service provision.                                   |                                                                                                                                                   |
| - day services                                         | Evaluation of the developments in secure provision.                           |                                                                                                                                                   |
| - secure services                                      |                                                                                     |                                                                                                                                                   |
| Improving choice and access to psychological services  | More choice.                                                                    | • Our Health, Our Care, Our Say – Department of Health  
• Improving Access to Psychological Therapies            |
|                                                      | Self-directed support.                                                          |                                                                                                                                                   |
|                                                      | Increased access to psychological therapies.                                   |                                                                                                                                                   |
| Developing the provision of perinatal mental health   | Improved support for women experiencing perinatal mental health problems.     | • Antenatal and postnatal mental health guidance – NICE  
• Delivering Race Equality  
• Positive Steps: supporting race equality in mental health care |
| support                                               | Increased attention to the needs of BME women.                                 |                                                                                                                                                   |
| Women from Black and minority ethnic communities       | Increased volume and coherence of services appropriate for women from BME communities. |                                                                                                                                                   |
| Prevention of violence and abuse                       | Routine exploration of violence and abuse in assessments                       | • Tackling health and mental health effects of domestic and sexual violence and abuse –Department of Health, Home Office, CSIP |
|                                                      | Increased access to and provision of therapeutic support                       |                                                                                                                                                   |
| Women in the Criminal Justice System                   | Improving access to mental health care for women who offend.                   | • Corston report of review of the mental health needs of women in the criminal justice system                                                  |
|                                                      | Development of community alternatives to prison for women.                     |                                                                                                                                                   |
Practical Solution 1: Service standards for women, Devon Partnership Trust

Devon Partnership Trust initiated a women’s mental health steering group that supports the implementation of Into the Mainstream. The group involves women who receive services, their advocates, representatives from the Primary Care Trust, clinicians from Devon Partnership Trust and voluntary sector organisations. The group developed a Women’s Mental Health and Well-being strategy for 2007-10 based around seven service standards for women-friendly services:

**Standard 1:** Resourcing women in the community and the development of women-friendly community hubs.

**Standard 2:** Women-centred psychological therapies to address specific issues and the hidden cause of women’s distress.

**Standard 3:** Safe accommodation for women – access to safe and supported housing options.

**Standard 4:** Crisis services for women – women-only provision at points of crisis.

**Standard 5:** Inpatient services for women – women-only inpatient provision.

**Standard 6:** Diversity in women’s mental health care – steps to ensure equal access to mental health care based on an understanding of the specific and diverse needs of women.

**Standard 7:** Cultural change – steps to mainstream gender and mental health care for women, focusing on the importance of leadership and mentoring across the Trust, with training for staff at all levels.

The Trust has also identified 10 High Impact Changes for Women, Gender Equality goals and an action plan to improve services for women.

For further information, contact: Terri.Warr@devonpartnership.nhs.uk

A number of Trusts have developed women’s mental health strategies in response to Into the Mainstream and are now reviewing their strategies in light of the Public Sector Gender Duty. Women’s mental health strategies have also been reviewed where organisational change is occurring – where, for example, Foundation Trusts are being introduced.

There is evidence that gender-specific roles have been identified by a significant percentage of mental health NHS Trusts (see Table 4 below). Responses from Trusts to the 2006 survey indicated that leadership and responsibility need to operate at different levels and across all services.

Table 4: Overview of leadership and strategy development in relation to women’s mental health

<table>
<thead>
<tr>
<th>Date</th>
<th>Source</th>
<th>Response rate</th>
<th>Leadership</th>
<th>Strategy development</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Source</td>
<td></td>
<td>Managerial</td>
<td>Clinical</td>
</tr>
<tr>
<td></td>
<td>Trust survey 2006</td>
<td>41% of NHS Trust members of the NHS Confederation Mental Health Network</td>
<td>96%</td>
<td>58%</td>
</tr>
<tr>
<td></td>
<td>National benchmarking exercise 2007</td>
<td>65% of all NHS Mental Health Trusts in England</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Working towards Women’s Well-being: Unfinished business
However, the 2006 survey indicated considerable variation between Trusts: management leads range from executive director to clinician or practitioner level (for example, a nurse consultant with a special interest in women’s mental health). A small number of Trusts have identified leads with responsibility for the development of gender-specific and gender-sensitive provision across the range of services. The picture in terms of clinical leadership is less robust, with fewer Trusts appointing an identified clinical lead. Where this role exists, the individual holding it is likely also to be the managerial lead.

There is evidence of significant activity in strategy development and/or action planning (see Table 4). Increasingly these strategies and plans form part of a broader Trust strategy, particularly in relation to equality and diversity, reflecting the introduction of the Public Sector Gender Duty in 2007 (see Practical Solution 2).

### Practical Solution 2: Gender equality scheme, Central and North West London Mental Health NHS Trust

Central and North West London Mental Health NHS Trust’s (CNWL) Gender Equality Scheme sets out how the Trust will promote equality of opportunity between women and men, both as an employer and as a service provider. It follows the same structure as the Trust’s Disability Equality Scheme for consistency and in preparation for moving towards adopting a Single Equality Scheme approach in the future. The action points identified for the CNWL 2007-10 Gender Equality Scheme include:

- systems and policies are in place to monitor incidents of gender-related bullying or harassment and violence
- the profile of the workforce is analysed annually by gender
- a corporate (Trust-wide) programme of gender awareness/gender equality training is commissioned
- a Women in Management programme enables female staff to shadow senior staff to encourage their professional development
- the Trust produces, publicises and implements a domestic violence/abuse policy
- local PALS link-workers have the relevant local information on gender-sensitive advocacy and support services to pass onto clients
- patients’ gender needs are recorded in patients’ notes
- procurement contracts with other bodies include a specific mention of the need to comply with the Gender Duty within the Equality Act 2006
- the Trust develops actions to improve PPI and sets objectives and actions to widen participation of all gender groups
- communities and other local populations (not just formal user groups) representing gender-specific issues are involved in service design and development and policy development
- centrally led service user satisfaction surveys are analysed by gender
- all operational directorates have local equality action plans which make reference to specific gender-related actions
- all assessment paperwork and pro formas include prompts for the collection of information on the Service Users’ gender and gender needs
- gender Equality Impact Assessments (embedded within the Trust’s generic approach to Equality Impact Assessment) are carried out on all new and proposed policies and services to determine the risk of adverse impacts on specific genders
- locally led service user satisfaction surveys are analysed by gender
- Trust-wide guidelines are developed as to how to handle patients’ requests for same-gender clinical staff
- a Trust-wide forum on men’s health is being developed.

For further information, contact Richard Bryant Jefferies: richard.bryant-jefferies@nhs.net
The value of local leadership at a senior level, with clear responsibility for strategy development in partnership with other organisations, cannot be overstated. This is a recurrent theme from the surveys and the case study examples. It is also well documented in feedback from organisations.

Such roles are not necessarily easy to undertake. They require organisational support and a solution-focused attitude to moving this agenda forward with clinicians and practitioners.

Strategy development needs to be part of a Trust-wide approach that recognises the difference between the service development agenda for women’s mental health and the human resource agenda that requires Trusts to address gender inequalities in their employment practices.

In general, the activities that supported strategy development included:

- developing and investing in a strategy group or forum
- involving women service users
- mapping, evaluating or benchmarking current activity
- consulting on proposals for service developments.

The main barriers to progress, identified in both the 2006 survey and 2007 benchmarking study, were competing priorities and lack of resources. Often these were mentioned together, particularly in areas with no strategy in place or where the strategy was still under development.

Another barrier was lack of resources earmarked specifically for the purpose. The lack of action to introduce gender-specific inpatient care was frequently cited as a casualty of this.

Other barriers included lack of a leader or champion and organisational reconfiguration.

**Workforce Development**

Training staff and managers in gender and women’s mental health issues should be integral to implementing and sustaining service development. The 2006 survey and 2007 benchmarking study found that some learning and development initiatives have been developed. These include:

- e-alerts to relevant courses
- the employment of a specific project worker to run regular courses
- mandatory training for all staff on sexual abuse, vulnerable adults and child protection.

**The most common learning topics are:**

- the prevention of violence and abuse
- perinatal mental health
- self-harm.

There are examples of training being targeted at staff in forensic and/or acute care settings, reflecting some development of gender-specific provision. A small number of Trusts also mentioned awareness training in relation to sexual orientation.

The infrequent mention of the involvement in training initiatives of women with experience of mental health issues suggests that this is an area for development.

The introduction of the Public Sector Gender Duty has stimulated training in relation to the broader equalities agenda. However, such initiatives need to go beyond simply providing information about the legislative framework and its implications. It is also important to build knowledge and skills in key areas so that the delivery of gender-specific and gender-sensitive services for women, men and transgendered people can be improved.

The provision of training in gender equality appears to be at the discretion of local Trusts. Indeed, 50 per cent of respondents to the 2006 survey had no specific plans for equalities learning and development activities and only a minority of those that had provided training reported undertaking a training needs assessment.

To support wider and deeper dissemination of training on this subject, the Gender Equality Programme commissioned an advanced module on gender equality. The module is underpinned...
by the 10 Essential Shared Capabilities (ESCs). These are a framework of core capabilities that have been developed to inform the pre- and post-registration education and training of all mental health professionals.

The advanced module also builds on and updates an earlier Department of Health Gender Training Initiative, which focused primarily on women’s mental health. The advanced module extends this to cover issues relating to men and transgendered people (see Practical Solution 3). The learning materials reflect service, legislative and policy developments in addressing gender-based inequalities.

The module is available on the NMHDU Equalities in Mental Health website at www.mentalhealthequalities.org.uk. The intention is to roll out the module across the regions but this is dependent on Strategic Health Authority commitment to contribute to its funding in their region.

Initiatives have also been undertaken by professional bodies, including the Royal College of Nursing (RCN), which has developed principles to guide gender-sensitive practice for women. The Royal College of Psychiatrists (RCPsych) has also developed a range of guidance to support improvements in the quality of mental health practice and provision for women. The RCPsych has also developed quality networks in, for example, perinatal mental health, that provide a mechanism not only for reviewing and identifying developments in service provision but also for supporting staff development.

Practical Solution 3: Advanced module on gender equality

Aims and objectives

The module supports the implementation of gender equality in mental health services by building staff confidence and competence in working from a gender informed perspective with men, women and transgendered individuals who have mental health needs. It aims to increase participants’:

- understanding of the ways gender and other inequalities can impact on mental health
- sensitivity to the ways mental health services can add to this harm
- knowledge about gender informed practice

by providing participants with:

- carefully structured opportunities to build on their existing knowledge
- opportunities to reflect on their own thinking, practice, and place of work
- time to think through the possibilities for change.

Who is it for?

The course has been designed to meet the needs of:

- staff working throughout mental health services, including managers and decision makers as well as those directly involved in providing care
- others working to improve mental health services, including advocates and user activists.

Outline

The four-day training module:

- has places for up to 16 participants
- can be provided at a venue of choice
- has two main components:
  - part one (sessions 1-4): Thinking about Gender
  - part two (sessions 5-8): Gender Informed Practice

For further information contact Sue Waterhouse: sue.waterhouse@nmhdu.org.uk or visit www.mentalhealthequalities.org.uk

Leadership development in relation to equalities is also lagging behind. There is a strong case for leadership development to be equally weighted with training and development. Leadership development courses should include training, coaching and mentoring and be available to all across the spectrum of mental health services.
Practical Solution 4 provides an example of one approach to developing the leadership capacity of women from BME community organisations.

Practical Solution 4: Developing leadership capacity in Dorset

Dorset Healthcare NHS Foundation Trust is taking forward the Delivering Race Equality agenda through partnerships with Focused Implementation Sites.

The Trust has links with women and women’s groups from Iran, Bangladesh, Thailand, China, Syria, Iraq, Africa, Korea, Brazil, the Caribbean and India. These groups inform the Trust’s service developments.

In 2008 the Trust’s Black and minority ethnic community development workers (CDWs) supported their local branch of Rethink in providing training for BME people to become mental health champions for their communities. These champions continue to be supported by the community development workers and to influence the service development of the Trust.

For further information contact Damaris Mwangi Damaris.Mwangi@dhft.nhs.uk; Ebi Sosseh Ebi.sosseh@dhft.nhs.uk or Julia Reid Julia.reid@dhft.nhs.uk

Governance

‘Clinical governance arrangements should formally include gender and other dimensions of inequality. For example, developing quality and monitoring standards that take account of gender.’

Into the Mainstream

Robust systems of governance need to be in place across the mental health service landscape.

- Mechanisms should be in place for reviewing and reporting back on needs and the extent to which services are meeting these needs.
- Gender impact assessments should be conducted as part of equality impact assessments on policies and service developments.
- Governance structures should be in place that state who has responsibility for addressing the issues identified. Mechanisms should also be in place for involving women from diverse communities who have experience of mental health services.

The 2006 survey indicated that some Trusts had developed governance arrangements for implementing the recommendation on clinical governance from Into the Mainstream. These arrangements have been strengthened further by the corporate focus on equalities, as a consequence of equalities legislation. Practical Solution 5 offers an example of positive governance arrangements.

Practical Solution 5: A corporate approach to implementing the women’s mental health strategy, Lincolnshire Partnership Trust

- The Women’s Mental Health Strategy is incorporated into the Trust’s five year strategy and annual business planning cycle. Plans have been approved to develop women-only rehab facilities. In adult mental health inpatient facilities, the use of swipe care technology is being implemented to zone female-only areas.
- The Trust is signed up to the county-wide adult protection policy, which covers all areas of risk to vulnerable adults. Where a woman is identified as vulnerable under the policy (this will include people with mental ill health), the adult protection policy will be implemented. LPT are working closely with Lincolnshire County Council’s adult protection co-ordinator and in partnership with Lincolnshire Police to ensure that the needs of vulnerable women are addressed. Training is being provided to ensure that the community knows who to contact if they are concerned about domestic violence.
There is also a rolling programme of training for LPT staff in identifying, investigating and co-ordinating responses to adult abuse and domestic violence and the issue is also covered in induction sessions for all staff.

- The Trust has developed a plan to strengthen perinatal mental health specialist provision and are discussing funding with commissioners.
- As part of the Race and Disability Equality Duty, all operational policies have been assessed for impact on race, gender, culture, sexual orientation and disability. Impact assessment will be part of the development of any new policies.
- The Trust has led a county-wide women’s mental health group to inform practice and commissioning of services in this area. As a result the Trust has approved a gender-sensitive practice policy and is undertaking a small scale study into patient’s perceptions of privacy and dignity and sexual safety.
- The Trust is a key partner in the development of a sexual assault referral centre.
- The Trust was a second wave pilot site for the mental health collaborative on acute care and has prioritised funding to roll this out across the Trust.
- The Patient and Public Involvement Forum is particularly interested in the issues pertaining to women and gender-sensitive services and the Health Overview and Scrutiny Committee is undertaking a themed review of mental health, which includes this issue.

For further information contact:

kay.darby@LPT.nhs.uk

Effective governance still has a long way to go. Only 50 per cent of Trusts in the 2006 survey reported that their Care Programme Approach (CPA) data/information were disaggregated by gender. Patient care statistics were disaggregated by gender in fewer than half the mental health Trusts, and serious untoward incidents by just over a third. These need to be a priority for the next phase of development and will be greatly helped by the equalities legislation and adoption of gender categories by the regulatory bodies.

Since Into the Mainstream was published, a number of tools have been developed at both national and local level to support governance. These include standards and good practice checklists. Aspects of governance have also been included in the annual autumn assessments completed by NSF Local Implementation Teams (LITs) (see appendix 2 for a good practice checklist developed with mental health Trusts).

Service Evaluation and Monitoring

‘All service monitoring and evaluation processes should include consideration of gender and ethnicity.’

Into the Mainstream

The 2006 survey found that a limited number of Trusts had set up service evaluation and monitoring processes. However, the subsequent introduction of the Public Sector Gender Duty in 2007 and associated equalities legislation have stimulated more Trusts to undertake this activity. There are good practice examples of evaluation initiatives led by women with experience of mental health issues (see Practical Solution 6).

Practical Solution 6: Evaluating Local Services, Brent User Group

Brent User Group (BUG) and the Women’s Service Development Group of Brent’s Mental Health Local Implementation Team undertook a questionnaire survey of the views of women using services with the aim of working towards ensuring that services meet women’s needs and provide what they want in the future. The key issues and action points to emerge from the survey included:

- the need to put the strategy into practice and improve existing practice through incorporating action into existing commissioning, delivery planning and provision
the need to link into work being carried out by the LIT, particularly in relation to improving choice, race equality, provision of psychological therapies, creating a suicide prevention strategy, reviewing different levels of secure provision, developing information about available resources and how to get access, redesigning mental health day services, addressing social exclusion, meeting the needs of people who use services to deal with mental health issues and also use drugs and alcohol, meeting the needs of people with learning disabilities, creating a mental health and housing strategy for Brent and the development of the new National Service Framework teams.

• using the recovery approach and having hope for the future in relation to the mental health needs of women. This will need to include training for women using services and staff to develop the use of wellness recovery action plans (WRAPs), and the adoption of these action plans across services.

• recognising women’s life experience is contributing to their distress and use of services and working with women’s own beliefs about their distress. For example, training to enable staff to work confidently with women who have had experience of abuse and understanding and responding appropriately to different coping strategies, including self-harm.

• incorporating research reports by service users and community groups into action to improve practice.

• providing a range of women-only options, supported by appropriate staff training.

• women staff were perceived as more likely to be kind, gentle, helpful and understanding, and therefore the option of working with women staff should be offered routinely.

• in relation to acute care, the need for action to ensure that women feel safe in hospital; the provision of women-only space and activities and space for children to visit; the use of advance decisions, so women can state their needs related to using services, and training of staff to ensure good practice.

A conference was held in March 2006 to build on the survey and enable women from different communities to identify additional ways of developing practice that is culturally appropriate and meets their needs.

For further information contact: Fiona Hill
director@brentusergroup.com

In addition a number of community engagement projects within the Department of Health Delivering Race Equality programme11 have focused specifically on the needs of women from BME communities (see Section 3.5.1 below).

A robust service evaluation and monitoring regime is vital to ensure that gender-specific and gender-sensitive services are sustainable and continue to meet the needs of service users. To be truly effective, service evaluation and monitoring need to involve, and be influenced by, service users.

Involving Women with Experience of Mental Health Services

‘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.’

The Service User Reference Group within the NMHDU Gender Equality Programme ensures that the views and expertise of women who have experience of using services are fed into its priorities and products and that future Gender Equality Programme activities truly lend themselves to gender-specific and gender-sensitive services. The group includes representatives who use mental health services from all over England. It has been particularly helpful in shaping programme publications such as Informed Gender Practice.12

Into the Mainstream
group has shared and developed strategies to improve service user participation at local level.

At regional level, the various CSIP/NIMHE regional development centres had appointed gender and women’s mental health leads (see Practical Solution 7). However, the national organisational changes that took effect in April 2009 and included the transfer of the remit of the regional development centres to the Strategic Health Authorities, have led to wide variation in how the regions are delivering regional gender equality programmes. Regional leads are the responsibility of the individual Strategic Health Authorities, and in many cases gender equality has been incorporated into the wider equality agenda.

Practical Solution 7: Involving women services users in Dudley

In Dudley the organisational Women’s Lead and the Women’s Service User Lead Representative work in partnership, taking forward at local level the regional agenda on gender and women’s equality issues. The head of mental health nursing (women’s lead is part of her portfolio) and local women’s service user lead have forged an excellent working partnership, which is reflected in the establishment of Dudley Women’s Mental Health Forum. This provides a forum for professionals and service user representatives to work together to make a difference at local level.

For further information contact: AlisonGeeson@dudley.nhs.uk

Involvement not only encompasses co-production but also service user-led initiatives developed by women from their lived experience of mental health issues. These innovations have much to offer statutory services and provide a mechanism for improving women’s access to appropriate support and care. They require investment and support; they also need to be considered in the context of the development of women-only day services. An example of such an innovation is provided in Practical Solution 8.

Advocacy

Advocacy is a key mechanism for ensuring that women’s voices are heard, and particularly the voices of women who are most vulnerable to being marginalised. The introduction of a statutory duty to provide advocacy for all those subject to the Mental Capacity Act 200513 and the Mental Health Act 200714 creates an opportunity to strengthen its provision. It is important that these developments are guided by an understanding of gender and are sensitive to the issues that women experiencing mental health problems may be facing.

Practical Solution 8: Women’s Recovery Group, Loughborough

Service users and health care professionals in the Charnwood area identified a need for women-only services. Discussions took place between service users, providers, the voluntary sector and CSIP. This led to three service users attending a recovery conference, a two-day Recovery and WRAP training course, and five days training as Recovery and WRAP educators. This led to the setting up of a Women’s Recovery Group in November 2006.

Recovery

We are specifically a Recovery group. This means that we focus on wellness and well-being, and on people’s strengths and dignity. We use the Wellness Recovery Action Plan (WRAP) as our Recovery model. It is a fluid, dynamic, simple and flexible programme that aids daily living and life mapping. It is very easily included in CPA care plans.

Current position

Roach Care, a private charity, hosts the Women’s Recovery Group. We meet twice a month, from 10am to 2pm. We currently have 34 members and interest in the group is constantly growing. We have a committee mainly comprising service users, and we encourage all our members to give feedback and direction on the service they receive. We encourage active participation in open discussion with visiting speakers, and in the
formal WRAP and Recovery programme. Members gain support, guidance, encouragement and companionship from each other, enhancing the way they view themselves and the way they manage their lives.

Some women have undertaken voluntary work within mainstream services and others have joined the gym or begun regular exercise. Many are recovering strengths and skills, and developing their personal value and social roles. Our members have expressed a wish to address the prejudice and stigma they experience from the general public and even from GPs and the Walk-in Centre. It is also clear that some members have changed their self-harming behaviour and are making significant other gains in their mental health.

**Future plans**

The group wishes to provide a full time women-only day service and eventually a crisis house and would also like to develop services to meet the needs of women with mild depression/anxiety and more acute long-term mental health issues.

For further information contact:
Rachael.Eldessouky@leicspart.nhs.uk or Della.Hopkins@leicspart.nhs.uk

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**Gender-Specific Provision**

**Women-only 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.’*

*Into the Mainstream/Mainstreaming Gender and Women’s Mental Health*

(*Practical Solution 9* provided a service specification for women-only community day services. This recognised and built on the contribution of the third sector to the provision of responsive, accessible and valued support for women with a range of issues, including mental health problems.*

*The Implementation Guidance* recommended that Primary Care Trusts should put in place specific measures to demonstrate that they had met the NHS Plan commitment to provide:

- services and support by women staff in women-only settings
- sustainable core funding and minimum standards for training, supervision and support for staff and volunteers providing these services.

Findings from the 2007 benchmarking exercise indicate that the third sector remains the main provider of women-only day services. In 2005 there were over 100 voluntary sector local women’s centres providing a range of support, including mental health support. There must be concerns about the sustainability of relying on the financially vulnerable third sector for this provision.

On the positive side, there are reports from some areas that the restructuring of mental health day service provision has included consideration of appropriate gender-specific services, as illustrated in Practical Solution 9. However, there is no clear evidence that this has occurred routinely.

*Practical Solution 9: Women-only day support in Essex*

There are two subgroups of the mental health Local Implementation Team in Essex. These focus on women’s mental health. Following publication of the Implementation Guidance, each of these groups developed an action plan. This has included the development of women-only day support. Self-help and peer groups within day services have been actively encouraged. The network of support includes a mother and child group, a group for survivors of sexual abuse, a women’s mental health forum and groups for women with eating disorders. Service user involvement has been tendered and this includes a focus on the encouragement of self-help and peer support, including women-only groups.*
Making Progress

Most developments reported in the 2005 LIT autumn assessment and the 2007 benchmarking study related to the introduction of women-only groups. Groups for women with specific needs relating to ethnicity, age, history of sexual abuse or perinatal issues were the most commonly mentioned.

It is possible that the contribution of local voluntary sector women’s centres and the ways in which they work are not well understood by commissioners, or they may be perceived as not targeting women with serious mental illness. However, a recent evaluation of the Calderdale Women’s Centre provides an example of the complexities and challenges encountered by these centres, and their unique capacity to combine informal accessibility with a highly professional approach to meet the range of emotional, legal, social, practical, immediate and long-term needs of the women who walk through the door.

The potential of this woman-centred approach to helping vulnerable women in contact with the Criminal Justice System (CJS) is also recognised in the 2007 Corston review of service provision for these women. These centres have a clear and important role in engaging women and fostering well-being, particularly women who are marginalised. Their women-focused ways of working aim to build confidence and empower women to develop their own solutions to their difficulties.

Crisis Services

‘Addressing accommodation needs is a key part of assessment and care planning . . . Local strategic planning should address the need for women-only safe, supported housing for women, both as an alternative to acute in-patient admission, as respite to avoid mental health deterioration, and for those women and their children who are victims of violence and abuse.’

Into the Mainstream

The National Service Framework for mental health stated as one of its seven standards that service users should be able to access services 24-hours a day, 365 days a year (standard four). The NHS Plan set a national target for 335 crisis resolution teams serving 100,000 users to be in place by December 2004. The Mental Health Policy Implementation Guidance outlined the requirements for crisis resolution teams, (CRTs) and described a key component of the service as sensitivity to age, culture, disability and gender. A key element of this was access to single sex accommodation and gender-sensitive services, as needed.

Making Progress

The 2006 national survey of crisis resolution teams in England provided an overview of their implementation and the extent to which national targets were being met. However, this study did not disaggregate data on the basis of gender. Nor did it comment on the extent to which teams were delivering services that were sensitive to age, culture, disability and gender.

There are examples of crisis houses for women: most notably Drayton Park in Islington, north London, as described in Into the Mainstream. There has not been widespread development of crisis houses and it seems likely that commissioners and providers have been focusing on the development of Crisis Resolution Home Treatment (CRHT) services to meet the requirements of the NHS Plan. CRHT is intended to meet the needs of service users presenting in a crisis and it is likely that women will have benefited from the introduction of these services.

However, the question remains about the extent to which considerations of gender have been incorporated into the development of the new community mental health teams and whether they are applying gendered understandings of crisis to their work.
Acute Inpatient Services

‘Given what is known about acute in-patient care in meeting the needs of women patients in particular, acute services should provide a self-contained women-only in-patient unit… In secure settings single-sex units should be the norm.’

Into the Mainstream

*Into the Mainstream* reported serious criticisms from service users about women’s safety in mixed sex environments. Research has found that over 50 per cent of women in specialist mental health services have experienced violence and abuse. *Into the Mainstream* built on earlier guidance on single-sex inpatient accommodation from 1999, noting that a choice between mixed and single sex accommodation is important to women and recommending that all mental health services should provide a self-contained, women-only inpatient unit. The importance of the gender mix of staff and the provision of designated family visiting facilities are also minimum requirements for women in acute care settings.

In response to the 2006 National Patient Safety Agency report highlighting concerns about safety, several guidance documents have been issued that address staff skills and attitudes and offer practical suggestions on how to adapt the physical environment of older buildings.

The 2006 survey and 2007 benchmarking study indicated that this remained a focus for service development, but progress appears to have been slow. Data collected for the Count Me In census of mental health inpatient units in 2006 found that, overall, 58 per cent of women inpatients were not considered to be in single-sex accommodation by the staff completing the returns, and among this cohort will be women from Black and minority ethnic communities for whom mixed sex accommodation may be culturally inappropriate.

The issue of women’s safety in acute care has been picked up recently by the Mental Health Act Commission in its 12th Biennial Report, and by the Healthcare Commission in its review of acute inpatient mental health services. It is evident that a number of issues have affected implementation of single sex accommodation. Where new build facilities exist, gender-specific provision is being incorporated into the design, and staff are being trained in gender-sensitive ways of working. Improvements to the physical environment of older buildings have been supported by £30 million in capital funds for 2007/08 from Department of Health. The evaluation of the bids for these funds demonstrated that some Trusts had not grasped the clinical considerations and had a rather mechanical, bricks-and-mortar approach to creating a women-only space.

There are some excellent examples of good practice where a whole-system approach has been adopted to create a therapeutic environment that is physically and emotionally safe and where healing from mental trauma and distress can take place. In many cases these Trusts started in 2002 from a very low base, with limited women-only provision and senior management leadership for women’s mental health.

An example of the progress that can be made is illustrated by the achievements in Mersey Care NHS Trust in Liverpool (see Practical Solution 10).

**Practical Solution 10: Development of gender specific provision in acute inpatient care in Liverpool, Merseycare NHS Trust**

In 2002, there was no senior leadership in relation to women and minimum standards regarding separate sleeping and bathing on inpatient units. By 2007 there was leadership at a senior level, women’s issues were firmly on the Trust agenda with a Project Group established and an action plan in place to implement Gender Mainstreaming. The following action had been taken:

- introduction of choice of single sex or mixed ward for service users as a result of feasibility study on gender specific inpatient areas for working age adults. Gender remodelling work and refurbishment on inpatient units completed in 2008, supported by successful bid to Department of Health to fund gender
separation within acute inpatient care. Evaluation of gender specific inpatient care now in progress.

- gender feasibility study on older people’s services under way
- training on women’s mental health commissioned, delivered to senior managers and now being rolled out to staff groups
- self-harm training and guidelines developed and delivered
- increase in women-only activities and improvements in gender-specific information
- gender-specific reported adverse incidents reviewed and monitored
- plans to improve knowledge and access to family planning and sexual health education
- introduction of Domestic Abuse Policy
- training on domestic abuse being developed.

Four key factors were identified that facilitated progress:

- commitment from Trust Board and senior personnel
- support of CSIP Women’s Leads group
- commitment from partner agencies
- input of service user.

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Key elements for successful change can be drawn from the examples submitted to the 2006 survey. These are:

- review of existing estate and implementation of action plan to achieve gender separation through reconfiguration and/or new build
- nominated women’s lead at ward and senior/director level
- policy and guidelines available to ward staff, with active encouragement to implement them
- bids made for additional resources, for example, Department of Health £30 million capital grant

- training for all staff in women’s mental health issues
- women-only health promotion/access to physical health advice.

Trusts working in these ways noted improvements in patient safety and satisfaction and in staff morale. Some Trusts were undertaking before and after evaluations of the outcomes from creating single gender units.

Making Progress

Concerns have continued to be raised about the safety of women in acute inpatient settings, the difficulties in reporting sexual abuse incidents, and the slow progress in implementing this aspect of Into the Mainstream.

To ensure universal application of evidence-based best practice for working with women, the roll out of the advanced gender module is required, in close collaboration with NMHDU colleagues in inpatient care.

The findings of the Healthcare Commission’s inpatient services review provide leverage and a golden opportunity to improve inpatient care for women, working with those Trusts that performed poorly on the gender questions.

Joint work to combine improvements to acute care with a gender equality perspective, using a portfolio of resources, including gender-specific material, will provide the most effective way to achieve high quality, appropriate services.

A useful resource, Informed Gender Practice, commissioned by the Gender Equality Programme, will help inpatient acute care teams progress or initiate improvements in gender-sensitive care.

Secure 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.’
‘An approach to the development of services to more appropriately meet the needs of women requires the provision of high quality, comprehensive care, [which] is much about the processes of care as it is about the setting.’

Into the Mainstream

Into the Mainstream⁴ called for a national reprovision of secure services, including a dedicated network of secure provision for women. This recommendation was welcomed by all involved, as the difficulties facing women in secure services were all too evident. Common problems identified in the report included:

• gender differences in expression and experience of mental distress and in social and offending profiles
• women in a minority in secure services, placing them at risk in mixed sex settings
• women inappropriately placed in high levels of security for less serious problems than men
• regimes of care inconsistent with social values regarding equality
• high levels of histories of abuse among women in secure units.

The aim of the reprovision was to develop:

• secure services for women with learning and associated disabilities/low secure services for all women
• high support community residential settings for women with complex needs
• integrated secure services for women.

Into the Mainstream⁴ and the Implementation Guidance⁶ both recommended processes and provided service specifications to implement these new services.

The development of dedicated secure services for women was helped by the Tilt Review,³⁶ which reviewed security in the three high secure hospitals in England. The review found that some women were inappropriately placed in these hospitals, and recommended a reduction in the numbers of women in the high security service. An accelerated discharge plan saw the movement of women out of high secure to local medium secure services, providing a driver to develop alternative provision.

Informed by the Implementation Guidance,⁶ high secure services for women were rationalised, including closure of beds for women at Ashworth in 2003 and at Broadmoor in 2007, and the concentration of women’s high secure services at Rampton.

Practical Solution 11: Introducing therapeutically enhanced medium secure care for women, Greater Manchester West NHS Mental Health Foundation Trust

In 2002, the provision for women at the Edenfield Centre, a medium secure mental health unit in Prestwich, comprised five beds that used a continuing care type model. The service, at that time part of Bolton, Salford and Trafford Mental Health NHS Trust, was developed in 2003 following the closure of the women’s service at Ashworth when an additional seven beds on a second ward were opened, thus extending the clinical pathway for women.

In 2004 it was agreed that the centre would be one of three national pilot sites for therapeutically enhanced medium secure beds for women (TEMSS). Included in this development was the re-provision of its existing beds in a dedicated women’s service. The new women’s build opened in summer 2007.

It provides accommodation over three wards, has dedicated resources for women within the new build, including access to a women-only recreation area and an internal courtyard, a specific room for new admissions, increased numbers of women-only groups and activities and events, and the ongoing involvement of WISH, the national user group for women in secure hospitals.

Prior to the opening of TEMMS a comprehensive staff training programme was implemented, based on the Gender Training Initiative and including training on therapeutic relationships and self injury.
The development has been helped by significant support and investment of resources at both a clinical and operational level and the commitment of the Trust to improving services for women.

In addition, flexibility in the planning and design of the new build alongside the support and direction of the secure commissioning team proved helpful. The commitment of the staff involved regular communication with other agencies and organisations involved and consultation with female patients. The TEMSS is fully occupied and participating in data collection at a national level and in local service evaluations aimed at capturing the women's experiences of the new service.

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Three Women’s Enhanced Medium Secure Services (WEMSS) were established in London, Leicestershire and Salford (see Practical Solution 11). Gender-specific secure services were also developed across medium and low secure provision. Significant developments have also taken place within the independent sector to meet shortfalls in NHS services provision. The independent sector provides an estimated third of the total secure care placements.

The emerging findings from a national evaluation of dedicated women’s secure services are reported in Practical Solution 12.

Practical Solution 12: Emerging findings from the evaluation of established, new and emerging dedicated women’s medium secure services in England

The aim of this study was to evaluate women’s medium secure mental health services that cater for women with complex needs and, in particular, the service specification for women’s secure services in the Mainstreaming Gender and Women’s Mental Health: Implementation Guide. The evaluation also set out to measure the extent to which these new services were:

- delivering differentiated care to meet the specific needs of women
- maintaining women’s psychological and physical safety
- facilitating the recovery process for women patients, including their rehabilitation and resettlement.

Participating services included NHS self-contained women-only secure units and independent sector services. The evaluation included a survey of all women’s medium secure services, a follow-up telephone survey and six case studies, which included capturing the perceptions and views of 50 women and interviews with more than 60 staff and other professionals.

Key findings

- There was considerable variation across women’s medium secure services in terms of the range and type of provision. Independent sector services tended to provide a higher number of beds for women, having more than the recommended number of 12 women per ward/unit.
- The case study services, selected on the basis of organisational structure and location, illustrate the range of ways in which the women’s mental health policy agenda has been implemented.
- Women and the professionals involved in their care were clear, regardless of terminology, about the key factors (in particular, relational security), that underpinned what services should work towards. However, the survey showed that policies about relational security were only in place in half of services.
- Essential to service provision was the development of a coherent and thought-through model or philosophy of care.
- The case study services demonstrated the difficulty at times of turning philosophy and policy into everyday practice. Core to this process was an understanding of the importance of reflective practice. Some women’s services were constrained by...
their location as a relatively small part of mixed provision.

• At times and in some areas, policy implementation was hindered by lack of staff, time, awareness and, in larger mixed medium secure services, understanding.

• The concept and practice of relational security were not universal. In some cases, services had adopted the philosophy but not the terminology. In others, a policy was in place but some staff was unclear about what it meant in practice.

• Some professionals and women were frustrated by the level of physical security and, in particular, inconsistency of security policy implementation. The physical environment was important and, while new buildings could be off-putting initially, most women appreciated efforts taken to make the unit look and feel homely. Some wanted more say in design and décor.

• Most services wanted to ensure women had opportunities to talk about their traumatic experiences, despite contradictory views about the type of psychological therapy to provide. Women and staff also recognized the value of ‘informal’ activities. Women wanted to do what was ‘ordinary’. Some professionals saw this as equally therapeutic to more formal interventions.

• Professionals valued multi-disciplinary and multi-agency structures, even though this was hard to achieve.

• Services wanted to work with dedicated, stable staff teams, with an appropriate gender mix. Difficulties of recruitment and retention meant this was rarely achieved.

• There were considerable gaps between training and supervision policies and what happened in practice, resulting in many staff receiving no gender awareness training. Supervision frequently took second place among a range of competing demands on senior staff.

Importantly, factors including the following appeared to provide the keys to successful implementation of the specification:

• A strong, transparent and embedded framework for staff and women service users underpinned by the concept of relational security and a clear understanding of the importance of boundaries

• An effective multi-disciplinary team that communicates across all staff groups and with women service users

• Gender-focused training and supervision for the entire staff group, including ancillary workers

• Gender-focused care pathways that enable women to move through and out of medium secure services

• Planned programmes of activities, including some fun.

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A major gap was high support community residential services for women, to facilitate the accelerated discharge programme. To fill this gap, four pilots were developed for women with multiple and complex needs, including borderline personality disorder, recovering from severe trauma with attendant risk, and/or offending behaviours.

The pilots are in Eastbourne, Sussex; Salford, Greater Manchester; Crosby, Liverpool; and York, and became fully operational in February 2009. Each has been designed to provide a pathway into community care, with a longer term aim of independent living and sustained recovery.

Each unit has accommodation for up to 12 women. Residents can stay for up to three years, and are offered a range of individual and group therapies. Discharge planning starts immediately on admission, through a responsive care planning process.

All of these developments are underpinned by a recognition of the specific needs of women in relation to secure care, the concept of relational security, and the development of clear care pathways.
Making Progress
Although there has been a major increase in the provision of gender-specific secure care, women remain a minority within secure services, representing just 12 per cent of the service population. Women are still more likely than men to be placed out of area, particularly as half of the beds available are in the independent sector. At least one third of secure beds for men are in NHS services.

Although the concentration of women’s secure beds at Rampton has provided the opportunity for the development of an appropriate therapeutic environment, being placed so far from home may compromise women’s ability to maintain links with family and social networks. This suggests that the provision of care is influenced by issues to do with critical mass in NHS secure services; that is, there are not enough women patients at particular stages of recovery or with similar needs to make gender-specific therapy or activity groups viable or to justify creating specialist wards. Further work is needed as a matter of urgency to move towards more personalised, tailored services for women so they can receive the care and support they need as close to home as possible.

Gender-Sensitive Provision

Mental Health Promotion
‘The way in which services are organised and delivered has a direct effect on the service user’s experience... a user-centred approach is fundamental to the work... Mental health practitioners should have positive listening skills, be non-judgemental, empathetic and respectful and understanding of the . . . complex needs of users.’

Into the Mainstream

The Implementation Guidance6 recommended that all relevant staff have training in mental health promotion in relation to the gender and ethnicity of their clients. It also recommended the inclusion of gender-sensitive and ethnically appropriate mental health promotion in service planning for the community.

Local Area Agreements (LAAs)7 provide a mechanism for local health, social care and other organisations to work with local communities to develop sustainable communities by identifying and addressing local priorities.

Overlaying this mechanism is a shift in health service commissioning (including mental health) towards prevention and promotion.

For women, this means:
- addressing violence and abuse
- developing safer communities
- improving child care and support for other caring responsibilities
- tackling mental health inequalities
- increasing choice and access to effective mental health care.

All of these will contribute to improving women’s mental health and well-being.

Making Progress
Mental health promotion is a critical area for activity if the causes of women’s distress are to be tackled and women at risk of developing mental health problems are to be identified and helped at an early stage. Although the Gender Equality Programme has not specifically focused on this area, there have been developments at local and regional levels. These initiatives either focus on women’s well-being or highlight issues where early intervention and prevention strategies are needed. Examples include a Women and Well-being event held in 2007 in the East of England, and the publication of a women’s magazine, Sanctuary, in the South East.

In terms of prevention and early intervention, Sure Start and increased attention to the importance of promoting women’s mental health for the mental health of their children have made a valuable contribution, but need to be strengthened.

The employment of community development workers within the Delivering Race Equality programme will have raised the profile of BME
women within the wider remit to explore the concerns and experiences of the BME community.

However, much more focus is required on suicide prevention among women in prison. The high suicide and self-harm rates for women in prison are a matter of urgent concern.

There are new opportunities for creating a gender-focused and gender-sensitive mental health service through new organisational models, such as the LAAs, as mentioned above. Introduced after the publication of *Into the Mainstream*, LAAs ensure a joined-up approach across the health and social care arenas. It is important that LAAs and the wider Local Strategic Partnerships (LSPs) do indeed focus on a public mental health agenda that includes appropriate provision for women.

This partnership approach to commissioning services offers opportunities for Public Health Observatories to ensure, through the collection and dissemination of relevant data, that women’s mental well-being is firmly on agenda and that there is the local capacity and commitment to address their needs.

Finally, there is a clear need to build on work to tackle violence and abuse. This work should focus on women’s mental and physical well-being and, by its very nature, would be cross-governmental and multi-agency.

**Primary Care**

‘Women’s mental health is worsening with more of them suffering depression, anxiety or suicidal thoughts . . . The proportion of women suffering a common mental disorder – typically, depression or anxiety – increased from 19.1 per cent in 1993 to 21.5 per cent (one in five of the adult female population) in 2007. The rate in men did not change significantly. The largest increase in rate of CMD between 1993 and 2007 was observed in women aged 45–64, among whom the rate rose by about a fifth.’

*Practical Solution 13: Key findings from the 2007 Adult Psychiatric Morbidity Survey* found that not only are women more likely than men to experience common mental health problems but that the rate has increased significantly for women in the past 15 years, particularly for those aged 45–64, but not for men. A substantial number of women are receiving no treatment at all for these very distressing and disabling conditions.

Women are more likely than men to seek help for mental health problems from primary care. *Into the Mainstream* recommended that primary care services needed to be responsive to the specific needs of women. It highlighted the following:

- early recognition of depression, including post-natal depression
- appropriate prescribing of medication and review of long-term use of benzodiazepines and antipsychotic and antidepressant medication
- detection and management of hidden mental health conditions such as self-harming behaviour, alcohol and substance misuse
- awareness of the high incidence of violence and abuse among women
- awareness of the increased risk of domestic violence during pregnancy and/or after child birth
- identification and support for women in their role as carers, recognising the physical and mental stresses that caring can cause
- access to information about community support services, particularly for women experiencing violence and abuse and those who self-harm.

NHS Information Centre, reporting the 2007 Adult Psychiatric Morbidity Survey

The 2007 Adult Psychiatric Morbidity Survey found that women were more likely than men to have a common mental disorder (19.7 per cent and 12.5 per cent respectively). Rates were significantly higher for women across all categories of common mental disorders (CMD), with the exception of panic disorder and obsessive compulsive disorder.
The proportion of women aged 16 to 64 suffering a CMD increased from 19.1 per cent in 1993 to 21.5 per cent (one in five of the adult female population) in 2007. The rate in men did not change significantly.

The largest increase in rate of CMD between 1993 and 2007 was observed in women aged 45-64, among whom the rate rose by about a fifth.

The proportion of women (aged 16-74) reporting suicidal thoughts increased from 4.2 per cent in 2000 to 5.5 per cent in 2007.

Rates of CMD varied by age: those aged 75 and over were the least likely to have a CMD (12.2 per cent of women; 6.3 per cent of men). In women, the rate peaked among 45–54 year olds, with a quarter (25.1 per cent) of this group meeting the criteria for at least one CMD.

Among men the rate was highest in 25–54 year olds (14.6 per cent of 25–34 year olds, 15.0 per cent of 35–44 year olds, and 14.5 per cent of 45–54 year olds).

Less than one in four (24 per cent) people with a CMD were receiving treatment, mostly in the form of medication.

The contribution of the third sector in providing women-only community support services was recognised in the Implementation Guidance, which also pointed out that sustainable investment in third sector services could not be guaranteed.

Making Progress

In theory at least, the initiatives that have been undertaken to strengthen capacity within primary care should have benefitted women. Primary care clearly has a central role to play in delivering treatment and access to a wide range of support for women who experience mental health problems.

Assessment and Care Planning

‘Local service planning should be informed by needs assessment processes that involve a range of woman – service evaluation and research should incorporate gender as a key variable in analysis and presentation.’

Into the Mainstream

The Care Programme Approach (CPA), introduced in mental health services in 1990, is the main vehicle for assessment and care planning in the specialist mental health services. The CPA provides the framework for holistic, user-centred needs assessment, with the active involvement of the woman, her family and carers and input from the multi-disciplinary team. From this assessment should arise a care plan that fully meets the health and social care needs of the individual.

In 2006, the Care Services Improvement Partnership (CSIP) and the Department of Health conducted a review of CPA policy and practice, including (for the first time) an equality impact assessment covering both race and gender. This resulted in the recommendation for a national equality and diversity strategy and implementation plan to ensure that equality issues are embedded in the CPA.

Refocusing the Care Programme Approach was published in 2008 and includes a section on...
addressing inequalities. It emphasises the need to ensure that services are alert to the potential for inequalities in outcomes from individual care assessment and planning, and the service they provide, and for services to be aware of their legal responsibilities in relation to inequalities under race, gender and disability legislation.

Making Progress

In the 2007 benchmarking study, nearly a third of Trusts reported that:

- steps were being taken to include gender issues and/or
- their assessment process was person-centred, and so by definition gender issues were being considered within the CPA (31 per cent), or
- the CPA process was being developed to include gender (11 per cent).

However, detail on the exact nature of the issues that commonly emerged and how they were addressed was often missing.

Of relevance is the finding in the 2006 survey that CPA data were not routinely disaggregated or analysed by gender. The survey report anticipated that the introduction of the Public Sector Gender Duty might change this.

A minority of Trusts in the 2007 benchmarking study said that:

- women were offered a choice of female care co-ordinator (13 per cent)
- issues regarding abuse and violence were routinely explored (13 per cent)
- women were involved in making decisions about their care (9 per cent).

A significant number reported:

- the provision of gender-sensitive services (31 per cent), including women-only groups and facilities
- the cultural appropriateness of provision (4 per cent).

It is important to note that the 2007 benchmarking study was undertaken before the publication of Refocusing the Care Programme Approach. However, these findings suggest that the inclusion of gender issues in care planning and assessment is far from routine and that more work is needed to promote understanding of what this entails among practitioners and professionals.

Care and Treatment

‘Services should provide a range of services to respond to [women's] diverse needs: social, therapeutic and creative, self-help, practical support, medication and psychological intervention… In a recent survey over 38 per cent of people who said they were recovered or were coping said that talking treatments provided by mental health services helped in their recovery.’

Improving Access to Psychological Therapies

Improving access to psychological therapies has become a central strand of mental health policy in the years since the publication of Into the Mainstream. A specific national initiative, the Improving Access to Psychological Therapies (IAPT) programme, was established in 2006 to help PCTs implement NICE guidelines for treating depression and anxiety disorders by making talking treatments more readily available in primary care.

The programme’s two national demonstration sites at Doncaster and Newham treated more than 5000 working age adults in 2006–07. Well over half achieved measurable recovery and there was a 10 per cent net increase in those who were able to continue to work without taking sick leave.

The programme has received funding totalling £173 million over three years for its national roll-out. The long term goal is that by 2011 psychological therapies will be available to everyone who needs them in primary care.

It is estimated that IAPT will enable 900,000 more people to be treated for depression and anxiety, half of whom are likely to achieve measurable recovery.
Making Progress

This is a very positive area of progress, where there has been significant policy and practice development. Previously, most counselling and talking treatments were provided in the voluntary and independent sectors; waiting lists of several months on average were common in the NHS and in the voluntary sector. The IAPT represents a major investment in increasing access to psychological therapies across all communities, from which women have benefitted.

The data from the Doncaster and Newham IAPT pilot sites showed that 60 per cent and 65 per cent of the referrals respectively were women. These referral rates are compatible with national prevalence data showing that women are more likely to have a common mental health disorder than men (12.5 per cent of men and 19.7 per cent of women).

The IAPT programme is committed to monitoring the outcomes of all patients receiving psychological therapies and, to date, has not found any significant effects of gender on patient outcomes.

The responses to the 2007 benchmarking study reflected improved access to talking treatments nationally, with 92 per cent of Trusts reporting new psychological services from which women would benefit. These included increased provision of specialist therapies, such as cognitive behavioural therapy; provision at different times of the day and in different settings, and initiatives to either review or improve the range of choices in treatments for mental health problems. Approximately half of these Trusts also reported specific initiatives for women. The most frequently mentioned were women-only groups, a choice of male or female therapist, availability of complementary therapies and joint working with other organisations with specific expertise on, for example, rape or abuse. A limited amount of staff training was mentioned, and there was some reference to the contribution of equality impact assessments in highlighting the gender issues that should be considered in service design and provision.

Responding to Self-harm

‘...mental health Trusts with primary care services, social services and accident and emergency departments [should] develop policies/protocols for the assessment and management of women who self-harm primarily as a coping mechanism or survival strategy, ensure that the views and experiences [of women who self-harm] fully inform the development of policies, staff training and support . . . [and] consider a harm minimisation approach rather than an exclusive prevention model.’

Mainstreaming Gender and Women’s Mental Health

NICE guidelines on the management of self-harm in primary and secondary care were published in 2004. The guidelines focused on the first 48 hours following a self-harm incident. These guidelines make it clear that people who have self-harmed should be treated with the same care, respect and privacy as any patient. Furthermore, healthcare professionals should take full account of the likely distress and psychosocial issues associated with self-harm.

The guidelines highlight the importance of a comprehensive assessment of needs, including a full mental health and social needs assessment. Other than for people who repeatedly self-poison, the NICE guidelines recommend a harm minimisation approach, including self-management of superficial injuries and exploration of appropriate alternative coping strategies.

Making Progress

There has been increasing attention to the management of self-harm since the publication of the Implementation Guidance. Concern has grown both within the mental health field and from women service users about the prevention model. The issue has also had a high media profile, in particular in relation to young people and women in prison.

NICE is revisiting this topic and aims to develop guidance that focuses on the longer-term management/response to individuals who self-harm, for publication in 2011.
Since the publication of the 2004 NICE guidelines, there have been a number of initiatives to promote a harm minimisation approach in relation to self-injury. Staffordshire NHS Trust is among those that have piloted a harm-minimisation approach for self-injury and have developed training to support its introduction (see Practical Solution 14). However, further work is needed to address concerns about the duty of care in relation to different types of self-harm and the harm minimisation approach.

Practical Solution 14: Piloting a harm minimisation approach to self-harm in South Staffordshire

Staff at South Staffordshire and Shropshire Healthcare NHS Foundation Trust are in the process of piloting a harm-minimisation approach. Three conferences have taken place to share and receive information about developing practice in this area. Specific care plans have been developed to facilitate safe self-injury in an inpatient setting and a self-injury practice development group has been taking the harm minimisation approach forward, including delivering and evaluating team training in acute settings. Trusts guidelines, a service user booklet and a leaflet for service users to use when presenting at A&E have been developed. The work is ongoing.

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Responding to Abuse and Violence

‘... childhood experience of sexual abuse is known to be more frequent in the histories of individuals who receive diagnoses of both mental illness and personality disorder. Research indicates that 50 per cent, or more, of women service users have been sexually victimised as children, rising to 70 per cent when adult abuse is taken into account. Mental health Trusts, in partnership with other organisations... should appoint a lead person to ensure the links between violence and abuse and women’s mental health are acknowledged and addressed in the delivery of mental health services.'

Into the Mainstream

Tackling violence and abuse has been an important focus both for health and broader government policy. It was identified as one of three priority areas by the Minister for Women.

In 2005 the Department of Health published a handbook for health professionals to improve service responses to domestic abuse. As this makes clear, there are three strands to effective strategies to tackle violence and abuse:

- prevention and early intervention
- support for victims
- protection and justice.

A national programme, the Victims of Violence and Abuse Prevention Programme (VVAPP), was launched by the Department of Health and NIMHE in March 2006. This has been superseded to an extent by the launch in 2009 of Together We Can End Violence Against Women and Girls. This cross-governmental strategy to address violence and abuse against women and girls covers:

- sexual violence and abuse
- domestic violence
- forced marriage, and crimes committed in the name of ‘honour’
- human trafficking.

The Department of Health, at the request of the Home Secretary, has set up a task force to review how the NHS identifies and should respond to violence against women and girls.

In autumn 2009 the government announced a review of the way people who have been raped are treated within the Criminal Justice System, and to make recommendations to improving the low percentage that come to trial and the even lower numbers that result in conviction.

An important and central strand of the work of the VVAPP programme is the Mental Health Trusts Collaboration Project (MHTCP) (see Practical Solution 15). This initiative is
currently being rolled out nationally to all mental health Trusts.

Finally, the introduction of the Public Sector Gender Duty will make a significant contribution to addressing this issue, as noted by the Equality and Human Rights Commission (EHRC). The Duty will require all public services to consider risks and responses to violence and abuse in the planning and provision of services.

**Making Progress**

Both the 2006 survey and 2007 benchmarking study of mental health Trusts indicated that initiatives to tackle violence and abuse were being actively developed. In 2007 these included, in order of frequency of reporting:

- multi-agency working, including working with local refuges, the voluntary sector, police and drug and alcohol teams
- service developments that take violence and abuse into account, such as the development of single sex wards, Sexual Assault and Referral Centers and women-only medium secure units
- provision of specific group and individual services and therapies, including survivors groups.

These activities were supported by a range of policies, most notably vulnerable adult procedures and staff training, supervision and support. The safety of female staff was also widely mentioned.

Just over a quarter of the Trusts were participating in the Mental Health Trust Collaboration Project (MHTCP) (Practical Solution 15). The purpose of the MHTCP was to pilot the implementation of a national policy on violence and abuse for adult mental health services. This would require mental health Trusts to:

- acknowledge and address the links between violence and abuse and mental ill health
- ensure that staff, when – and only when – trained, routinely explore experiences of violence and abuse in assessments with all service users, and work with survivors using the CPA.

**Practical Solution 15: Mental Health Trust Collaboration Project**

The focus of the project is on female and male adult survivors of child sexual abuse. Implementation includes the following ‘building blocks’ to embed violence and abuse as core business for mental health service providers:

- cascading one-day sexual abuse training to all practitioners/clinicians before they start using this model
- ‘asking the question’ in all assessments – that is, ‘Have you experienced physical, sexual or emotional abuse at any point in your life?’
- ensuring sexual safety in inpatient units and reducing incidence of retraumatisation
- establishing multi-agency forums to develop clinical practice
- providing support to staff (including staff who are also survivors)
- working in partnership with specialist services in the voluntary sector
- developing appropriate care, support and therapy for survivors.

**Year One (July 06 to June 07).** The first wave process involved eight Trusts delivering services across Devon, Plymouth, West Sussex, Camden & Islington, Warwickshire, Nottinghamshire, Brantley and Sheffield. The independent evaluation of Year One focused primarily on the efficacy of the training and the trainers’ process and subsequent cascade training to multi-disciplinary staff. The outcome was overwhelmingly positive.

**Year Two (July 07 to June 08).** The first wave continued to roll out the project on an incremental basis across each of the nine locations. The independent evaluation moved on to evaluate the link between the cascade training and ‘asking the question’, from the staff and service user/survivor perspectives. A second wave of Trusts joined the project in September 07, covering Leicestershire, Lincolnshire, Surrey, Wolverhampton, Dorset, Kent and Medway, East London and City, and Birmingham and Solihull. The evaluation framework for the second wave focused on the effectiveness of the cascade training.
National roll-out from November 2008 was informed by the learning outcomes from the MHTCP evaluation:

- roll-out of the one day sexual abuse training to all mental health provider Trusts, initially by training a two person team within each Trust (on a regional basis) to subsequently commence cascading to mental health practitioners/clinicians within each Trust
- dissemination of Department of Health practice-based guidance outlining the building blocks necessary to embed the addressing of violence and abuse in service delivery.

Ongoing support for Trusts includes:

- national and regional websites, with an interactive dimension, to provide a range of detailed supplementary information and an opportunity for Trusts to share progress/problems they are experiencing with the process
- quarterly clinical practice development forums in each region for practitioners/clinicians for shared learning, practice development and informal supervision.

For further information contact:
Liz Mayne liz.mayne@nmhdu.org.uk

The third sector and women’s centres play an important role in tackling childhood sexual abuse and domestic violence, both as service providers and in training staff working in statutory services. An example of such an initiative is provided in Practical Solution 16 below.

Practical Solution 16: Not mad or bad but traumatised

This is a DVD developed by CSIP South East Development Centre and CIS’ters, a national specialist training provider on the impact of childhood sexual abuse that also hosts services for women who were sexually abused as children.

The DVD was made possible through the Gender Equality Programme within the Mental Health Equalities strand of NMHDU, and the National Victims of Violence and Abuse Prevention Program and Serious Media Company.

In the DVD, survivors, including a male survivor, talk personally and directly about the impact of being abused as children and their personal experiences of accessing mental health services. Their stories are a powerful reminder that it is only by understanding and acknowledging the impact of the underlying trauma of childhood sexual abuse that appropriate care pathways can be identified for survivors.

Participants in the DVD have given their agreement for it to be used only by workers in statutory mental health services, either to complement training or as a stand-alone training resource on the issue of childhood sexual abuse. Copies of the DVD have been sent to every chief executive of NHS mental health services in England, and they have been asked to cascade the awareness programme within their Trust. CIS’ters, as agreed previously with CSIP and SEDC, are in the process of following up implementation and will provide summarised feedback at intervals to Strategic Health Authorities and the Department of Health.

For copies of the DVD or for more information about the DVD or the bespoke training to support the DVD, please contact:
CIS’ters, Box 119, Eastleigh, Hampshire SO50 9ZF. tel: 02380 233 8080 email: admin@cisters.wanadoo.co.uk

Perinatal Mental Health

‘All those involved in the care of women before, during and following pregnancy should be aware of their mental as well as physical health needs. Early identification, the availability of appropriate and timely interventions and support, and effective inter-agency approaches to service delivery are essential elements of good mental health support for all key service providers.’

Mainstreaming Gender and Women’s Mental Health: implementation guidance
The Implementation Guidance outlined actions for PCTs, specialist mental health services and social services to enable them to meet the mental health needs of women who have, or have had, serious mental health problems and women with no previous history of mental ill health during pregnancy, childbirth or immediately following childbirth. These included ensuring antenatal and postnatal care are alert to the possibility of depression and other mental health problems, and knowing where to refer women for support and treatment. The guidance also recommended that PCTs responsible for commissioning specialist mental health services and local authority social services commissioners review provision and ensure that sufficient specialist mother and baby psychiatric beds are available for any women needing acute mental health care following birth.

Standard 11 of the National Service Framework for Children, Young People and Maternity Services recommended that women should have access to supportive, high quality maternity services. These services should be designed around their individual needs, including their mental health needs, and those of their babies.

In 2007 NICE published guidance on antenatal and postnatal mental health. This guideline made recommendations for the identification, treatment and management of mental disorders in women during pregnancy and the postnatal period. It included advice on the care of women with existing mental disorders who are planning a pregnancy, and on the configuration of mental health services. It argued that mental health problems during pregnancy and postpartum can have serious consequences for the health and well-being of a mother and her baby, as well as for other family members, including partners.

The NICE guidance highlighted the variations in service provision across the country and recommended the development of managed clinical networks. These would link groups of services in primary, secondary and tertiary care to ensure the availability of high quality clinical services. The functions of a managed clinical network as described by NICE are outlined in Practical Solution 17.

Practical Solution 17: Functions of a managed clinical network, NICE guidance on antenatal and postnatal mental health

Managed clinical networks should provide:

- a specialist multi-disciplinary perinatal service in each locality, providing direct services, consultation and advice to maternity services, other mental health services and community services. In areas of high morbidity these services may be provided by separate specialist perinatal teams
- access to specialist expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding
- clear referral and management protocols for services across all levels of the existing stepped-care frameworks for mental disorders, to ensure effective transfer of information and continuity of care
- pathways of care for service users, with defined roles and competencies for all professional groups involved.

Each managed perinatal mental health network should have designated specialist inpatient services and cover a population where there are between 25,000 and 50,000 live births a year, depending on the local psychiatric morbidity rates.

www.nice.org.uk

Making Progress

Perinatal mental health and reports of difficulties in accessing appropriate care through primary care and specialist mental health services have attracted considerable attention since the publication of Into the Mainstream.
and have been the focus of media attention, questions in parliament and debate among professional groups.

A study of motherhood and depression by Mind52 found that many mothers do not receive the mental health care they need. The women in this survey had problems gaining access to advice, information and care. Over two thirds of the women surveyed said they had to wait a month or more for treatment, and one in ten had waited over a year. Of those women who required inpatient care, 63 per cent were admitted to a general psychiatric ward and four fifths of these were admitted without their baby. The study found that the service response varied widely across the country: 67 per cent of women in the south of England were admitted to a specialist mother and baby unit, compared with just 11 per cent in the north.

The 2006 survey, the 2007 benchmarking study and responses to requests for examples of good practice indicated that there are significant developments in process. Nearly half of Trusts responding to the benchmarking study reported that services for perinatal mental health were currently being reviewed or were under development. Reflecting Into the Mainstream recommendations, there is an emphasis on the development of dedicated provision, which includes mother and baby units and development of multi-disciplinary teams. A number of respondents to the 2006 survey indicated that they were working on the development of a care pathway, although little mention was made either in the 2006 survey or the 2007 benchmarking study of managed clinical or care networks.

Responses from primary care also indicated service developments, including training for health visitors and midwives. However, there was little evidence of the development of a whole-system approach to perinatal mental health services; improvements often appeared to be championed by one or two committed individuals. There was no clear evidence of robust commissioning practice in this area and a number of respondents to the 2007 benchmarking study reported that they had highlighted their concerns about the lack of local provision to their commissioners.

In October 2008, the Gender Equality Programme set up a national project on perinatal mental health. The national project’s aims are:

- to facilitate the development of managed clinical networks within each region
- to make connections with the wide number of key stakeholders who have a responsibility for maternal mental health
- to facilitate the development of a national network to address issues related to perinatal mental health
- to develop strategies for addressing the specific needs of women from a Black and minority ethnic groups, introducing these strategies to the regional network.

The project aims to work alongside the initiatives that are taking place within the statutory and voluntary sectors, complementing this work and supporting its development (see Practical Solution 18 below).

### Practical Solution 18: ACACIA Family Support, West Midlands

ACACIA was established in 2004 in response to a major gap in level one service provision for families affected by postnatal depression in the West Midlands region. The aims of the organisation are to offer support consistent with good clinical practice to mothers and their families affected by symptoms associated with prenatal and postnatal depression and to promote and encourage family well-being.

Since then, the organisation has flourished. Listed below are key points that have contributed to its development:

- A united steering group, with a broad skill base and a passion to improve the services offered to women and their families
- A dedicated chair, with a gift in administration and a great knowledge and understanding of family life
- Members of the management team have themselves experienced PND and have first-hand experience of services
Personalised Support and Care

This section reviews activity and key issues for diverse groups of women that need to be considered in addition to those already identified. These specific issues often reflect multiple dimensions of discrimination and inequality that need to be addressed in the provision of individualised care and support.

The section focuses on specific needs that were identified in Into the Mainstream and/or where there have been significant developments either in policy or practice. There are significant gaps that need addressing; in particular, issues relating to age, sexuality and disability have received little attention. These will need to be addressed and this will be supported by Equalities legislation and by care planning that is informed by an understanding of social inequalities and knowledge of and skills in meeting diverse needs.

Despite the important developments noted in this report, significant gaps in services continue to exist and require addressing to bring about fairness and equity for women. There are three areas of specific need:

- women from Black and minority ethnic (BME) communities
- women as mothers
- women in contact with the criminal justice system.

Women from Black and Minority Ethnic (BME) Communities

‘Many individuals from minority ethnic groups have... negative experiences... there are indications of important difference in mental health and illness between different ethnic groups. Of particular concern among women is the high level of suicide, self-harm and eating disorders among Asian adolescent girls and... the experience of post traumatic stress disorder linked with increased risks of violence and abuse for women refugees and asylum seekers.’

Into the Mainstream

The Implementation Guidance makes it clear that gender-specific and gender-sensitive provision will not of itself meet the mental health needs of women from Black and minority ethnic communities or prevent discrimination and racism. When the Implementation Guidance was published, a national strategy to improve the experiences of mental health services of people from BME communities was anticipated.

Addressing health inequalities is a central plank of current health and social care policy and the public health agenda. It is well established that health is significantly influenced by socio-economic factors and there is evidence to suggest there are differences in health status between ethnic groups that are linked to socio-economic differences and circumstances.

Women from BME communities face multiple barriers in overcoming social exclusion and accessing health and social care services, and wider opportunities such as education, training and employment. It is clear that action to
address these inequalities and to strengthen participation in society of women from BME communities is needed to underpin any strategy to improve their mental health.

The BME mental health strategy, Delivering Race Equality (DRE), launched in 2005 with the government’s response to the report of the inquiry into the death of David (Rocky) Bennett, reflected increasing concern about inequalities in service provision and, in particular, the over-representation of BME groups in restrictive mental health services and their under-representation in empowering services. DRE set out a five year plan to improve mental health service provision for BME communities, with 12 characteristics as summarised in Practical Solution 19 below.

**Practical Solution 19: Delivering Race Equality** — mental health service characteristics for BME communities

1) Less fear of services among BME communities.
2) Increased satisfaction with services.
3) A reduction in the rate of admission of people from BME communities to inpatient units.
4) A reduction in the rates of compulsory detention of BME service users.
5) Fewer violent incidents linked to inadequate treatment.
6) A reduction in the use of seclusion in BME groups.
7) The prevention of deaths in mental health services following physical intervention.
8) More BME service users reaching self-reported states of recovery.
9) A reduction in the ethnic disparities found in prison populations.
10) A more balanced range of effective therapies, such as psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective.
11) A more active role for BME communities and BME service users in the planning and provision of services.
12) A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

See [www.mentalhealthqualities.org.uk](http://www.mentalhealthqualities.org.uk) or contact the Mental Health Equalities team on 020 7307 2400

The strategy brought significant investment in a range of initiatives, including:

- a national programme to co-ordinate actions towards delivering race equality in mental health services
- focused implementation sites to test out innovative approaches to improving mental health services for BME communities
- a national programme of community engagement projects that worked with BME communities to survey local mental health needs and make recommendations for improvements
- employment of 500 community development workers within PCTs across England to support and build capacity within communities.

A number of community engagement projects and focused implementation sites included projects that focused specifically on the needs of women (see Practical Solution 20).

Other projects that were focused on BME communities included attention to the needs of women – see, for example, the project looking at the experience of BME inpatients on mental health wards in Redbridge.
### Practical Solution 20: Delivering Race Equality mental health projects focusing on BME women

(CE = Community engagement project; FIS = Focused implementation site)

<table>
<thead>
<tr>
<th>Project name</th>
<th>Area</th>
<th>Focus</th>
<th>Target group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karma Nirvana</td>
<td>Derby (CE)</td>
<td>South Asian women resettling following domestic violence</td>
<td>South Asian women (who have experienced domestic violence)</td>
</tr>
<tr>
<td>Morton Hall Prisons Project</td>
<td>Lincolnshire (FIS)</td>
<td>Improve understanding of the mental health support needs of BME women in Morton Hall prison</td>
<td>African and Caribbean women</td>
</tr>
<tr>
<td>Sahara Spotlight</td>
<td>Middlesbrough (FIS)</td>
<td>Whether current mental health services meet the cultural and language needs of South Asian women</td>
<td>South Asian women</td>
</tr>
<tr>
<td>Milan project</td>
<td>Middlesbrough (FIS)</td>
<td>To provide emotional support identified by women themselves and to build a social network to alleviate isolation, depression and anxiety and encourage social inclusion and community integration</td>
<td>South Asian women</td>
</tr>
<tr>
<td>Saheli</td>
<td>Manchester (CE)</td>
<td>To establish whether women have appropriate access to preventative mental health services</td>
<td>South Asian women (who have experienced domestic violence)</td>
</tr>
<tr>
<td>CSIP, University of Salford and Asian Women's Refuge</td>
<td>Liverpool (CE)</td>
<td>Women who have no recourse to public funds</td>
<td></td>
</tr>
<tr>
<td>Big Life Services</td>
<td></td>
<td>Why Black and Muslim women in Liverpool do not access mental health services and what information is available for them</td>
<td></td>
</tr>
<tr>
<td>African Caribbean Citizens Initiative</td>
<td>Wolverhampton (CE)</td>
<td>Pathways into mental health services, the causes and experiences of mental ill health, and the cultural appropriateness of services</td>
<td>African Caribbean women</td>
</tr>
<tr>
<td>Young Women's Christian Association (YWCA)</td>
<td>Doncaster</td>
<td>Gender-specific issues relating to women and their mental health needs</td>
<td>BME women (and asylum seeking and refugee women)</td>
</tr>
<tr>
<td>Sahara Spotlight</td>
<td>Middlesbrough (FIS)</td>
<td>Whether current mental health services meet the cultural and language needs of South Asian women.</td>
<td>South Asian women</td>
</tr>
</tbody>
</table>
Making Progress

The 2006 survey and 2007 benchmarking study found little mention of initiatives to meet the needs of women from BME communities. This may be because such initiatives were regarded as part of a Delivering Race Equality action plan. However, the results of the Count Me In annual censuses of mental health inpatient services in England suggest that, while there are similar trends for women and men from BME communities, as outlined in the Delivering Race Equality report, there are also important gender differences. Further, the continued provision of inpatient care in mixed sex environments or single sex areas with minimal separation is also a concern.

Many community projects have developed in response to the lack of appropriate provision for women from BME communities. These are an invaluable resource, often providing a range of support and information, including recreational and leisure activities that serve to enhance women's mental well-being, confidence and participation. These projects are typically highly visible, well used and have the confidence of women in the local community. Nevertheless these services should not be regarded as a substitute for acceptable, appropriate provision within mainstream mental health services.

Community development approaches are critical to building community capacity and networks of women from BME communities. The point has been made repeatedly elsewhere that third sector community groups require sustainable investment, but there is little evidence that they are being adequately funded or commissioned. The Black community and voluntary sector (BCVS) is often funded on a short-term, ad hoc basis, in common with much of the voluntary sector but much worse. DRE’s five-year programme ended in 2009, but its vision continues to be a priority for the Equalities and New Horizons programmes. For women from BME communities, the priorities include:

- provision of culturally specific or sensitive advocacy to facilitate access to services and protect rights
- respect for and understanding of cultural, religious and gender issues
- single sex inpatient accommodation
- initiatives to increase the participation of women from BME communities
- sustainable investment in community groups and capacity building to promote women’s well-being
- action to tackle stigma
- improved perinatal mental health care provision
- inclusion of culturally specific issues in initiatives and training to address violence and abuse
- increased access to personal budgets to enable individuals to make their own arrangements for culturally competent support.

Within these, the specific needs of asylum seekers and refugees should be addressed.

Action to address inequalities for women from BME communities needs to be evident in commissioning and provider plans for improved service provision.

Women as Mothers and Carers

‘Forty per cent of women spend over 50 hours a week caring for someone living with them... 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.’

Into the Mainstream

The Implementation Guidance recognised that women who are mothers need ‘tangible and sensitive support’ to enable them to continue to care for their children while they are experiencing mental health problems, and that this is particularly so for women with a serious
mental illness. The guidance makes a number of recommendations on how to support women and recommends a shared approach to risk management and to identifying and meeting the needs of the children.

In recent years there has been a notable and welcome shift in children’s and adult social care policy and guidance that places greater emphasis on the need to support parents in their parenting role. One of the main policy drivers in this area has been the Mental Health and Social Exclusion report published in 2004. This report examined the wider social and economic costs of mental health problems for the individual and for society as a whole, the impact of mental health problems on family well-being and child development, and how people with mental health problems can be enabled to maintain their lives and roles in their families, friendship networks, workplaces and communities. The report set out a 27 point action plan to improve social participation, employment opportunities and access to mainstream public services for those affected by mental health problems. Action 16 focused on action to promote the mental health and tackle the social exclusion of parents with mental health problems and their children.

Two reports on supporting families at risk were subsequently published by the Social Exclusion Task Force outlining the government’s commitment to ensuring that adult services support whole families, not just the individuals within those families. To help local services put these principles into action, the government also committed to:

- piloting a programme of Family Pathfinder projects to test and develop the ‘Think Family’ model of social care and to generate and share evidence of what works on the ground
- continued investment in evidence-based interventions, including Family Nurse Partnerships and Family Intervention Projects (FIPs), with the aim to embed early intervention and prevention within the existing system of support and extend targeted family services to reach a wider range of vulnerable families (see Practical Solution 21)
- extending collaboration across children’s services to include adult social services, so that all services share responsibility for family outcomes. The aim is to encourage and empower frontline staff to innovate and work together to meet the whole family’s needs.

Practical Solution 21: Family Intervention Projects

Fifty Family Intervention Projects (FIPs) were set up as part of the Respect Action Plan, launched in January 2006. These FIPs were expanded to 67 in 2008–2009. The aim of the projects was to reduce anti-social behaviour (ASB) perpetrated by the most anti-social and challenging families in order to prevent cycles of homelessness due to ASB and also to achieve the five Every Child Matters outcomes for children and young people in these families.

Following independent evaluation by NatCen, the FIP model is now being adapted to work with other families who have other significant problems, including drug and alcohol misuse, mental health problems, domestic violence, offending, long-term unemployment and poverty.

From April 2009 and March 2011, all local authorities are to receive funding for the development of a FIP, and an additional £6 million will be provided by the Department of Health to meet health improvement needs.

A landmark government protocol, Putting People First, was published in 2007, setting out the government’s commitment to independent living and personalised public services for all adults. Among the key elements of Putting People First are that:

- all people, irrespective of illness or disability, should be supported to sustain a family unit in which children are not required to take on inappropriate caring roles
- services should treat family members and carers as experts and care partners
- carers should be supported by programmes that develop their skills and confidence
• systems should support integrated working with children’s services, including transition planning and parent carers, and identifying and addressing concerns about children’s welfare.

Adult social care services are also required to take responsibility for championing local action to tackle the stigma experienced by people with mental health problems.

Making Progress

The Refocusing the Care Programme Approach (CPA) report states that the needs of key groups, including parents, should be fully explored to make sure that all their circumstances are examined, understood and addressed when deciding their need for support under the new CPA. These are important changes to the CPA process, which for the first time explicitly recognises that people using mental health services may be parents and the importance of taking a holistic approach to the assessment and care planning process.

A briefing paper on CPA summarises why it is important to address the needs of parents with mental health problems and to ensure that they, and their children, receive support. It describes the potential of the CPA to improve outcomes for affected families.

The new CPA guidance recommends that the needs of the parent, the child and the family are assessed routinely at each stage in the care pathway, from referral to review. Service activity data should be recorded, collected and used to inform local commissioning and eligibility criteria for access to assessment and services, as well as professional training and development. The briefing also references relevant policy guidelines, practice developments and further reading.

With the emphasis on parents as one of the key groups whose needs should be addressed through the Care Programme Approach and the Family Intervention Projects, it is hoped that the current gaps in gender-specific and gender-sensitive services will be addressed, although these are not necessarily specific to mental health.

Women within the Criminal Justice System

‘There are many factors that affect women’s mental health but these are often the same factors that impact on their risk of offending.’

Into the Mainstream

The similarity between factors affecting women’s mental health and their risk of offending generated a partnership approach between the Department of Health and the Home Office to consider how the women’s mental health strategy and the Home Office Women’s Offending Reduction Programme could work together to tackle these factors.

The Implementation Guidance recommended that this partnership working should be replicated at a local level through PCTs, criminal justice agencies, mental health and social care services and other relevant agencies, and the establishment of multi-agency forums. These forums would develop joint action plans to provide tailored community packages of care for women offenders with mental health problems, ensuring women prisoners receive individualised care and resettlement within their home communities.

Increasing attention and concern has been focused on the needs of women in the criminal justice system. The most significant policy development since the publication of Into the Mainstream has been the review of women with particular vulnerabilities in the Criminal Justice System (CJS), conducted by Baroness Corston. This review was prompted by concerns about the high number of suicides in women in prison custody.

The aim of the review was to consider provision for vulnerable women at each point of contact with the CJS: at police stations, on arrest; in court, on remand; on sentencing, while serving a sentence; in the community or in prison, and on release.

In relation to women’s mental health and well-being, the report of the review confirmed the need for an integrated and distinct approach for
women. It called for the development of high-support, women-only day services in the community, as an alternative to prison for non-violent offenders. It also recommended investment in rigorous training and ongoing support and supervision for all those charged with meeting the complex needs of women offenders and those at risk of offending, including gender awareness and how community sentences can meet their needs. This training should be extended to include all staff within the criminal justice system in contact with women, particularly those who make sentencing and bail decisions.

In addition, the report recommended that the management and care of women who self-harm should be led by the NHS, either within an NHS centre or through shared multi-disciplinary care in prison, and this was accepted in part by the government. The government published a National Service Framework for Women Offenders (NSFWO) in May 2008, to address the specific needs of female offenders. It is supported by the publication of Prison Service Gender-specific Standards, and the Offender Management Guide to Working with Women, which provide more detailed operational guidance for prison and probation staff.

A consultation document Improving Health, Supporting Justice, developed jointly by the Ministry for Justice, Home Office, Department for Children, Schools and Families and the Department of Health, was launched in November 2007. This document pointed to the fact that women in contact with the CJS have restricted access to healthcare and social services, despite high levels of illness and poor health. It also points out that women offenders may be single parents, and possibly carers for older people and/or someone with a disability.

The much higher risk of suicide in prison for women and the high incidence of self-harm are a major problem. Over half (56 per cent) of all recorded incidents of suicide and self-harm in prison involve women, even though they constitute just six per cent of the prison population. The response to the consultation confirmed the need for strong partnership working and, in particular, cross-agency training and information systems. This systemic change would encourage information and knowledge sharing between the various agencies in the same locality. This approach would improve support to women who have multiple problems. The need for specific services for women was also advocated, including the provision of community-based women’s centres providing a holistic service.

The Bradley review of people with mental health problems or learning disabilities within the Criminal Justice System was published in April 2009. The report highlights women offenders as a group with special needs, alongside offenders from BME communities. The government is currently developing a strategy to deliver offender mental health and social care, in response to the Bradley review. Women will be a cross-cutting theme in this strategy.

Making Progress

Awareness of the health needs of women in contact with the Criminal Justice System has clearly been raised and there is a better understanding of these needs. There have also been general developments that should have benefitted women experiencing mental health issues. Positive progress has been made within prisons, with Primary Care Trusts (PCTs) taking over responsibility for health care in prison settings for both women and men since April 2006. There has also been the development of prison mental health in-reach teams and the publication of guidance to improve the transfer of prisoners to psychiatric care.

NIMHE (NMHDU’s predecessor) commissioned a review of the research into issues that affect the mental health of women in custody. The review made recommendations for PCTs, the Department of Health and Strategic Health Authorities to enable them to develop, commission and provide services that would be most effective in supporting women’s mental health. These recommendations, published in a report entitled Women at Risk, are summarised in Practical Solution 22.
Practical Solution 22: Recommendations from Women at Risk

Department of Health

To work with other government organisations on data sharing to facilitate adequate planning, service development and provision including prisoners before release.

NIMHE

To include women in contact with the judicial system, both in and out of custody, in regional strategic planning forums for women’s mental health.

All Primary Care Trusts

- Public health reports to include information about all women in the area in and returning from custody.
- Lead director for women’s mental health to work in partnership with other statutory and voluntary organisations, through the Crime and Disorder Reduction Partnership.
- Work in partnership with other organisations so that adequate and appropriate services are developed and include:
  - appropriate community services linked to alternatives to custodial sentences
  - linking women into community services in preparation for their return from custody
  - supporting the families and in particular the children of women in custody
  - have in place clear and agreed criteria and protocols for the transfer of women to forensic services
  - identify at least one practice under the Enhanced GMS scheme to accept women in contact with the CJS who have no identified GP.

Primary Care Trusts with a women’s prison in their catchment area

- Prison health delivery plan includes clear guidelines/criteria for referral from primary care to the in-reach team.

- The prison primary health care team provides a good mental health service; has adequately and appropriately trained staff; considers using a care planning approach to mental health patients seen in primary care; has good primary health care data collection systems; contacts the relevant primary care team in the women’s returning area when she is released and has support to provide good mental health promotion.
- In-reach team provides appropriate mental health care; makes full use of the CPA; implements care plans fully and liaises with other prisons and CMHTs when women on CPA are transferred or released; liaises with prison staff to develop appropriate programmes; has in place clear, agreed criteria and protocols for the transfer of women to forensic services; facilitates mental health training for all prison staff.

Following publication of the Corston report, a cross-government team was set up to take forward the recommendations. This team sits within the Ministry of Justice but includes representatives from the Court Service, Bail, Offender Health, Government Equalities Office and the Criminal Justice Women’s Strategy Unit. This team is responsible for delivering and developing the Together Women’s Project. The team has also now moved on to developing One Stop Shops for women, with a focus on those in, or at risk of being in, the Criminal Justice System.

The Together Women Project began operating between late 2006 and early 2007 at five centres in the North West and Yorkshire and Humberside National Offender Management Services (NOMS) regions (see Practical Solution 23). The project has recently been evaluated and early indications are that these initiatives are highly valued by women and have a clear role to play in enabling women offenders and those at risk of offending to access mental health support.
It is evident that further development of mental health support for women in contact with the CJS is needed and that this provision should be a whole-system approach, built on the recognition that issues that lead to offending are often intertwined with mental health issues. This points to the need for action at a number of levels, including preventive interventions and early identification of those vulnerable to the risk of offending as a consequence of psychosocial issues.

Practical Solution 23: Together Women Project, Liverpool

The Together Women Project (TWP) is a female only service facilitated solely by women. TWP seeks to divert women away from offending and the criminal justice system by identifying, acknowledging and resolving the issues that some women offenders face in society – issues like housing, drugs/alcohol addiction, physical and emotional abuse, financial problems, isolation, mental/physical health problems and family breakdowns.

TWP seeks to work with women in a holistic, needs-led, client centred approach. Practically, we aim to provide a service that fits with the needs and demands of the women themselves.

Emotionally, we aim to work with women as women, not as clients or customers or patients.

TWP offers spacious, light and attractive women-only accommodation and has a drop-in service that can be accessed four days a week by women attending the service. We offer a range of activities on a needs-led basis to enable women to make positive lifestyle changes. These include addressing personal issues such as coping with loss, stress management, domestic violence awareness, dealing with aggression, healthy relationships and self-harm; creative activities including arts and crafts, family days out, bookclub and art therapy, and practical skills including DIY, household management, physical health classes, literacy and numeracy. A crèche facility is available during access times and an outreach service available for those with access difficulties or who need enhanced community support. Additionally, the TWP has a strong volunteer commitment and its own mentoring scheme.

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Chapter 4

Strategic Direction for 2010-2015

‘I want New Horizons to make a big difference to the way we promote equality. There are inequalities in mental health and in access to services. People with mental health problems experience unjustifiable discrimination and avoidable inequalities in physical health. New Horizons will build on and extend the excellent work that has begun in those areas in recent years.’

Phil Hope MP, Minister of State for Care Services, New Horizons

The focus of Into the Mainstream was modernising mental health care for women. From its publication in 2002, the report and its recommendations provided a catalyst for change.

Eight years on, while progress has been made on a range of fronts, there is still much to do to achieve fair and equitable mental health services for women that recognise their particular life experiences and mental health needs and are genuinely gender-specific and gender-sensitive.

The National Service Framework for mental health recognised this and began the work towards this goal. New Horizons will build on the NSF successes by supporting the development of higher quality, more personalised services at local, ground level, and by taking a cross-government, multi-agency approach to tackling the root causes of poor mental health, including those specific to women. Future health and social care policy, including mental health policy, aims to promote well-being and ensure people receive the support they need where and when they most need it, and in the way that they find acceptable. Reflecting this, the key themes within New Horizons are:

- early intervention
- personalised care
- multi-agency commissioning/collaboration
- innovation
- value for money
- strengthening transition (moving through life stages).

Working towards Women’s Well-being is the contribution on women’s mental health and well-being to future mental health policy and New Horizons. Each of the key themes within New Horizons is reflected within this report.

Our review of progress towards Into the Mainstream highlights four areas for action:

- consolidate and strengthen the progress that has been made in the last seven years in developing gender-specific and gender-sensitive provision.
- increase access to and availability of gender-specific and gender-sensitive provision
- take steps to promote women’s mental well-being (and that of their children and families) through investment in evidence-based interventions
- strengthen information and the infrastructure of service provision.
Consolidating Progress

*Working towards Women's Well-being* charts the progress that has been made towards gender-specific and gender-sensitive services for women. There is an increasing awareness and understanding of the different needs of women and men and that a one-size-fits-all framework is unlikely to be either clinically or cost effective, and that a high quality service is a personalised service.

It is important during the next five years to build on and sustain the progress that has been made to ensure that women-only services become the norm, form part of an integrated care pathway and are subject to review in order to inform their further development. There are a number of critical elements to this:

- strong leadership
- building coherent multi-agency workforce development
- ensuring the development of integrated care pathways
- improved response to diverse needs
- maintaining and extending action to tackle violence and abuse, as a priority.

**Strong Leadership**

The 2006 survey and 2007 benchmarking study undertaken by the Gender Equality Programme point to the critical importance of strong leadership on gender equality within organisations. Senior managers, senior clinicians and board members are central to fostering the values and understanding that will support the further development of gender-specific and gender-sensitive services. It is also important to ensure a gender balance within the senior leadership of the organisation. The Equality Bill highlighted research that shows that company boards with a good gender balance outperform those that are not balanced.

Coherent Multi-Agency Workforce Development

For a workforce to be able to deliver appropriate high quality services for women, there needs to be a real understanding and appreciation of how inequalities singly and collectively affect women and men of different backgrounds. This has implications for the commissioning and delivery of pre- and post-qualification training and induction programmes. The 2009-2010 roll out of the Advanced Module of Gender Equality (10 Essential Shared Capabilities) provides a timely resource for organisations to use in staff development. However, training in itself is not sufficient to effect sustainable change; organisations will need to ensure infrastructures and processes are in place to support and develop staff through supervision and evaluation of the outcomes of training/service provision.

Integrated Care Pathways

Integrated care pathways play an important part in achieving women’s well-being. Poorly considered or poorly planned care pathways can result in women’s needs being left unmet. This is particularly vital where several organisations and agencies are involved. Maternal mental health is an example of this. The lack of multi-disciplinary/multi-agency working was highlighted in the Confidential Enquiry into Maternal and Child Health annual reports on maternal and child deaths *Why Mothers Die 2000-2002* and *Saving Mothers’ Lives 2003-2005* as having failed to address the high mental health-related mortality and morbidity rates in the past. As a result, improvements made to multi-disciplinary working in maternal mental health saw a reduction in the number of maternal deaths in the perinatal period.

Women who are in contact with the Criminal Justice System are also vulnerable to poor multi-agency working, inhibiting appropriate service responses. Here too there is a need to ensure that interventions are underpinned by an understanding of gender and how gender issues can impact on mental health.
In addition, transition between services for women in the CJS needs more consideration. ‘Step-down’ from secure services is reported as being problematic and in many areas it is absent.

Transition between adolescence and adulthood is of particular importance for young women with eating disorders. For this group of women, a change of approach or loss of consistency can have negative outcomes.

Diverse Needs – Moving Forward
While equality and diversity have gained increased profile in recent years, the focus has been on specific strands, such as race equality. Gender issues have often been neglected. There is a need to extend consideration to include all women. Lesbian and bisexual women, disabled women and older women have not received a high enough profile in policy and service development. It is also important for organisations and clinicians to recognise that women may experience disadvantage as the result of race, religion, sexual orientation, age and disability. Also overarching and interwoven with specific forms of disadvantage is the persistent inequality of social class: that is, a woman’s family background or where they were born. The single equality legislation recognises this reality and therefore is likely to provide a sound legislative framework.

A key element for organisational success will be ensuring there are effective frameworks that fully engage a diverse selection of service users as part of the service development and evaluation processes. This will facilitate the development of responsive services designed to meet the needs of the populations they serve.

Tackling Violence and Abuse
Cutting across all service provision is the need to both prevent and address the impact of violence, abuse and neglect. This would make a major and long-lasting impact on women’s mental well-being. It includes ensuring the physical and sexual safety of women in contact with mental health services. Services need to ensure that they have effective policies that give clear guidance on addressing issues of safety and respond effectively where safety of women is compromised.

Many women in contact with mental health services have a history of violence and abuse. There is a need for better identification and the development of appropriate responses to these women. The recommendations from the Together We Can End Violence Against Women and Girls cross-governmental strategy will require implementation. The third sector plays an important role in supporting women who have a history of abuse. Commissioning to ensure the sustainability of these services remains a challenge that needs addressing, as many of these services only receive short-term funding and are constantly at risk of closure.

Increasing and Broadening Access to Gender-Specific and Gender-Sensitive Provision
There is evidence of positive developments towards achieving women’s mental health and well-being at national and local levels since Into the Mainstream was published. This is evident in the increased numbers of gender-specific services in a variety of settings, including acute inpatient care, secure inpatient care and women-only day services.

The next five years provide a critical opportunity to consolidate this progress, so that both gender-informed practice and dedicated
women-only services are routinely part of the whole mental health system. It is crucial that integrated services and clinical pathways are regularly evaluated in terms of their effectiveness to inform further developments. This does not appear to be happening; responses to the 2006 survey and 2007 benchmark study indicated a low level of evaluation activity.

Organisations will need to balance decisions regarding gender-specific services with the choice agenda, recognising those groups that are marginalised and thus do not have the opportunity to express their preference with regard to gender-specific provision.

Strengthening Information and the Infrastructure of Service Provision

The Equality Bill, once enacted, and the Public Sector Gender Duty will guide service design and provision so that the differing and individual needs of women and men can be met. Successful implementation requires commitment to the principles and values enshrined in the legislation as well as practical action to identify differing needs and appropriate responses at local level, in partnership with local stakeholders. This includes organisations assessing the impact of major policies and service provision. Community organisations and women’s groups should be engaged as key stakeholders in the process. The implementation of the legislation also creates an opportunity for developing an integrated approach to equalities, including gender-based inequalities for men and transgender people. It will be important to ensure that, in pursuing an integrated approach to equalities, progress in relation to women is consolidated and dilution of focus is avoided.

Competent Commissioning

World Class Commissioning also has the potential to promote women’s well-being through its focus on well-being, early intervention and tackling inequalities. New Horizons highlights the impact of social inequalities on mental health morbidity. Experiences of oppression, discrimination, violence and abuse, poverty, lack of educational opportunities and lack of political power and a sense of social value are all contributors to poor mental health and result in a greater representation within mental health systems of people experiencing these inequalities. This has implications for commissioning strategies, which need to include a focus on commissioning for women’s well-being as well as commissioning gender-specific and gender-sensitive services. The translation of this into practice at a local level is likely to have implications for workforce development.
Performance and Quality Assurance

As previously mentioned, the Equality Bill will strengthen protection, advance equality and bring together the range of equality legislation that has been issued over the past four decades. It is anticipated that this high level leadership and swift action in setting priorities will bring increased profile and activity in the area of women’s needs.

Most NHS organisations are becoming Foundation Trusts, which means they are accountable to their local communities and these communities have a say in the development of their mental health services. Robust systems of governance need to be in place across the mental health system to ensure that local population needs assessments are disaggregated by gender. Governance structures should include individuals with clear responsibility for addressing the issues identified, and mechanisms for involving women from diverse communities who have experience of mental health services.

The Local Government and Public Involvement in Health Act 2007 requires PCTs and local authorities to produce a Joint Strategic Needs Assessment (JSNA) of the health and well-being of their local community. The JSNA requires stakeholder involvement and engagement with local communities to inform commissioning decisions.

The increased high profile of the Equality Bill, the work of the Equalities and Human Rights Commission, the regional and local partnerships, and responsibilities to involve stakeholders and engage with local communities will play a significant role in the performance and quality of services.

Research and Development

There is a need for ongoing research to support and underpin progress in promoting women’s mental well-being. The priority areas for research are:

- evaluation of gender-specific provision in acute care

- effective services for women from BME communities

- women offenders – non-custodial approaches and interventions to stop the downward spiral of disadvantage

- self-injury interventions

- interventions to promote women’s well-being.

Moving Forward

The upcoming Equality Act and the introduction of the Public Sector Gender Duty are and will have a major impact on mainstreaming the women’s mental health agenda. Gender impact assessments provide an opportunity to influence the implementation of gender-specific and gender-sensitive services for women. Awareness of the different mental health needs of women, men and transgender people is improving, although it has been hindered by the absence of disaggregated data and the consideration of gender as a variable. There is no stronger persuader than the evidence base and therefore monitoring, evaluation and research is essential.

Leadership at a senior level, mechanisms for accountability, strong partnership working between the statutory and voluntary sector, and the involvement of women with experience of mental health problems emerge as critical factors in the implementation of this agenda.

Energetic, solution-focused leadership across the range of organisations that need to deliver outcomes for women’s mental health and well-being and investment in leadership development and capacity building in relation to inequalities are important if action to tackle these is to be mainstreamed.

The development of New Horizons offers an opportunity for this work to be taken forward, enabling a mainstreamed approach to gender equality. Table 5 summarises the areas that still require action. Underpinning all of these areas is women’s safety, which remains a fundamental issue to be tackled.
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Action required</th>
<th>Measurables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvements in the safety and perception of safety of women</td>
<td>• Continued development of gender-specific provision</td>
<td>• Governance arrangements in place to ensure that there is reporting of incidents where safety is</td>
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<tr>
<td>who use mental health services</td>
<td>• Training and educational opportunities to build capacity within the workforce in relation to gender</td>
<td>compromised and that these issues are addressed</td>
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<tr>
<td></td>
<td>• Further improve all areas of mental health services to ensure that they are more accessible to all women</td>
<td>• Increase in the development of women-only wards</td>
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<tr>
<td></td>
<td></td>
<td>• Gender equality training available to all frontline staff</td>
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<tr>
<td></td>
<td></td>
<td>• Evidence of policies in all mental services relating to safety</td>
</tr>
<tr>
<td>Increased access to appropriate services and understanding of</td>
<td>• Practice and service developments in response to the differing needs of women from BME communities,</td>
<td>• Equality training to form a central strand of pre-qualification and induction programmes</td>
</tr>
<tr>
<td>women with diverse needs (ie. older women; BME women;</td>
<td>older women, lesbian and bisexual women and disabled women. This will involve rolling out equality training that covers all equality strands and recognises the inter-relationship between the different strands</td>
<td>• Regional Equality and Diversity Networks to benchmark current service provision of all equality strands</td>
</tr>
<tr>
<td>lesbian and bisexual women, and women with disability)</td>
<td>• Implementation of Equality Act including Equality Impact Assessments on all new developments and relevant existing service provision</td>
<td>• Equality impact assessment to evidence attention to women’s needs</td>
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<td></td>
<td>• Facilitate the involvement of woman service users in the development and evaluation of services</td>
<td>• Service user led evaluation of services to report on the responsiveness of services to meet the needs of women from diverse groups</td>
</tr>
<tr>
<td></td>
<td>• Improve experience of services for women with diverse needs</td>
<td></td>
</tr>
<tr>
<td>Improved maternal mental health, with a positive impact on</td>
<td>• To improve identification of women with perinatal mental health problems</td>
<td>• Increased access to specialist perinatal community and inpatient services</td>
</tr>
<tr>
<td>child and family mental health</td>
<td>• Provision of appropriate and timely treatment responses for women in the ante- and post-natal period through the development of appropriate evidence-based interventions in primary care</td>
<td>• Evidence of a care pathway for women both in the ante and postnatal period spanning primary care through to tertiary care</td>
</tr>
<tr>
<td></td>
<td>• Development of Managed Care Network at regional level to improve multi-disciplinary/agency working and ensure comprehensive provision of all levels of care including specialised perinatal community and inpatient services</td>
<td>• Perinatal mental health screening at ante-natal and post-natal bookings</td>
</tr>
<tr>
<td>Outcome</td>
<td>Action required</td>
<td>Measurables</td>
</tr>
<tr>
<td>---------</td>
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</tbody>
</table>
| Improve responses to women who experience violence and abuse. | • Identification of women who have a history of and/or are currently experiencing violence and abuse  
• Improve response and support for women who have a history of and/or are currently experiencing violence and abuse  
• Develop care pathway for women who experience violence and abuse that utilises the independent sector where appropriate  
• Development of local commissioning arrangements to ensure that independent sector services are sustainable | • Continued roll out of staff training on ‘routine enquiry’  
• Evidence of routine enquiry during mental health assessments in all service areas  
• Appropriate contribution of mental health clinicians into multi-agency processes such as Multi-Agency Risk Assessment Conferences  
• Response to the recommendations of the Violence against Women and Girls Taskforce, when these are published |
| Improve responses to women who self-harm | • Support recovery by improving service provision for individuals who self-harm  
• Assist women who self-harm to develop alternative coping strategies | • Development and implementation of policies that cover a wide variety of responses to service users who self-harm  
• Established comprehensive training for staff working with individuals who self-harm to enable them to identify and address the underlying causes  
• Implement new guidance from NICE (anticipated 2011) |
| Improving support for women in contact with the Criminal Justice System (CJS) | • Earlier identification of mental health issues in women in contact with CJS  
• Improved care pathways of women entering and exiting the CJS  
• Further development of alternatives to custodial provision  
• Development of ‘step down’ provision for women in secure mental health services | • Commissioning of community services that divert women from the CJS and provide a ‘one stop shop’ for women at risk of offending  
• Provide gender training for prison in-reach teams to assist them to understand the impact of gender issues on mental health  
• Provision of court assessment to be informed by an understanding of the influences of gender on the pathway into the Criminal Justice System  
• Clear care pathways for women exiting secure mental health services |
## Appendix 1: Implementation at a glance

<table>
<thead>
<tr>
<th>Aim</th>
<th>Status as of 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Planning at a local level</strong></td>
<td>PCTs do not appear to be well engaged with the agenda. However, 70% of Trusts report having a lead and there are examples of multi-agency forums that bring together local stakeholders to plan for women’s mental health services and drive forward change.</td>
</tr>
<tr>
<td><strong>Workforce development</strong></td>
<td>Gender training workshops held in the majority of regions and received extremely well. However, not an integral part of training and not clear how to further develop. Many organisations are taking a single equality perspective to the six strands of equality. This allows for a more proportionate approach and more likely to ensure the issues are understood and embedded. There have been specific developments at a national level, particularly the development of an advanced module on gender equality and mental health to form part of the 10 Essential Shared Capabilities. Most CSIP RDCs have developed a network targeted at senior staff in mental health commissioning and provider roles.</td>
</tr>
<tr>
<td><strong>Governance</strong></td>
<td>Healthcare Commission and Mental Health Act Commission standards and requirements are applicable to this aim. Public Sector Gender Duty requires organisations to routinely collect data with regard to gender. The level to which this has been implemented is unclear at this stage.</td>
</tr>
<tr>
<td><strong>Service evaluation and monitoring</strong></td>
<td>A variety of audit tools have been developed to establish progress in implementing Into the Mainstream and Delivering Race Equality. The extent to which they are being used is variable.</td>
</tr>
<tr>
<td><strong>Service standards</strong></td>
<td>Standards have been developed for secure services and women-only day services. The extent to which these have been adopted is unclear but there is no evidence to indicate routine use.</td>
</tr>
<tr>
<td><strong>Mental health promotion</strong></td>
<td>No knowledge of systematic implementation.</td>
</tr>
<tr>
<td>Individual assessment and care planning</td>
<td>Some examples of women centred care planning. Some examples of women centred care planning. The new CPA takes into account gender-sensitive care planning.</td>
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<td>----------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>To ensure that in all assessment and care planning, key components are particularly relevant to women.</td>
<td>To ensure that women service users are prescribed appropriate medication only if and when required. To enable women service users to access a range of appropriate psychological therapies in the assessment of their mental health problems.</td>
</tr>
<tr>
<td>Care and treatment</td>
<td>Not clear. Gender sensitivity is being included within the development of the pilots for psychological therapies. NICE are in the process of developing guidelines for Borderline Personality Disorder.</td>
</tr>
<tr>
<td>Primary care</td>
<td>No overall pictures available as yet; however, there are concerns about the access to appropriate support for women experiencing perinatal mental health problems. Development of women-only day services. No system in place requiring PCTs to do this. There is an agreed approach to integrate the women-only day service guidance with more generic guidance produced by NIMHE. However there are many examples of positive initiatives in the voluntary sector. Core funding remains an issue placing the sustainability of some of these potentially under threat.</td>
</tr>
<tr>
<td>Supported housing</td>
<td>A number of local initiatives. No national audit of provision is available.</td>
</tr>
<tr>
<td>Acute care services</td>
<td>Data indicates that 99% of mental health trusts that provide mixed-sex inpatient wards now meet the single-sex accommodation objectives. The NPSA report highlights that sexual safety is still an area of significant concern. The Healthcare Commission focused review of Adult Acute Inpatient wards shows that gender issues are some of the poorest outcome areas. Informed Gender Practice was developed and published in anticipation of this outcome.</td>
</tr>
<tr>
<td>Women-only crisis houses</td>
<td>Isolated examples of women-only crisis houses. Needs to be part of a whole-system response to crisis and to supporting women in their parenting and other roles. The needs of women for women-only crisis houses have not been clearly established in the context of the development of crisis resolution teams and the development of women-only day services.</td>
</tr>
</tbody>
</table>
### Secure services

To provide safe and effective secure services for women with learning and associated difficulties and to provide safe and effective low secure services for all women patients. To provide high support community residential settings for women with complex needs who may have a diagnosis of borderline personality disorder, be recovering from severe trauma with attendant risk and/or offending behaviour.

<table>
<thead>
<tr>
<th>To provide safe and effective secure services for women with learning and associated difficulties and to provide safe and effective low secure services for all women patients. To provide high support community residential settings for women with complex needs who may have a diagnosis of borderline personality disorder, be recovering from severe trauma with attendant risk and/or offending behaviour.</th>
<th>Significant progress has been made in developing women-only medium secure services. Unlike a few years ago, far fewer women are now detained in mixed-sex medium secure units. Four pilots have been established and are being evaluated. Baroness Corston has completed a review of women in the criminal justice system. She has made a number of recommendations which the women offender healthcare team are responsible for taking them forward.</th>
</tr>
</thead>
</table>

### Meeting the needs of specific groups of women

| Women who have experienced violence and abuse. | Mental health Trusts in partnership with other organisations to appoint a lead person to take appropriate action to ensure that the links between violence and abuse and women’s mental ill-health are acknowledged and addressed in the delivery of mental health services. |
| Women who are mothers. | For mental health and primary care services to work in partnership with children and family services to provide tangible and sensitive support for women in their mothering role and adopt a shared approach to risk management and contingency planning and identifying and supporting the needs of children, who are often called upon to assume caring responsibilities. |
| Women offenders with mental health problems. | PCTs with their relevant partners to establish multi-agency forums to improve the understanding, develop multi-agency training, and explore ways of enabling women offenders with mental health to remain in the community, if appropriate. For PCTs to improve access to the same quality of primary and specialist mental health care as women residing in the community. |
| Women who self-harm. | Development of policies, protocols, staff training and support to effectively assess and manage women who self-harm. |
| Women with perinatal mental health problems | Actions to ensure that there are steps in place for the early detection of mental health in women at the ante-natal or post-natal stage: to ensure that women with a current or previous history of serious mental health problems receive timely and appropriate care and support and to ensure that mothers requiring acute inpatient care are accommodated appropriately with their babies. |
| Women with eating disorders. | To increase awareness of eating disorders, improve early detection and intervention and improve service provision through the development of clear treatment protocols, steered staff training and capacity in services to respond appropriately to girls and women with mild to severe eating difficulties. |
Appendix 2: Good Practice Checklist for Mental Health Trusts

Responding to the needs of women with mental health problems

Introduction

This self-assessment framework is intended to help Mental Health Trusts assess how well they are doing in providing a service that delivers gender equality for women. It is a starting point for Trusts to evaluate their current position in responding to the needs of women with mental health problems. It has been developed at the request of the National Mental Health Partnership to guide work at a local level.

Section A: Organisational Context

1) There is leadership at a senior level within the organisation for gender equality and women’s mental health.
2) The Trust has a strategy for delivering gender-sensitive services for women.
3) Gender equality goals have been identified for the Trust, supported by a gender impact assessment.
4) The Board regularly receives reports on progress to improve gender equality.
5) Information (CPA, SUI and patient information) is routinely disaggregated on the basis of gender and ethnicity.
6) The Trust has policies which operationalise gender (and race) equality and include:
   - Recruitment
   - Employment and family-friendly working practices
   - Child protection
   - Domestic violence
   - Physical and sexual harassment, intimidation and violence experienced by service users within the service
   - Risk assessment (to self and others).
7) Women with a range of mental health needs are substantially involved in the development and review of services designed to meet their needs.
8) There is a strategy for training and supervision to support providing gender-sensitive services for women.

Section B: Is an overview of the values and principles that all services need to adhere to in delivering gender equality, with particular reference to women.

Section C: Focuses specifically on the delivery of gender-sensitive services for women.

Section D: Considers workforce development to support the delivery of gender-sensitive services.

Section E: Provides items for service monitoring.
Section B: Values/Principles

1) There is a demonstrable commitment to addressing gender inequalities.

2) Services promote equality of access and opportunity.

3) Services promote self esteem, empowerment and builds on women's strengths.

4) Services have a holistic approach to health (including sexual health) and well-being.

5) Services respond to the social, economic and family context of women's lives including their parenting and other caring responsibilities.

6) Services promote and support access to mainstream opportunities.

7) There is zero tolerance of gender-based violence and a commitment to ensuring safety for women who use and/or work in the Trust's services.

Section C: Gender-sensitive Service Provision

Information and access

1) Information about services is available in a variety of formats accessible to a broad range of women.

2) Information about mental health issues and local resources is available in a variety of formats accessible to a broad range of women.

3) Services are accessible to all women and provided at a time that is convenient to local women.

4) The service provides outreach or additional support to facilitate access for women who might need it.

Staffing

1) The staff team includes women and is representative of the local communities.

2) There is sufficient diversity in the staff team to allow women to have a choice of key worker or therapist.

3) Staff have:
   - The ability to empathise and engage with women who use the service
   - An understanding of the complex social, economic and family context of women's lives including their parental and other caring responsibilities
   - Health, social care or appropriate life experiences.

Responding to the needs of women

1) Services are able to respond effectively and appropriately to the following health and social issues:
   - Diversity including ethnicity, disability and sexuality
   - Domestic violence
   - Childhood sexual abuse
   - Self-harm
   - Childcare issues
   - Health issues, including sexual health concerns
- Offending (of a non-serious nature) arising predominantly as a result of social deprivation.

Care Planning

1) Individual assessment and care plans consider:
   - Parenting and caring responsibilities of women
   - Their home, social and economic situation
   - Generic health needs of women, eg. cervical/breast screening/contraception/fertility needs
   - Race and culture
   - Experience of violence and abuse
   - Access to mainstream opportunities including training and employment
   - Women, both as service users and as carers, involved in planning and delivery of their own care.

Gender-specific service provision

In adopting the good practice identified here, mainstream provision will improve the gender-sensitivity of the services provided. In addition, specific provision needs to be made for women. This includes:

1) Women-only secure services, in line with the specification outlined in *Into the Mainstream*.

2) Acute in-patient care, compliant with Safety, Privacy, and Dignity Guidance.

3) Women-only day services, in line with the specification outlined and good practice standards in Supporting Women into the Mainstream.

4) Perinatal mental health services, in line with NICE guidance.

5) Eating disorder services.

6) Specialist therapeutic interventions, individual and group, for women who have experienced sexual abuse and/or domestic violence.

Inter-agency working

1) There is inter-agency working to ensure that the mental health needs of a broad range of women, identified in assessment and care planning, are met through a range of integrated provision including statutory services (eg. day centres) and voluntary sector services (eg. women’s centres) services working with women with the following needs:
   - Support with parenting
   - Domestic violence
   - Child sexual abuse
   - Depression and anxiety, including post-natal depression
   - Eating disorders
   - Self-harm
   - A diagnosis of personality disorder, primarily borderline personality disorder
   - Living with or recovering from serious mental ill health
   - Substance misuse and mental ill health
   - Learning disabilities and mental health problems
   - Involvement with the criminal justice system.

2) The service is well co-ordinated between all staff and across agencies.
Section D: Workforce development

1) Staffs are appropriately trained in social inequalities and mental health issues that have specific relevance to women and may also be relevant to men (e.g. childhood sexual abuse).

2) Training on gender equality is targeted at staff and managers at every level within the organisation.

3) Training is delivered by those with identified expertise in gender (and race) equality.

4) Training for staff covers:
   - The complex interplay of the economic, family and social context of women’s lives
   - The interplay between gender and other dimensions of inequality such as race, culture, ethnicity and age
   - The potential impact on women of specific experiences, notably childhood sexual abuse, domestic violence, parenting and caring responsibilities
   - Gender differences in the prevalence of risk and protective factors for mental ill health
   - Gender differences in the experience and expressions of mental distress particularly those most prevalent in women, e.g. self-injury, eating disorders, depression, personality disorder, and pathways into services
   - Gender differences in appropriate support, therapeutic needs and responses
   - The relationship between gender and other inequalities and how they may affect individual service users and staff in their experience of services, their working lives and day-to-day living
   - Tackling physical and sexual harassment, intimidation and violence
   - The need for reflective practice to enable staff to reflect on the ways in which they use their power, to ensure that it is in the best interests of the client group.

5) Women service users are involved in the design and delivery of training.

6) Training is supported by supervision, which focuses on gender (and race) equality, in particular, and is regularly provided.

Section E: Service Monitoring

1) There is a process in place to monitor and review provision on a regular basis.

2) This process involves a systematic process for reviewing against national or locally agreed standards.

3) Local women who have a range of mental health needs and who represent different communities are fully involved in the process of review.

4) There is evidence of changes leading to improvements in quality as a result of monitoring arrangements.
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>AMH</td>
<td>Adult Mental Health</td>
</tr>
<tr>
<td>BCVS</td>
<td>Black Community and Voluntary Sector</td>
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<tr>
<td>BME</td>
<td>Black and minority ethnic</td>
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<tr>
<td>BUG</td>
<td>Brent User Group</td>
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<tr>
<td>CDWs</td>
<td>Community Development Workers</td>
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<tr>
<td>CJS</td>
<td>Criminal Justice System</td>
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<tr>
<td>CMD</td>
<td>Common Mental Disorders</td>
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<tr>
<td>CMHTs</td>
<td>Community Mental health Support Teams</td>
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<tr>
<td>CNWL</td>
<td>Central and North West London Mental Health NHS Trust</td>
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<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
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<tr>
<td>CRHT</td>
<td>Crisis Resolution Home Treatment</td>
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<tr>
<td>CSIP</td>
<td>Care Services Improvement Partnership</td>
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<tr>
<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>DRE</td>
<td>Delivering Race Equality</td>
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<tr>
<td>EHRC</td>
<td>Equalities and Human Rights Commission</td>
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<tr>
<td>ESCs</td>
<td>Essential Shared Capabilities</td>
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<tr>
<td>FIPs</td>
<td>Family Intervention Projects</td>
</tr>
<tr>
<td>GE&amp;WMH</td>
<td>Gender Equality and Women's Mental Health Programme</td>
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<tr>
<td>GMS</td>
<td>General Medical Service</td>
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<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
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<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
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<tr>
<td>LAA</td>
<td>Local Area Agreement</td>
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<tr>
<td>LIT</td>
<td>Local Implementation Team</td>
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<tr>
<td>LPT</td>
<td>Lincolnshire Partnership Trust</td>
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<tr>
<td>LSPs</td>
<td>Local Area Agreements and Local Strategic Partnerships</td>
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<tr>
<td>MHN</td>
<td>Mental Health Network</td>
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<tr>
<td>MHTCP</td>
<td>Mental Health Trust Collaboration Project</td>
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<tr>
<td>NatCen</td>
<td>National Centre for Social Research</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<tr>
<td>NIMHE</td>
<td>National Institute for Mental Health in England</td>
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<tr>
<td>NMHDU</td>
<td>National Mental Health Development Unit</td>
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<tr>
<td>NMHP</td>
<td>National Mental Health Partnership until 31.3.07. From 1.4.07, known as the Mental Health Network</td>
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<tr>
<td>NOMS</td>
<td>National Offender Management Services</td>
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<td>NPSA</td>
<td>National Patient Safety Agency</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>NSF</td>
<td>National Service Framework</td>
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<td>NSFWO</td>
<td>National Service Framework for Women Offenders</td>
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<tr>
<td>PALS</td>
<td>Patient Advice and Liaison Services</td>
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<tr>
<td>PCTs</td>
<td>Primary Care Trusts</td>
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<tr>
<td>PPI</td>
<td>Patient and Public Involvement</td>
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<tr>
<td>RCN</td>
<td>Royal College of Nursing</td>
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<tr>
<td>RDC</td>
<td>Regional Development Centre</td>
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<tr>
<td>RCPsych</td>
<td>Royal College of Psychiatrists</td>
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<tr>
<td>SCIE</td>
<td>Social Care Institute for Excellence</td>
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<tr>
<td>SEDC</td>
<td>South East Development Centre</td>
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<tr>
<td>SPN</td>
<td>Social Perspectives Network</td>
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<tr>
<td>TEMSS</td>
<td>Therapeutically Enhanced Medium Secure Service</td>
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<tr>
<td>TWP</td>
<td>Together Women Project</td>
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<tr>
<td>UCLan</td>
<td>University of Central Lancashire</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>VVAPP</td>
<td>Victims of Violence and Abuse Prevention Programme</td>
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<tr>
<td>WEMSS</td>
<td>Women’s Enhanced Medium Secure Services</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<tr>
<td>WISH</td>
<td>Women in Secure Hospitals</td>
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<tr>
<td>WRAPs</td>
<td>Wellness Recovery Action Plans</td>
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Resources

This section provides tools and guidance to support the development of gender-sensitive and gender-specific provision for women. Other helpful reports and papers are to be found in the Policy Context section below and the References section.

Inequalities
World Health Organisation. *Gender disparities in mental health.*
www.who.int/mental_health/prevention/genderwomen/en/

Copies from WRC on 0207324 3030 or email info@wrc.org.uk

Government policy and legislation

**Women’s mental health strategy**
Department of Health (2002). *Women’s mental health: into the mainstream.*
Strategic development of mental health care for women.


**Equalities legislation**
Fawcett Society briefing on the public sector gender duty
www.fawcettsociety.org.uk/documents/Gender%20Equality%20Duty%20briefing%201.9.05.pdf

Workforce development

**Values and principles**
Women’s Mental Health Group, Royal College of Nursing (2005). *8 principles for anti-oppressive practice.*
www.rcn.org.uk/development/communities/specialisms/mental_health/forums/womens_mental_health_group/8_principles_for_practice

**Ten Essential Capabilities**
lincoln.ac.uk/ccawi/publications/Ten Essential Shared Capabilities.pdf

Care planning and assessment

**Psychological therapies**
www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_090011

**Addressing violence and abuse**


Perinatal mental health

Gender-specific services
Day services

Acute care


Policy context
Government policy documents relevant to women’s mental health and well-being (see Table 2, p10)

Department for Constitutional Affairs


Department for Communities and Local Government


Department for Children, Schools and Families


Home Office


Department of Health


References


8) Gender Training Initiative. See www.inequalityagenda.co.uk


10) Brent Mental Health User Group (BUG) (2006). Survey of women using services to deal with mental health issues – or to deal with issues which affect their mental health – in Brent. London: BUG/Women’s Service Development Subgroup, Brent Mental Health Local Implementation Team.


15) National Directory of Women’s Centres (2004). Available from Keighley Women’s Centre, 182 Skipton Road, Keighley, West Yorkshire BD1 2SY.


37) Sainsbury Centre for Mental Health (2007). Forensic mental health services: facts and figures on current provision. London: SCMH.


44) See www.iapt.nhs.uk


77) See www.mentalhealthqualities.org.uk for practice examples.

78) See www.idea.gov.uk for more information on LAAs.

79) The distinction needs to be drawn between self-harm, a comprehensive term referring to both self-injury, and self-poisoning, and self-injury, which includes cutting and other forms of injury to the body.
Acknowledgements

The report has been developed by the previous and current national leads for Gender Equality specifically Karen Newbigging, Jenifer Paul, Sue Waterhouse and Cathy Freese.

We are grateful to the Regional leads within CSIP (predecessor of NMHDU) for their key role in supporting this process. Also to Benedicta Okai and Ann Rainford for administrative and research support. We would also like to thank our Service User Reference Group for their valuable perspectives and comments.
