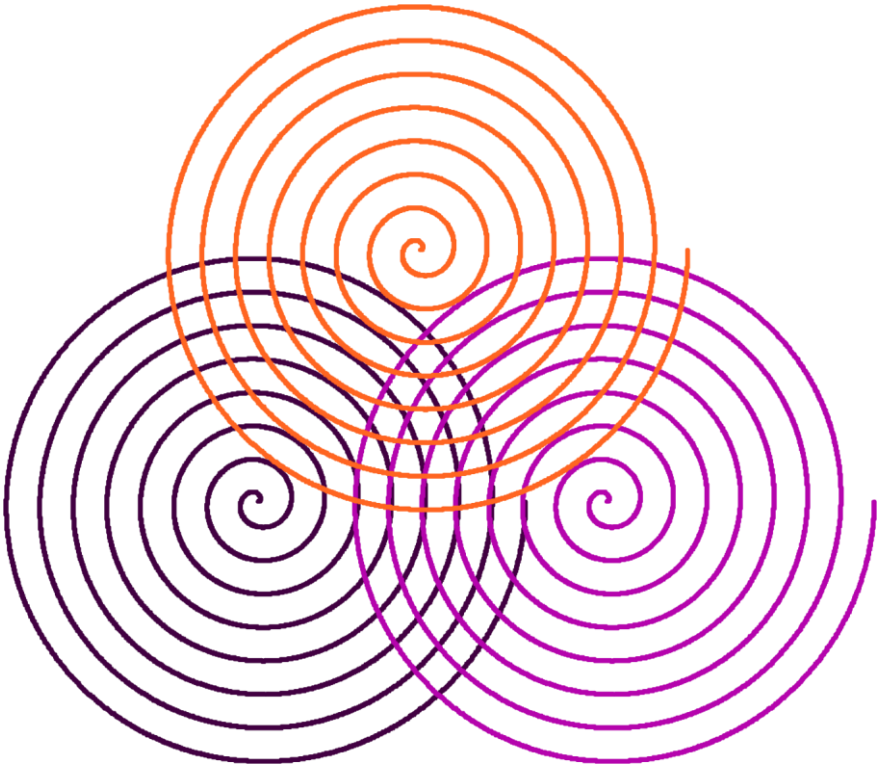
‘I AM MORE THAN ONE THING’:

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

Executive Summary

May 2014



WHEC Women's Health & Equality Consortium

imkaan

POSITIVELY UK

RAPECRISIS ENGLAND & WALES

The research is commissioned by the Women's Health & Equality Consortium (WHEC), a Health and Care Strategic Partner, and was delivered in partnership between Imkaan, Positively UK and Rape Crisis England & Wales. The report focuses on three specific groups of marginalised women: Black and minority ethnic (BME) women, HIV-affected women, and women who have experienced childhood sexual abuse and/ or sexual violence.

A snapshot of women's mental health in England

At least one in four people will experience a mental health problem at some point in their lives.[1] Women are more likely to live with a long-term mental health problem and will be prone to experiencing specific mental health issues.[2] For example, women make up two thirds of the population that suffer from dementia, are twice as likely as men to experience anxiety disorders, and are disproportionately affected by post-traumatic stress disorder,[3] self-harm and eating disorders. Despite actual and perceived shifts in gender equality, women are more likely than men to face the challenges associated with working whilst also having caring responsibilities for immediate as well as other dependent family members. Women also face greater likelihood of poverty as a consequence of unemployment, or through insecure, irregular and poorly paid employment. Violence against women and girls (VAWG) also remains a pervasive feature of our society, which has major implications for women's mental health.[4]

The guiding paper focuses on women's mental wellbeing within the context of the effects of sexual violence.[5] as well as an assessment of different levels of social exclusion or marginalisation, that may be experienced by black and minority ethnic (BME) women, and women affected by HIV. However, we recognise that many of these issues may be overlapping. Therefore, women who have experienced rape and sexual violence, may also be living with HIV, as well as experiencing particular social inequalities that are specific to ethnicity and / or culture.

Key findings from the literature review

- The link between violence against women and girls and mental health is well established in existing literature. For instance, the World Health Organisation (2002) has estimated that 60 per cent of women using mental health provision in the UK have experienced some form of sexual abuse, and that sexual violence can perpetuate further emotional, physical and social harms in the form of nightmares, depression, eating disorders, and self-harm, with consequences on parenting, employment, intimacy within future relationships.[6]
- There is a significant correlation between HIV and violence against women and girls in England and across the UK, yet the link remains under-researched and relatively

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[1] Department of Health (2011) No Health Without Mental Health, A Cross-Government Mental Health Outcomes Strategy for People of All Ages, at p8
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

[2] Department of Health (2013) No Health Without Mental Health, Mental Health Dashboard, https://www.gov.uk/government/publications/mental-health-dashboard

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

[4] Department of Health (2013) – see above footnote 2

[5] Which could be within the context of domestic violence

[6] See Carol, Dianne Whitfield and Samantha A. Piggott (2013) 'Supporting Victims of Sexual Violence: Whose Responsibility?' 21(5) Journal of Integrated Care 238-247, at p240

unacknowledged, and there is a need to investigate violence as a cause and consequence of HIV for women living in England.[7]

- Women may be less attentive to HIV prevention messages, face challenges to disclosing their HIV status, implementing risk-reduction, engaging in other preventive health behaviours and adhering to HIV treatment.[8]
- Socio-cultural and political factors, such as asylum or immigration status, family circumstances, employment, education, marginalisation on the basis of ethnicity and/or culture both within and across society, need to be taken into account in addressing the mental health needs of BME women.[9]
- Stigma and discrimination in the NHS could be part of a range of reasons why BME people often first come into contact with mental health services at the acute stage of their condition.[10]
- Experiences of detention and prison can significantly exacerbate women's mental health problems, particularly where there are pre-existing mental health concerns. Women refugees and asylum seekers may have been subjected to violence including rape, and are therefore likely to have high mental health support needs. They may face questioning about their experiences, often before they are able and willing to talk about them.[11] The detention of women asylum seekers could have an on-going impact on the mental health of vulnerable women.[12]

Key issues emerging from interviews and focus groups

Local policy

Whilst local areas are recognising to some extent the links between sexual and domestic violence and the mental health impact on women, Joint Strategic Needs Assessments are developed inconsistently and often without data from the women's sector. The understanding of issues in relation to BME women, as well as women living with HIV and women who have experienced sexual violence (included adult survivors of child sexual abuse), lacks integration across the different strategies. Islington, however, offers an example of promising practice i.e. the development of a separate strategy on women and mental health, which is a useful template for other authorities to consider.

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[7] Sophia Forum Violence as a Cause or Consequence of HIV for Women in England. A Feasibility Study Regarding a Potential National Investigation, at p4, http://www.sophiaforum.net/events/launch-of-report-on-gbv-and-hiv-in-england.html

[8] World Health Organisation (2013) 16 Ideas for Addressing Violence against Women in the Context of the HIV epidemic. A Programme Tool, at p37 http://www.who.int/reproductivehealth/publications/violence/vaw_hiv_epidemic/en/index.html

[9] Mental Health Foundation (2011) Recovery and Resilience: African, African-Caribbean and South Asian Women's Narratives of Recovering from Mental Distress, http://www.mentalhealth.org.uk/publications/recovery-and-resilience/

[10] MIND (2013) We Still Need to Talk. A Report on Access to Talking Therapies, http://www.mind.org.uk/media/494424/we-still-need-to-talk_report.pdf

[11] Keating, Frank, David Robertson and Nutan Kotecha (2003) Ethnic Diversity and Mental Health in London: Recent Developments, King's Fund Working Paper,

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/ethnic-diversity-mental-health-london-recent-developments-frank-keating-david-robertson-nutan-kotecha-kings-fund-1-august-2003.pdf

[12] Girma, M et al (2014) Detained: Women Asylum Seekers Locked Up in the UK, Women for Refugee Women, http://refugeewomen.com/wp-content/uploads/2014/01/WRWDetained.pdf

Women's experiences of support

Women spoke about individual challenges in managing their mental health and different factors that impacted on their help-seeking processes:

- Not only does violence have negative impact in terms of health, this then becomes more acute in the context of situational factors including homelessness, concerns around deportation and immigration status, poverty, social isolation.
- A specific coping strategy for some women, particularly in terms of the trauma experienced in relation to child sexual abuse, was to detach themselves from what had happened and therefore they may not have sought help earlier.
- The stigma of having a mental problem, as well as the discrimination that arose from being HIV positive often compounded women's health problems.
- Women living with HIV spoke about experiences of discrimination relating to being HIV positive including verbal and physical assault. Women did not feel safe seeking help and this also affected whether they told family members of their HIV status or whether it remained a secret; leaving women isolated and living 'a double life'.
- Decisions to seek support were often undermined when women felt that they were not always understood by professionals, felt judged, were discharged from care before they were ready or were not accessing the type of support they valued consistently enough.
- Women spoke about the importance of women-centred on-going and specialist support services which did not purely rely on more clinical forms of intervention.

Women's voluntary sector perspectives

Violence against women and girls and its impact on women's mental health is not sufficiently understood or prioritised across policy and service delivery. Women's sector practitioners raised a number of concerns including:

- A lack of gendered thinking and approaches within current work on HIV which leads to gaps in specialist HIV support services for women.
- Restrictive thresholds for accessing mental health support, which are linked to clinical diagnosis, and leave many women vulnerable to deteriorating mental health.
- Specialist women's services are not sufficiently acknowledged as key service providers within the mental health policy landscape. This means that they are not recognised as legitimate providers of therapeutic services by policy makers, even though they deliver a range of interventions to support women's emotional wellbeing.
- The lack of integration of women-centred provision within mental health commissioning frameworks makes it exceptionally difficult for specialist women's providers to further develop existing services.

Concluding comments

The findings of this report demonstrate the need for a consistent gender-specific approach in national and local policy and commissioning structures, if the ambitions around mental health set out in the NHS Mandate[13] are to be effective.

Specialist voluntary sector women's providers frequently play a pivotal role in providing immediate emotional support that prevents the onset of more chronic mental health conditions and therefore avoid the need for more intensive statutory mental health interventions. These services are able to adapt to the individual circumstances of women, whether this is through long or short-term support interventions. This means that statutory mental health services and commissioners need to work more closely together with specialist voluntary sector women's providers, such as local Rape Crisis Centres and ending violence against women and girls services. Voluntary specialist women's services need to be sustained in order to be able to survive on a long-terms basis, so that better outcomes are achieved for the longer-term health needs of women.

Having a gendered analysis would prevent inconsistency in meeting women's mental health needs, and ensure that Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, will successfully identify the needs of the entire community, including those in vulnerable groups who experience inequalities. In a 2013 report, WHEC published a guide with a five-step process for ensuring a gendered analysis.[14]

National leadership is required to ensure that current mental health strategies reflect a gendered analysis, and this is used to influence policy and practice on a local level. To ensure that underlying gender inequality issues are addressed effectively, it is vital for work to be carried out, with organisations addressing gender and other equality issues as a fundamental and integral part of their culture, and in their mainstream activity, not as an afterthought. This means that organisations as a whole need to begin to consider how they might develop a culture in which the gender inequalities that affect service users and staff are considered and addressed.

Recommendations

1. The Minister of State for Care and Support and the Parliamentary Under-Secretary of State for Public Health works with the women's VCS to improve mental health provision for women and girls and ensure the effective implementation of the government's mental health strategy, taking into account duties and responsibilities within the Equalities Act 2010, the Human Rights Act 1998 and the NHS Constitution.
2. NHS England works with the Health and Social Care Information Centre to ensure that all data is disaggregated on the basis of gender and all the protected equality characteristics. This data should be published and used to shape the thinking and development of service responses.
3. The Department of Health promotes promising practice and approaches to meet the mental health needs of women, drawing on the lessons learned from 'Into the Mainstream'.

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[13] Department of Health (2012) The Mandate. A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015, http://webarchive.nationalarchives.gov.uk/20130922140506/https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127193/mandate.pdf

[14] WHEC (2013) Better Health for Women: How to Incorporate Women's Health Needs into JSNAs and JHWSs, http://www.whec.org.uk/wordpress/?page_id=306

4. Healthwatch England promotes women's mental health needs as a priority theme within local monitoring and consultations and across national health and care agencies.
5. The Home Office ensures immigration and asylum cases are processed with an understanding and sensitivity to any mental health issues, in addition to case owners having an awareness of and understanding of the Gender Guidance. And with the UK Human Trafficking Centre and Ministry of Justice, to urgently review current interview tools, frameworks and processes, such as the National Referral Mechanism, to ensure that first responders/ UKVI (UK Visas & Immigration) Case Officers appropriately and adequately interview women seeking asylum, who have been trafficked into, within, and out of the UK, and who have experienced or are experiencing trauma as a result of trafficking, taking into account the negative impact of experiences of violence on women's emotional and mental health.
6. Women's voluntary and community sector organisations engage with their local Healthwatch and health and wellbeing boards to offer intelligence and expertise around women's mental health needs to inform JSNAs and local service planning.
7. Health and wellbeing boards address women's mental health issues by engaging local women's VCS organisations in local service planning and map women's mental health services as part of their asset mapping process.
8. Clinical Commissioning Groups collate information about women's mental health needs and experiences and commission specialist women-only services to meet the needs of all women.
9. Statutory mental health services, GPs and other health practitioners build on the effectiveness of the IRIS (Identification and Referral to Improve Safety) model on domestic violence to improve processes of identification, referral and support to address women's mental health. Work in partnership with local voluntary specialised women's sector experts to co-deliver training and awareness-raising initiatives targeted at addressing women's mental health.

Read the full report at www.whec.org.uk