WOMEN'S MENTAL HEALTH AND WELLBEING:

Access to and quality of mental health services

This briefing paper reports on women's experiences of mental health and wellbeing, access to mental health services, effective services, and gaps in service provision

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WHEC Women's Health & Equality Consortium

imkaan

POSITIVELY UK

RAPE CRISIS ENGLAND & WALES

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INTRODUCTION

In 2014, WHEC (Women's Health Equality Consortium) partners, Imkaan, Positively UK and Rape Crisis England & Wales produced 'I am more than one thing,' a report on women and mental health. Based on a series of interviews and discussions with survivors of VAWG (violence against women and girls), practitioners working within the specialist sexual violence, BME 'by and for' ending VAWG and HIV sector and commissioners of mental health provision were also interviewed.

It is well recognised that VAWG is a cause and consequence of gender inequality, and at any stage in the life course, causes varying degrees of harm, vulnerability and disadvantage in a number of overlapping ways. This includes impacts on physical and mental health, damage to self-esteem and confidence, isolation, homelessness, and reduced economic prospects. For a BME woman living with HIV who is also a survivor of sexual violence, the experience of accessing support can be further compounded by multiple, intersecting inequalities and a broader context of social exclusion and marginalization.[1]

In 2014, we found:

- Poor responses by health professionals, partly due to a lack of understanding about the mental health impact of living with HIV combined with stigmatising treatment of women who are HIV positive within healthcare settings.
- Women did not always feel that they were understood by health professionals, which at times meant that they felt 'judged,' or were discharged from receiving mental health services before they were ready.
- Women also spoke about the importance of dedicated spaces for women and women specialist support services. The need and value of a consistent, gender-specific approach in the commissioning of specialist services was identified.

In 2015, we produced further guidance for Clinical Commissioning Groups and Health and Wellbeing Boards to assist them in integrating women and mental health within local policy and practice.

1 Women who are also subject to inequalities of race, class, poverty and/ or being part of a particular minority group (such as a Traveller or migrant community) face multiple risks. In other words, when thinking about women and girls at risk, understanding gender inequality is absolutely essential – but alone it is not enough. McNeish, Di and Sarah Scott (2014) Women and girls at risk. Evidence across the life course, http://lankellychase.org.uk/wp-content/uploads/2015/10/Women-and-Girls-at-RiskEvidence-Review.pdf (accessed 30/3/16)

APPROACH

This report follows on from our previous work to consider whether there have been any shifts or improvements in women's access to appropriate service provision particularly given that mental health continues to be a core governmental priority.

Imkaan, Rape Crisis England & Wales (RCEW), and Positively UK collaborated with Bradford Rape Crisis & Sexual Abuse Survivors Service (BRC&SASS)[2] and Saheli[3] in Manchester, to coordinate a series of survivor-centred community discussion groups in January 2016. Positively UK also hosted a dedicated discussion in London with women living with HIV.

The discussions focused on women's experiences of mental health and wellbeing, access to services provision as well as the quality of services they may have received.

49 women participated in the discussion groups, the majority of whom were survivors, as well as a smaller number of voluntary sector experts/practitioners predominantly working in specialist women's organisations. This report presents findings from the discussion groups, along with recommendations.

NATIONAL POLICY COMMITMENTS

Following the Coalition government's policy direction of seeking to place mental health needs 'on par with' physical health in 2011,[4] the National Mental Health Taskforce published its national Five Year Forward View for Mental Health in February 2016.[5] Along with the current government's refreshed Ending Violence against Women and Girls Strategy 2016-2020,[6] these two strategies represent significant national policy opportunities for improving mental health provision.

The NHS has committed itself to 'the biggest transformation of mental health care across the NHS,'[7] following publication of the Five Year Forward View for Mental Health, and pledged to help more than million extra people, investing in more than one billion pounds a year by 2020-21. The three Priority Actions[8] for the NHS by 2020-21 identified by the national Independent Mental Health Taskforce are:

- A 7-day NHS – improving access to services, reducing waiting times and involving crisis resolution and home treatment teams
- An integrated mental and physical approach – ensuring that both physical and mental health care needs are addressed at the same time

2 BRC&SASS, is an independent specialist service, working with women and girls who have experienced all forms of sexual violence including childhood sexual abuse.

3 Saheli, is a BME 'by and for' ending VAWG (violence against women and girls) organisation working with South Asian/BME women.

4 Department of Health (2011) No Health Without Mental Health, A Cross-Government Mental Health Outcomes Strategy for Peoples of All Ages, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf (accessed 16/3/16)

5 National Mental Health Taskforce (February 2016) 'The Five Year Forward View for Mental Health: A report from the independent Mental Health Taskforce to the NHS in England, https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf (accessed 16/3/16)

6 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/505961/VAWG_Strategy_2016-2020.pdf (accessed 16/3/16)

7 https://www.england.nhs.uk/2016/02/fyfv-mh/ (accessed 17/3/16)

8 See Executive Summary of The Five Year Forward View for Mental Health, pages 11-18

- To promote good mental health and prevent poor mental health at community level, with multi-agency partnerships, including local Health and Wellbeing Boards

The refreshed VAWG Strategy commits to providing £80 million to provide 'core support for refuges and other accommodation-based services...[and] will include specific provision for women from BME backgrounds and innovative services for the most vulnerable with complex needs' up until 2020/21.[9] In addition, the funding will be used to 'support a network of rape support centres and a network of national helplines.' From 2017, the increased funding will support the launch of a 'VAWG Service Transformation Fund' to support, promote and embed best local practice.[10] Furthermore, the strategy is clear that local NHS services must increase spending on mental health, with an expectation from the government for Clinical Commissioning Groups to play a vital role in the local commissioning of services to address VAWG including mental health.[11]

Examples of the more detailed recommendations and actions relevant to women and girls are identified below:

NHS Five Year Forward View

Increased access to integrated evidence-based psychological therapies for adults with anxiety and depression, with a focus on people living with long-term physical health conditions and supporting people into employment (Rec 14, page 33).

More support to be provided to women to increase access to evidence-based specialist mental health care during the perinatal period, which should include access to psychological therapies and the right range of specialist community or inpatient care (Rec 15, page 33)

Core mental health training for all GPs (Rec 36, page 48)

Standards to be developed for all prescribing health professionals that include discussion of the risks and benefits of medication, taking into account people's personal preferences, including preventative physical health support and the provision of accessible information to support informed decision-making (Rec 38, page 48)

Department of Health, NHS England, PHE and Health & Social Care Information Centre to develop a five-year plan to address the need for substantially improved data on prevalence and incidence, access, quality, outcomes, prevention and spend across mental health services (Rec 39, page 52)

NHS England should disaggregate the inequalities adjustment from the baseline funding allocation for CCGs and primary care, making the value of this adjustment more visible and requiring areas to publicly report on how they are addressing unmet mental health need and inequalities in access and outcomes (Rec 48, page 58)

9 Ending Violence against Women and Girls Strategy 2016-2020, page 11
10 Ending Violence against Women and Girls Strategy 2016-2020, page 11
11 Ending Violence against Women and Girls Strategy 2016-2020, page 32

ENDING VIOLENCE AGAINST WOMEN & GIRLS STRATEGY 2016-2020

Preventing violence

- Preventing harmful practices, i.e. FGM, forced marriage (pages 18-20)
- To support women in isolated communities to understand that domestic abuse is a crime and to seek help if needed (Action 4)
- Strengthening the role of the health services (pages 21-22)
- To intervene early and refer victims to the most appropriate statutory and non-statutory services.
- To support improvements in responses to health professionals to VAWG, e.g. roll out of IRIS programme and to more firmly embed routine enquiry into domestic abuse in maternity and mental health services. From April 2016, to introduce sensitive routine enquiry of adverse childhood experiences in a range of targeted services where people who have been abused are likely to present, e.g. sexual assault referral centres and sexual health clinics (Action 20)

Provision of services

- Local commissioning and accountability (pages 28-30)
- Devolved responsibility for local service provision to local commissioners, which includes PCCs, health and local authority commissioners.
- The government will publish a National Statement of Expectations (NSE) to give clarity to local partnerships on good commissioning and good service provision. The NSE will become a blueprint for all local areas to follow, and will set out core expectations, with the freedom to respond to local need (Page 10 and Action 39)
- Central government funding and expectation that local NHS should increase the amount they spend on mental health. Clinical Commissioning Groups to play a vital role in local commissioning of services to address VAWG including mental health (pages 31-32)
- From April 2017, national funding model will change, and a new VAWG Service Transformation Fund will support local service provision by 'supporting community-based services through funding local programmes which encourage new approaches incorporating early intervention; establish and embed the best ways to help victim and their families and prevent perpetrators from re-offending. The Transformation Fund is meant to drive improvements in local commissioning, and give specialist guidance to health commissioners, and to meet the needs of women experiencing multiple disadvantages (page 31` and Actions 37, 40, 42)
- Partnership working, improved multi-agency working and improved asylum system (pages 36-40)
- Home Office to work with NHS England, Public Health England, Health Education England and other partners to disseminate the findings from policy research relating to violence against women and children and good practice arising from grants to third sector organisations (Action 66)

WOMEN'S EXPERIENCES OF MENTAL HEALTH AND WELLBEING

In the three discussion groups women described the multiple impacts of living with poor mental health and wellbeing in their day-to-day lives. Women shared experiences of feeling silenced and not speaking openly to anyone about their mental health because of the isolation and stigma they experienced. Women expressed feeling a loss of confidence, self-neglect, a lack of motivation and 'not having energy.' Anxiety and depression often prevented women from leaving their home and consequently increased their isolation. Women spoke about the different ways in which they had internalised the violence and how this negatively compounded on women's sense of self and confidence. It is well documented that experiences of violence and abuse can have a devastating and enduring impact on women's mental wellbeing.[12]
For example:

Anxiety	Post-natal depression
Schizophrenia	Unstable state of mind
Bi-polar Disorder	Post-Traumatic Stress Disorder
Self-harm	Dissociative Disorder
Crying	Psychosis
Suicidal ideation	Sadness
Nightmares	Combination of physical illness
Hearing voices	impacting on mental health

Women spoke about the challenges of coping with multiple, intersecting issues including financial difficulties, racism, unstable living conditions, sexual abuse, being diagnosed with HIV.

- Being controlled physically and emotionally (by an intimate partner, in-laws, family members)
- Being an adult survivor of child sexual abuse
- Limited and restricted movement due to insecure immigration status, which leads to fear of the future, financial difficulties, working restrictions, restrictions accessing support and services
- Diagnosis of HIV causes stress due to worry about the future
- Financial difficulties
- HIV status contributing to isolation due to non-disclosure of status because of fear of discrimination and worrying 'someone may find out'
- Isolation
- Language barriers
- Not understanding how the UK system works
- Racism
- Domestic violence
- Sexual violence and abuse
- Trauma associated with past experiences, including childhood sexual abuse
- Unstable living conditions
- HIV stigma in the community and internalised stigma with consequent loss of self-esteem, loss of social status, changed sense of identity and belonging, association of HIV to 'sexual promiscuity,' immorality

BARRIERS TO ACCESSING HELP

A number of reasons, described by women, prevented access to support.

Framing of trauma preventing women from seeking help:
Women do not always frame their own experiences of trauma in the same way as the medical profession. Women wanted more information and support to be able to talk about their experiences in a safe and accessible space.

12 See for example, Garcia-Moreno, Christina Pallitto et al (2013) Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner, http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf (accessed 30/3/16); Imkaan, Positvely UK and Rape Crisis England & Wales (2014) I am more than One Thing, http://www.whec.org.uk/wordpress/wp-content/uploads/downloads/2014/05/I-am-more-than-one-thing-Full-Report.pdf (accessed 30/3/16)

One woman commented that, "most women are unaware of what mental health is. Meetings like these should take place everywhere in community places so women can find out and get help."

> **I think first of all you need to have the information and you need to know what is happening to you as well. You need to be educated to know what is happening to you. If you've got diabetes and are having the symptoms you need to have had knowledge to tell you it's diabetes.**

Stigma: associated with poor mental health is a prominent reason for why women stated that they had not sought help earlier. Women gave various reasons including, "you are ashamed to get help" or "there is a fear of society saying that we are mad."

Psychological violence: Some of the reasons that prevent women from seeking help are inextricably linked to the impact of psychological violence which led to the decline in their mental health in the first place, as in the following example, "your partner can also say to you that you are going to that [mental health support] because you are mad, and this proves that you are the problem and have something wrong with you."

Women living with HIV: When women living with HIV access help from GPs and counsellors they are reluctant to disclose their HIV status because of a fear of judgement, which arises due to the stigma of living with HIV. One woman described her experience of accessing the GP surgery, "when the GP knows your status they don't even want to treat you. And when the receptionist rang to tell me she called it an infection clinic [referring to HIV clinic], and the way she left the message was not nice." Another woman stated that "the minute you mention HIV you have a fear of their [professionals'] response."

Being prevented from leaving the house: Some women described an excessive control of their lives by an intimate partner or in-laws which prevented them from leaving the house to seek help. One woman told us that, "if I am going to leave the house I would need to explain where and there would be suspicion." While another explained, "my family wouldn't let me leave the house."

Immigration status: Some women were affected by their immigration status, which was restricted for different reasons, "the main thing for me is immigration status, if we have that we can go to the GP, that is the most important thing."

> **For me, I am on section 4 so when I had to access the mental health services in Leeds, it was a challenge for me to get there. Spending on bus fares. Section 4 is a cashless form of support so I couldn't access the services because I didn't have money to get there. I'm not given a pass or anything.[13]**

A lack of financial independence: Lack of money, or no access to money was raised by women who could not

13 Section 4 *(Immigration and Asylum Act 1999)* support is provided to failed asylum seekers - whose claim for asylum has been refused and any subsequent appeals have been unsuccessful. Unsuccessful asylum seekers would need to meet the eligibility criteria. Support is given to the unsuccessful asylum seeker, along with dependents and support would be in the form of accommodation and a prepaid payment card for food and essential toiletries, see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/487381/Asylum_Support_Section_4_Policy_and_Process_PUBLIC_v6.pdf(accessed 17/3/16)

access services as they could not afford public transport.

Falling through the gap in service provision: There were concerns that mental health practitioners lacked an understanding of the impact of violence on women's lives. One professional informed us that "sometimes [the counselling service] can't take women if they experience domestic violence." In addition, the threshold for accessing help from a statutory mental service was high, as one woman told us "you have to be at the point of having a nervous breakdown or episode before you can get help. You have to be in crisis."

Poor experience of one service can put survivors off from getting the help they need from other services for many years[14]

- poor experiences of a service presented as a barrier for accessing a further service (2015:28)
- survivors rated social services, A&E and hospital services as consistently poor and the least satisfactory services (2015:25)
- experiences within the least satisfactory services correlated to survivors' feeling that they had not been listened to, believed or respected. Less than half of those who used social services and A&E felt they had been listened to believed or respected (2015:21)

Waiting lists for counselling services, including NHS mental health services: was also reported as a barrier to accessing services, "at times the waiting lists can be up to 12 months long" and a professional working within a BME 'by and for' VAWG organisation reported "it's impossible to make counselling referrals. There is one year waiting list. It is difficult to refer women to the Urdu speaking counsellor." While another professional added "our community service waiting list is 12 weeks... at the moment everything is on hold because we don't know about funding for next year."

WOMEN'S EXPERIENCE OF MENTAL HEALTH SERVICE PROVISION

GPs' over-reliance on prescribing medication:

Women access mental health services via their GPs. Women continue to tell us about the problem of GPs' over-reliance on prescribing medication to address their 'symptoms.' One of the women stated that, "when you are in crisis you have to wait, then the GP will give you pills because that's a quick fix." While another woman spoke about having to insist on being referred to a counsellor, "I felt there is something not right here so I went to the GP and said I am feeling like this, it's not normal. So he said take these pills, these will help. I said no, I want to go for counselling, so I asked for counselling and then I was able to access a crisis unit where they had a crèche, which was really important for me because I had babies [also] important for young mothers because young mums are totally being missed and isolated."

Women acknowledged that medication could be helpful and unhelpful at the same time, "they do have a place, they do help but medication on its own is not going to help. It just suppresses your feelings." Another commented that, "You feel numb and a bit flat."

14 Smith, Noel, Cristian Doganru and Fiona Ellis (2015) Hear Me, Believe Me, Respect Me. Focus on Survivors: A survey of adult survivors of child sexual abuse and their experiences of support services, http://www.ucs.ac.uk/Faculties-and-Centres/Faculty-of-Arts,-Business-and-Applied-Social-Science/Department-of-Psychology,Sociology-and-Social-Work/Focus-on-Survivors-Final-Copy-Logo-Blk.pdf (accessed 30/3/16)

> Some of these services don't ask what is suitable for us they just push pills on you. It happened when I came to this country and I was living in South Wales. I was isolated, I was the only black woman living in the place, it was quiet and cold. I was already withdrawn because I was isolated, the only days I would go out was Sunday and Tuesday so when I went to my clinic in Cardiff hospital, I was straight away told to see a mental health nurse who didn't ask me what I think is good for me and what treatment I prefer so they just prescribed me anti-depressants straight away.
>
> When I moved to London my GP here made it worse...so I went berserk and I ended up in accident and emergency for mental health, so then I had to go to post traumatic stress disorder.
>
> After two years they called me for an assessment with the NHS, and after three appointments of that they discharged me and wanted to put me in CBT and I didn't want that, I wanted one for PTSD, because I was running in the night, I was fighting, killing, flying, swimming everything [referring to nightmares]. So I needed something to help me but nobody noticed that.
> They referred me to psychiatrist again and I said I don't need this and then they discharged me again.
>
> My experiences with NHS and providers is that you are hitting a brick wall every time.

A lack of understanding from the mental health professional: Once women are in the system, other problems arise. One woman explained that, "the doctor doesn't understand us and treats us like we are mad but all we need is support. You tell him one thing and he tells you something else. He doesn't ask why you have this problem, he just gives you medicine."

A range of comments highlight problems of professionals not understanding how to support women who have experienced violence, including sexual violence, and violence as a cause of women's mental health illnesses. One woman stated that, "my counsellor said that she had never come across the stuff I have experienced and even she was not sure how to deal with it." Another woman commented, "doctors don't understand why depression exists," in relation to doctors who have not had training on VAWG or who lack understanding of the link between poor mental health and violence against women.

Services need to be more vigilant in identifying whether service users have experienced abuse[15]

- 80% of survivors were not asked by professionals within statutory services if they had experienced child sexual abuse.
- a quarter of survivors had accessed services to seek help for experiences of child sexual abuse, without having disclosed their abuse.
- to make disclosures survivors had to bring up the subject themselves. Disclosing experiences of child sexual abuse is traumatic for survivors and on average they do not receive the support they need for twelve years after disclosure (2015:34).

Accessibility:

One woman told us that, 'there is often a language problem[16] with GPs so you give up." Once they are within the mental health system, the language barriers experienced by women were expressed as manifesting in different ways. Women described the difficulty in being able to explain fully how they were feeling when they were unwell whilst women also described the language of mental health as difficult to relate to on a personal level and inaccessible:

> **We need the mental health service to simplify words, if they ask me if I have mental health I would say no, not at all, if someone said are you worried about your son I would say yes and cry. Or are you eating well? I would say no because I have no money. Using the words mental health, I have never been mental and I don't have mental health.**

For those women whose first language was not English, there are additional barriers to accessing help:

"If you don't know English you have to ask someone else to book you an appointment, someone else then knows about your problem."

RECOMMENDATIONS FROM WOMEN FOR IMPROVING SUPPORT

A number of suggestions were made in response to what was considered as the most valuable elements of a mental health service.

Group activities alongside one to one counselling

One to one talking therapy was considered to be helpful, however group therapy enabled women to have a shared experience and helped to build resilience:

"I went to the GP and he asked all the mental health questions such as 'are you thinking of killing yourself? I said no but I need to speak to somebody so I was referred to talking therapy, and from there they referred me to a CBT group, I started going to meetings. Men, women, old, young, of all walks of life...the CBT group helped and it was from that experience I decided to be a mental health nurse. At the end I came out very strong."

Additionally, group activities was highlighted as being able to significantly contribute to reducing isolation, which has been found to exacerbate poor mental health:

"Isolation is a key thing. Being connected and having connections, that helps. Just being in the same room as other people. Counselling is a really useful tool for understanding your own

15 Smith, Noel, Cristian Doganru and Fiona Ellis (2015) Hear Me, Believe Me, Respect Me. Focus on Survivors: A survey of adult survivors of child sexual abuse and their experiences of support services

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

health and development and awareness of yourself but just having places where you can go and have a cup of tea and do some crafting or just meet other people."

Furthermore women described the need for group activities such as social activities and activities which allow for self-expression, for example, activities with music. Those who have already accessed group activities through women's organisations or other voluntary sector services told us that they "keep your brain active"; "you feel fresh" and "[group activities] helps because we talk."

A variety of interventions

The causes and impacts of mental health and wellbeing, common among women, are also multiple and intersecting, which means that the experience is unique to each individual. In light of this, women highlighted that it was essential to be able to choose from a variety of therapies. One woman described the need for "an organisation that listens and offers different types of therapy that you feel may be beneficial to you as an individual." While another woman informed us that she would be attending a mental health organisation where "you can go there and join an activity, for example, do a course, join a cookery class, you can volunteer, up to [you] what you want to do."

In supporting the need for a variety of therapies, a professional who provided mental health support commented:

"When you talk about health and wellbeing services there isn't a one-size-fits-all model at all. That's totally inappropriate because of the uniqueness of each person's experience and the actual response to that. There are some themes, there are some patterns, but it's difficult for service providers because they have so much limitation on what they're providing. So if you're seeking support and help you're forced to fit within a certain framework. That can just add stress to what you're already going through. So it's not helpful."

Longer term support

Often the nature and number of NHS counselling sessions available offered a generic service and was insufficient. Women were in need of longer term support, particularly from specialist women's organisations where there is an understanding of the causes and links of mental health to the violence that women have experienced. Many women need lifetime support to live with their trauma, not just at the point of crisis:

"Quite often you'll have a block of counselling sessions and you'll get to a point where you feel all right about yourself or situation and that's fine, but actually if you've got tons more stuff that you know is aggravating you, you need to work through it, you have to go through the referral process all over again. At times the waiting list can be up to 12 months long."

A lack of longer term support could be counter-productive to women's emotional health and wellbeing in the long term as they are likely to experience a relapse. Not only does this impact on women's self-motivation to get better but also results in a revolving door scenario. One woman spoke about her experience of short-term counselling:

> **"You approach your counselling with the mind-set I have got six sessions and I have to cover everything and it puts a lot of stress on you, it's not a natural way to work through things and it can be counter-productive. And it can leave you hanging which is potentially really dangerous. The practitioner, for example, the therapist say they are trained to leave you in a safe place as you come to the end of your time but even so who are they to say when you are better?"**

One woman who was able to secure longer term support informed us, "I have been attending ongoing counselling for many years and I keep attending because I see the benefits."

Professionals identified a need for specialist training on VAWG for statutory professionals, such as medical, social services and CMHTs.

HIV aware services and peer-led women focused HIV services

Women living with HIV emphasised that they felt safe to disclose their HIV status within HIV aware support services. The reasons being that the diagnosis of HIV can cause poor emotional health and wellbeing, and the fear of disclosure of a woman's HIV status due to stigma contributes to isolation and poor mental health,

"I think it's important to go to an organisation which is HIV aware because the stress, depression is all caused by HIV."

To ensure that mental health support services are providing the level of care required and do not contribute to exacerbating poor mental health, it is essential that mental health support services are HIV aware. A woman commented, "if you get a service which is HIV aware you find you can talk about it."

Women also described their experience of voluntary sector organisations that are HIV aware and the importance of peer-led women focused HIV services as, "these groups [listed a number of organisations] the moment you go to them they start linking you to other organisations where you can get support. We are free to say anything with an HIV organisation."

Acknowledging, valuing and funding existing specialist women's support services, BME 'by and for' ending VAWG organisations and peer-led women focused HIV organisations

Women clearly valued the support provided by the host organisations, Bradford Rape Crisis & Sexual Abuse Survivors Service, Saheli and Positively UK. Overall, women highly valued support from women's specialist services, BME 'by and for' ending VAWG organisations, including organisations that have developed dedicated approaches and expertise to supporting women who present with a range of vulnerabilities in relation to their mental health. They found the support they received from women's specialist organisations, 'BME 'by and for' ending VAWG organisations and peer-led women focused organisations extremely helpful as points of access for information, and for providing direct and indirect mental health support.

As points for access to information

BME professionals and service users described BME 'by and for' ending VAWG organisations often as first points of access when experiencing violence, immigration, housing issues, and when language services are needed.

Knowledge of 'BME 'by and for' ending VAWG organisations was often through a person in the community making the woman aware of the services or through a woman searching on the internet which would lead to self-referrals. For women who do not find out about a service through 'word of mouth' the route to access is often through referrals by the police, GPs, hospitals, social services, schools, clothes shops or grocery shops.

One woman explained that "sometimes you don't know where to go and it is only when you come here [local women's specialist organisation] you can ask people, but sometimes you can't ask anybody else because no one is telling you anything."

Providing direct and indirect mental health services

One woman informed us that a women's specialist service was her first point of call as a direct mental health service and acted as providing buffer and continuity of support to the NHS, "the first place I had counselling was with [a women only organisation]. Then at the hospital and through a neurologist they referred me to a psychiatrist. I didn't even know of these services before. I had six weeks of counselling with a psychologist, that was part of the NHS. Now I go to drop in groups with [a women only organisation]."

With the lengthy wait for NHS mental health services, specialist women's services are vitally needed to support

women. Another woman told us that at the point she really needed to talk to somebody, and she asked her GP about counselling, she was told that the waiting list for counselling was six to nine months. However, because she was able to search for women's services, she managed to locate a specialist women's service that "gave me a whole block of counselling and they got me through the issues" after only waiting for two weeks.

A woman who had experienced sexual and/ or physical violence described the indirect support she received, within a BME 'by and for' ending VAWG organisation, to begin overcoming the psychological and emotional impacts of violence, and to improving emotional health and wellbeing: "Key working sessions with support staff is like a counselling session asking us what do we want, are we happy." Another woman said, "when I have [mental] tension it hurts my body, but now my body doesn't hurt as much, as I can speak to [BME 'by and for' ending VAWG organisation] workers."

BME professionals providing mental health services within BME 'by and for' ending VAWG organisations highlighted that BME women have unique support needs in which community based support and an understanding of language, cultural context, racism and immigration issues is essential to providing adequate care and support. BME women also reinforced this and expressed that it was "better if all kinds of support is in one place, such as housing, mental health, asylum etc."

With the freedom to feel safe in disclosing their HIV status, women were able to access information about services that may help them to improve their mental health and wellbeing and prevent poor mental health being triggered. Women living with HIV valued the opportunity of meeting somebody who is undergoing similar experiences in a safe and supportive peer-led women-centred space. As one woman stated, "I think it's important to go to an organisation which is HIV aware because the stress, depression is all caused by HIV."

Preventing poor mental health

Professionals from the voluntary sector also commented that BME 'by and for' ending VAWG organisations, women's specialist services and women focused peer-led HIV services take action to prevent the deterioration of women's mental health and wellbeing,

"You're actually preventing. I think it's very difficult to measure prevention, the support groups that we hold for women. It's very difficult to measure that, but women actually tell us that it actually prevents them getting more seriously ill, by talking to them, and them befriending each other... they feel that they're not being judged, they're not stigmatised, because mental health is still a huge stigma in society."

Acknowledging, valuing and funding women's specialist organisations, BME 'by and for' ending VAWG organisations and women focused peer-led HIV services

Professionals explained that women's specialist organisations, BME 'by and for' ending VAWG organisations and women focused peer-led HIV services are not acknowledged and valued as mental health services by commissioners and policy makers. One professional commented that "voluntary services provide mental health support, even though it's not statutory and we don't have the word mental health." Another professional informed us, "we are supporting people in the community and we are enabling people to support each other, like we are today. Then you're going to lessen the demand on statutory service, it's a no brainer, isn't it?"

Professionals also told us that women's specialist organisations and BME 'by and for' ending VAWG organisations are not funded adequately, "you always find the community groups, like the ones that we have, are struggling constantly for funding because they're not given recognition or valued." Another professional stated, "there are very few services for women and mental health. In the voluntary sector there is a women's counselling service, and this is called a health group. There was a women's group focusing on healthy eating but the funding ended."

A BME professional working within a BME 'by and for' ending VAWG organisation told us that,

> **There is a need for funding for one to one work and group work for the mental health needs of women. In terms of the number of women with mental health needs, this is the highest ever, so far. A few women have attempted suicide and not spoken about it before. We have developed specific counselling for women who experience domestic violence but it is difficult to get funding.**

The value placed by women living with HIV on the supportive and empowering nature and benefits gained from women focused peer-led HIV services, which prevents isolation, also needs to be acknowledged by commissioners, so that these services continue to be funded. As one woman informed us, "When I was first diagnosed, my doctor sent me here. If 13 years ago [the women focused peer-led HIV service] didn't listen to me, I would be on the road naked, I would have died."

The Need for Timely Action

The government's current policy direction in seeking to place mental health needs 'on par with' physical health appears to be reinforced by its promises of funding and guidance on 'good' commissioning and service provision.

However, when the 2016 findings from this briefing is viewed within the context of our 2014 report, we are concerned that there has not been sufficient improvements in mental health provision for women who are survivors of different forms of violence; BME women; and women living with HIV, who experience different levels of social exclusion or marginalisation.

2016	2014
A lack of understanding from mental health professionals as to why women who are survivors of violence, including sexual violence and/or childhood sexual abuse; BME women; and women living with HIV experience poor mental health and how best to support them.	"Poor responses were directly linked to the health professional they [women] had accessed not fully understanding or engaging with the full impact of sexual violence or how living with HIV has particular consequences for the safety and mental health of women." (2014:17)
Women's specialist and BME 'by and for' ending VAWG organisations are highly valued by women.	"On-going casework support from a specialist BME women's support worker was highly valued. A number of women spoke about feeling safe and understood and the importance of these types of services in managing their health and wellbeing." (2014:20)
Group activities and a variety of therapies significantly improve emotional health and wellbeing.	"Women wanted improved access to other types of therapeutic activities including group-work, exercise, and social activities to combat social isolation and strengthen their overall sense of wellbeing. Women gave examples of activities that were particularly helpful, such as women's gardening project, where women grow fruit and vegetables and cook together and do other activities." (2014:20)
A barrier to accessing help for women living with HIV is a reluctance to disclose their HIV status due to a fear of judgement and discrimination, i.e. 'double discrimination.' Women living with HIV would be more likely to disclose their HIV status within an HIV aware or peer-led women focused HIV service.	"Agencies described women experiencing 'double discrimination,' and therefore a key reason women were fearful of disclosing is connected to the significant levels of stigma they experience associated with being HIV affected and the nature of discrimination women experience from some agencies and from wider society." (2014:27)
Women's specialist services and BME 'by and for' ending VAWG organisations are not acknowledged as valuable, providing preventative services, and funded.	"Specialist women's services are not sufficiently acknowledged as key service providers within the mental health policy landscape. Statutory mental health services and commissioners need to work more closely with specialist women's providers, such as local Rape Crisis Centres, as they frequently play a pivotal role in providing immediate emotional support that prevents the onset of more chronic mental health conditions and therefore avoid the need for more intensive statutory mental health interventions. As highlighted by one interviewee, 'We try to keep women out of statutory services. We work with many women with undiagnosed personality disorders, and we do this work very well." (2014:29)

SUMMARY AND RECOMMENDATIONS

While some of the support needs expressed by the women in this briefing could partially be met by the National Mental Health Taskforce's national Five Year Forward View for Mental Health, and the government's Ending Violence against Women and Girls Strategy 2016-2020, these strategies also present significant shortfalls.

Our 2016 briefing presented evidence of causes of women's poor emotional health and wellbeing as multiple and intersecting, and impact their lives on a day to day basis to varying degrees of intensity. Women who experience barriers to seeking help have informed us that they do not always frame their own experiences of trauma in the same way as the medical profession. Other barriers women mentioned include: stigma at a societal level; psychological violence; 'double discrimination' towards women living with HIV within the mental health system and from health practitioners; being prevented from leaving the house; restrictive immigrations status; a lack of financial independence and long waiting lists for NHS mental health services, including counselling.

Once women had accessed help, their experiences of mental health service provision were that GPs over-relied on prescribing medication. There is a lack of understanding from mental health practitioners of women who have experienced violence, those living with HIV and BME women, particularly in relation to the accessibility of the language of mental health. Women made suggestions for improving support, such as group activities alongside one to one counselling and informed us of a need for a variety of therapies; longer term support; and HIV aware and women focused peer-led HIV services. In addition, women told us that they valued specialist women's services, while professionals highlighted the fact that these services were not valued as mental health services by commissioners and policymakers.

Recommendations made by the National Mental Health Taskforce are a step towards a more responsive mental health provision for women, such as:

- Recommendation 36 (core mental health training) and
- Recommendation 38 (prescribing standards)

Improvements in these areas would assist in a better understanding of the mental health needs of women who approach their GPs as the first point for assistance.

The following recommendations have the potential to address inequality to mental health services for women:

- Recommendation 39 (improved data),
- Recommendation 48 (disaggregating inequalities adjustment to Clinical Commissioning Groups and primary care funding)

However, at a local level the involvement of women's sector organisation is crucial for a robust response. For example, the Health and Wellbeing Boards would need to adopt an approach to data gathering that is informed by direct collaboration with women's sector organisations. In addition, information should be collated through surveys, and meetings held with women who have mental health illnesses who are being supported by voluntary sector specialist women's services.

Yet, the National Mental Health Taskforce recommendations do not mention the unique needs of BME women, women living with HIV and survivors of different forms of violence, who experience social exclusion or marginalisation. Should the National Mental Health Taskforce recommendations be implemented, by taking into consideration the needs of these groups of women, the NHS would begin to address some of the barriers that prevent women from seeking help in the first place.

The government's Ending VAWG strategy 2016-2020 promise to publish a National Statement of Expectations (NSE) to give clarity to local partnerships on good commissioning and good service provision is an opportunity for collaborative work with specialist women's organisations, including BME 'by and for' ending VAWG organisations. Given that all forms of violence against women as a cause of common mental health 'disorders' disproportionately affect women (WHO)[17] and the wealth of knowledge and experience the women's specialist sector holds, the NSE should take into account the unique mental health needs of women who experience different levels of social exclusion or marginalisation. Work carried out in the drafting of the NSE should be done in partnership with specialist women's organisations to ensure the needs of BME women, women living with HIV and survivors of different forms of violence, whose needs are often ignored and over-looked, are met.

In addition, the government expects Clinical Commissioning Groups to play a vital role in the local commissioning of services to address VAWG, including mental health. It is vital that Clinical Commissioning Groups are monitored in this area, with appropriate outcomes, which are reviewed, to ensure that different models of intervention and support reflect women's diverse needs.

The changing funding structure (Actions 37, 40, 42 of the Ending VAWG strategy) is a concern to the women's specialist sector at a time of continuing widespread economic challenges and associated austerity measures. The changing funding structure could potentially cause further systematic failures to adequately address women's mental health and wellbeing needs. Therefore we recommend the following actions to improve mental health service provision for women.

RECOMMENDATIONS

IMPROVING ACCESS TO SUPPORT

The Home Office to work in collaboration with Rape Crisis England & Wales, Imkaan and Positively UK and other specialist women's organisations on the National Statement of Expectations to ensure the mental health and wellbeing needs of survivors of different forms of violence are met.

Statutory mental health services, GPs and health practitioners

- to identify and establish relationships with local voluntary sector women's specialist services, BME 'by and for' ending VAWG organisations and women focused peer-led HIV services, and refer women who experience violence and/ or require BME 'by and for' ending VAWG specialist support.
- need to work in partnership with local specialist women's sector experts, such as Positively UK, Rape Crisis centres, BME 'by and for' ending VAWG organisations, to co-deliver training and awareness-raising initiatives targeted at addressing women's mental health and wellbeing.
- need to develop expertise and knowledge of groups of women who are often ignored and overlooked in society, such as survivors of different forms of violence, women living with HIV, young women, BME women, older women, LBT women, disabled women, and so on, to understanding the specific mental health needs of these groups.

Local Health and Wellbeing Boards to work with local Clinical Commissioning Groups to collate information on a regular basis which could also be used to inform the local Joint Strategic Needs Assessment

17 Gender and Women's mental health, http://www.who.int/mental_health/prevention/genderwomen/en/ (accessed 7/4/16)

- from specialist women's organisations, BME 'by and for' ending VAWG organisations and women focused peer-led HIV services.
- through surveys and meetings with women who have mental health difficulties who are being supported by specialist women's organisations.

Local Clinical Commissioning Groups to commission a variety of interventions and models of support that meet women's diverse needs, that have been identified by women, specialist women's organisations, BME 'by and for' ending VAWG organisations and women focused peer-led HIV services in recognition of the need for safe women-led, dedicated space for women.

Voluntary sector specialist women's organisations counselling services need to be sustainably funded in order to be able to provide longer term support and crèche facilities for women who have children.

EFFICIENT AND EFFECTIVE REFERRAL PATHWAYS

Local Health and Wellbeing Boards to acknowledge and value the wealth of knowledge and experience of women's voluntary sector specialists and work in collaboration with women's specialist services, BME 'by and for' ending VAWG organisations and peer-led women focused HIV services in the delivery, planning and tendering processes of mental health support services for women and girls. This needs to be reflected in the local Joint Strategic Needs Assessment.

Local Health and Wellbeing Boards, alongside Clinical Commissioning Groups, to regularly collate information on the outcomes of statutory services.

SAFETY AND QUALITY

Ensure that statutory health practitioners, such as GPs and counsellors have access to training on violence against women and girls and women living with HIV and are clear about referral pathways to specialist support.