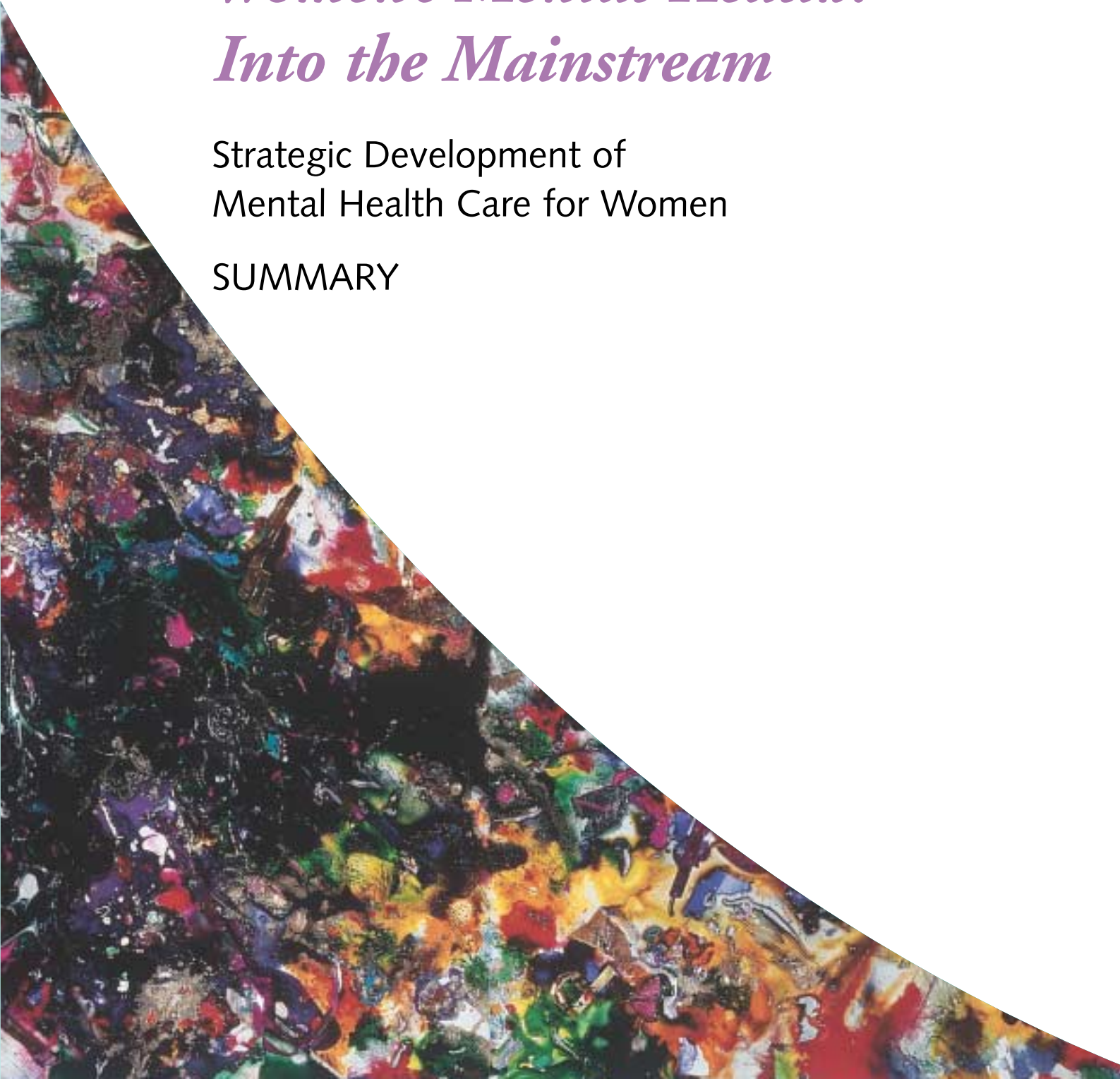


Women's Mental Health: Into the Mainstream

Strategic Development of
Mental Health Care for Women

SUMMARY





Flower to earth
by Christine Daddy

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

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

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

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Foreword

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

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

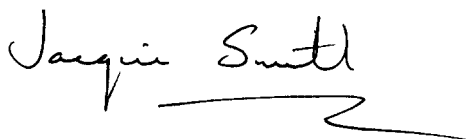
Women's Mental Health: Into the Mainstream highlights that women make up over half of the general population, play a significant role in the workforce and assume the major responsibility for home making and for the caring of our children and other dependent family members. At the same time, many women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

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

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

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

Whilst this summary is useful in conveying the key messages, the full length consultation document provides a comprehensive overview of women's mental health care and the proposed way forward. I urge you to read and reflect on the full version.

A handwritten signature in black ink that reads "Jacqui Smith". The signature is written in a cursive style with a long, sweeping underline that extends to the right.

Jacqui Smith
Minister for Mental Health

1. Mainstreaming women's mental health

Policy Context

The development of a women's mental health strategy forms part of the government's commitment to address inequalities in the delivery of mental health services and to tackle discrimination and disadvantage. In March 2001, the then Minister for Mental Health, John Hutton, announced the development of a strategy for women that would:

“pull together issues of concern for women across the Mental Health Framework and the NHS Plan and link with work of other government departments; ensure that women are listened to and their views translated who currently provide valuable services for women in crisis”

Aim of Women's Mental Health: Into the Mainstream

The aim of the consultation document is to provide information, to generate discussion and to outline a strategic direction to mainstream women's mental health care needs.

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. *Women's Mental Health: Into the Mainstream* focuses on gender differences that are relevant to women but many of the principles outlined are relevant to all age groups and to men as well as women. It covers services for adults of working age in line with the Mental Health National Service Framework.

This summary conveys the key messages from the full length consultation document. It does not include quotes from women service users, examples of mental health services working positively with women and references to research that informs the evidence base, which are all contained in the full length version.

Consultation

The public consultation, from October to December 2002, provides an opportunity for the Department of Health to listen to your views – whether you are a service user, carer, practitioner, manager, commissioner or policy maker. Written comments are invited and a number of listening events will be held around the country.

We are asking all stakeholders concerned with the improvement of mental health services for women to comment on:

- whether the consultation document has met expectations;
- if there are any gaps;
- proposed service specifications for women-only community day services and women's secure services;
- key priority areas for implementation;
- how improvements should be measured.

Written comments should be submitted (up to 31st December 2002) to: Kathy Billington, Policy Manager, Department of Health, Mental Health Services, Room 311, Wellington House, 133–155 Waterloo Road, London SE1 8UG, e-mail kathy.billington@doh.gsi.gov.uk.

A consultation questionnaire is included in the full version of the consultation document as Appendix II.

If possible, we would encourage you to read the full length version of the consultation document before submitting your feedback/views to the Department of Health as you will then be in a position to comment more fully on the detailed overview presented and the proposed way forward.

Further copies of this summary and/or the full length version of the consultation document (and other policy documents referred to in the document) can be obtained from the internet on www.doh.gov.uk/mentalhealth or free of charge from Department of Health, P.O. Box 777, London SE1 6XH, telephone 08701 555 455, fax 01623 724524, email doh@prolog.uk.com.

Implementation

Service specifications will be published in the Mental Health Policy Implementation Guide. A strategic implementation plan will be developed outlining key actions with performance indicators to measure improvements in priority areas identified during the public consultation period

2. Understanding women's mental health

Understanding the nature and causes of mental ill health in women, and how these differ from those in men, is essential to the development of mental health care that is responsive to women's needs.

Mental ill health in the general population

Whilst mental ill health is common in women and men, there are clear gender differences in the occurrence of mental illness between women and men. For example, anxiety, depression and eating disorders are more common in women and substance misuse and anti-social personality disorders are more common in men. There are also gender differences in the way in which women and men present with mental ill health. For example there is evidence to suggest that schizophrenia may have an earlier onset and a more disabling course in men.

Risk and protective factors for mental health

Whilst there are a number of risk factors linked to mental health, research into the impact of factors that give protection against mental ill health is in its infancy. However the role of family ties, positive parenting experiences, social networks and good housing are all likely to play a part. Risk factors that impact particularly on women are:

- *socio-economic factors* eg poverty, 'work in the family';
- *physiological factors* eg hormonal and reproductive changes;
- *psychological factors* eg life events, social isolation;

Violence and abuse¹

One of the most devastating life events that can impact on women's mental health is experience of violence and abuse. Women are at greater risk than men of child sexual abuse, domestic violence, sexual violence and rape. Child sexual abuse is relatively common, it affects more girls than boys including abuse in the family and the majority of their abusers are men. Most studies suggest that women are three times more likely to have been abused than men are. Between 18 and 30% of women experience domestic violence during their lifetime and between 14 to 40% of women have experienced sexual violence.

¹ Throughout the document, the term 'violence and abuse' refers to child sexual abuse, domestic violence, sexual violence and rape.

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

An understanding of the risk factors helps to identify groups of women who may be particularly vulnerable to mental ill health. Whilst most women within such groups will not suffer mental ill health, recognising this vulnerability to illness is one step towards increasing the chances of detecting and managing it effectively.

- Women who are mothers and carers
- Older women
- Women from black and minority ethnic groups
- Lesbian and bisexual women
- Transsexual women
- Women involved in prostitution
- Women offenders
- Women with learning disabilities
- Women who misuse alcohol and drugs

3. Mental health care for women

What is provided now

Most mental health care for women is provided in mixed sex environments and there is tremendous variation across the country in the number of women-only services, sessions and activities. The voluntary sector leads in the provision of community based women-only services eg community day services, counselling, supported accommodation, services for women who have experienced violence and abuse and those who self-harm. The private sector currently leads in the provision of women-only secure services.

Models of care

Although there is limited published research comparing different models of care that specifically address women's needs, there has been serious criticism of mixed-sex acute inpatient care, community residential and secure care in relation to women's safety. Concerns focus on the vulnerability of women patients to harassment, intimidation, violence and abuse by other patients, visitors, intruders or staff members.

Women experience women-only services as safer services and more attuned and responsive to their needs. Some studies suggest that it may be access to choice over mixed versus single-sex provision that is important to women.

What women say

There is a substantial body of small scale research which collectively repeats consistent and compelling themes expressed by women service users, survivors and carers. In addition to their fundamental right to be 'kept safe', women want services that:

- promote empowerment, choice and self-determination;
... women express an overwhelming sense of 'not being listened to'

- place importance on the underlying causes and context of their distress in addition to their symptoms;
... women say they want recognition that their psychological vulnerability is not rooted in their 'biology' but in the context of their lives
- address important issues relating to their role as mothers, the need for safe accommodation and access to education, training and work opportunities;
... women want staff to be sensitive and responsive in supporting them to care for their children
- value their strengths, abilities and potential for recovery.
... women say that too much attention is focused on their problems and not enough importance placed on the positive aspects of their lives

4. Developing gender sensitive mental health care

Gender sensitivity

Mental health policy has increasingly emphasised the '*centrality of the service user*' and the importance of working in partnership with service users in the delivery of effective services.

Key issues that influence an individual's experience of the world – gender alongside race, sexuality, class, disability and age – must therefore be incorporated into research, service planning, organisation, delivery and evaluation. To turn these aspirations into action, values and behaviours of organisations and individual staff working within them need to be addressed and challenged.

Gender describes those characteristics of women and men that are socially determined and is fundamental to our sense of who we are, the roles we adopt, the way in which we perceive others and in which they perceive us. It is also important to continue to recognise the uniqueness of the individual and understand that differences between individual women are just as important as the differences between women and men.

Gender specific services

To ensure that service planning and delivery are sensitive to gender, there will be a need to provide single sex services in some instances. Reasons for women-only developments include:

- expressed preference of women to ensure choice is available;
- specific gender, cultural or religious needs;
- creation of a safe environment which has particular relevance to women with experience of violence and abuse, women with sexually disinhibited behaviour, older women or lesbian women.

Section 5 – 11 of the consultation document outline a way forward to ensure that all aspects of mental health care – service planning, organisation, delivery, research and evaluation – are sensitive to gender and specifically the needs of women.

5. Underpinning values and principles

The principles enshrined in the Mental Health National Service Framework are equally relevant to women and men but it is in their application that gender issues need to be addressed. Involving and listening to women should be fundamental to all service planning, delivery and evaluation. A broad spectrum of women need to be included, from all parts of the community, as well as existing service users and carers.

6. Organisational development

To provide gender sensitive services, organisations should acknowledge and address gender issues as a fundamental part of organisational culture and the inter-relationship between the organisation, the practitioner and the service user. For example, understanding the ways in which power can be abused to the detriment of women service users and staff; the potential role an organisation can play in retraumatisation² of service users.

An aware and informed workforce is essential in providing gender sensitive services who have an understanding of the impact of gender on, for example, the economic and social context of women and men's lives; differences between women and men in the way they experience mental ill health, their treatment needs and responses.

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 eg family friendly employment policies.

Clinical governance arrangements should formally include gender and other dimensions of inequality. For example, developing quality and monitoring standards that take account of gender; including gender and other dimensions of inequality in training programmes; developing a culture of evidence-based practice with respect to gender.

² Retraumatisation: This refers to the reawakening of previous negative life experiences, such as child sexual abuse, in response to a variety of stimuli eg organisational, and even therapeutic processes, that are experienced as oppressive such as restraint procedures or close quarters nursing observation. A related phenomenon is re-victimisation where the experience of past abuse can produce a tendency for a sufferer to develop inappropriate or further abusive situations/relationships.

7. Planning, research and development

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

Assessment of Need

Local service planning should be informed by needs assessment processes that involve a range of women. Information from a number of different sources should be used in assessing need eg resource mapping, views of all key stakeholders, analysis of service usage as a means of identifying potentially excluded groups eg homeless or rural based women.

Commissioning

When assessing need and planning services, all elements of service provision should be incorporated into a ‘whole systems’ approach. The importance of voluntary sector provision of mental health care for women should be reflected in commissioning arrangements that ensure their financial sustainability.

Research and development

It is essential that gender is a key dimension in research to develop a better understanding of the differences in the mental ill health of women and men. Similarly all service monitoring and evaluation should take account of gender.

8. Service principles

The way in which services are organised and delivered has a direct effect on the service user’s experience. Principles that should apply across all service settings include access to women staff, women-only therapy groups and acknowledgement of women’s caring responsibilities.

Workforce issues

Service users and carers should be involved with the whole process of workforce planning, education, training and recruitment. Training for practitioners should be underpinned by an understanding of gender and other dimensions of inequality, and address specific issues eg surviving child sexual abuse, self harming behaviour.

Staff support structures should acknowledge and address the fact that mental ill health and life events may be shared by practitioner and service user eg experience of violence and abuse, depression, eating disorders.

9. Service delivery

Individual assessment and care planning

The following should be key components of assessment and care planning that take place in all settings (eg GP's surgery, a day centre, in-patient ward) although the terms are more often associated with specialist mental health services. An holistic approach should be adopted in partnership with service users.

Experience of violence and abuse

Whilst studies indicate that 50% or more of women in touch with mental health services have experienced violence and abuse, the level of awareness amongst mental health professionals appears low and women are rarely asked about these experiences. Sensitive exploration of abusive experiences and addressing their serious consequences for women's mental health are fundamental to the delivery of appropriate care and treatment.

Parenting and caring responsibilities

The majority of women using mental health services are mothers and/or carers and a sensitive and supportive response is required to the needs of women and their children.

Social and economic support

In taking full account of the social and economic context of an individual's life, there are gender issues relating to women that need to be addressed eg work and education may be regarded as a lesser priority for women; the impact of the benefits 'trap' and low income on mothers particularly loan parents.

Physical health

Awareness of gender issues relating to women is important in addressing the physical health care needs of service users eg women survivors of abuse may be understandably reluctant to participate in health screening programmes; women should be given the fullest information on the potential risks of medication during pregnancy.

Ethnicity and culture

Services are not always sensitive to cultural needs. Food, language, personal hygiene, spiritual needs are not always understood and, for women in particular, the potential unsuitability of mixed in-patient settings. Racial abuse, that may take place on the part of other service users or staff, can also exacerbate mental ill health.

Dual diagnosis with substance misuse

Substance misuse and mental ill health commonly occur together, women may hide their addiction due to social stigma and/or fear of loss of children and are more likely than men to misuse prescription drugs.

Risk assessment and management

Risk assessment should acknowledge gender differences particularly with regard to:

- making an accurate judgement about risk to the public, staff or other services users by assessing offending/dangerous behaviours within the family and social context of a service user's life;

- differentiating between self harm with and without active suicidal intent in assessing risk to self;
- giving equal attention to the potential for a service user to act as an abuser as to the vulnerability of a service user to abuse.

In addition, it is important that practitioners do not make assumptions or value judgements regarding **women's sexual identity**, sexual behaviour and/or the choices they make regarding their sexuality. Women may feel that their sexuality is ignored, denied or frowned up. Irrespective of a woman's sexual orientation, respect and sensitivity should be accorded at all times.

Care and treatment

Medication

Although there is good evidence for the effectiveness of a range of medication, user research often highlights a perceived over-reliance on medication. There are also some specific issues for women that should be considered when prescribing medication eg women may require lower doses than men; some psychotropic drugs may have a damaging effect on foetal development; weight gain is problematic with some drugs.

Psychological therapies

Women service users clearly want more access to 'talking therapies' and less reliance on medication. Therapeutic interventions need to be based on the principles of empowerment, partnership and giving women a sense of control over the pace and movement of the therapeutic process.

Whilst psychological therapies should be routinely considered as an option in the assessment process, there is a current shortfall in their availability. Planned developments in primary care and the work being undertaken by the Mental Health Care Group Workforce aim to address this.

Advocacy

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

The White Paper *Reforming the Mental Health Act* made a commitment that people subject to the new mental health legislation will have a right of access to specialist mental health advocacy.

10. Service organisation: non-specialist mental health services

Mental health promotion

Mental health promotion is a vital part of local planning and should address specific issues for women eg support for women with young children; women with experience of abuse and violence; in reducing social isolation and poverty, women's need for improved public transport and childcare facilities.

Primary Care

Primary care services will see the majority of women with mental ill health and need to ensure that experiences/conditions more prevalent in women are detected and effectively addressed: depression (including post natal depression), anxiety, eating disorders, self harm, substance misuse and experience of violence and abuse.

Women-only community day services

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

This policy initiative arose from a particular concern for women who:

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

However, flexibility at local level is essential to ensure that individual community day services reflect the specific needs of local women eg who are socially isolated, are experiencing depression and/or anxiety. These services are intended to promote mental health and cater for women with, and at risk of developing, mental health problems

Women-only community day services should be staffed by women, provide safe, confidential and open access services and adopt an holistic approach to working with women. The range of services provided may include counselling, groupwork, self-help groups, complementary therapies and educational programmes.

Proposed service specification for women-only community day services is contained in the full version of the consultation document.

Employment services

A range of employment opportunities should be provided to ensure that the needs of service users for daytime activity are met. Currently few employment services/schemes are specifically for women or specifically address the needs of women. They need to address gender differences in women and men in educational backgrounds, employment experience and the need for flexibility to accommodate childcare responsibilities.

Supported housing

Addressing accommodation needs is a key part of assessment and care planning. Local strategic planning should address the need for women-only safe and supported housing for women surviving violence and abuse, that can also accommodate women's children.

11. Service organisation: specialist mental health services

The range of care needed is the same for women and men but all services should consider how they address gender and identify the need for single-sex provision. This section concentrates on residential and in-patient care including secure services.

In-patient and other residential settings

In accordance with guidance on *Safety, Privacy and Dignity in Mental Health Units*, all residential settings should provide single-sex accommodation, toilet and bathing facilities, a women-only lounge in 'new build' mental health units and, wherever possible, in existing settings. In addition, every trust should have an officer at senior level responsible for women's safety, privacy and dignity to ensure that trust-wide policies and procedures are effective for women.

Given the concerns regarding women's safety in mixed-sex settings and the preference of some women service users to be cared for in a women-only environment, acute services should provide the option of a self contained women-only unit (refer to the *Department of Health Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision*).

Crisis Houses

The Mental Health National Service Framework refers to the development of crisis houses as a possible alternative to admission. Recent evaluations indicate that women-only crisis houses are highly valued by many women residents because they feel safer and more comfortable in an all-women environment than on mixed hospital wards. Women also said that staff were easy to talk to and that they gained valuable support from other residents.

Secure/forensic services

Context

There are distinct differences in the social and offending profiles of women and men, their experience of mental ill health, patterns of behaviour, their care and treatment needs. As women represent a small minority within a system primarily designed for men, their needs are poorly met. In addition women are often placed in levels of physical security greater than they need. They are generally less of a risk to the public, less likely to abscond and are more likely than men to have been transferred from other NHS facilities than from the criminal justice system.

These concerns led to the government's commitment to women being a high priority group for movement out of high secure hospitals under the *NHS Plan*, and to the commitment to develop a strategic approach to women's secure services. Additional resources, made available for the accelerated discharge of high secure patients, have been allocated to enable the development of new secure services for women across the country.

A model for the development of women's secure services

Women's secure services should be developed as part of a whole system of care providing for a range of security and treatment needs including the needs of women with personality disorder, challenging behaviours and learning disabilities.

Women's secure services need to:

- be provided in single sex settings alongside the development of women specific programmes of care and women-only secure outside space;
- incorporate a range of in-patient settings eg for women who need intensive care; have challenging behaviour; who receive a personality disorder diagnosis;
- facilitate easier movement of patients across levels of security;
- provide women-only activities as the norm with the capacity for mixed-sex activities as part of a recovery/rehabilitative process, dictated by a woman's capacity to make safe and informed choices and risk assessment as to which men patients would be safe and appropriate for inclusion in mixed-sex activity.
- developed alongside other facilities to provide an effective pathway of care, such as high support community residential placements, and with formal links with the criminal justice system and general mental health services

Proposed service specification for integrated, dedicated secure care services for women is contained in the full version of the consultation document.

Service development next steps

Following the establishment of two providers of Category B high secure women's services, consideration will be given to the appropriate siting of the reducing high secure women patient population. This should include careful monitoring of admissions to ensure their suitability.

Ongoing work is also required between commissioners and the high secure hospitals to plan longer term for the small number of women who may need Category B security.

12. Mental health provision for specific groups of women

Women with experience of violence and abuse

Experience of childhood sexual abuse, domestic violence and sexual violence are common amongst women, are a significant factor in the development of mental ill health and poorly provided for in all settings.

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

- facilitate appropriate interagency working;
- ensure access to staff training;
- monitor assessment and care planning processes to ensure that violence and abuse are sensitively addressed;
- facilitate the provision of specific support/appropriate treatment interventions;
- develop staff support processes;
- help the organisation address issues that may lead to the retraumatisation (see page 11 for definition) of survivors.

Women who self-harm

Self-harm is relatively common and covers a range of behaviours including cutting, burning, self-poisoning and insertion of harmful objects. It is particularly common amongst women in prison and women in secure mental health services.

The majority of people who self-harm repeatedly are women many of whom have histories of multiple deprivation and violence and abuse as a child and/or in adulthood. It is widely accepted that self-harm can be a means of releasing negative feelings, coping with psychological distress, increasing a sense of reality or of self-punishment.

The distinction between self-harm with and without suicidal intent and the overlap between the groups is a complex area. Whilst many women who self-harm make a clear distinction, for practitioners making this distinction in individual cases may be difficult and generate considerable anxiety. However this should form an integral part of the assessment process.

Local services need policies and training to enable practitioners to effectively assess and manage women who self-harm. Overall the aim should be to develop a balance between:

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

Women who receive a diagnosis of borderline personality disorder

Women are more likely to be diagnosed as having a borderline personality disorder and men more likely to receive an anti-social personality disorder diagnosis. The diagnosis of borderline personality disorder is experienced by many women as stigmatising and this, alongside general fears about treatability, has led to their needs being marginalised and poor service provision.

In view of the high proportion of women with this diagnosis who have experienced severe, repetitive abuse involving multiple traumas, in recent years there has been increasing work on links between complex post traumatic stress disorder (PSTD) and borderline personality disorder. These understandings have led to the development of therapeutic models based on concepts of trauma and recovery.

Although there is still much to learn, there is evidence to suggest that effective interventions do exist. Key issues are ensuring adequate and accurate assessment, consistency of care and treatment and adequate in-patient support. In addition, both community mental health teams and primary care staff need training and support to work with this group of women. Specialist psychological therapy services could provide appropriate training and outreach in addition to providing therapeutic interventions.

Women with dual diagnosis with substance misuse

Dual diagnosis should be considered as usual rather than exceptional and mental health services need to provide appropriate interventions (refer to the *Department of Health Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide*).

For women this means ensuring that alcohol/substance misuse is explored in assessments as it may remain hidden, providing for the misuse of prescription medication, monitoring the prescription of benzodiazepines, giving consideration to women's childcare needs and addressing the impact of violence and abuse.

Mental health practitioners are likely to need training and support to provide for this group of women alongside support and supervision from specialist workers or teams.

Women with perinatal mental ill health

The months surrounding the birth of a baby carry the greatest risk for women of developing mental illness and this can have a significant impact on the child as well as the mother. The most common is postnatal depression (between 10 and 15% of mothers) and the most serious, puerperal psychosis. Perinatal mental ill health is a potentially preventable cause of maternal mortality. Vulnerable mothers can be identified at antenatal stage; early interventions can be effective.

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

Local specialist perinatal mental health services need to be developed with formal agreements between maternity, primary care (including health visitors) and specialist mental health services to ensure that a range of provision, training and support is available.

Maternal health will be addressed in the *National Service Framework for Children* which aims to ensure that childbearing women, children and young people have opportunities to achieve optimum health and well-being.

Women with eating disorders

Eating disorders are far more common in girls and women and include bulimia nervosa, anorexia nervosa and binge eating disorders. They can be mild and amenable to self-help but for some the illness can be severely debilitating and anorexia has a significant mortality rate. Although most women with eating disorders will be seen in primary care and not need specialist mental health care, detection in primary care is low particularly for bulimia.

Large areas of the country have no access to NHS dedicated services which is reflected in significant private sector provision. Services for people with eating disorders have been defined as specialist mental health services and therefore primary care trusts will be expected to collaborate to ensure that the right level and quality of service is available.

The minimal requirement should be:

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

Women offenders with mental ill health

The prison mental health strategy *Changing the Outlook* and the *NHS Plan* makes clear the commitment to improving mental health care for offenders. The government's *Strategy for Women Offenders* highlights the specific needs of women and the *Women's Offending Reduction Programme* promotes an holistic response to the range of factors that impact on women's offending eg mental and physical health, caring responsibilities, experience of abuse and violence.

Local service planning should include the prison population as part of its community. A crucial issue for both mental health services and criminal justice agencies is to examine ways of improving women's community based mental health care and access to it by women in the criminal justice system.

Availability of and confidence in community alternatives to custody need to be improved if the female prison population is to be reduced. The female prison population has been increasing dramatically over recent years, and almost twice as many women prisoners suffer from mental ill health than male prisoners.

Perhaps the most compelling justification for a distinct response to women's offending, including the provision of women-specific services and interventions, is the fact that women's offending carries a higher individual and social cost than men's offending. It is all the more important therefore that custody for women offenders is only used as a last resort for the most serious offences, and where it is necessary for the protection of the public.

Many of the factors that affect women's mental health eg lone parenthood, experience of violence and abuse are often the same factors that impact on the risk of offending. The Department of Health and the Home Office are therefore working together to consider how the *Women's Mental Health Strategy* and the *Women's Offending Reduction Programme* could link up to tackle these factors. Relevant agencies and organisations will be invited to contribute ideas to develop a co-ordinated approach to address the needs of women offenders with mental ill health.



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