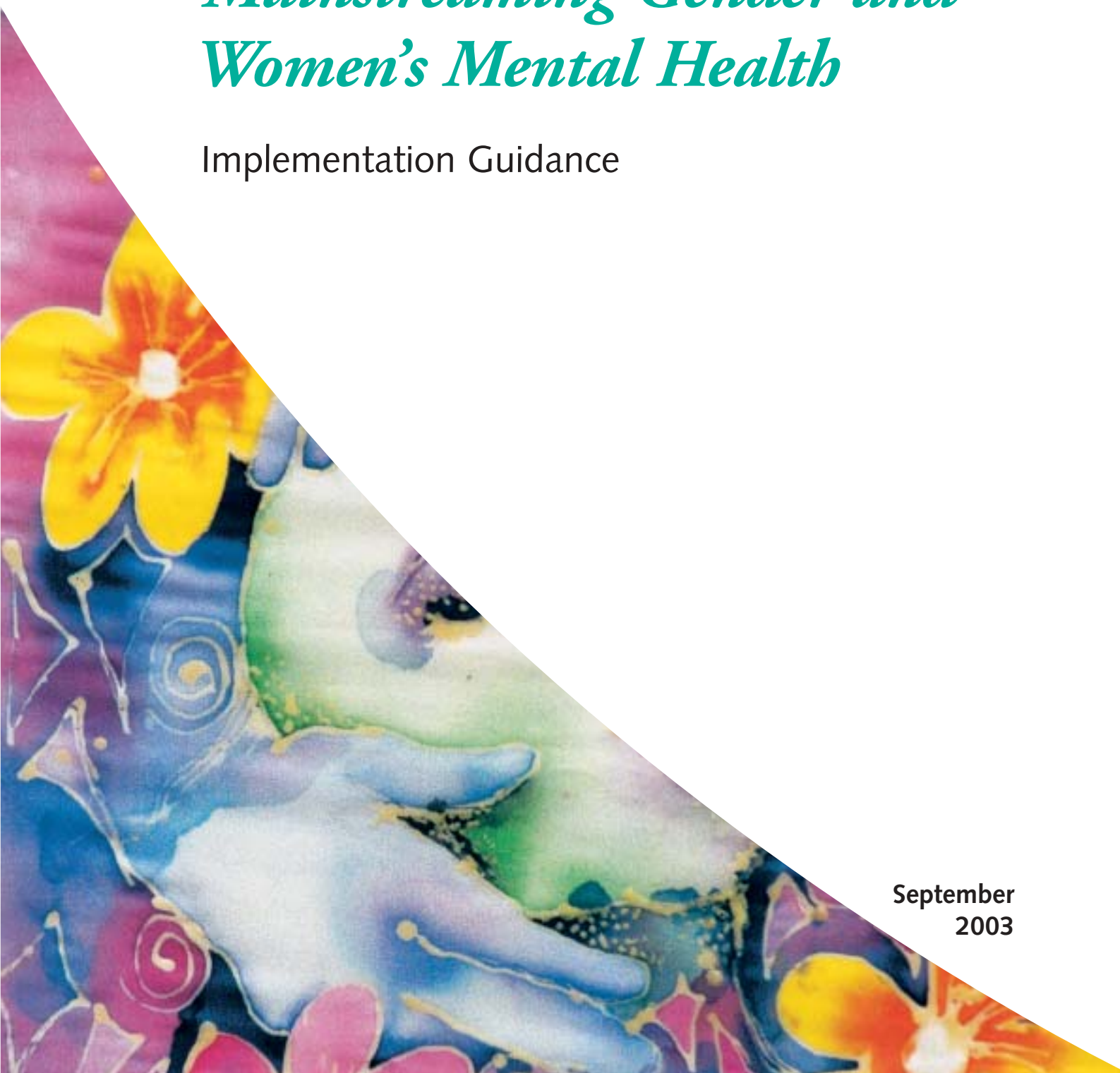
Department of Health

Mainstreaming Gender and Women's Mental Health

Implementation Guidance



September 2003

Produced by Louise Dillon

Network Arts Lewisham is an arts project for people with mental health support needs.

My art and creativity are very important to me and helps keep me well and alive.

I am no longer a mentally ill person with a label – I am an individual and identify myself as a sensitive and artistic person. Having a talent personal to myself and the fact that nobody else has the same style as myself gives me a feeling of well being and worth.

As well as this, it is a great bonus if people appreciate my artwork and enjoy my artwork and I can share my love of art with other people.

By Louise Dillon
Network Arts Lewisham

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Foreword

The Government is taking a wide-ranging approach to tackle the inequalities that persist in our society. Inequalities that, in most cases, still affect more women than men.

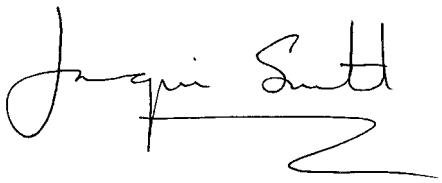
On 12 June 2003 Patricia Hewitt, then Secretary of State for Trade and Industry and Minister for Women, launched the Government's report "*Delivering on Gender Equality*" which highlights the variety of initiatives that are being taken across Government to tackle issues around gender and to raise standards for everyone.

This Implementation Guidance on mainstreaming gender and women's mental health contributes to this broad approach in a key clinical priority area. It will help those planning and delivering mental health services to understand better what is meant by being "sensitive to the needs of women" and ensure that women feel better served by the mental health care system in terms of their individual experience.

There has been overwhelming support for this initiative. We have received key messages about the need to listen to and involve women in planning and delivering services. We have been urged to take extra measures to tackle long-standing issues such as the impact of violence and abuse on women's mental health.

Understanding the needs of women – both as service users and in the workforce – requires cultural change. This can only be achieved through the increased involvement of the public, staff, service users and carers and through a partnership approach to service delivery. We hope that this guidance will help make the changes needed to improve quality and choice in mental health services.

Rosie Winterton
Minister for Mental Health



Jacqui Smith
Deputy Minister for Women and Equality

Section 1
Introduction

1.1 Policy context

This guidance has been developed in the context of broader Government and Department of Health (DH) policies to tackle inequalities, improve public services and promote social inclusion.

Modern mental health and social care must ensure that the needs of individuals are addressed and informed by an understanding of social inequalities with regard to gender, ethnicity, age, class, disability and sexual orientation. This guidance, a recommended way forward to mainstream gender and women's mental health, forms part of the DH's commitment to address inequalities in the delivery of mental health services and to tackle discrimination and disadvantage.

DH will be publishing implementation guidance shortly on mental health and ethnicity. *Both* these documents will provide a guide to understanding and addressing the interplay between gender, race and cultural inequalities, a vital prerequisite to meeting the needs of women from black and minority ethnic communities.

1.2 Aim and development of the guidance

Women's Mental Health: Into the Mainstream was published as a consultation document in October 2002. It provides a strong evidence base to inform and demonstrate the need for gender sensitive and gender specific services, and outlines broad areas for the development of women's mental health care and to ensure that gender is embedded in every aspect of mental health and social care.

Consultation between October and December 2002 included six national listening events, meetings with different constituency groups including women service users, and written responses from individuals and representative organisations. The overall response was very positive and a broad consensus emerged concerning perceived gaps in the consultation document and important areas to highlight for implementation. An overview of the responses is on www.doh.gov.uk/mentalhealth/women.htm

The aim of this guidance is to recommend a way forward for local planning processes and for the implementation of *key* areas for action to mainstream gender and women's mental health, identified during the public consultation period. The underlying theme is that gender differences in women and men need to be equally recognised and addressed across policy development, research, planning, commissioning, service organisation and delivery.

This guidance is intended to assist services in delivering gender sensitive and gender specific services within the context of the *Priorities and Planning Framework* and Local Delivery Plans. It directly supports the aims of *Improvement, Expansion and Reform in Health and Social Services* to "transform the quality of services by raising standards, tackling inequality, becoming more accessible and flexible and designing our services around the needs and choices of the people we serve" (Nigel Crisp, Chief Executive, 2002). If services are not sensitive to gender (and race) and are not providing choice (such

as single-sex services) then they will not meet these aspirations. The ultimate test of success will be through service user and community views on whether services are meeting their needs.

This guidance focuses, to a large extent, on gender differences that are relevant to women because there are specific areas of women's mental health care that have been neglected in the past. It is not the intention to focus on the needs of women services users at the expense of men, but to ensure equality of service delivery to all. It covers services for adults of working age in line with the *Mental Health National Service Framework* (*MHNSF*), but many of the principles outlined are relevant to all age groups and to men as well as women.

This guidance should be read with *Women's Mental Health: Into the Mainstream* and the forthcoming implementation guidance on mental health and ethnicity. Copies of these documents can be obtained from www.doh.gov.uk/mentalhealth and 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.

1.3 Structure of the guidance

In this guidance, we are recommending approaches, activities and actions for consideration by strategic health authorities (SHAs), mental health trusts, primary care trusts (PCTs), local implementation teams (LITs), local councils, professional organisations and training bodies, to mainstream gender and the needs of women service users. It covers their respective roles as employers, planners, commissioners, performance managers and providers. The recommended ways forward and principles outlined in the guidance apply equally to the independent sector.

The guidance follows a similar sequence to the consultation document *Women's Mental Health: Into the Mainstream*, and comprises the following sections:

Section 2 outlines essential principles that need to be adhered to by **all organisations responsible for the planning, commissioning, delivery, performance management, research and evaluation of mental health care** in line with the *Priorities and Planning Framework 2003–2006*.

Section 3 recommends a way forward to plan effectively at local level to mainstream gender and women's mental health care, with **PCTs as the lead stakeholders in assessing need, improving health and planning and securing all health services**;

Sections 4 to 8 recommend key areas for implementation to inform local planning processes, identified during the public consultation period, relating to:

- Cross-cutting issues of workforce, governance, research, service monitoring and evaluation, service standards and mental health promotion. **Key actions for mental health trusts, PCTs and social care services.**
- The improvement of existing service delivery. **Key actions for mental health trusts, primary care providers and social care services.**
- Extending women-only provision. **Key actions for primary care commissioners and mental health trusts with other stakeholders.**
- The needs of specific groups of women. **Key actions for mental health trusts and PCTs with other stakeholders**.

Sections 3 to 8 comprise all or some of the following:

- general information;
- recommended way forward comprising aims, key actions, expected outcomes;
- advice on implementation;
- resources to assist with implementation;
- examples of positive practice with respect to implementation;
- actions at national level by the DH, other government departments, NIMHE and the eight development centres to facilitate delivery of high quality services for women service users within a gendered context.

Final service specifications are included in full for women-only community day services (see *Section 6.1*) and women's secure services (see *Section 7.2*).

1.4 Implementation context

Shifting the Balance of Power has changed the focus of health and social care services delivery by moving resources and responsibility to local services to ensure that the needs of local health communities are better met. SHAs and PCTs, with social care partners, now have an opportunity to deliver more closely integrated services focused on improving services and outcomes for individuals and communities.

Improvement, Expansion and Reform: the Next 3 Years, Priorities and Planning Framework 2003–2006, has set a number of targets for the NHS and social services. Specific mental health targets have been set around early intervention, crisis resolution/home treatment, assertive outreach, breaks for carers, improving prison mental health care and the care and management of older people. *The Priorities and Planning Framework* also points out that services should be delivered in line with *MHNSF* standards and national mental health policies. The performance of social services is assessed through the *Performance Assessment Framework* operated by the Social Services Inspectorate (SSI) and this assessment forms part of the overall judgement of a council's services. These provide important routes to ensure that services are improved for women service users.

Mental Health LITs will continue to play a critical role at the centre of mental health services in bringing together key stakeholders in planning and reviewing services to deliver *NSF* and *NHS Plan* commitments.

1.5 Role of NIMHE and the development centres

NIMHE aims to improve the quality of life for people of all ages who experience mental distress. Working beyond the NHS, it helps all those involved in mental health to implement change, offering new opportunities to share experiences and one place to find information. It supports staff to put policy and guidance into practice.

NIMHE, in conjunction with the development centres will support the implementation of this guidance on *Mainstreaming Gender and Women's Mental Health* by establishing a National Gender and Women's Mental Health Programme. The exact programme of activity to support implementation will be developed in conjunction with each development centre and other key stakeholders. A number of proposals that have arisen from the consultation on *Women's Mental Health: Into the Mainstream* have been submitted for consideration. These are indicated as proposals in the text of this guidance (*proposed*).

In addition, Professor Catherine Itzin has been appointed a fellow of NIMHE to lead a national programme of work on Violence Abuse and Mental Health. This will cover the mental health implications of child sexual abuse, domestic violence and sexual assault and rape for services and professionals identifying and responding to sexually victimized children, to adolescent and adult survivors of child sexual abuse, to victims of rape and sexual assault, to (the largely) women and children victims of domestic violence and to their abusers.

As there is a strong link between part of the Violence Abuse and Mental Health Programme (in relation to Adult Women) and the Women's Mental Health Programme, it has been agreed that these elements will become integrated and implemented jointly. A national team will be established hosted by East Midlands Development Centre with a designated lead, in each of the other seven development centres, for violence and abuse, gender and women's mental health.

Implementation Guidance: Mainstreaming Gender and Women's Mental Health

Section 2
Essential organisational principles

The integration of gender (and ethnicity) and the specific needs of women should take place within the broader policy context of the *MHNSF*, the *NHS Plan* and *Priorities and Planning Framework 2003–2006*. Mainstreaming gender and the needs of women service users is as much to do with making adjustments to existing structures and processes that are consistent and sustainable, as 'additional things to do'. To achieve this mainstreaming approach, organisations responsible for the planning, commissioning, performance management, delivery, research and evaluation of mental health and social care, and those employing staff in these areas, should aim to adhere to the principles outlined below.

2.1 Mainstreaming gender and the specific needs of women

All organisations should aim to ensure that they are sensitive to gender (and ethnicity) and the specific needs of women. Addressing these issues should be an integral activity and not an afterthought. It will not be possible to address the needs of women and men equitably, appropriately and effectively if gender is not considered.

Defining 'gender'

Gender describes those characteristics of women and men that are *socially* determined, as opposed to 'sex' which is *biologically* determined.

> *"The term 'gender' refers to the economic, social, political and cultural attributes and opportunities associated with being male and female. In most societies, men and women differ in the activities they undertake, in access and control of resources, and in participation in decision-making. In most societies women as a group have less access than men to resources, opportunities and decision making"*
>
> Beijing Platform of Action (1995)

Gender is therefore fundamental to our sense of who we are, the roles we adopt, the way in which we experience and perceive others and in which they perceive us.

Defining gender sensitive mental health care

Mental health care that is informed by a knowledge and understanding of gender differences in women and men, and their inter-relationship, with respect to:

- *childhood and adult life experiences*
  e.g. women are more likely to experience violence and abuse; young male victims of abuse have a propensity to become abusers.
- *day-to-day social, family and economic realities*
  e.g. women are more likely to live in poverty, be lone parents; men are more likely to be in full-time employment and not be primary carers.
- *expression and experience of mental ill health*
  e.g. women are more likely to self-harm, suffer from depression and anxiety; men are more likely to receive a diagnosis of anti-social personality disorder, experience an earlier onset and more disabling course of schizophrenia; women are more likely to attempt suicide and men more likely to succeed.
- *pathways into services*
  e.g. women with dual diagnosis with substance misuse are more likely to be seen initially in mental health or primary care services; men are more likely to present at drug/alcohol services.
- *treatment needs and responses*
  e.g. women are more likely than men to actively seek 'talking therapies' and benefit from self-help.

(Refer to Women's Mental Health: Into the Mainstream, Section Two for further details)

Within this, it is of course important to continue to recognise the important differences between individual women (and men). The needs of the individual should be paramount but *informed* by an understanding of gender and other dimensions of inequality.

One aspect of ensuring that service planning and delivery is sensitive to gender is to recognise when there is a need for gender specific or single-sex services (*see Sections 6.1, 6.2, 7.1 and 7.2 of this guidance*)

2.2 Involving women

The overall objective is to improve and enhance service delivery for women service users and their carers. Women need genuinely to feel at the heart of this process and the real test will be that *they* feel better served by the mental health care system in terms of their individual experience.

Women are saying very clearly that they want to be listened to, to have their experiences validated and to be kept safe while they are suffering mental ill health. They want importance placed on the underlying causes and context of their mental distress in addition to their symptoms, and be cared for and supported by services that promote empowerment, choice and self-determination e.g. choose the gender of their key worker; rely less on medication and have more access to a range of 'talking' and complementary therapies. They want services to recognise the exacting day-to-day family, social and economic realities of their lives, to receive concrete support in their role as mothers and to ensure that they are safely and comfortably accommodated. At the same time, they want importance placed on their aspirations to access education, training and decent employment.

Ultimately they want services to adopt a 'whole person' approach to their care, treatment and rehabilitation, to value their strengths and abilities and to recognise their potential for recovery, in the context of holistic assessment and care planning.

The *NHS Plan* and mental health policy have increasingly emphasised the 'centrality of the service user', and have established the principle that that their needs, experiences and choices should be at the forefront of planning and delivering mental health services. A broad spectrum of women need to be included, from all parts of the community, as well as those who are existing service users or carers. There is a range of ways that this 'representativeness' will be gained. Specific consultation exercises for hard-to-reach groups, such as women in rural areas or some black and minority ethnic groups who live very home-based lives, may be necessary. Practical issues also need to be considered e.g.. the provision of childcare, the timing of meetings and the safety and accessibility of venues. It may also be necessary to provide information, interpreting or training to help women be involved in processes that may be unfamiliar or seem daunting to them.

2.3 Whole systems approach

In modernising mental health and social care, a whole systems approach is required across the functions of planning, commissioning, performance management, delivery, research and evaluation. The delivery of effective women's mental health care services is dependent upon robust planning and commissioning processes, genuine service user and carer involvement, skilled and supported staff teams, a gendered approach to service evaluation and relevant clinical and user-focused research to inform the delivery of appropriate care and treatment.

To provide a seamless service in the continuity and quality of care, the interface between different services and settings needs to be addressed. For example, any improvements to the mental health services delivered to women prisoners will be diminished if appropriate support packages are not provided on their release into the community.

The need or demand for any one aspect of mental health services is determined by the capacity or effectiveness of other aspects. For example, if acute inpatient and community based services effectively meet the needs of young women who have severe experience of violence and abuse, may self harm, misuse substances and are at risk of offending, the need for women's secure services is likely to decline; the increase in community based acute care provision like women-only crisis houses and crisis intervention/home treatment teams may reduce the need or demand for inpatient acute care. If the demand and therefore the capacity of a service reduces, the quality of those services should not be compromised.

2.4 Partnership and multi-agency working

Effective partnership working across specialist mental health and primary care services, social care, the voluntary and private sectors will ensure that women receive appropriate and timely mental health care.

Multi-agency working across the spectrum of health and social care is required to ensure that social and economic factors that impact on women's mental health are effectively addressed e.g. housing, poverty, social isolation, lone parenthood, experience of violence and abuse, parenting and caring responsibilities. This requires the engagement of local councils in a broader context than the provision of social services. Councils have a duty of community leadership and responsibilities to address the social, economic and environmental well-being of the population. Strategies need to promote connections across these responsibilities to the advantage of women and men with mental health problems. Connections could include links with Community Plans, Community Safety Strategies and Local Strategic Partnerships.

An holistic approach to care planning with an emphasis on hope and recovery encompasses the need for women to be safely accommodated (with their children where appropriate), have access to education, training and employment, receive their full benefit entitlements, receive support in their mothering and caring roles, establish social networks and have their physical health needs met.

2.5 Role of the voluntary sector

The consultation responses fully endorsed the positive role of the voluntary sector in supporting women's mental health. The voluntary sector should be regarded as:

- An integral provider of existing women's mental health provision that complements statutory provision. In instances where voluntary sector provision is a vital component of local mental health services, PCTs need to establish three-year service level agreements with specific standards on a sound financial basis.
- A potential lead provider in the development of women-only services e.g. community day services, crisis and respite houses.
- A valuable source of expertise in the improvement of statutory services e.g. directly providing 'woman' centred counselling and therapy within psychological services (*see Section 5.2.2*); input to staff training on working with women survivors of violence and abuse (*see Section 8.1*) and with those who self-harm (*see Section 8.5*). Conversely, the voluntary sector could benefit from accessing relevant training delivered by the statutory sector.

Section 3
Planning at local level to mainstream gender and women's mental health care

Establishing planning processes at local level, to address the recommended key areas identified in this guidance, may seem a daunting task, particularly in the context of existing priorities and pressures within the mental health care system. Therefore the suggested approach to implementation, expressed in the tables below, sets out a series of 'steps in the planning process' on the basis that improvements will take place through solid, incremental change rather than through any attempts to tackle everything 'all at once'.

Aims: Local services to develop: a three year planning process for implementation within every PCT in the context of their local delivery plans for 2003/04 to 2005/06; a local planning process that is informed by the recommended actions outlined throughout this guidance and by the views of all relevant stakeholders.

Recommended key actions for PCTs with mental health trusts, social services and all other stakeholders

Establishing a conducive context

- PCTs appoint lead to steer the development of the local planning process.
- Establish a multi-agency forum ideally using an existing forum (e.g. joint commissioning panel; LIT) comprising senior representation from both mental health and primary care trusts, social services, voluntary sector, housing, criminal justice agencies and service users (ensuring a gender and ethnic balance).
- Establish a women's service user group to inform the work of the multi-agency forum, and to ensure that the local planning process is strongly user focused.
- Mental health trusts appoint a senior lead to drive the implementation within their trusts who would be directly responsible to their trust boards.

Steps in the planning process:

- Undertake a resource mapping exercise – build up a picture of existing women's mental health services including secure settings (structures, skills, staff) and how much is spent on them (*see resources overleaf*).
- Identify unmet need/gaps in provision particularly the need for women-only services.
- Link this information to service planning and commissioning, and consider whether the statutory or voluntary sector is best placed to develop potential new services.
- Review existing mixed-sex mental health services and consider what steps are needed to ensure that they are safe and sensitive to women's needs, in both acute inpatient and community based settings.
- Review primary care services and consider what actions are necessary to meet women's needs more effectively.
- Review existing service evaluation, monitoring, clinical governance and audit procedures to ensure a gender analysis.

Expected outcomes: Achievable, phased planning processes to mainstream gender and women's mental health care, in which stakeholder groups have a sense of ownership and commitment. A multi-agency, whole systems approach to implementation. Women service users will feel, and be, listened to and involved in all steps of the process.

Advice on implementation

Services are at varying stages in awareness of, and in tackling, gender issues and the development of gender sensitive and single-sex services. In many areas of the country there is a tremendous commitment and energy to effect change for women service users, which has been sustained for a number of years. A significant number of trusts have appointed women's leads with implementation underway, but many areas have not started to address these issues. It is important to acknowledge this variability and the value of sharing positive practice and effecting a mutual learning process on a local, regional and national basis.

In identifying the most appropriate person to lead on implementation, it is important that there is a 'self-selection' element to the appointment to ensure commitment to the values and process.

Refer to and engage with Best Value review and implementation processes used by the local council for all services relevant to mental health.

Use relevant information from the annual 'satisfaction' survey undertaken by social services.

Resources to assist with implementation

DH Annual Assessment Exercise undertaken by LITs comprising service mapping, financial mapping, self-assessment (of priority areas) and themed reviews (www.dur.ac.uk/service.mapping/amh/).

Modernisation Agency process mapping, analysis and redesign techniques to look at defined areas to tackle change and service improvements (www.modern.nhs.uk).

Positive Practice Examples

Camden and Islington Mental Health and Social Care NHS Trust appointed a women's lead who has adopted an action research approach to **developing a women's strategy**. This is supported by a Women's Strategy Group comprising mainly current women service users plus a psychiatrist, with a specialist interest in women, and the Trust's Co-Director of Nursing. A growing network of trust-wide staff are also supported in the delivery of women-specific care e.g. within substance misuse services. The women's strategy is one of seven strands of the Trust's diversity strategy, others include race, faith and disability. Contact: Shirley McNicholas, telephone 0207 607 2777

Plymouth Primary Care Trust appointed its local implementation officer to co-ordinate the development of a **local implementation plan** and identified the local Joint Commissioning Board/LIT as the appropriate multi-agency forum. Through a series of stakeholder meetings the 'local picture' has been established. Gaps in provision have been identified and the 'next steps in the process' include a cost analysis, a training plan for key areas and taking action in areas with no cost implications (e.g. protocols for joint working between health visitors and community mental health teams). **Contact:** Julie Wilson, telephone 01752 315387 email julie.wilson@pcs-tr.swes.nhs.uk.

Women's leads have been appointed from a range of disciplines within the following trusts (not an exhaustive list): Gloucestershire Partnership Trust, Plymouth Primary Care Trust, Derbyshire Mental Health Services NHS Trust, Derby City Trust, Leeds Community & Mental Health Services NHS Trust, Calderstones NHS Trust, Camden & Islington Mental Health & Social Care NHS Trust, South Staffordshire Healthcare Partnership Trust.

Action at national level – NIMHE/development centres

NIMHE will devise a means of disseminating positive practice nationally. Jan Wallcraft, 'Expert by Experience' Fellow at NIMHE, is collecting positive practice examples of service user involvement.

The lead in each development centre on violence and abuse, gender and women's mental health will support and encourage both primary care and mental health trusts to appoint a designated women's lead and to establish local planning processes. Each development centre will also set up a regional network to enable women's leads to meet on a regular basis to identify any problems, discuss solutions, learn from and support each other (*proposed*).

Recommended Key Areas for Local Development

Section 4
Cross Cutting Issues

The areas outlined below were identified from the public consultation as critical to the delivery of mental health services that mainstream gender and the specific needs of women: workforce development, governance, research, service evaluation and monitoring, service standards to meet the specific needs of women service users and mental health promotion.

4.1 Workforce Development

4.1.1 Training

Gender and women's mental health cannot be mainstreamed in any sustainable way unless it becomes an integral element in the training of staff and managers at every level and within every organisation; training for practitioners is identified as the suggested starting point under this section. In the longer term, these issues need to be incorporated into pre and post-graduate training for all mental health disciplines (*see Actions at National Level below*).

Aim: To develop local gender awareness training initiatives on a partnership basis, so that staff working in specialist mental health and primary care services can participate.

Recommended key actions for mental health trusts with primary care services, social services, workforce development confederations and relevant voluntary sector organisations

- Identify relevant expertise to assist in the development of gender awareness training initiatives e.g. from within the Trust, local universities/colleges, voluntary sector, liaison with the local Workforce Development Confederation, by 'buying in' trainers or booking existing relevant training courses e.g. Gender Training Initiative (*see positive practice example overleaf).*
- Ensure that education and training include competencies in relation to:
  - the social and economic context of women's and men's lives;
  - life experiences that may impact on their mental health e.g. violence and abuse;
  - the interplay between gender and other dimensions of inequality such as ethnicity, age and sexual orientation;
  - differences in the risk and protective factors for mental health in women and men;
  - differences in women and men in presentation and their pathways into services;
  - differences in the treatment needs and responses of women and men;
  - the relationship between gender and power inequalities and how this may affect individual service users, staff and the organisations in which they work or are cared for; the day-to-day family, social and economic realities of women and men's lives.

Expected outcomes: The workforce will be aware, informed and competent with respect to gender (and other dimensions of inequality). Mixed-sex services will deliver differentiated care, treatment and support to both women and men service users. Single-sex services will be delivered specifically to meet the needs of women or men, and therefore differ significantly in their therapeutic ethos. Training will facilitate staff to work more positively with women service users, and demonstrate genuine respect for them.

Advice on implementation

As a starting point first consider training for practitioners of all disciplines who work directly with service users in view of the importance of the attitudes and perceptions of 'frontline' staff.

Resources to assist with implementation

Video 'What Women Want', accompanied by a training manual, features a number of women service users talking about the context and presentation of their mental distress, their experiences of the mental health system with positive reference to specific mental health settings that have been truly responsive to their needs (which are also highlighted in *Into the Mainstream*). Available from: Mental Health Media by fax 0207 686 0959, email sales@mhmedia.com or via the website www.mhmedia.com

Positive Practice Example

Inequality Agenda was set up in 2003 by Dr Jennie Williams to help mental health providers respond progressively to the mental health needs of women. The **Gender Training Initiative**, a successful gender awareness training course, was initially designed for multi-disciplinary staff working with women in secure mental health and prison health care settings (with DH funding). A three day course for staff working with women in inpatient and community services has now been developed and successfully piloted. **Contact** Carey Sellwood, telephone 01795 597744 email inequalityagenda@btconnect.com

Action at national level – DH/NIMHE

The Mental Health Care Group Workforce Team (MHCGWT) with the NIMHE Workforce Programme are:

- developing a core curriculum for pre-qualification training of all mental health practitioners with professional training bodies/Workforce Development Confederation incorporating gender (and ethnicity) issues and the specific needs of women;
- ensuring that national core competencies for mental health professionals include gender issues/needs of women;
- considering the need for a national approach to developing staff training in violence and abuse (*proposed*)

4.1.2 Staff support

Workforce development plans should include structures and processes for providing staff support. For example: regular, systematic supervision, opportunities for reflective practice, regular staff appraisal and out-of-hours crisis support and confidential counselling services.

Aims: To ensure that formal and informal staff support structures are sensitive to gender. To enhance the ability of practitioners to develop effective therapeutic relationships with service users. To promote the emotional health of the workforce.

Recommended key actions for mental health trusts, PCTs and local councils

- Ensure that all personnel providing formal and informal support to staff are made aware and mindful of the following factors:
  - the majority of the workforce are women and potentially juggling multiple roles including their work;
  - many of the life experiences of women service users are common and therefore likely to be shared by a significant number of staff e.g. violence/abuse, bereavement;
  - similarly, aspects of mental ill health experienced by women service users e.g. depression, anxiety, substance misuse and eating disorders will also be/have been experienced by a significant number of staff;
  - if these issues are unresolved, they can cause stress for the practitioner, have a negative impact on staff ability to develop therapeutic relationships or, at worst, have a detrimental effect on service users' potential for recovery.
- Ensure that the availability of work-related counselling is an essential element of staff support e.g. out-of-hours crisis support; confidential counselling services.

Expected outcomes: Staff will feel understood, valued and supported. Staff retention will improve and sick leave diminish. Service users will experience staff as more understanding and empathic.

4.1.3 Leadership in organisations

Leaders should be identified at every level to 'lead by example' in developing structures, behaviours and relationships that value staff and that are sensitive to gender.

Aims: To ensure that women *and men*, with a clear commitment to addressing gender (and ethnicity) and the specific needs of women, are in leadership and mentoring roles within organisations. To ensure that managers and practitioners actively and equally value women and men staff, as well as service users.

Recommended key actions for mental health trusts, PCTs and local councils

Identify women and men who are managers and practitioners with the commitment and ability to lead by example in:

- demonstrating collaborative and partnership working particularly between managers and clinicians;
- the delegation and transparency of decision making;
- establishing robust policies to deal with bullying, sexual and/or racial harassment;
- developing family-friendly employment policies including job shares, carers leave, term-time contracts, childcare facilities, generous maternity and paternity entitlement;
- the equitable promotion/appointment of able men *and* women to managerial and practitioner posts; valuing equally women and men staff, in addition to service users.

Expected outcomes: An organisational ethos and expectation will be established in which gender and women's issues are the responsibility of both sexes i.e. part of 'everyone's agenda'. Women and men will be equally respected and valued irrespective of whether they are practitioners, clinicians or managers. There will be a reduction in power inequalities and the hierarchical ethos of organisations.

Action at national level

The Royal College of Nursing (RCN) 'Challenging Perceptions' Programme is a unique leadership and career development programme that addresses the absence of female nurses in senior positions in many mental health trusts. It involves matching thirty female mental health nurses from six NHS trusts with mentors from within the directorate level of their respective organisations. For further information contact Helen Woolnough at helen@nursingleadership.co.uk, telephone: 0161 237 2459.

4.2 Governance

Clinical governance provides a "*framework in which local organisations can work to improve and assure the quality of clinical services for patients*" to ensure that equal importance is placed on the quality of care to service users and financial probity. In mental health care, given the necessity of multi-professional and multi-agency input into service planning and delivery, it is particularly important that governance and quality issues are addressed across health and social care and with other agencies such as housing and the criminal justice system. Social services departments may adopt new organisational arrangements in partnership with NHS bodies.

Aim: To formally include gender (and ethnicity) in all governance arrangements including reporting procedures and relevant council reviews and consequent actions.

Recommended key actions for mental health trusts, PCTs and local councils working within a multi-professional and multi-agency context

- Address gender in all elements of clinical governance. Examples:
  - in *clinical risk management*, review the safety of the environment for all service users; ensure equity in assessing a patient's vulnerability to abuse and the risk of a patient acting as abuser;
  - in *clinical audit*, review the extent to which the differentiated needs of women and men are considered in the delivery of services;
  - in *evidence based practice*, evaluate efficacy for women and men separately;
  - in *user/carer involvement*, ensure that forums enable both women and men to comfortably convey their views and that feedback includes a gender breakdown;
  - in *staff training and support*, include reference to gender (*see Sections 4.1.1 and 4.1.2*);
  - develop *quality and monitoring standards* that refer to gender e.g. choice of key worker and therapist, availability of women-only activities and lounge areas in mixed-sex settings, family friendly visiting areas (*see Sections 4.4 and 4.5*);
  - present clinical governance reports with a gender breakdown/analysis for each element.
- Establish connections with Best Value processes within local councils.

Expected outcomes: Quality of care will be reviewed and delivered on an equitable and consistent basis to women and men. Service users will experience a gendered response to their care, treatment and support needs. Staff will be aware of the need to address gender in the delivery of care. Reviews of services and implementation plans will reflect gender issues.

4.3 Research

Sex should be a consistent key study variable in both clinical and user-focused research. Whilst the overall prevalence of mental ill health does not differ significantly between women and men, they differ strikingly in the:

- risk and protective factors for different mental disorders;
- causation, prevalence and the clinical course of specific disorders;
- response to a range of treatment interventions e.g. medication; psychological therapies.

A better understanding of these differences will inform the development of a more tailored and effective approach to both the maintenance of mental health and the care and treatment of mental ill health in women and men.

There is also some evidence that women may be excluded from research for inappropriate reasons. Those commissioning or undertaking mental health research should consider gender issues as an integral part of the planning and delivery of research programmes and projects. The principle should be one of inclusion, although this must be balanced with the aim of delivering high quality, meaningful outputs.

Given the range of potential studies within the mental health domain, there is no single template to guide the design of research programmes or individual studies. Suitable approaches need to be developed according to the nature of the research question. Where analyses of data are carried out separately, there may be issues of low statistical power. These should be considered against the possibility of combining data from different studies using meta-analysis techniques.

There is also the need for further research of forms of mental distress solely or predominantly experienced by women e.g. peri-natal mental ill health, eating disorders, and the trauma of violence and abuse.

Also, there needs to be greater emphasis on user-led and user-focused research and the involvement of service users in setting the research agenda, rather than merely responding to it. This should be followed through with equal value and attention given to clinically based and user-focused research, qualitative and quantitative in approach. This applies equally to women and men service users.

Action at national level – DH

The DH Research and Development Programme is currently considering the above issues e.g. Mental Health Forensic Mental Health Programme has signed up to ensuring that women (and black and minority ethnic groups) are appropriately included in the research that it commissions.

Action at national level – NIMHE

The Mental Health Research Network (MHRN) within NIMHE are keen to host research on gender issues and will encourage funding organisations to take special notice of priority areas for research on women. Any research studies using the MHRN should be conducted along the above lines.

4.4 Service evaluation and monitoring

Service planners and providers need to ensure that service evaluation and monitoring includes a gender (and ethnicity) dimension so that they can accurately measure whether the needs of women and men are being addressed on an equal basis.

Aim: To review all service monitoring and evaluation processes to ensure a gender (and ethnicity) underpinning.

Recommended key actions for mental health trusts, PCTs and local councils. Commission for Health Improvement (CHI) and SSI to consider in their performance monitoring and inspection roles

- Ensure that monitoring, audit and research data in all specialist mental health and primary care settings is collected, analysed and presented by gender (and ethnicity).
- Undertake specific local audits where there is an identified gender bias which is cause for concern e.g. serious incidents; close quarters observation practice in inpatient settings; certain forms of prescribing like benzodiazepines; referral rates from primary care to specialist mental health services.
- Where single-sex environments are established, evaluate the impact on women service users, and men if appropriate.
- Provide a safe means for service users to give their views.
- Ensure that these key actions take place within the clinical governance framework.
- Maximise the use of process and data from local council activity and related inspection and evaluation workstreams e.g. Best Value reviews; scrutiny; satisfaction surveys; specific audits and inspections.

Expected outcomes: An accurate analysis of a service's capacity to meet the needs of women and men service users on an equal basis. Governance processes will determine the extent of differentiation in the care delivered to women and men, and therefore assess the quality of care delivered to both.

Positive Practice Example

Health and Social Services in Slough jointly commissioned East Berkshire Mind to **investigate service user views** of mental health services and to make recommendations for future service options. Women complained about both having their mental health issues discounted as 'women's problems' and a refusal by professionals to recognise any relationship between their family and social lives and their mental ill health. Findings suggest that the quality of service user-provider conversations is vital and the recommendations revolved around improving the quality of relationships between service users and mental health professionals. **Contact** Steve Gillard, telephone 01344 861195 email admin@mindbracknell.fsnet.co.uk.

Positive Practice Example

SERICC (South Essex Rape & Incest Crisis Centre), with Home Office funding, commissioned Sheffield Hallam University to develop a **gender mainstreaming approach** to service provision in the field of mental health (and crime and disorder and regeneration/neighbourhood renewal) for the area of Thurrock in Essex engaging with all relevant statutory and voluntary sector agencies. The Thurrock Partnership and Commissioning Forum has identified gender mainstreaming as one of its' five priorities. **Contact** SERICC, telephone 01375 381322/Prof Sue Yeandle, Sheffield Hallam University telephone 0114 225 3073.

4.5 Service standards for meeting the specific needs of women service users

It is suggested that service planners and providers need to develop service standards against which to monitor and evaluate the effectiveness of both mixed and single-sex services for women service users.

Aims: To develop and implement service standards for women service users. To monitor and evaluate the effectiveness of services for women (mixed and single-sex) against these standards, across specialist mental health and primary care services.

Recommended key actions for mental health trusts, PCTs and local councils. CHI and SSI to consider in their performance monitoring and inspection roles

- Develop quantitative and qualitative standards to assess the quality and appropriateness of care delivered to women service users.
- Develop these standards in close consultation with multi-disciplinary teams and women service users.
- Include in the quantitative standards: choice of gender of key worker and therapist; clear policies on working with women who self-harm; addressing physical health care needs; the extent to which violence and abuse is being addressed; safety of the environment; close-quarters observation practice; availability of family friendly visiting areas in in-patient settings/childcare facilities for out-patient appointments.
- Include in the qualitative standards:
  - do women feel safe and comfortable in the environment?
  - do they feel that their distress is being dealt with appropriately and that they are given 'time to talk' with their key worker?
  - are they satisfied with the treatments they are receiving e.g. medication, 'talking' therapies?
  - do they feel supported in their role as mothers/carers?
  - do they feel genuinely involved in the assessment and care planning process?
- Provide women service users with the means of giving their views in a safe and confidential manner.
- Develop an effective means of taking remedial action on the basis of the findings if and whenever necessary.
- Incorporate the service standards into governance and quality improvement processes.

Expected outcomes: A robust process of monitoring and evaluating the quality and appropriateness of care provided for women service users, in both mixed and single-sex settings. A process for taking remedial action in response to the findings. Women service users will feel genuinely consulted and valued through the opportunity to give their views in an open, unreserved manner.

Resources to assist with implementation

The North West Region Secure Commissioning Team has produced a comprehensive set of Standards for Women in Secure Services. Many of the service standards are relevant to non-secure mental health settings. Copies of the Service Standards are available from: Pat Edwards/Carol Elford, telephone 0151 920 5056 email carol.elford@southsefton-pct.nhs.uk.

Actions at national level – NIMHE/development centres

NIMHE to develop benchmarking/national service standards for women's mental health services (*proposed*).

4.6 Mental health promotion

Mental health promotion and the antecedents of presenting mental illness should be considered for gender and ethnically sensitive service planning. Effective early intervention and careful discharge planning could have a significant impact on the future health of individuals and prevent referrals and re-admissions to secondary care services. Many causes of women's mental ill health, and failure to manage them in the community, lie in their social environment, including poverty, sexism, racism, housing, parenting and family issues, violence and abuse. These can often be influenced by public health measures that offer support and early intervention for vulnerable women and communities. It is therefore important that mental health promotion is addressed by planning across health, social care and local authorities.

Aims: To ensure that all staff have adequate training to make them mindful of the mental health promotion needs relating to the gender and ethnicity of their clients. To ensure gender (and ethnically) sensitive mental health promotion are included in service planning for the community.

Recommended key actions for all relevant clinical staff and senior managers in health, social care, local councils with relevant voluntary sector organisations

- Undertake an audit of training needs of relevant staff groups.
- Develop a programme of multi-professional training on mental health promotion.
- Carry out a health needs assessment for the mental health promotion needs of local women and ethnic groups.
- Map existing services and identify gaps.
- Address mental health promotion needs in future service planning.

Expected outcomes: Staff will have the skills to promote gender (and ethnically sensitive) mental health in all appropriate client contacts. Women will have adequate access to staff and resources that can offer mental health promotion, reducing their potential need for specialist mental health services.

Resources to help implementation

Specific recommendations for mental health promotion interventions are included in the *MHNSF* Standard 1 and '*Making it Happen, a guide to delivering mental health promotion*' (Department of Health 2001).

NIMHE has commissioned 'mentality' to produce a mental health promotion toolkit for black and minority ethnic groups. This will be available on the NIMHE website www.nimhe.org.uk

Primary Care Mental Health and Education (PriMHE) has produced a resource pack for *MHNSF* Standard 1 for Primary Care. Copies of the pack can be obtained from Lundbeck Ltd and also ordered from the PriMHE website – www.primhe.org

Section 5
Service Delivery

This section relates to the way in which services are delivered and key areas, identified during public consultation, are individual assessment and care planning and two treatment interventions, medication and psychological therapies.

5.1 Individual assessment and care planning

Fundamental to user-focused delivery of mental health care is a whole person, individual assessment of need and the development, in partnership with the service user (and where appropriate with their carer(s)/family), of a care plan to address those needs including crisis planning. This process is formalised as the Care Programme Approach (CPA) in specialist mental health provision. Recent care co-ordination guidance makes explicit that the service user's needs must be central and that gender, ethnicity and sexuality should be taken into consideration. Importantly, the CPA needs to be placed within the broader context of women's lives e.g. take account of their family, social and economic realities and inherent conflicts and obligations alongside their strengths, aspirations and competencies.

Aim: To ensure that, in all assessment and care planning, key components are included which are particularly relevant to women.

Recommended key actions for mental health trusts and social services

Exploration of the following is included in all assessment and care planning processes:

- *violence and abuse* in child and adulthood (see Section 8.1);
- *medication concerns* (see Section 5.2.1);
- support for *caring responsibilities* particularly women who are mothers, whether their children are being raised by them or are 'looked after' children (*see Section 8.3*);
- *cultural needs* of women from black and minority ethnic communities (*see Section 8.2*);
- *respite or crisis support* particularly in view of the multiple and often unsupported roles women may be juggling (*see Section 7.1.2*);
- *physical health* issues relevant to women including menstruation/hormonal changes, contraception, pregnancy and preventative screening procedures (*see Section 8.8*);
- differentiation between active suicidal intent and other acts of *self-harm* (*see Section 8.5*);
- *alcohol and substance misuse* (*see Section 8.7*)
- *social and economic support* e.g. need for safe housing (*see Section 6.2*); education, training and employment.

Expected outcomes: Women's needs will be addressed within a whole person approach. A gendered approach to assessment and care planning will be achieved. Women service users will feel a greater sense of engagement and empowerment throughout this process.

Advice on implementation

Although not a formal component of assessment and care planning, practitioners should respond sympathetically to service users if they choose to disclose and wish to discuss any aspects of their sexuality. Mental health practitioners should not make assumptions or value judgements regarding women's sexual identity, sexual behaviour and/or the choices they make regarding their sexuality.

The use of Direct Payments can offer greater flexibility and autonomy to women wishing to exercise choice over the components of their care package.

Action at national level – DH

DH is piloting the implementation of outcome measures using standardised instruments routinely in mental health care to measure outcomes. Outcomes will be measured in terms of morbidity, quality of life and user and carer satisfaction. It will be important to identify gender differences in outcomes for individuals. This project is currently being piloted in four trusts with a view to national implementation beginning in 2004.

Action at national level – NIMHE

NIMHE is considering a review of available research on suicide amongst lesbian, gay, bi-sexual and transsexual (LGBT) groups. A decision on whether this literature review will go ahead will be made in consultation with the DH Equality Strategy Group following a scoping study of available research.

5.2 Care and treatment

Mental health services should provide a range of services to respond to individuals' diverse needs: social, therapeutic and creative activities, self-help, practical support, medication and psychological therapies. Key areas covered in this guidance are medication and psychological therapies. Women service users clearly say that they want more access to a range of 'talking therapies' and less reliance on medication.

5.2.1 Medication

Aims: To ensure that women service users are prescribed appropriate medication only if and when required. To address the concerns of women service users that there is an over-reliance on medication.

Recommended key actions for mental health trusts, PCTs and social services

- The prescribing of medication is not regarded as the only option of treatment even though it may be the treatment of choice.
- In the prescribing of medication, the following issues are taken into account:
  - that women may require lower doses of drugs than men;
  - some side effects are of particular concern for women e.g. weight gain, loss/restart of menstruation, hair loss;
  - some drugs have a damaging effect on foetal development, others are required at lower doses in pregnancy and some are excreted in breast milk;
- Appropriate review of long-term prescribing, particularly of benzodiazepines, anti-psychotic and anti-depressant medication.

- All relevant medication issues are discussed with service users i.e. reasons for prescribing, possible side effects and any possible alternatives.

Expected outcomes: Medication will be prescribed as one option alongside a range of treatment options. Women service users will be reassured that the use of medication is only one element of an holistic approach to their care.

Action at national level – DH

Proposed mental health indicators for 2002/03 performance ratings include a prescribing indicator for benzodiazepine and atypical anti-psychotic medication.

5.2.2 Psychological therapies

Aim: To enable women service users to access a range of appropriate psychological therapies in the assessment of their mental health problems.

Recommended key actions for mental health trusts, PCTs and social services.

- Psychological therapies are routinely considered alongside the potential benefits of complementary and creative therapies.
- The preference of service users informs treatment choice;
- Psychological therapies adhere to the principles of empowerment, partnership and giving women a sense of control over the pace and movement of the therapeutic process.
- Service users are asked whether they have a preference for a woman or a man for the assessment and delivery of psychological therapies.
- In the delivery of psychological therapies:
  - gender inequalities in society which impact on women's mental health needs are acknowledged, particularly those aspects of women's lives that can create dependence and powerlessness;
  - connections between women's lives and their mental health difficulties remain highly visible within the therapeutic process, which should address both the causes of women's distress and the distress itself;
  - give consideration, wherever possible, to both individual and/or group approaches that enable women to benefit from the strong support of other women.

Expected outcome: A more 'woman centred' approach to delivering psychological therapies; meeting women's expressed need for more access to a range of 'talking therapies' and less reliance on medication.

Advice on implementation

In developing a range of 'woman-centred' psychological therapies (in addition to complementary and creative therapies), specialist psychological therapy services may wish to consult with and/or consider appointing counsellors and therapists experienced in working with women in the non-statutory sector.

Resources to assist with implementation

DH publication *Treatment choice in psychological therapies and counselling – evidence based clinical practice guidelines* (2001) available at www.doh.gov.uk/atozpubs.htm

Mental Health Foundation's Action Research on efficacy of art/creative therapies, *Healing Minds* available at www.mentalhealth.org.uk

Guidance on the appointment of 1000 graduate primary care mental health workers was published in October 2002 (available at www.doh.gov.uk/atozpubs.htm). As part of their brief these workers will be trained in brief therapy techniques of proven effectiveness to assist GPs in managing and treating common mental health problems.

5.3 Primary care issues

Mental health problems are common and primary health care teams provide most of the help that people need. What in reality 'detection' of mental health problems represents is complex and is affected both by the attitudes of GPs, and other primary care practitioners, and the way in which patients present their problems. Where women are concerned, the combination of physical complaints and mental ill health can militate against the accurate detection of mental health problems.

Aim: To ensure that primary care services are responsive to the specific needs of women.

Recommended key actions for primary care services with specialist mental health services and social services

Focus on the following key issues that are of specific relevance to women (*see Section 2.1*):

- early recognition of depression including post-natal depression *(see Section 8.8*), anxiety and eating disorders (*see Section 8.9*);
- appropriate use of medication (*see Section 5.2.1*) alongside prompt access to psychological therapies (*see Section 5.2.2*);
- detection and management of conditions that often remain hidden, for example self-harming behaviour (*see Section 8.5*), alcohol and substance misuse in women including the abuse of prescription medication (*see Section 8.7*);
- the high proportion of women who have experienced violence and abuse, in child and/or adulthood, which is a significant contributory factor to many forms of mental distress and physical ill health, particularly as a result of childhood sexual abuse (*see Section 8.1*);
- increased risk of domestic violence during pregnancy and/or after childbirth;
- review of long term prescribing, particularly benzodiazepines, anti-psychotic and anti-depressant medication;
- provide information on, and facilitate access to, relevant community support services largely provided by the voluntary sector e.g. benefits or housing advice, childcare facilities, day services, local learning opportunities, counselling, support groups and helplines particularly for women survivors of violence and abuse and those who self-harm;
- identify and support women in their role as mothers and carers and recognise the physical and mental stresses that caring can cause (*see Section 8.3*).

Expected outcomes: Earlier detection of and intervention in a range of conditions that women suffer from. Potential reduction in referrals to specialist mental health services. Potential reduction in the use of and reliance on medication. Increase in women patients' satisfaction and potential reduction in GP appointments.

Resources to assist with implementation

The World Health Organization (WHO) *Guide to Mental Health in Primary Care* (UK edition, WHO Collaborating Centre for Research and Training for Mental Health, 2001) is a resource for primary care teams in delivering mental health care to their patients and, jointly with mental health care teams, reviewing current services provided, identifying service gaps/training needs and developing shared criteria for patient referral to specialist mental health services (www.who.int).

Positive Practice Example

Lancashire Postgraduate School of Medicine runs a module, as part of a **MSc course for General Practitioners**, on the mental health needs of women in the community. This course is aimed at raising awareness of epidemiological issues and improving the recognition of affective disorders, minor psychiatric morbidity such as generalized anxiety, panic attacks, fears, phobias and obsessions. It also equips GPs in the understanding of premenstrual dysphoric disorder as a psychiatric diagnosis and self-harm as an index of deprivation. The course offers information on psychopharmacological differences between the genders and psychotherapeutic treatment options for women. Social concomitants of mental illness in women such as violence and abuse, and their association with other diagnoses, are also discussed. **Contact** Prof Dora Kohen, telephone 01942 264562, email dorakohen@doctors.org.uk

Action at national level – DH

DH is funding the piloting of routine ante-natal screening procedures for domestic violence in Bristol to inform further developmental work on early and effective intervention in maternity care. Outcomes of the pilot will also inform the maternity element of the *Children's National Service Framework (CNSF)* to be published in 2004.

DH is working with WHO to ensure that the revised edition of the *WHO Guide to Mental Health in Primary Care* is sensitive to gender and ethnicity (*see Resources above*).

Action at national level – NIMHE/development centres

NIMHE is taking forward a three year primary care mental health programme to help practitioners improve the fundamentals of care and to facilitate and encourage innovative practice. The programme developments will include issues relating to gender and ethnicity.

Section 6
Non-specialist mental health services: Extending women-only provision

6.1 Women-only community day services (including service specification)

PCTs in their commissioning role, have the responsibility for co-ordinating service redesign, through commissioning and planning processes, to ensure that there is provision for women to have access to a network of women-only community day service support, as outlined in the *NHS Plan*. This will need to be planned with LIT partners and, crucially, with the involvement of existing and potential voluntary sector providers who currently provide the majority of these services. This provision should be seen as part of a range of mental health and general health provision for women in each PCT area so that women are offered a choice of support that fits their needs at different times and life stages.

This initiative is not about meeting the diverse range of women's needs in one setting, but about providing a range of support to meet these needs in different settings that will change for each woman over time. There should be an emphasis on choice rather than over-prescription. However, women with very specific treatment and support needs, such as those with substance misuse problems, should be provided for in other settings.

These services may be best provided by the voluntary sector, in partnership with statutory providers, or as stand-alone services with clear and demonstrable links to the statutory sector. It may be that such services could be provided across localities enabling a critical mass, rather than in each PCT/LIT area or central locality. Initially commissioners and planners may wish to consider including women-only days in mixed-sex facilities or services but should eventually aim to provide protected women-only spaces on a permanent basis. *The service specification for these services is set out overleaf.*

From 2004/5, the set of indicators for awarding star ratings to PCTs for their mental health provision will include meeting NHS Plan commitments, including women-only community day services. Key measures that PCTs should put in place to demonstrate that they have met this commitment are that:

- services and support are provided by women staff in women-only settings;
- core funding for these services and sustainability of funding are provided by statutory sector sources, demonstrated by inclusion in Local Development Plans;
- minimum standards are specified for induction and mental health focused training, supervision and support for staff and volunteers providing these services.

Action at national level – DH

DH has sponsored two national demonstration projects in East Sussex and Manchester that have taken different approaches to the planning and development of enhanced women-only community day services. Progress to date is set out on the DoH website www.doh.gov.uk/mentalhealth/women.htm

Service specification for women-only community day services

Who is the service for?
These services have the potential to provide community support for women with a range of experiences and needs including those:

- who are mothers living with or recovering from a serious mental illness;
- suffering from post-natal depression;
- who self-harm;
- are survivors of/recovering from violence and abuse in child and/or adulthood;
- who need a women-only setting (e.g. for religious or cultural reasons, women who are lesbians, survivors of violence and abuse, older women);
- who are suffering from depression and anxiety;
- who are socially isolated and would benefit from the support of other women e.g. lone parents;
- who would benefit from advice and support to maintain good mental health (links should be made to the development of local mental health promotion strategies).

The aim of combining the needs of these groups is to help remove the stigma experienced by many women of accessing mainstream mental health services. There needs to be an emphasis on links to other community-based services to avoid such stigmatisation.

What should the service do?
The aim of the services should be to improve and promote mental health and well-being, to help prevent mental ill health or relapse by supporting women in their own homes and communities. A range of services, support and activities should be provided in a variety of settings, dictated by local need and informed by local consultation. The range of provision should include:

- educational programmes;
- therapeutic interventions and activities (on an individual and group basis);
- self-help and support groups;
- crisis support (within CPA for those currently in touch with mental health services: for others, signposting to other forms of out-of-hours support);
- information;
- parenting support;
- workshops and activities;
- art and complementary therapies.

Service principles
Women-only community day services should:

- promote self-esteem, empowerment and build on women's strengths;
- be safe, confidential and non-stigmatising;
- be supportive and welcoming;
- have an holistic approach to health and well-being;
- take account of women's parenting and other caring responsibilities e.g. the need for crèche or childcare facilities, access to carer support;
- be accessible to all women by taking account of their race, culture, religion, age, disability, sexual orientation, and where they live – also accessible with regard to location and safety of environment;
- consider the provision of transport or access to transport for women who have difficulties getting from home to services e.g. as a result of physical disabilities, suffering from agoraphobia, living in a rural setting;

- encourage access to mainstream community services e.g. lifelong learning: leisure and cultural services;
- maintain strong links with primary care and specialist mental health services and other voluntary/statutory agencies.

Planning and commissioning of women-only community day services
Within this process, PCTs and partners will need to:

- understand, uncover and tackle the "hidden" needs of women (*refer to Women's Mental Health: Into the Mainstream, Section 7.1 Assessment of Need*);
- consult with local women and organisations, including black and minority ethnic groups in their own languages if necessary;
- build on existing positive practice and existing women-only day services (many provided by the voluntary sector);
- strengthen partnerships with voluntary sector organisations (including related provision such as women's refuges) in planning and delivering services and take a longer-term view on funding these services to ensure stability and continuity.

Staffing
Services should:

- be staffed by women to allow for the development of safe environments and to allow choice for women who prefer a women-only setting;
- use appropriately trained staff and provide mental health focused induction and training programmes for volunteers and paid workers;
- appoint staff and volunteers who have:
  - the ability to empathise and engage with women who use the service;
  - an understanding of issues relating to gender and ethnicity;
  - health, social care or appropriate life experience (including personal experience of mental health problems).
- provide supervision and support for staff and volunteers (including external supervision for e.g. women who are managing the service; therapists/counsellors).

Hours of operation
Services and support should be flexible and responsive to the range of women's needs and at times that are convenient for them.

Referrals
By a number of means which may include:

- open access;
- drop-in;
- referral from primary care or specialist mental health services.

An outreach facility should be considered to reach women for whom access is problematic e.g. because of a disability, isolated location.

Assessment of risk and policy on violence
Services should have clear policies and guidance in place on risk assessment and violence. Much existing women-only provision enters into a contract with women who use the service around risk (to self and others), confidentiality and acceptable behaviour.

Information to women who may be interested in using the service
Should include:

- description of the range of services available, times of opening, etc;
- philosophy of the service ie operated on an open access basis 'by women for women';
- how to access other community based support/self-help networks.

Continual service improvement
Services should be led by the women using the service and be flexible and responsive to the developing and changing needs of the client group. PCTs should consider regular service audits to ensure that services are effectively meeting gaps in provision for women and providing a needs-led service. Audits should always include feedback from the women who use the service.

6.2 Supported housing

Safe and supported housing is an important prerequisite for recovery from mental ill health and/or discharge from inpatient care and there is a wide range of women, with and without children, who require it. Many women form part of the 'hidden' homeless: those remaining in abusive relationships or, through social networks, 'staying with friends'; young women vulnerable to abuse if living in lodgings or with abusive partners/families; women awaiting discharge from secure mental health settings; women offenders with mental health problems; homeless women with enduring mental health problems.

Aims: To provide a range of safe and supported housing for women service users, with and without children e.g. women-only short term shared housing; permanent tenancies in self-contained flats; short term crisis housing. To provide assistance to support and sustain tenancies during periods of greater illness or pressure.

Recommended key actions for commissioning body for Supporting People (incorporating representation from local council housing and social services, PCT and probation)**, housing authorities/ associations, Benefits Agency, voluntary organisations, social services.**

- As part of a local authority's strategy for Supporting People under the mental health priority, identify and address the specific needs of women service users.
- Similarly, within the requirement for every local authority to develop a homeless strategy, address the specific needs of homeless women with mental health problems.
- Put in place better communications so that individual situations can be sensitively managed to the advantage of both tenant and housing provider.

Expected outcomes: Access to appropriate accommodation, a key component of assessment and care planning. Women's safety will be maintained within a supportive environment while they recover from mental ill health. Women will be enabled to continue to care for their children and/or maintain any other caring responsibilities. Women will experience better continuity of living arrangements.

Section 7
Specialist mental health services: Extending women-only provision

This section deals with specialist mental health and social care that requires additional or reconfigured provision. Key areas are the establishment of women-only provision in acute and secure settings and women's safety in all mixed-sex residential settings.

7.1 Acute care services

Key areas in acute care services are identified as women-only provision in both inpatient and community based settings.

7.1.1 Women-only inpatient services

A significant number of women express the wish to be cared for in a women-only ward as it makes them feel safer, more comfortable at a time when they are acutely distressed and they feel that their needs are more appropriately met in an all-women environment. Some women advocate the need for choice of either a mixed-sex or women-only setting which reinforces the need to consult with women service users at the planning stage on the option of retaining a proportion of mixed-sex wards or changing to solely single-sex wards.

The provision of a self-contained women-only ward or unit (*the meaning is the same*) is a requirement of the *Mental Health Policy Implementation Guidance on Adult Acute Inpatient Care Provision*. Anecdotal evidence from services that have single-sex wards is that it has enabled a more focused and effective approach to meeting the therapeutic needs of women and men. The feedback from services that have both women-only and mixed-sex wards is that the demand for the women-only ward(s) exceeds capacity.

Aims: To provide a self-contained women-only ward/unit* in every acute inpatient service by reconfiguring existing services (or provision of a new-build facility if one is planned). To address the wish of many women service users to be cared for in a women-only inpatient environment.

Recommended key actions for mental health trusts and social services

As part of the process towards a reconfigured service:

- consult with all relevant staff, referrers and women service users, in particular, on their preferred option for:
  - all single-sex wards or a combination of women-only and mixed-sex wards;
  - solely women nursing staff or a combination of women and men nursing staff on the women-only ward(s);
- consider issues relating to the capacity and demand for beds for women and men service users;
- decide which reconfiguration is more appropriate;
- address staffing issues e.g. staff preference for working with women and/or men, desired ratio of women to men staff/women-only staff;
- liaise with other acute care settings in establishing a revised referral system;

- establish criteria for admission to women-only wards *if* mixed-sex wards are also incorporated in the service;
- review provision for mothers and their children and pregnant women;
- review provision of visiting facilities to ensure that they are child/family friendly;
- address the impact on sectorisation if this applies;
- once established, evaluate the impact on women and men service users.

Expected outcomes: Women's safety will be maintained in relation to men service users, visitors and intruders. The wish of many women service users to be cared for in a women-only setting will be addressed, in particular women survivors of violence and abuse, women from minority ethnic communities, older women and lesbian women. Staff will be enabled to focus on the therapeutic needs of women service users thereby increasing their expertise and skills. Trusts will be compliant with *the Mental Health Policy Implementation Guidance on Adult Acute Inpatient Care Provision* (DH 2001).

* A 'self-contained women-only ward' (or 'unit') is a stand-alone women-only ward that is secure in terms of monitoring the entry of visitors. The only optional facility *not* included within the ward environment might be a 'family friendly' visiting area if it functions as a central facility accommodating all wards.

Advice on Implementation

Consider the Acute Care Forum as the appropriate vehicle for taking this initiative forward. Similarly use the emerging regional Practice and Development networks to share/exchange progress and problems. Examples of reconfigured services that accommodate this requirement are highlighted in *Into the Mainstream (refer to Section 11.2 Inpatient and Other Residential Settings).*

If a combination of mixed-sex and women-only wards is the preferred option, ensure that the same level of consideration is given to the needs of women on the mixed-sex as on the women-only ward(s).

Potential barriers to implementation may relate to sectorisation, organisational inconvenience and/or an inclination to maintain historical practice, whereas the motivation for change should be a commitment to provide a truly patient-focused needs-led service for the period of crisis only.

Other reasons that are given for maintaining the status quo (i.e. solely mixed sex-wards) include the reluctance of staff to work in a women-only (or men-only) environment and that, in a mixed-sex environment, the presence of women has a 'moderating' effect on the behaviour of men service users. The experience of reconfigured services indicates these contentions to be myths. A lack of motivation to provide women-only wards can also arise from an unacceptable level of staff tolerance of sexual incidents against women.

Action at national level – NIMHE/development centres

To facilitate the implementation of the Acute In-patient Care Guidance, NIMHE has established an Acute Inpatient Programme and national Steering Group with representation from all eight development centres. Every development centre has appointed an Acute Care Lead to co-ordinate the setting up of regional Practice and Development networks. Acute care leads will support the establishment of women-only wards through the regional Practice and Development networks (*proposed*).

7.1.2 Women-only community based acute care services (residential)

The *MHNSF* refers to the development of crisis houses as a possible alternative to admission. There was an overwhelming consensus in favour of, particularly, crisis houses in the consultation responses and recent evaluations indicate that they are highly valued by many women residents (*see Resources below*). However, crisis houses are clearly regarded as an alternative to, not a total replacement for, acute inpatient care as there will remain occasions when an inpatient admission is more appropriate. Opportunities for respite (including when appropriate respite from women's parenting and/or caring responsibilities) will reduce the potential for women to experience a period of a crisis.

Aims: To establish: women-only crisis houses, as an alternative to acute inpatient admission and respite houses, as an intervention to avoid women's mental ill health deteriorating to an acute or crisis phase; community based residential acute care settings that can accommodate women's children as appropriate; women-only crisis and respite housing for all women including those with learning and associated disabilities.

Recommended key actions for PCTs in their commissioning role with mental health trusts and the voluntary sector as potential providers

- Identify essential components of service specifications for crisis houses and respite houses respectively including the following: capacity and siting of facility; service values and philosophy; admission and exclusion criteria for residents; referral and assessment process; geographical catchment area; staffing (staff : resident ratio and skills base); length of stay for residents; discharge protocol; monitoring and evaluation processes; desired measurable outcomes for residents; required planning period and projected opening date.
- Consult with existing acute inpatient and community based settings and women service users on: the above service components; the suggested operational principles (*as outlined below*); the appropriateness of the provider being the mental health trust or a voluntary sector provider.
- Formulate the service specifications taking full account of the views received during the consultation phase.
- Instigate a tendering process if a voluntary sector provider is required or commission the mental health trust to proceed within the required time-scale.

Expected outcomes: Women will have access to women-only community based crisis and respite provision, with or without the children in their care as appropriate. Demand on in-patient beds will be reduced, contributing to the local delivery plan requirement to reduce bed capacity by 30% by 2006.

Suggested operational principles

It is suggested that the following operational principles should apply to the provision of both crisis houses and respite houses, which are consistent with the operation of the few that do exist across the country:

- women-only staff;
- strong resident-led focus with no element of compulsion to use the service;
- a 'homely' rather than an institutionalised ethos;
- be open 24 hours per day, 365 days per year (particularly in the case of crisis houses);
- length of stay, ideally, of not more than four weeks;
- number of residents should not exceed single figures;
- sited in a house with garden and car parking space in close proximity to convenient public transport;

- location of the provision should promote service partnerships, social inclusion and mental health promotion;
- high level of integration with other specialist mental health services, primary care services and community based support services;
- recovery orientated residential care including the provision of complementary therapies;
- specific consideration given to the needs of any women residents from black and minority ethnic communities to ensure that they feel as comfortable and as sensitively supported as white women residents;
- provision of nursery nurses if women are accommodated with their children;
- take positive action to recruit a proportion of staff who have experience of recovery from mental distress.

Resources to assist with implementation

A comparative study of women using an acute inpatient ward and a women-only crisis house in Camden and Islington Mental Health and Social Care NHS Trust, contact Sonia Johnson, telephone 0207 527 8800.

A report on the learning from eight mental health crisis services '*Being There in a Crisis*' produced and published by the Mental Health Foundation in association with the Sainsbury Centre for Mental Health.

Action at national level – NIMHE

NIMHE with development centres will develop service specifications and commissioning guidelines for single-sex crisis houses and respite houses including those that would accommodate women's children (*proposed*).

7.1.3 Community based acute care teams (non-residential)

It is essential that existing and emerging teams – community mental health, assertive outreach, crisis resolution/home treatment and early intervention in psychosis – deliver a gender sensitive service (*as outlined in the DH Policy Implementation Guidance*) and meet the specific needs of their female clients as recommended in this guidance. Of particular relevance are the following:

- concrete support to women who are mothers and their children and sensitivity to women's potential fear of 'losing' their children;
- sensitive exploration of experience of violence and abuse in child and/or adulthood particularly the possibility of current domestic violence which will impact on the suitability of home based care;
- potential drug/alcohol abuse, the tendency for women to hide their addiction arising from social stigma, fear of 'losing' their children and women's propensity to abuse prescription drugs;
- issues relating to self-harm;
- women's need to feel safe and to be given the choice, wherever possible, of a female or male worker which may be more important to women survivors of violence and abuse, women from minority ethnic communities, older women and lesbian women.

7.2 Women's secure services (including service specification)

In view of the significant differences in the social and offending profiles of women and men, and the experience and expression of their mental ill health, a national reprovision process has been initiated to establish a dedicated network of secure services for women. These services, some of which have already been established, will complement and substantially add to those services hitherto provided predominantly by the independent sector.

The aim is to provide:

- a safe, validating and self-affirming environment that will enable women to begin to heal and recover from severe abuse and trauma that they may have experienced as children, adolescents and adults (both outside and within the mental health system);
- a conducive therapeutic context, including a high level of relational security, that will enable women to address the complexity of their mental distress including risk behaviours and offences they may have committed;
- a level of environmental (or physical) security no greater than women require;
- a flexible and responsive secure service that is fully integrated into the broader mental health system.

(*See Service Specification on page 41*)

As part of the national reprovision process, residual gaps in women's secure services are identified as follows:

7.2.1 Secure services for women with learning and associated disabilities/low secure services for all women patients

Aims: To provide safe and effective secure mental health services for women with learning and associated disabilities. To provide safe and effective low secure services for all women patients.

Recommended key actions for regional catchment groups with PCTs, providers in the statutory/independent sectors and social services

- Review current low secure provision for all women including those with learning disabilities.
- Review existing medium secure provision specifically for women with learning disabilities across the statutory and independent sector.
- Identify current gaps in provision and develop an appropriate regional commissioning strategy to:
  - enable women to be detained as close to their originating authority as possible;
  - create improved or new provision in line with the Service Specification *(see page 41)*

Expected outcomes: Dedicated and appropriate settings for women with learning and associated disabilities as close to their originating authority as possible. Effective pathways of care particularly to enable discharge of women with learning disabilities from high security care. Safe and appropriate low secure provision for all women patients, which will expedite discharge from or prevent admission to higher tiers of secure care.

7.2.2 High Support Community Residential Settings

Aim: To provide high support community residential settings for women with complex needs who may have a diagnosis of borderline personality disorder, be recovering from severe trauma with attendant risk and/or offending behaviours.

Recommended key actions for regional catchment groups with PCTs, social services, relevant criminal justice agencies and potential voluntary providers

- Identify any existing provision.
- Assess the numbers of women who may benefit from this type of provision currently residing in secure mental health settings or at risk of being transferred to secure care/receiving a custodial sentence for non-serious offences.
- Develop an appropriate service specification to meet the needs of this group of women *(see suggested operational principles below)*.
- Undertake a tendering process to identify appropriate voluntary sector/independent providers with the necessary expertise and proven track record to deliver this provision, in partnership with a relevant housing association who would provide the capital input required.
  (*see also Section 8.4.1, Women Offenders in the Community, an Early Intervention Approach*)

Expected outcomes: This gap in provision, identified at national level, will be addressed. Women detained in secure provision (including appropriate women in high security) who require a slow stream supportive community pathway of care will be discharged at an earlier stage. Beds in secure care will be unblocked to enable e.g. admission of women awaiting transfer from prisons. The likelihood of women entering secure mental health services or the prison system (due to non-serious offences) will be reduced with resultant cost benefits.

Suggested operational principles

It is envisaged that this form of provision would represent *a hybrid* of the therapeutic community model ie on a smaller scale working in partnership with residents in the context of a responsive and integrated therapeutic ethos with a strong community interface. It is suggested that the service specification for this form of provision would need to include the following requirements:

- a therapeutic (and non-institutionalised) milieu that would provide a high level of psychological safety and containment to enable the residents to progress, at their own pace, towards *sustained* recovery and independent living;
- long term development of community and social networks so that these settings become a part of the local community and assist the residents in their journey towards independent living;
- an integrated and responsive approach to providing comprehensive psychological, complementary and creative therapies;
- development of individually tailored 'daily living programmes' for each resident including access to education and training opportunities with a strong interface with local resources and activities;
- importance of working with women to improve and maintain their physical well-being in addition to meeting their emotional and psychological needs;
- length of stay: in the region of one to three years;
- number of residents: should not exceed 10;
- high level of staffing including 'key worker' system;

- staffing complement: a mix of qualified staff (mental health and social care including 'woman centred' therapists), unqualified staff (with relevant commitment, attitude and life experience) plus sessional staff and the capacity for volunteer/'buddy' involvement;
- regular and systematic formal and informal structures for providing staff support;
- robust monitoring and evaluation procedures;
- ensure awareness of and compliance with the standards of social work provision in secure mental health settings and the development of a consistent approach to discharge preparation, family support, etc.

Action at national level – DH

The National Oversight Group (NOG) will continue to oversee and monitor the reprovision of women's secure services that includes the following:

- delivery of the Accelerated Discharge Programme of women patients from high secure care;
- closure of the women's service at Ashworth Hospital by March 2004 and transfer of any residual women patients to Rampton Hospital by that date;
- timing of cessation of admissions and eventual closure of Broadmoor Hospital's Women's Service, and transfer of residual women patient group to Rampton Hospital;
- establishment of new models of secure care for women including therapeutically enhanced services for the *small* group of women with very challenging behaviours;
- establishment of a single category 'B' high secure women's service, together with a national assessment service (including outreach), at Rampton Hospital.

NOG will consider the allocation of resources to enable an independent evaluation of a designated number of dedicated women's secure services as they represent new models of care.

A national group has been set up, led by the Director of Mental Health Nursing, to examine issues relating to women's expressions of sexuality in secure mental health settings.

Action at national level – NIMHE/development centres

NIMHE will support PCTs in reviewing low secure provision for women that they are currently commissioning (*proposed*).

NIMHE will:

- highlight to PCTs the urgent gap in the provision of high support community residential services identified at national level (*proposed*);
- identify four regions to develop pilot sites with DH funding (two commencing in April 2004 and two in April 2005), develop a core service specification and a process of comparative independent evaluation, to provide a blueprint for replication nationally;
- distribute the core service specification to all regional catchment groups and primary care trusts to assist them in developing similar provision locally (*proposed*).

Service specification for integrated, dedicated secure care services for women

This specification should be considered in close conjunction with **all other sections of the guidance**.

Client group

Women with complex mental health care needs. Women in this group often:

- have more than one diagnosis including mental illness, substance misuse, learning disabilities, eating disorders and personality disorder, particularly borderline personality disorder;
- have a history of significant and sustained violence and abuse and significant experience of separation and loss, including that of their children;
- experience intense feelings of powerlessness and vulnerability with difficulties in forming trusting relationships;
- present with self-harm, offending behaviours, pervasive anger, depression, mood instability, dissociation and/or anxiety;
- are managed in conditions of physical security greater than their needs.

Structures

Provision of secure inpatient services

A range of provision is required to create an integrated, dedicated system of secure inpatient care for women.

> Women's needs for security are predominantly for relational and procedural security and therefore making a distinction between existing (physical) medium and low secure care, particularly for longer term care, is probably unnecessary. This approach is likely to create a sufficient critical mass of patients that will facilitate the development of an effective therapeutic service as outlined below.

The development of an integrated women's service would benefit from close proximity to other mental health services to ensure a range of facilities, adequate open space, the potential back-up of extra staff if needed and to allow for any mixed-sex activities, if and when appropriate.

This system will need to provide:

- short assessment and longer-term placements;
- a range of inpatient settings that can cater for the range of needs including intensive care, challenging behaviour, remand assessment, rehabilitation; for women with a diagnosis of personality disorder, women with learning and associated disabilities; women within the prison service who require a secure mental health setting given their high levels of psychiatric morbidity;
- services for the *small* number of women, currently in high secure care, who have committed severe offences or who have very challenging behaviours who could not be catered for within existing medium secure care, but who do not need Category 'B' high secure care;
- multi-disciplinary, multi-agency teams to support inpatient services.

Services ideally need to be large enough to support at least two multi-disciplinary teams to enable mutual learning and support, and to provide specialist cover for times of additional need/holidays, etc.

Physical design

- environmental security provided by the built environment, wherever possible, rather than perimeter fences and specifically address maintaining an environment that reduces as far as possible the capacity for serious self-harm;
- ward lay-out in which zonal observation is a realistic alternative to high levels of one to one, or more, nursing;
- crisis suite(s) i.e. bedroom, day and bathroom area(s) that are separate, or can be separated off;
- child/family visiting areas;

- women-only secure outside space;
- wards with no more than 12 beds;
- quiet/low stimulus area(s).

Access is also required to non-specialist, non-secure services including acute inpatient and community settings (e.g. assertive outreach teams, high support community residential placements) that will accept women with challenging/offending/self-harming behaviours.

Physical health care.
Inpatient services should have dedicated primary health care input including well-woman sessions, dentistry and general practice and suitable arrangements for the provision of specialist, secondary physical health care when required. Health promotion services should also be provided.

Forensic community teams
These should be multi-disciplinary and include input from the following disciplines: psychiatry, psychology, psychotherapy, social work, occupational therapy and nursing. Sessional input from other services/disciplines such as substance misuse and eating disorders may be required. It may be appropriate to arrange secondments from learning disabilities/ rehabilitation/probation services to increase the range of experience, the likelihood of recruitment and the capacity for inter-agency liaison.

Functions to be provided by the service
Outreach – consultation, liaison and crisis intervention
Support to:

- criminal justice system: probation service (including bail and probation hostels), courts and prisons;
- local adult and child and adolescent mental health and learning disabilities services, giving advice on how women may be cared for without admission to secure beds;
- private sector/out-of-area placements.

Assessment and care planning
- assessment should inform a formal care planning process under CPA;
- should be multi-disciplinary, holistic and comprehensive including violence and abuse, self-harm, substance misuse, eating disorders, sexuality and gender sensitive assessment of risk.
- will need to take place in a variety of settings including the community, family and residential homes, and distant secure placements including prisons, high secure hospitals and the independent sector;
- links with local court/police diversion and liaison services should be explicitly agreed.

Treatment and continuing care
Teams should provide the following:

- A *therapeutic and non-institutionalised ethos* which consistently incorporates the following in all areas of the unit e.g. ward, activity areas, psychological therapy settings:
  - a high level of relational security;
  - a positive expectation of hope and recovery;
  - recognition of the strengths, abilities and competencies of women patients;
  - development of 'non-punitive' strategies for the management and reduction of threatened and actual aggression towards staff and patients;
  - ensure that, in all aspects of clinical practice, situations are not created that may be perceived or experienced as abusive by women patients (or staff).

- A range of *outpatient and inpatient interventions* including:
  - a range of integrated psychological therapies that are psycho-dynamically informed e.g. family, systemic, cognitive/behavioural approaches in group and individual settings to help women address e.g. their self-harm, substance misuse, eating disorders; patterns of offending (particularly fire-setting) – the therapeutic process should be fully informed by an understanding that these presentations are inter-linked symptoms of primary distress located in the lives and experiences of women, notably childhood sexual abuse;
  - creative therapies;
  - complementary therapies;
  - medication: to be maintained at the lowest level possible for satisfactory therapeutic benefit without undue suppression of feelings/emotions and/or undue weight gain.
- An *integrated 'daily living' programme* including: education (including basic numeracy/literacy), creative arts, sports and opportunities for exercise, occupational activities, health promotion, development of coping, social and parenting skills, social/leisure opportunities. Activities should be tailored to an individual's ability and level of confidence to enable women to learn new skills and increase their self-esteem through concrete achievement.

  Note To minimise women's sense of isolation and enhance their movement towards independence, services should facilitate their involvement/contact with all relevant community settings and activities.
- *Community follow-up* of all women discharged from secure care including those who do not require secure placement, but whose behaviours are too unusual/severe to be contained by local general mental health teams, and those with established forensic/offending problems and mental illness/personality disorder.

Service standards, evalution and monitoring procedures
These need to be developed in close consultation with women patients in all new service models of care.

Operational policies and procedures
Policies and procedures should include the following:

- Clarity regarding the operational management of an environment with a high level of *relational security.*

  Note: This relates to the nature and quality of therapeutic relationships developed and sustained between patients and staff, primarily nursing staff, within the context of safe, contained and fully explained boundaries. It is dependent upon high staff : patient ratios; the appropriate level, attitude and quality of staff engagement with patients; appropriate staff training and activities/interventions provided by the staff group. Relational security needs to be informed by an understanding of the impact of surviving severe violence and abuse on women's profound sense of powerlessness and vulnerability. A positive experience of 'here and now' relationships is crucial to the recovery process, those that address the ways in which women have been silenced and begins to give them a 'voice'.

- *Mixed-sex activities*, if and when, clinically appropriate.

  Note: Women-only activities should be the norm with the potential for mixed-sex activities confined to the recovery/rehabilitative process. Any mixed-sex activity should be organised with around equal numbers of women and men. Decisions on appropriateness should be made on an individual basis: the inclusion of women patients should be dictated by a woman's ability to make safe and informed decisions about her welfare; the inclusion of men patients should be based on a risk assessment to ensure that they have the ability to engage in mixed-sex activity in a safe and appropriate manner.

- Observation policies sensitive to women's need for privacy and *least restrictive care* such as zonal observation, high level of staff : patient engagement (*see relational security above*) and additional support plans.
- *Self-harming* behaviour including agreements with local emergency care providers (*see Section 8.5*).

Workforce
Development of:

- a dedicated, appropriately skilled staff group with capacity for cross cover and the development of specialist skills;
- a stable staff group which will help consistency in practice and the development of therapeutic relationships;
- an appropriate gender mix of staff (existing women-only services often use a minimum of 70% female nursing staff with access to women staff at all times).

Staff should be recruited who have made an active and appropriate choice to work with women patients, are committed to working holistically and have an understanding of key gender issues relevant to women in secure care.

The introduction of shared posts/secondments/reciprocal placements across secure and general mental health services would provide a means of extending staff skills, promoting a greater mutual understanding and knowledge and reducing the risk of staff 'burnout'.

Training
The service will need to be able to provide training to other organisations and professionals as well as appropriate training for its own staff group.

Staff support
This should be integral to the organisation of services and include supervision, space for reflective practice and access to work-related confidential counselling and crisis support.

Management
Multi-disciplinary/multi-agency management teams to help create gender sensitive organisational culture, policies and practice.

Research
Sufficient funding should be available to ensure that services are established with a culture of research and audit. Formal links to an academic base should be made.

7.3 Safety in mixed-sex secure, inpatient and residential community settings

There is still a concern expressed by women service users across the country that they do not feel safe, or have not been kept safe, in mixed-sex residential settings. Whilst this guidance highlights the importance of safety in residential settings, it should be borne in mind that safety is a key issue in non-residential settings as well (*see Resources below*).

Aim: To ensure that women service users on mixed- sex wards are protected from intimidation, coercion, violence and abuse (including rape) by other patients, visitors, intruders or members of staff.

Recommended key actions for mental health trusts and primary care commissioners

Appoint an officer at a senior level within each trust to be responsible for women's safety to lead on the:

- implementation of trust-wide policies and procedures to address patient safety, privacy and dignity in relation to both the physical layout and day-to-day management;
- provision of training to ensure that staff operate them sensitively and vigilantly;
- elimination of mixed-sex accommodation, bathing and toilet facilities;*
- establishment of a women-only lounge, social activities and therapeutic groups.

* National target: compliance by all residential settings in 95% of trusts by December 2002

Expected outcomes: Full compliance with *Guidance on Safety, Privacy and Dignity in Mental Health Units* (DH 2000). Establishment of a safe environment for women service users.

Note This guidance equally applies to high dependency units and psychiatric intensive care units that are normally located alongside acute inpatient services.

Resources to assist with implementation

The DH document '*No Secrets*' outlines action to ensure that vulnerable adults, who are at risk of abuse, receive protection and support in all social care settings. It identifies the main forms of abuse as being physical, sexual, psychological, financial or material and discriminatory abuse plus neglect and acts of omission. The principles are equally applicable to all mental health care settings.

Action at national level – NIMHE/development centres

The Acute InPatient Programme within NIMHE is working with a national steering group on delivery of the *Mental Health Policy Implementation Guidance on Acute Inpatient Care Provision* that includes the issue of women's safety.

An Acute Care lead has been appointed in every development centre that is establishing regional practice and development networks for acute inpatient care concerns. Through this forum, the Acute Care Lead will encourage and support full compliance with the *DH Safety, Privacy and Dignity guidance* including the appointment of senior leads in mental health trusts with responsibility for women's safety (*proposed*).

Section 8
Meeting the needs of specific groups of women

Introduction: The roots and expression of mental distress

The impact of *violence and abuse* on women's mental ill health is relevant to all of the following sections and is identified as such. In addition, although specific forms of mental distress are addressed separately e.g. self-harm, eating disorders, it is important to recognise their inter-relationship. There can be a tendency in the mental health system to make arbitrary divisions between them, albeit unwittingly, which can result in the origins of women's mental health difficulties becoming obscured.

It is evident that, for example, women who self harm are also often the same women who have eating disorders, who have post-natal depression and who may also be given a diagnosis of borderline personality disorder. There is in fact more that links these symptoms than divides them in that they are all secondary symptoms of primary distress located in the lives and experiences of women, notably childhood sexual abuse.

8.1 Women who have experienced violence and abuse*

Experience of child sexual, physical and emotional abuse, all forms of domestic violence and sexual assault/rape (both inside and outside the home) are common amongst women and are a significant factor in the development of mental ill health (and its many manifestations) and physical ill health.

Research has consistently shown that between 20-30% of women have been sexually abused as a child (and up to 10% of male children). Domestic violence accounts for 25% of all violent crime, two out of five murders of women in England and Wales are by partners/ex-partners and around 30% of domestic violence begins during pregnancy or after childbirth; existing violence often escalates at this time. Figures indicate that one in ten women have experienced some form of sexual victimisation including rape, and that 'strangers' are only responsible for 8% of rapes. Research has also consistently shown a link between domestic violence and the physical and/or sexual abuse of children by the same male perpetrator, in addition to the majority of children witnessing the violent and abusive behaviour to their mothers.

Moreover, some women sexually abused as children, can be vulnerable to revictimisation and find themselves in violent or abusive situations and relationships subsequently.

Women survivors of child sexual abuse can also experience retraumatisation in response to treatment and care which, unintentionally, triggers or reawakens early experiences of abuse e.g. close quarters observation, response to self-harming behaviour, the administering of medication and care which is inappropriately provided by male staff. Mental health professionals need to be aware of the possibility of revictimsation and retraumatisation and take steps to respond appropriately.

* The term 'violence and abuse' refers to child sexual abuse, all forms of domestic violence and sexual assault and rape.

Studies indicate that 50% or more of women within the mental health system are survivors of violence and abuse; in secure settings the figure is much higher. At the same time, the level of awareness about the nature and extent of domestic violence and child sexual abuse and its effects appears to be low generally amongst mental health professionals, and these women often do not receive the care they need as a result. To remedy this, services need to be able to identify women with histories of violence and abuse so this can be taken into account in their care and treatment. Raising these issues routinely in assessment and care planning requires great sensitivity and understanding, alongside the availability of appropriate support and psychological therapy. Therefore staff need training in how to handle this appropriately *before* routine exploration is introduced. If done in the right way, the experience of being asked and listened to can be helpful to survivors; if not, the experience may be distressing and damaging for service users and result in their retraumatisation.

Aim: To acknowledge and address the links, between violence and abuse and women's mental ill health, in the delivery of mental health services in inpatient and community based settings.

Recommended key actions for mental health trusts with primary care, social services, councils and relevant voluntary sector organisations

Appoint a lead person at a senior level in every mental health trust to:

- help the organisation address issues that may lead to the retraumatisation of survivors;
- facilitate appropriate inter-agency working;
- produce a map of existing services ie all agencies including the voluntary sector and assess their quality, accessibility and viability;
- ensure access to appropriate staff training, in particular ensure that training equips staff to address issues of violence and abuse routinely in assessment and care planning;
- ensure that issues relevant to confidentiality have been fully considered;
- *once satisfactorily trained*, ensure staff raise issues of violence and abuse routinely and consistently in assessment and care planning;
- ensure that appropriate follow-up takes place by means of audit procedures;
- develop the provision of specific support and treatment interventions;
- develop staff support processes;
- ensure that confidentiality issues are properly addressed in liaison with the Caldecott guardian.

Expected outcomes: The impact of violence and abuse will be established as a core mental health issue. Sufficient local expertise will be generated to address the needs of survivors of violence and abuse within the mental health system and, where appropriate, to commission specialist services in the voluntary sector. Assessment and care planning processes will take full account of the context of violence and abuse on a routine and consistent basis.

Advice on implementation

It is important that there is an element of 'self-selection' in the appointment of *a senior lead for violence and abuse* (who may come from any of the mental health disciplines) to ensure a genuine interest and commitment rather than any imposition of responsibility. At the same time, care should be taken to ensure that the appointment is an appropriate one.

Inter-agency working with regard to domestic violence should include Domestic Violence Forums, Area Child Protection Committees, Sure Start Programmes, Crime and Disorder Reduction Partnerships. Managers and health professionals across specialist mental health services and primary care need to be jointly involved in establishing and implementing domestic violence policies and protocols to reflect local need. It is also important for mental health services and primary care to be linked with locally based community provision for both victims of domestic violence and survivors of childhood sexual abuse

e.g. counselling, help-lines including self-help groups. A list of such agencies can be obtained from The Survivors' Trust who can be contacted through either RoSA on 01788 551150 or by emailing cisters@btinternet.com

It is essential that staff receive *training* in raising issues of violence and abuse and supporting disclosures *before* they begin to do this routinely in assessment and care planning. In recognition of the fact that the majority of services are currently provided by the voluntary sector, these agencies should be approached and involved in advising on what constitutes appropriate training for mental health staff (and other agencies that might lack similar training provision). For example, there are seventy member organisations of The Survivors' Trust that can assist in the development of appropriate training for staff working with these individuals.

Although the priority needs to be training for qualified staff directly involved in the assessment and care planning process, in the longer term general awareness training should be developed for other staff working with those affected by domestic violence and child sexual abuse.

Training and education should enable staff to:

- establish a clear understanding of the range of symptoms and presentations in which violence and abuse, particularly childhood sexual abuse, may be a significant contributory factor and the potential inter-relationship between these;
- develop skills in asking questions about violence and abuse, and creating an environment in which women feel safe enough to talk about their experiences without becoming overwhelmed by doing so;
- ensure that the issue of confidentiality is also addressed so that disclosures of violence and abuse do not make already vulnerable women more vulnerable (e.g. to stigma);
- increase their knowledge of the wider context and implications for survivors e.g. the potential need for safe housing, links with the police and criminal justice system;
- provide information to survivors on community support that may be available in the voluntary sector e.g. counselling, support groups, helplines, and make appropriate referrals.

Once staff are trained, appropriate *audit procedures* should ascertain whether:

- issues of violence and abuse are being addressed on a routine and consistent basis at the initial assessment stage with all service users rather than staff waiting for the 'right time', and that it is done in a manner that conveys a sense of trust and safety;
- appropriate follow-up is initiated (plus time-scale) once needs relating to these issues have been identified;
- staff continue to be aware of the possibility that issues of violence and abuse may be raised at any time in the care planning process and be prepared to support this.

Raising issues of violence and abuse routinely in assessment and care planning should lead to the provision of *appropriate therapeutic interventions.* Some of these can be commissioned from specialist providers in the non-statutory sectors. NHS psychological therapy services will also want to draw on the experience of these agencies in working with individuals to develop and provide appropriate mainstream psychological therapies.

Staff support processes need to take account of the possibility that some of these staff may themselves have had similar experiences of violence and abuse, particularly as the majority of nursing staff are women.

Resources to assist with implementation

Domestic Violence: A Resource Manual for Health Care Professionals, DH, London 2000.

Understanding Domestic Violence: A Training Pack for Community Practitioners (CPHVA 2001).

Training Packs on general awareness and routine questioning on domestic violence for health visitors and midwives; issues relating to domestic violence for counsellors; advice and support services for survivors and perpetrators: available from Redbridge and Walthamstow Forest Domestic Violence Health Project on website www.dvhp.org.

Positive Practice Examples

See www.doh.gov.uk/mentalhealth/women.htm for the description of trusts who have adopted different routes towards addressing violence and abuse as a core mental health issue, namely Devon Partnership Trust and South Staffordshire Healthcare NHS Trust

SERICC (South Essex Rape & Incest Crisis Centre), with HO funding, is delivering **training on violence against women by known perpetrators** in partnership with Leeds Inter-Agency Project (LIAP) in Thurrock, Essex. The training enables a multi-disciplinary approach to improving the safety of women and their children by focusing on the continuum of sexual and domestic violence and its impact on women's lives. **Contact** SERICC, telephone 01375 381322/LIAP telephone 0113 234 9090.

Action at national level – DH/other government departments

DH has appointed a senior lead responsible for addressing all health issues related to domestic violence, and to represent the Department in all cross-government initiatives.

A HO led consultation paper sets out a cross-government strategy (including DH activity) to: prevent domestic violence in the first place and/or prevent it recurring; increase protection and support for victims; bring more offenders to justice; increase confidence in the criminal justice system; improve inter-agency working. The consultation paper 'Safety and Justice' is available on the HO website www.homeoffice.gov.uk/docs2/violence.htm

Action at national level – NIMHE/development centres

Professor Catherine Itzin has been appointed a Fellow of NIMHE to lead a programme of work on Violence Abuse and Mental Health. This will cover the mental health implications of child sexual abuse, domestic violence and sexual assault/rape for services and professionals identifying and responding to sexually victimised children, to adolescent and adult survivors of child sexual abuse to victims of rape and sexual assault, to (the largely) women and children victims of domestic violence and to their abusers. There is a strong link between parts of the NIMHE Violence Abuse and Mental Health national programme and the violence and abuse elements of the Women's Mental Health Strategy. It has been agreed that these elements will become integrated and implemented jointly. A national team will be established hosted by the NIMHE East Midlands Development Centre with a designated lead, in each of the other seven development centres, for violence and abuse, gender and women's mental health.

NIMHE/lead development centres, with the national Mental Health Care Group Workforce Team (MHCGWT), will address the need for a national approach to developing staff training and education in addressing violence and abuse (*proposed*).

8.2 Women from black and minority ethnic communities

Organisations that plan, commission and deliver services for women also need to consider the needs of women from black and minority ethnic communities. It should not be assumed that gender sensitive or single-sex services automatically meet the needs of women from these communities or that discrimination and racism against them will not occur in these settings.

The Race Relations (Amendment) Act places a general duty upon public authorities and those carrying out public functions to promote race equality and positive community relations. This general duty is reinforced by specific duties including the requirement to:

- consult with different racial groups on policy/services;
- assess the potential effect of new proposals on different racial groups;
- monitor the impact of policy/services on different racial groups;
- take remedial action where adverse and unjustifiable impact is identified;
- make information on services accessible to the public, including minority ethnic groups;
- monitor the workforce by ethnicity.

Issues of particular relevance to women from black and minority ethnic communities

- There is a higher incidence of self-harm and suicide in young Asian women than in any other group of women. This may be difficult to detect and address as many women are reluctant to disclose their distress within their own community (due to a perceived stigma attached to any form of mental distress) and therefore may also be hesitant to seek help from outside their immediate community.
- For similar reasons, they may feel unable to disclose experiences of violence and abuse that they are recovering from or currently experiencing e.g. in their domestic lives and therefore these issues should be explored with great sensitivity.
- Services who are working with women whose first language is not English must ensure that, wherever possible, women translators are made available. This will enable them to discuss confidentially any issues that they may be more reluctant to disclose if their partner or male community representative is translating on their behalf. The use of an independent translator would also eliminate the potential for the 'known' translator to convey their own interpretation or 'view of the events' rather than strictly conveying the woman's expressed feelings or needs.

Actions at national level – DH

Guidance on service delivery to black and minority ethnic communities will be published for consultation shortly. Both documents provide essential guidance on understanding and tackling the interplay of gender, race and cultural inequalities in mental health services.

An important element of this guidance is the appointment of 500 community development workers by 2006, one of the 'critical success factors' of the *Priorities and Planning Framework.* This will enable female community development workers to build relationships with women of the same ethnicity in the communities in which they live, and facilitate their appropriate access to specialist mental health and primary care services plus a range of relevant, broad based community support.

Actions at national level – NIMHE

The Black and Minority Ethnic Programme within NIMHE will be supporting the delivery of culturally sensitive mental health services for the benefit of both female and male services users.

8.3 Women who are mothers

The majority of women who have mental ill health are mothers and they need tangible and sensitive support to continue to care for their children while they are experiencing mental health problems, particularly women who have a serious mental illness. All relevant services need to acknowledge that having a serious mental illness does not necessarily mean that women cannot be 'good' parents.

In situations where women's children are 'looked after', specialist mental health and primary care services, in partnership with Children and Families Services, need to recognise and address the depth of distress this causes for mothers and their children, and that it can result in the further deterioration of a mother's mental health and militate against her recovery. Wherever possible and appropriate, sustained efforts should be made for mothers to maintain links with their children and/or consider the suitability of children being returned to their mothers with appropriate support and management of risk.

Aims: To enable women service users, particularly those with a serious mental illness, to maintain their parenting role wherever possible. To fully recognise and address women's fear of their children becoming 'looked after' as a result of their mental health problems.

Recommended key actions for specialist mental health and primary care services working in partnership with Children and Families Services (operated by Social Services)

- Provide tangible and sensitive support to women in their mothering role by:
  - facilitating their access to local Sure Start and Newpin projects or any other community based support services for women and their children (e.g. women-only community day services);
  - ensuring that children are safely and properly looked after if their mother is admitted to inpatient care (acute and secure settings), that contact is maintained and that children are able to visit their mother during this time whenever possible;
  - ensuring that discharge/rehabilitation planning incorporates consideration of women's parenting role and the well-being of their children;
  - providing 'family friendly' visiting areas in inpatient care (acute and secure settings), creche facilities for outpatient appointments and at times that are most convenient for women if they have any childcare arrangements in place;
  - exploring a woman's need for respite or 'time out' without their children or conversely residential crisis support where they can stay with their children *(see Section 7.1.2 Women-only community based acute care services)*;
- Adopt a shared approach to:
  - risk management and contingency planning which are essential elements in enabling women to retain their parenting role. (*Note. Children and Families Services are not confined to child protection issues although the welfare of the children remains paramount*);
  - identifying and supporting the needs of children who are, by their relationship with a parent with a mental illness, often called upon to assume caring responsibilities. They need to be identified and supported via the local Carers Strategy and through flexible care arrangements for the family unit;

- responding to women's caring responsibilities, other than parenting, through the local Carers' Strategy;
- developing training that raises staff awareness and develops a mutual understanding of the complementary roles of mental health and social care staff. (*Note. It may be appropriate to establish reciprocal secondments, placements or liaison posts to facilitate this mutual understanding*);
- working in partnership with women in using a range of services from a variety of providers (primarily in the voluntary sector) to support family functioning, reduce women's anxiety of 'losing' their children and avoid stereotypical assumptions.

Expected outcomes: Women service users will feel valued as mothers and receive the necessary support to maintain their mothering role. Children of women with mental health problems will receive the support they require. A greater mutual understanding will be established between staff from mental health and social work disciplines.

Resources to assist with implementation

Crossing Bridges, a training resource for staff working with mentally ill patients and their children advocating collaborative working across health and social care (DH 1998).

Framework for the Assessment of Children in Need and their Families (DH, DfEE, HO, 2000).

Working with Families, Alcohol, Drug and Mental Health Problems (Kearney P, Levin E, Rosen G, published by the National Institute for Social Work, 5 Tavistock Place, London WC1H 9SN, www.nisw.org.uk, ISBN 1 899942 41 6. This work is being developed further by the Social Care Institute for Excellence (SCIE).

Also see Section 8.8 Women with peri-natal mental ill health

8.4 Women offenders with mental ill health

There are significant gender differences between women and men in:

- *Routes and patterns of offending*
  Women are more likely than men to commit 'acquisitive' crimes e.g. shoplifting, fraud through financial hardship particularly in relation to children (high proportion receive sentences of less than twelve months) and less likely to commit arson, violent or sexual offences;
- *Social and economic context of their lives*
  Women are more likely to experience poverty, lone parenthood, poor housing, poor physical health, misuse substances, childcare problems and have suffered high levels of violence and abuse in child and adulthood (including sexual exploitation).
- *Experiences of mental ill health, both in prevalence and presentation*
  Women are twice as likely as men to have received help for a mental/emotional problem in the twelve months prior to custody, have symptoms associated with post-traumatic stress disorder and more likely to have a serious mental illness.

8.4.1 Women offenders in the community – an 'early intervention' approach

DH and the HO recommend that:

- a gender specific approach is required to meet the needs of women offenders and those with mental health care needs if there is to be equality of outcomes for women and men;
- custody should only be used for women offenders as a last resort for the most serious offences and where it is necessary for the protection of the public;
- an 'early intervention' approach should be adopted by establishing comprehensive community based packages of care and support for women offenders with a community disposal in respect of their offence.

Probably the most compelling justification for a distinct response to women's offending, and the services and interventions they require, is the higher individual and social cost of women's offending in view of their role as mothers and carers.

Aims: To enable women offenders with mental ill health to remain in the community (*unless they are convicted of offences that pose a severe risk to the public*). To co-ordinate the joining-up of services to develop tailored community packages of care for women offenders with mental ill health. To ensure the same level of tailored support for women prisoners on resettlement in their originating locality.

Recommended key actions for PCTs with criminal justice agencies, mental health and social care services and other relevant agencies

Establish a multi-agency forum by using/extending existing forums such as Crime and Disorder Reduction Partnerships, LITs comprising representatives from key criminal justice agencies, specialist mental health and primary care services and other relevant agencies (e.g. drug action teams, social services, housing and voluntary sector organisations)

Suggested remit of the multi-agency forum:

- develop a mutual understanding and knowledge of the roles, responsibilities, structures and processes of all relevant stakeholders;
- consider the development of multi-agency training to ensure the above on a consistent local/regional basis;
- increase the awareness of criminal justice agencies (and the courts) of what facilities/services are available to deal with women's mental health problems in specialist mental health, primary care and community based services e.g. women's community day services;
- explore the ways in which these facilities/services could support the greater use of community, rather than custodial, sentences;
- identify ways of providing other services/support that women may need e.g. drug treatment and rehabilitation, support with parenting, abuse counselling, supported accommodation, education and training, access to full benefits entitlement;
- identify the means of providing earlier and more detailed mental health assessments for women e.g. at the point of arrest, following arrest, at the pre-sentencing report stage;

- consider the means by which one organisation/individual could act as case manager in co-ordinating appropriate community packages of care e.g. a voluntary based link worker (Revolving Doors Agency provides this service in some areas); supported housing worker; probation officer; mentoring scheme, local assertive outreach team; mental health diversion scheme.

Expected outcomes: The women's prison population will reduce. Women will receive a tailored and co-ordinated package of care to meet their complexity of need within the community. An early-intervention approach will be adopted to meeting the mental health needs of women offenders in the community. Women will have a greater opportunity to maintain their mothering role/reduce the possibility of their children becoming 'looked after'.

Positive Practice Example

The Asha Centre based in Worcester aims to benefit women who are isolated by disadvantage from resources to help them to achieve their potential in a safe, women-only environment with on-site childcare and help with transport if necessary. Around 35% of women using the Centre are **offenders on community rehabilitation orders**, many of whom have mental health problems, who are directly referred by West Mercia Probation Service. Personal Action Development Plans are developed with every woman offender reviewed at three weekly, three monthly and six monthly intervals e.g. they can access counselling for rape and abuse, undertake group work at the Centre led by Probation Officers, participate in workshops and educational facilities, attend appointments with their Probation Officer at the Centre. Research is currently taking place to examine whether this involvement reduces the risk of (future) offending. **Contact** Jane Gallagher, telephone 01905 767552 email ashaproject@btconnect.com.

Actions at national level – DH/NIMHE and HO

In view of the many commonalities between women's offending and their mental ill health, the DH (led by the Policy and Performance Management Branch) and the HO (led by the Women's Offending Reduction Programme) have initiated an integrated approach to addressing women's needs. As part of this process, a two-day working event took place in March 2003 with broad representation from these two government departments and the 'field' e.g. prison service, mental health care services and the voluntary sector. Discussions are underway to further develop this integrated approach and identify the means of supporting the recommended key actions outlined above.

8.4.2 Women offenders in prison

A significant number of women prisoners require effective assessment and care planning to address both their mental ill health within prisons and/or appropriate transfer to secure mental health settings. *Changing the Outlook* (available at www.doh.gov.uk/prisonhealth) requires all prisons to examine critically the services they provide and develop action plans to ensure that they meet the identified needs of their particular prison population. Women in custody should receive the same level of mental health care as women living in the community.

Aims: To ensure that women prisoners receive the same quality of primary and specialist mental health care as women residing in the community. To ensure that, on resettlement, continuity of mental health care is provided for women.

Recommended key actions for PCTs with mental health trusts and prisons within their locality

- Ensure that all NHS funded mental health in-reach develops, in particular, assessment and therapeutic interventions for women who:
  - have severe and enduring mental health problems; have acute mental illness; are surviving violence and abuse in child and/or adulthood (*see Section 8.1*); have dual diagnosis with substance misuse (*see Section 8.7*); self-harm with or without suicidal intent (*see Section 8.5*); have eating disorders (*see Section 8.9*); receive a diagnosis of Borderline Personality Disorder (*see Section 8.6*);
  - recognise that violence and abuse is often a significant contributory factor to all the above forms of mental distress;
  - reduce, wherever possible, reliance on medication (*see Section 5.2.1*).
- With the prison services, provide prison health care staff with the training, support and supervision required to support women with mental ill health that complements the provision of specialist mental health service input.
- Appropriately transfer women prisoners, with severe mental ill health, to secure mental health settings.
- Identify the number and location of women prisoners within each local primary care trust to ensure that, on release, they receive the continuity of mental health care they require.

Expected outcomes: Women prisoners will receive comparable mental health care to women in the community. On beginning their sentence, the mental ill health of women prisoners will not deteriorate further and hopefully, in time, improve. Women, on release, will continue to receive the mental health care they require.

Actions at national level – DH/HO Prison Health

As part of national policy to provide specialist mental health care in-reach to all prisons within a phased approach, by March 2004 in-reach should be in operation or in the process of development in fourteen establishments housing women prisoners.

DH Prison Health policy unit has worked closely with a collaborative research team from the University of Newcastle to develop a new and more effective three stage health screening process on first reception into custody, which is designed to detect 90% of significant mental health problems experienced by prisoners, with a distinct screening process developed and piloted for women prisoners. Following the evaluation of this screening process at a number of pilot sites, a year long programme of implementation in all prisons (receiving prisoners directly from court) began in April 2003. The screening process will continue to be modified/improved based on the experience of 'early implementers'. Prison Health is also developing a distinct screening process for female juvenile prisoners.

Prison Health has commissioned the development of a mental health awareness training programme for prison officers that will be piloted in six prisons during the course of 2003 (including one woman's prison) for subsequent roll-out nationally.

8.5 Women who self-harm

The distinction between self-harm with and without suicidal intent and the overlap between the two groups is a complex area. However many women who self-harm make a clear distinction. For health and other practitioners, making this distinction in individual cases may be difficult and generate anxiety and uncertainty. However staff should be trained in addressing the possibility of self-harm routinely as part of the assessment and care planning process (*see Section 5.1 Assessment and Care Planning*).

Guidelines to be published by the National Institute for Clinical Excellence (NICE) in 2004 will focus primarily on the link between self-harm and suicide which will be of particular benefit to Accident and Emergency Departments and hopefully reduce the number of suicides through the means of self-poisoning.

The focus of this section is on women who self-harm primarily as a coping mechanism or survival strategy. This should be recognised and responded to appropriately as such, whilst at the same time recognising that self-harming in certain ways can inadvertently lead to suicide in some instances. Consistently research, clinical evidence and women's own writing indicate a strong link between the experience of childhood sexual abuse and self-harm, which is clearly a manifestation of women's distress and a means, however maladaptive, of surviving painful experiences.

Many women in this category feel unsupported and misunderstood, and the only response they usually experience from in-patient settings is to be kept under close observation to prevent them self-harming and, in some instances, to be evicted from acute in-patient services. Rather, women need treatment and care in an environment in which they are actively encouraged to address their self-harm, and to take steps to minimise it or prevent it, without coercion, and be supported to retain their autonomy, dignity and responsibility wherever possible.

Aim: To develop policies/protocols, staff training and staff support to effectively assess and manage women who self-harm – primarily as a coping mechanism or survival strategy – in inpatient and community mental health services.

Recommended key actions for mental health trusts with primary care services, social services and accident and emergency departments

- Develop policies/protocols for the assessment and management of women who self-harm, primarily as a coping mechanism or survival strategy.
- Through a continuing dialogue with women service users who self-harm, ensure that their views and experiences fully inform the development of policies, staff training and support.
- Ensure that policies, staff training and support take account of the following factors:
  - the importance of the woman's view of the event;
  - that staff can behave in a punitive or dismissive way which may exacerbate a woman's negative feelings about herself;
  - that many women experience constant close quarters observation to prevent their self-harm as intrusive and inappropriate;
  - that alternative approaches to maintaining a safe environment will be more acceptable to women service users e.g. additional support plans and crisis suites (with respect to life-threatening self-harm);
  - that staff may find dealing with repeated or serious episodes of self-harm frightening and/or rejecting and need support to deal with this in a way that will help women overcome the need to self-harm in this way;

  - the need for an integrative and holistic approach to working with women to address the underlying causes and context of their distress, and to support them in moving towards other, more positive, means of coping and expressing themselves.
- Consider a 'harm minimisation' approach rather than an exclusive 'prevention' model of approach.
- Ensure that clearly defined policies and protocols are made available to and discussed with women service users.

Expected outcomes: Women service users will feel more supported and empowered in addressing their self-harming behaviour. Staff will be enabled to provide more sensitive and insightful support to women in addressing their self-harming behaviour. Staff's emotional response to a woman's self-harming behaviour will be appropriately addressed within a clearly defined support structure.

Advice on implementation

The aims of a 'harm minimisation' approach are to:

- adopt a non-judgemental and non-punitive attitude to understanding the reasons why women self-harm based on listening and hearing what women have to say;
- actively support and encourage individuals to take steps to contain their self-harm within reasonable limits while working with them to replace self-harming with other, more positive, means of coping and expressing themselves which are primarily 'user-led';
- provide the means by which individuals can address the underlying causes of their self-harm;
- recognise and provide the level of support staff require when working with women who self-harm;
- advise and support women in taking care of their own injuries except in instances where hospital treatment is required;
- clarify the instances in which staff's responsibility to protect should override the responsibility resting with the individual ie when the severity of self-harm may become dangerous/life threatening even though there may be no suicidal intent.
- provide a structure in which individuals can retain their autonomy, dignity and responsibility wherever possible.

Resources to assist with implementation

National Self-Harm Network (a user-led organisation that provides information, training and assistance with developing appropriate policies). Contact NSHN, P.O. Box 7264, Nottingham NG1 6WJ.

Bristol Crisis Service for Women offers a detailed training pack for staff working with people who self-harm and good practice guidelines for working with people who self-harm (funded by the DH). Contact Hilary Lindsay telephone 0117-927-9600.

A video: 'Visible Memories', about people who self-harm produced by Croydon Mental Health Users Group can be ordered from the local MIND's website: www.mindincroydon.org.uk.

Voluntary sector organisations in your locality who may offer services for women who self-harm e.g. helplines, counselling, self-help/support groups, crisis housing.

Examples of services that work in partnership with women to minimise the risk of self-harm with clearly defined policies and protocols

- Crisis Recovery (Residential) Unit, Bethlem Royal Hospital, Beckenham, Kent (part of South London and Maudsley NHS Trust), contact Jane Bunclarke, telephone 0208 776 4102.
- A range of residential community based settings provided by the Mental Health Care Group, head office in Denbighshire, contact Heather Brown, telephone 01824 790 600.
- Rampton Women's Service is introducing a modified harm-minimisation approach compatible with the procedural security requirements, and severe level of distress experienced by women patients, within a high secure setting, contact Chris Milburn, telephone 01777 248321.

Actions at national level

NICE will be issuing guidance, primarily on the link between self-harm and suicide, in 2004.

8.6 Women who receive a diagnosis of Borderline Personality Disorder

In the process of implementing the policy implementation guidance *Personality Disorder: No longer a diagnosis of exclusion* (NIMHE 2002), mental health trusts need to ensure that they mainstream the specific needs of women who receive a diagnosis of borderline personality disorder. They have a complexity of need as their propensity to self-harm, have eating disorders, misuse substances, suffer from episodes of (or long term) psychosis, have major depression and a compulsion to engage in abusive relationships (depending on the severity of their distress) are co-occurring features. They are likely to be survivors of severe and prolonged abuse, notably childhood sexual abuse (research by Herman cites a figure of 89%) and, increasingly, clinicians now regard women who receive this diagnosis as suffering from a variant of post-traumatic stress disorder and advocate trauma based therapeutic approaches.

The NIMHE guidance on Personality Disorder:

- highlights the need to address the perjorative or stigmatising nature of the diagnosis;
- states that it is the responsibility of specialist mental health services to treat and support people who receive a diagnosis of personality disorder;
- recommends the development of community based specialist multi-disciplinary teams in personality disorder and specialist day patient services as part of general mental health services in areas of high morbidity;
- recommends a combination of psychological treatments (reinforced by drug therapy at critical times) together with a list of key guiding principles e.g. that they be well structured, have a clear focus, be relatively long term.

Actions at national level – DH/NIMHE

DH will invite tenders from recognised sites of positive practice and from training providers to enable them to provide a range of inputs to trusts delivering personality disorder services, and to expand the pool and range of training in personality disorder nationally.

DH will work with the lead Workforce Development Confederation and NIMHE to work up a tendering exercise, and to examine a range of options to develop appropriate training opportunities. This is to ensure that new training opportunities, as a result of the tendering exercise, do not themselves become fragmented and adhoc in their delivery.

8.7 Women with dual diagnosis with substance misuse

The main contention of the recent implementation guidance: *Dual Diagnosis Good Practice Guide* (DH 2002) is that substance misuse is usual rather than exceptional amongst people with severe mental health problems and that the relationship between the two is complex. Individuals with these dual problems deserve high quality, patient focused and integrated care that should be delivered *within* mental health services.

There are significant gender differences in the social context, form of substance misuse and presentation of women and men with dual diagnosis that need to be fully addressed in the development of local service planning.

The key issues for women as highlighted in the *Dual Diagnosis Good Practice Guide* are as follows:

- women who misuse substances are significantly more likely than other women or men to have experienced sexual, physical and/or emotional abuse as children;
- substance misuse lifestyles can impact on women's sexual health and establish a pattern of re-victimisation e.g. abusive relationships, prostitution;
- women are more likely to present at specialist mental health or primary care services for psychological difficulties rather than for any associated substance misuse problem and therefore may be more difficult to detect;
- detection may also prove difficult as women have a greater propensity to misuse prescription drugs and are more likely to hide their addiction due to social stigma;
- women therefore tend to access alcohol and drug services later than men, and this may explain their more severe presentation;
- women may have children, or want children, and this can deter them from contact with statutory services for fear of their children being removed.

The complexity and severity of need amongst women with a dual diagnosis requires the development of tailored services that are both attractive to women (that address their fears, take account of childcare responsibilities) and relevant to their specific needs e.g. need to be aware of and sensitive to the needs of survivors of child sexual abuse.

8.8 Women with peri-natal mental ill health

All those involved in the care of women before, during and following pregnancy should be aware of their mental as well as physical health needs, and the impact of a mother's mental health on her child(ren). Early identification, the availability of appropriate and timely interventions and support, and effective inter-agency approaches to service delivery are essential elements of good mental health support during and after pregnancy. Early identification can be aided by providing women with information through health promotion and public health initiatives on mental health and pregnancy and how to access appropriate help.

Depression during and after pregnancy can range from mild to medium, for which treatment in primary care will normally be appropriate, to severe post-natal depression, which requires specialist treatment and in some cases inpatient treatment.

(Refer to Women's Mental Health: Into the Mainstream for further details).

8.8.1 Women with a current or previous history (including family history) of serious mental health problems

Aim: To ensure that women with a current or previous history (including family history) of serious mental health problems, receive timely and appropriate care and support to minimise the potential for recurrence and/or deterioration of their mental health.

Recommended key actions for specialist mental health trusts, primary care services, social services and hospital maternity services

- Pre-conception advice should be given to women with an existing or past history of serious mental illness so that they are fully informed of the risks during and following pregnancy.
- Specialist mental health services should routinely meet the needs of women known to them who become pregnant through the assessment and care planning process (*also see Sections 5.1 and 5.2.1*). This plan should follow through to the post-delivery period and ensure an urgent planned response to any early signs of developing or worsening illness (*also see Section 8.8.3 'Mother and baby' units*).
- Pregnant women requiring a period of acute inpatient care, where no specialist provision exists, should receive care and treatment by staff who are skilled in meeting their needs and in an environment in which they feel safe.
- At the first ante-natal appointment women should be sensitively asked about any personal and/or family psychiatric history, its nature, severity and care received.
- All relevant services should work jointly to meet women's needs on a seamless basis through the ante-natal and post-natal stages.

Expected outcomes: The risk of women's mental ill health recurring or deteriorating during pregnancy, childbirth or immediately following childbirth will be anticipated, and appropriate and timely interventions and support provided. The potential for this group of women to maintain stability and care for themselves and their babies will be maximised. Suicide as a factor in maternal deaths will be reduced.

8.8.2 Women with no previous history of mental ill health

Aim: The early detection of any aspect of mental ill health in women at the ante-natal or post-natal stage, with no personal or family history of such difficulties.

Suggested key actions for primary care services with social services, hospital maternity and relevant community based services

- All staff working in primary care, notably midwives and health visitors, and hospital based maternity services should be alert to the possibility of depression (the most common) and other mental health problems, at the ante-natal and post-natal stages.
- Services should consider the training needs of the above staff.
- Women should be provided with information through health promotion and public health initiatives on mental health and pregnancy, and how to access appropriate help.

Expected outcomes: An early intervention approach to the potential incidence of mental ill health in women at the ante-natal and post-natal stage, resulting in the prevention/amelioration of mental health problems.

8.8.3 'Mother and baby' units

Aim: To ensure that mothers requiring acute inpatient care are accommodated appropriately with their babies.

Recommended actions for PCTs with specialist mental health services and social services

To review provision for mothers with young babies requiring acute inpatient care to ensure that:

- any existing mother and baby unit is run in the best interests of both mother and baby;
- mothers are not routinely cared for in general acute inpatient wards with their babies;
- in the absence of a local mother and baby unit, PCTs act collaboratively to ensure that mothers within their locality have access to a high quality mother and baby unit within reasonable travelling distance.

Expected outcome: Specialist mother and baby units are available for any mother requiring acute inpatient care if this is in the best interest of mother and baby.

Advice on Implementation

Effective detection and adequate management of all mental health problems linked to pregnancy and childbirth requires the effective co-ordination of a wide variety of primary and secondary care services provided by: midwives, health visitors, clinical psychologists, community psychiatric services, general practitioners, pharmacists, obstetricians and psychiatrists, with other agencies, notably voluntary organisations and social services, providing further support. This will ensure an integrated care pathway from the point that pregnancy is confirmed through to the post-childbirth phase to maintain the health of mother and baby wherever possible, and to effect an early intervention approach for vulnerable mothers and their families.

Initiatives such as Sure Start and Newpin have a vital role to play in the early detection of post-natal depression and therefore increase the likelihood of mothers receiving the help they require in the community, without referral to specialist mental health services.

Services should recognise that improvements in outcomes are largely determined by the availability of and prompt access to local services and should ensure that all relevant staff, notably midwives and health visitors, are aware of the kinds of support and interventions that are appropriate and available.

Voluntary organisations can provide a range of support to women during pregnancy, childbirth and early parenthood. Statutory services should be aware of the availability of these services locally.

There are widely varying cultural traditions and rituals around pregnancy and childbirth and a lack of cross-cultural equivalents in concepts of depression. Effective detection and management of peri-natal mental ill health in women from black and minority ethnic groups requires an understanding of these differences.

PCTs may wish to approach local workforce confederations to develop competencies in the detection, referral and interventions for ante and post-natal depression as part of basic training for health visitors, midwives, community mental health nurses, GPs and other community nurses such as practice nurses.

Positive Practice Example

A multi-professional team in **Portsmouth and SE Hants health district** has developed a **strategy and care pathway** to promote the identification and primary management of maternal depression in the ante and post-natal period. A training programme undertaken by health visitors and primary mental health workers has supported the launch of the strategy. It used a cascade approach developing a network of local trainers and experts. Midwives will be trained in the future.
Contact Jenny Gilmour, telephone 02392 434900 email Jenny.Gilmour@porthc-tr.swest.nhs.uk

Actions at national level – DH

The national Specialist Mental Health Commissioning Group is currently considering the best means of assisting primary care trusts in the commissioning of specialist mother and baby units.

The *CNSF*, which is currently being developed for publication in 2004, includes maternity services. The maternity module of the *CNSF* will define standards to deliver support to childbearing women and babies to achieve the optimum health and well being of both. In recognition of the importance of this issue, a group has been set up to specifically review the mental health and well-being of women at this important time to ensure that advice, support and care from appropriate health professionals are available to those women who are at risk of peri-natal mental ill health.

DH and NIMHE are reviewing the need for further research around peri-natal mental ill health identified at the consultation stage including research into the effectiveness of mother and baby units (for the mother and for the baby) and the long-term impact of maternal mental illness on children.

The Association for Post Natal Illness is receiving DH funding to enhance its support for women suffering from postnatal depression, severe or prolonged depression or other illness arising from pregnancy and childbirth.

8.9 Women with eating disorders

Eating difficulties and eating disorders are far more prevalent in girls and women and include bulimia nervosa, anorexia nervosa (both having a typical age of onset during teenage years) and binge eating. Eating disorders often co-occur with other aspects of mental ill health notably anxiety symptoms, depression, obsessive-compulsive disorder (OCD), self-harm and post-traumatic stress disorder (PTSD). Whilst a significant number of people suffer eating disorders that are mild, self-limiting and amenable to self-help, for some the illness can be severely debilitating and have a substantial impact on social functioning. Anorexia has the highest mortality rate of any single psychiatric illness if deaths from medical complications, starvation and suicide are combined.

Young women can often fail to acknowledge the seriousness of their eating difficulties and they, and their families, need help and education to recognise this and to encourage them to visit their GP for help. Health promotion and public health initiatives in communities and schools can help to increase understanding.

Caring for someone with an eating disorder can be demanding and emotionally draining and this can be exacerbated by the need to travel frequently and possibly long distances to participate in family therapy, and to visit in-patient settings. Supporting carers is an important aspect of supporting and treating the service user.

Aim: To effectively meet the needs of, predominantly, girls and women with mild to severe eating difficulties

Recommended key actions for primary care and general mental health services with specialist eating disorder services in the statutory and independent sectors

- Detect, at the earliest stage possible, eating difficulties and eating disorders in both primary care and general mental health services. As part of the process of detection, recognise that eating disorders often co-occur with anxiety symptoms, depression, OCD, self-harm and PTSD.
- Increase awareness of eating disorders in schools and communities through health promotion and public health initiatives.
- Improve service user experience of service provision by:
  - ensuring that clear treatment protocols are in place to allow for the smooth management of care across service interfaces;
  - providing joint training for staff in primary care and general mental health services to enable them to work with women with eating difficulties and to make referrals to specialist eating disorder services if and when necessary;
  - ensuring that referrals to secondary care are to settings where staff have experience of the treatment of eating disorders and that are appropriate to the age of the service user;
- Take account of the impact of severe eating disorders on physical ill health including infertility, osteoporosis, dental problems, heart and renal failure.
- Ensure all families and carers are made aware of support available to them (*see Standard Six of the MHNSF*) and their right to request an assessment under the Carers and Disabled Children Act. Support families and carers through provision of information on eating disorders and establish effective communications (while respecting patient and carer wishes on confidentiality).

Expected outcomes: Girls and women experiencing mild eating disorders will receive the support they require within primary care services. Girls and women experiencing more serious eating disorders will receive the care and treatment they require in acute care settings or specialist eating disorder settings. Families and carers will be informed and supported and better enabled to continue their caring role.

Aim: To develop and establish specialist eating disorder services on a consistent basis countrywide that can provide assessment, consultation, liaison and treatment.

Recommended key actions for PCTs as commissioners

- PCT commissioners consider acting collaboratively to ensure that access to specialist eating disorder services is available to their populations.
- Consider commissioning day programmes for those requiring specialist support as an alternative to inpatient treatment.

Expected outcome: Care, treatment and support will be provided to service users, and support to their carers/families, as close to home as possible.

Advice on implementation

Many women experiencing mild eating disorders may respond to education about eating and dieting, attendance at a self-help group together with counselling to address underlying causes within primary care services or services provided by the voluntary sector e.g. Eating Disorder Association, a national organisation. Families and carers should also be made aware of locally or nationally available self-help and support groups.

Resources to assist with implementation

A manual-based self-help programme for sufferers of bulimia (Institute of Psychiatry Research Report 2002) has been shown to be useful in a range of different cultural and healthcare settings www.iop.kcl.ac.uk/IoP/Departments/PsychMed/EDU

Actions at national level

NICE has commissioned a clinical guideline for patients and clinicians on the management of anorexia nervosa, bulimia nervosa and binge eating disorders. The guideline will provide advice on effective care using the best possible research evidence. It will cover primary, secondary and tertiary and specialist care, and will consider adults and children. The guideline is expected to be issued in January 2004.

The DH Specialist Commissioning Group is compiling advice to support the specialist commissioning of eating disorder services, currently mainly provided by the private sector.

Graduate mental health primary care workers may assist with short therapeutic interventions for sufferers of milder eating disorders and 'gateway' workers can help ensure smooth pathways between primary care and specialist services – including sufferers of eating disorders.

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32039/*Mainstreaming Gender and Women's Mental Health* can also be made available on request in Braille, audio-cassette, disk, large print and in other languages.