



Department  
of Health &  
Social Care



**agenda**  
Alliance for Women & Girls at Risk

# **The Women's Mental Health Taskforce**

**Final report**

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# Foreword from Co-Chairs



Rising rates of mental ill health are one of the biggest challenges we face as a society. With increasing awareness and diagnosis, understandably, the pressure on our services increases.

That's why mental health is a priority for this Government. We are determined to make services more numerous and importantly more accessible, tackling the stigma around mental ill-health.

Rates of mental health issues are rising more quickly for women than for men, but many are facing barriers because of their gender. This is unacceptable.

Furthermore, women are more likely to be victims of gender-based violence and trauma. Some have described their experience within the mental health system as 'retraumatising' because of the use of practices like restraint – yet this is rarely reflected in the support they receive.

These are the reasons why this Taskforce was set up and why we have now started a conversation around better gender- and trauma-informed mental health care.

We have brought together experts from across health, public and voluntary sectors to look at how we can better support some of our most vulnerable women. I am extremely grateful to the women themselves who gave evidence to the Taskforce.

This report is a call to action for all providers, commissioners and practitioners across the health care system to drive forward the ethos of trauma- and gender-informed mental health care. I urge you to use the guiding principles developed by the Taskforce when developing and delivering services.

The strategic priorities within this report set out the need for a whole-system approach when tackling the injustices that women face. We need partners across the health, justice and social care system to work together to ensure that women receive the high-quality care that they need.

The Taskforce has made an important step forward in recognising the needs and experiences of women with mental health problems, but the work should not stop there. It is all of our responsibility to ensure the momentum created by this report continues, so everyone can access the support they need, no matter who they are.

**Jackie Doyle-Price MP, Parliamentary Under Secretary of State for Mental Health, Inequalities and Suicide Prevention**



It is against a backdrop of rising rates of mental health problems amongst women and girls that the Women's Mental Health Taskforce was formed. And why I was so pleased to co-chair this important and timely piece of work.

The Taskforce heard a range of evidence including, crucially, from women themselves. They told us how they had struggled to get the support they needed from mental health services. In some cases, even being left further traumatised by the treatment they received.

This is simply not good enough.

The Taskforce identified an urgent need for support to better respond to women's experiences and the realities of their lives, including their experiences of abuse and trauma and their roles as mothers and carers.

We hope that the principles set out in this report provide a framework for providers, practitioners and commissioners to improve the access to and quality of support women receive.

Much of the evidence heard by the Taskforce and its resulting conclusions are not new. Indeed, there are those who have been calling for these changes for many years. I hope this report will help invigorate that debate and generate new conversations about how and why our response to women's mental health needs to change.

We look forward to working with government, national bodies, providers and commissioners in the years ahead to improve our response to women's mental health so that all women get the help they need when they need it.

**Katharine Sacks-Jones, Chief Executive, Agenda**

# 1. Executive Summary

## The work of the Women's Mental Health Taskforce

The Women's Mental Health Taskforce was set up in response to evidence of deteriorating mental health amongst women and poor outcomes experienced by some women in mental health services.

Women are more likely to experience common mental health conditions than men, and while rates remain relatively stable in men, prevalence is increasing in women (McManus et al, 2016). Young women are a particularly high-risk group, with over a quarter (26%) experiencing a common mental disorder, such as anxiety or depression – almost three times more than young men (9.1%).

The Taskforce was established to set out priorities for improving women's mental health and their experiences of services. The work of the Taskforce was informed by the voices and experiences of women.

## Context and core themes in women's mental health

There can be gender-related differences between women's and men's experiences of mental illness and mental health services. Yet the Taskforce found that discussions about mental health, alongside service design and delivery, frequently fails to take gender into account. This can lead to situations where services can be inadvertently discriminatory towards women because they have been designed, whether consciously or unconsciously, around the needs of men.

Women described challenges in their **experiences of mental health services**, including problems building trusting relationships with staff, and a profound lack of voice or control. Those who had been in inpatient settings described a lack of ongoing support or aftercare, and a feeling of being "left to get on with it" when they left hospital.

The Taskforce heard that women's roles as **mothers and carers** was rarely considered in the support they received, with little provision to help them maintain relationships with their children and wider family. Women are sometimes reluctant to seek support in the first place for fear of having their children removed from their care, and for those who no longer had their children with them, the impact this had had on their mental health was frequently overlooked.

Despite the clear relationship between **gender based violence and trauma** and poor mental health, the Taskforce heard that this link is rarely reflected in the support available to women with mental health problems – with trauma informed services rare. Taskforce members heard from women that contact with mental health services could even at times be re-traumatising, for example through restraint or observations, often by male staff members. Some women spoke of feeling unsafe in inpatient services, and at risk of sexual assault or harassment from both members of staff and patients, and where incidents occurred they felt that these were not always well responded to.

Women with **multiple needs**, many of whom have faced extensive violence, abuse, poverty and inequality, are often deeply traumatised and can face other challenges alongside poor mental health, such as addiction and homelessness. Yet the Taskforce heard that services are not always well set up to meet women's needs or be flexible to respond to where women are in their lives.

**Eating disorders, self-harm and suicide** can also affect women and men differently. Eating disorders are more common among women and girls than men and boys, and young women and girls are more at risk of self-harm. And while young men are still more likely to take their own lives than young women, the rates for young women (those aged 20-24) have increased rapidly and are currently the highest on record (Office for National Statistics, 2018).

## Outputs of the Taskforce

The Taskforce worked on delivering four key outputs.

### 1. What matters to women

Through a series of focus groups, the Taskforce experienced the power of hearing women's experiences and expectations of the care they receive in their own words. From this, a set of statements were developed on what matters to women in the care they receive.



## **For commissioners, providers and practitioners to consider**

### Voice and control

"I am treated with respect and given the time to express how I feel, and not made to feel a burden when seeking help."

"I can take back control of my own life, be involved in my care and am able to discuss a range of options, which are personally suited to me, including alternatives to medication."

"I can choose who provides my care, am given a choice of male or female staff, and support is provided consistently."

### Accessibility

"Services work together to consider how best to support me in a way that is culturally appropriate and understanding of my sexuality."

"The support I receive is easy to access and provided in a non-stigmatised setting, including in primary care."

"I have a safe space at times of difficulty and easy and timely access to women-only support when I am in crisis."

"There is good mental health awareness in all key services together with practical support linking me in to the right services."

"I have ongoing support, particularly after discharge from hospital, to strengthen my resilience and ability to cope with difficulties in the future."

### Safety, respect and dignity

"I can access support from someone I trust and can speak to, who understands me and takes a holistic view of me every day and when in crisis."

"I meet with other people who have had experiences of mental health problems and who share my background."

### Understanding trauma

"I want therapeutic support with my current difficulties and past traumatic experiences including bereavement, sexual abuse and domestic violence."

Children and caring responsibilities

"I am valued for and supported in my role as a mother and/or carer, with my concerns about the welfare of those dependants are listened to."

## 2. Gender- and trauma-informed<sup>1</sup> principles

The Taskforce heard repeatedly about failings and gaps in current service provision. In order to help address these, the Taskforce developed a set of gender and trauma-informed principles, as a high level strategic tool to help commissioners, providers and practitioners consider the specific needs of women with mental illness at a local level.

**The Taskforce encourages commissioners, providers and practitioners to use these principles - alongside the statements of what matters to women - in their own work to ensure they are supporting women in a gender- and trauma-informed way.**

**These tools should also be used by others with the power to influence, design and deliver services for women who have experienced trauma, such as those working in the criminal justice system, addiction treatment, domestic and sexual abuse services, and housing and homelessness services.**

### Summary of gender- and trauma-informed principles

Theme	Principle
Governance and leadership	There is a whole organisation approach and commitment to promoting women's mental health with effective governance and leadership in place to ensure this.

<sup>1</sup> To work in a 'trauma-informed' way refers to an approach by which organisations operate with an awareness of trauma and its impact and avoid re-traumatisation.

Theme	Principle
Equality of access	Services promote equality of access to good quality treatment and opportunity for all women, including LGBTQ and BAME women.
Recognise and respond to trauma	Services recognise and respond to the impact of violence, neglect, abuse and trauma.
Respectful	Relationships between health and care professionals and women using services are built on respect, compassion and trust.
Safe	<p>Services provide and build safety for women, creating a safe environment that does not retraumatise.</p> <p>Services respond swiftly and appropriately to incidents that put women's safety at risk, including robust processes for reporting and investigating sexual abuse and assault.</p>
Empowerment through co-production	<p>Services engage with a diverse group of women who use mental health services to co-design and co-produce services.</p> <p>Services promote self-esteem, build on women's strengths and enable women to develop existing and new capacities and skills.</p>
Holistic	Services prioritise understanding women's mental distress in the context of their lives and experiences, enabling a wide range of presenting issues to

Theme	Principle
	<p>be explored and addressed, including with a focus on future prevention.</p> <p>Services support women in their role as mothers and carers.</p>
Effective	<p>Services and treatments are effective in responding to the gendered nature of mental distress.</p>

### 3. Commitments across the health system

To achieve change at the national level, the Taskforce worked with those with the power to influence policy and practice and improve the experiences and treatment of women experiencing mental illness, such as NHS England, Public Health England, Health Education England and the Care Quality Commission. The full list of commitments made as part of this work can be found in the full report but include:

**NHS England** has committed to: ensuring that their on-going work to improve services across all the protected characteristics will have a particular focus on women; piloting a new model of women's forensic inpatient services; and scoping the development of a toolkit to support system leaders to practically address health inequalities.

**Public Health England (PHE)** has committed to: practically endorsing and promoting the work of the Taskforce through the Prevention Concordat for Better Mental Health; producing guidance on how the NHS could promote the messages of the Taskforce; and making an explicit ask to focus on women's mental health through the additional funds given to the Health and Wellbeing Alliance.

**Care Quality Commission (CQC)** has committed to: building on the learning from their recently published [sexual safety on mental health wards report](#) and to eliminating mixed sex accommodation; promoting the Taskforce's work, particularly the gender and trauma-informed Principles; and looking at how the Mental Health Act Code of Practice 'guiding principles' are applied to Long-Term Segregation settings in practice.

**NHS Improvement** has committed to: aligning their sexual safety work with the objectives of and building on the findings of the recent CQC report; promoting the

work of the Taskforce through the Mental Health Safety Improvement Programme to deliver more gender- and trauma-informed care; and to endorsing and promoting the positive impact that trauma-informed approaches have on mental health services and outcomes.

**Health Education England (HEE)** have committed to: engaging with Strategic Transformation Partnerships to raise the profile of gender and trauma informed care and promote the findings of the Women's Mental Health Taskforce; exploring how women's mental health can be better supported in primary care; promoting this report to employers and education institutions, and reviewing with Higher Education Institutes the inclusion of trauma-informed care in their curricula over time.

### **Wider Leadership**

Following the work of this Taskforce, Jackie Doyle-Price will be chairing a new Taskforce for Women's Health over the coming year. **Jackie Doyle-Price is committed to ensuring that the new Taskforce builds on and learns from the work of this Taskforce including by looking at progress made on the commitments set out here, and the potential to go further.**

### **Voluntary and community sector (VCS) and academia**

The Voluntary, Community, and Social Enterprise Health and Wellbeing Alliance<sup>2</sup> will publish a toolkit based on the findings of this report, due to be completed in Spring 2019. This toolkit will set out what is required to successfully operationalise the strategic principles on trauma informed care produced by the Taskforce.

In addition, a new Violence, Abuse and Mental Health research network will be launched in December 2018, to facilitate cross-disciplinary understanding and research on domestic and sexual violence and abuse with mental health problems.

## **4. Recommendations and next steps**

### **Future strategic priorities**

The Taskforce encourages the following strategic priorities to be owned and led centrally by the Department for Health and Social Care, alongside its Arms' Length

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<sup>2</sup> The Voluntary, Community, and Social Enterprise Health and Wellbeing Alliance is a partnership between voluntary sectors and the health and care system.

Bodies (ALBs), and implemented locally by Mental Health Trusts, commissioners and practitioners.

1. Explicitly considering women's needs in all future mental health policy development, locally and nationally;
2. Further embedding trauma-informed care by raising expectations across services and awareness across the system and developing the evidence base to demonstrate this value of these approaches;
3. Supporting Routine Enquiry about violence and abuse in future policy development, including consideration of a requirement to gather and report data;
4. Using the principles of the Taskforce to inform service design and delivery so that there is better access for women and girls to gender-informed and gender-specific holistic services and after care, including through the women's sector. The Taskforce would like to see such support accessible in every area, providing specialist treatment for women including those from diverse groups e.g. BAME, LBTQ+;
5. Recognising that women's identities, and often their roles as mothers and carers, are important in individual treatment and in-service planning. Awareness needs to be raised of this across the system.
6. Ensuring the safety of women in residential mental health care by ending breaches of single sex wards and pursuing robust policy, practice and reporting processes around sexual harassment and sexual violence.

### **Suggestions for research and data**

The Taskforce makes the following suggestions for researchers and for research and data commissioners to improve the value and utility of data and research around women's mental health.

1. **Study Design:** To improve consideration of sex and gender, research should be informed by involving women and considering gender from the outset.
2. **Collect Data:** More should be done by researchers to collect data on topics that are relevant to women and their health, such as violence and abuse, poverty, physical health and the impact of different medications on women of different ages.
3. **Data Access:** To make progress in women's mental health research and to understand women's lives and use of services, it is important to be able to access timely, affordable, research-quality data.

4. **Data Analysis:** Research gaps must be identified and addressed that currently limit understanding of women's mental health and their service needs.

5. **Publish Data:** Statistics and routinely collected data, disaggregated by sex and other characteristics, must be published in meaningful and accessible formats.

## Conclusion

The Women's Mental Health Taskforce has been a step forward in recognising the needs and experiences of women with mental ill-health and in sharing that learning with the health and care system.

It is important that everybody with a responsibility for delivering and improving mental health services for women take heed of this report and maintain the momentum in driving forward change.

**Taskforce members urge commissioners, providers and practitioners to consider the findings of this report, including women's lived experiences of mental illness, and to embed and promote these in their work and organisations.** The Taskforce looks forward to the results of the actions committed to by the Arm's Length Bodies' (ALBs)<sup>3</sup> and other organisations engaged with through this process, and to seeing how this work can be continued in future to further improve women's mental health.

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<sup>3</sup> The Department of Health & Social Care works through a number of arm's-length bodies which share in managing the use of resources across the NHS, public health and social care systems.

## 2. Context and case for change: why women's mental health matters

Mental ill health amongst women is on the rise, with the most recent (2014) Adult Psychiatric Morbidity Survey (McManus et al., 2016) showing that women (19%) are more likely than men (12%) to experience a common mental health condition<sup>4</sup>. And while the overall rates of common mental health problems are increasing in women (particularly in young women), they are remaining relatively stable in men.

Young women have emerged as a particularly high-risk group for mental health problems (Kessler et al., 2005). Over a quarter (26%) of young women experience a common mental disorder, such as anxiety or depression – almost three times more than young men (9.1%). A quarter of young women (25.7%) have self-harmed, which is more than twice the rate for young men (APMS); and 1 in 7 young women (16-24) have Post Traumatic Stress Disorder (compared with 3.6% of young men) (McManus et al., 2016).

There can be gender-related differences between women's and men's experiences of mental illness; presentations of mental ill health are often quite different for women and men. Women are more likely to use self-harm as a coping strategy than men, as well as to report somatic complaints, which are physical symptoms of psychological ill health (APMS).

Similarly, there are differences in boys' and girls' presentation of distress, with girls and boys likely to respond differently to similar risk factors (McNeish et al., 2016). Where boys and young men often respond to trauma in ways that may get them excluded from school, and/or encounter the criminal justice system, girls are more likely to internalise their distress and develop mental health difficulties, and to enter early sexual relationships, sometimes encountering violence, abuse or sexual exploitation.

And amongst women, experiences and prevalence can vary, with some experiencing even higher rates of poor mental health and barriers to services. The prevalence of common mental health problems varies significantly by ethnic group for women, but not for men, for example McManus et al. (2016) found that black and black British

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<sup>4</sup> In this context, common mental disorders comprise different types of depression and anxiety.



women were the most likely to have a common mental health problem (29.3%), compared to white British women (20.9%) and non-British white women (15.6%).

Poverty and socio-economic disadvantage is also a significant factor. Women in poverty are more likely to face poor mental health, with 29% of women in poverty experiencing a common mental health disorder compared to 16% of women not in poverty (McManus et al., 2016). Women tend to have lower incomes across their lives than men, and almost half of single parents – the majority of whom are women - live in poverty. Women are also more reliant on public services, which have been operating in an increasingly challenging environment in recent years (Women's Budget Group, 2018). In addition, women are also more likely to be vulnerable to social isolation, longer life expectancy, lack of mobility and fear.

Female prisoners also have poorer mental health than both women in the general population and male prisoners in relation to self-harm, suicide attempts, psychosis, anxiety and depression (Light, Grant & Hopkins, 2013). For example, in 2016 there were 1,987 self-harm incidents per 1,000 female prisoners, compared with 399 incidents per 1,000 male prisoners (Ministry of Justice, 2017). It has also been found that women have different experiences of custody to men (Bloom & Covington, 1998; Corston, 2007), for example, reporting an acutely more painful experience of imprisonment than men (Crewe, Hulley & Wright, 2017).

Despite the evidence of these gendered differences, discussions about mental health, alongside service design and delivery, frequently fail to take gender into account. This can lead to situations where services can be inadvertently discriminatory towards women because they have been designed, whether consciously or unconsciously, around the needs of men (Aitken & Noble, 2001). In one study, for example, only one NHS mental health trust who responded to a Freedom of Information (FOI) request had a strategy for providing gender-specific services to women (Agenda, 2016).

The Women's Mental Health Taskforce was established in response to this evidence of poor and deteriorating mental health amongst women, and to address the gender inequalities in mental health and treatment that some women can experience.

Through its work, the Taskforce heard and discussed a wealth of evidence about the inequalities women can face in access to services, as well as experiences of poor treatment and negative outcomes. This included testimony from women themselves, who bravely shared their personal experiences with Taskforce members in the hope that these would not be repeated for other women.

The Taskforce heard alarming cases of women who had experienced trauma (often through childhood, domestic or sexual abuse) who then experienced further trauma

in mental health services through restraint, assault and/or disturbing experiences of one-to-one observations. They heard cases across the system of women being silenced throughout their lives by abuse, and then feeling further silenced and disempowered in mental health services. They heard cases of mothers becoming mentally unwell, and, instead of receiving support for their mental health and role as a parent, being deemed to be unfit as a parent because of their illness with their children taken into care.

Whilst many women who experience mental illness are successfully supported and cared for by mental health services, in the cases heard by the Taskforce, the response to these situations had been inadequate.

### **3. About the Women's Mental Health Taskforce**

The Women's Mental Health Taskforce was set up in early 2017. It aimed to define and address priorities for the next phase of improving the mental health of women, and their experiences of mental health services.

The Taskforce brought together experts in women's mental health to develop proposals to improve not only the mental health of women, but also their experience of mental health services. It was co-chaired by Jackie Doyle-Price, Parliamentary Under-Secretary for Mental Health, Inequalities & Suicide Prevention, and Katharine Sacks-Jones, CEO of Agenda, the alliance for women and girls at risk.

Membership of the Taskforce included key national organisations responsible for policy, commissioning and delivery of services (health, social care, voluntary and community care), including system partners such as NHS England and Public Health England, key academics in the field and public-sector policy leads in critical areas. Over the 17-month period in which the Taskforce met, it sought evidence from key experts and heard from women with lived experience through focus groups and meetings. Further information about the Taskforce and its membership can be found in annex A.

Through its work, the Taskforce aimed to recognise the importance of considering women as individuals, with all their various characteristics, including their race, class, disability, sexuality, gender identity, socioeconomic circumstances, and/or age. Wider experiences of inequality and discrimination can increase the risk of mental illness so the Taskforce took, and encourages others to take, an intersectional approach considering the overlap of social identities.

The focus of the Taskforce's work was on adult women, although some of the themes and the outputs of the Taskforce are relevant to, or could be developed for, girls and younger women in the future.

The Taskforce took a specifically gendered approach focusing on women, because the presentation and experiences of mental ill health can differ between women and men. The Taskforce recognised that there also mental health issues that differently affect men, such as conditions and presentations that are much more prevalent in men. For example, men experience higher rates of suicide and substance dependence disorders, and when men have an anxiety or depressive disorder they are much less likely than women to receive treatment for it (McManus et al., 2016). These gender differences in experiences of mental health and access to services demonstrate the need to take a gendered approach in considering mental health and

improving outcomes for both women and men. The Taskforce welcomes and supports other work underway to address the mental health issues that are more prevalent in men, such as the [National Suicide Prevention Strategy](#), which highlights men as a group at high risk of suicide.

## 4. About this document

This document summarises the work of the Women's Mental Health Taskforce. It sets out the evidence heard alongside the outputs produced by the Taskforce to drive change, all of which are underpinned by the voices and experiences of women with lived experience of mental health services.

With a focus on improving women's experiences of mental health services, the Taskforce set out to identify the core themes in women's experiences of mental health and mental health services. Following this, the Taskforce worked on delivering four key outputs that could be most effective in delivering the changes needed across the system:

1. Hearing women's voices to develop a set of statements of **what matters to women** in their experiences of mental health services;
2. Developing a set of **gender- and trauma-informed<sup>5</sup> principles**, underpinned by the statements of what matters to women, to help providers, practitioners and commissioners consider women's specific needs for mental health access and support;
3. Securing **commitments of members and other organisations** with the power to influence policy and practice across the health system and improve the experiences and treatment of women experiencing mental illness, such as NHS England, Public Health England, Health Education England and the Care Quality Commission; and
4. Setting out **suggestions** for the next stage in understanding, improving and responding to women's mental health, through outlining:
  - a) **future strategic priorities**, to continue to progress and improve women's mental health; and
  - b) Suggestions for how **research and data** could be improved to better understand and respond to women's mental health problems.

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<sup>5</sup> To work in a trauma-informed refers to an approach by which organisations operate with an awareness of trauma and its impact and avoid re-traumatisation.

This document opens with the core themes that emerged through the evidence gathering process. It then set out the statements developed by women as to what matters to them in mental health services (1), followed by the gender and trauma-informed principles (2) that the Taskforce developed, describing how these could be used and implemented to improve outcomes for women. It goes on to outline the commitments made by members and other organisations to improve the experiences and treatments of women (3), and then the suggestions for the future, including the strategic priorities and suggestions for how current research and data could be improved for women (4).

**Taskforce members urge practitioners, service providers and commissioners to take note of the findings of this report, including women's lived experiences of mental illness, and to embed and promote these in their work and organisations.**

Whilst the work of the Taskforce has focused specifically on mental health services, it is clear that a number of the solutions to improve women's mental health outcomes lie outside of, and are delivered in partnership with, the mental health system. In order to provide the best outcomes for women, **Taskforce members urge other bodies and organisations to take account of the findings and principles set out here, including criminal justice, addiction treatment, domestic and sexual abuse, housing and homelessness services.**

## 5. Core themes in women's mental health

As the Taskforce reviewed evidence, and heard from women with lived experience of mental health services, a number of core themes emerged. These are set out below, supported by direct quotes from women themselves. These are broken down into:

- Women's experiences of mental health services
- Women as mothers and carers
- Gender based violence and trauma
- Multiple needs

### Women's experiences of mental health services

Women can face different barriers to men in accessing appropriate mental health treatment, and in their recovery from mental illness. Evidence heard by the Taskforce clearly showed that there are also gendered differences in women's experiences of services, demonstrating that the same treatment of women and men does not necessarily result in equal outcomes.

Women with lived experience of mental health services described some of the barriers they faced in getting the support they needed. They spoke powerfully of their reluctance to seek mental health support due to fear of their child being taken away by social services, as well as the stigma or judgement they felt they faced as to whether they were seen to be a fit parent.

When in mental health services, women described problems in being able to develop the relationships of trust and rapport with staff that they needed to feel safe and supported. This was due in part to care continuity issues that arose from high turnover of staff, as well as being able to see the same professional over a period of time. The ability to develop trusting relationships with staff was particularly highlighted by women as important in being able to open up about their lives and past experiences of abuse or trauma which may be impacting on their mental health.

For those who had experienced abuse and trauma in their lives, as well as discrimination and marginalisation, mental health services could be experienced as disempowering and, in some circumstances, re-traumatising. The Taskforce also heard alarming cases of women who had experienced trauma, often through

childhood, domestic or sexual abuse, who then experienced further trauma in mental health services. A worrying number spoke about practices, such as restraint or one-to-one observations, often by male members of staff, having re-traumatised them, as well as sometimes being traumatic events in and of themselves. This theme is explored in more detail in the '**gender based violence and trauma**' section later in this core theme chapter.

Many women reported feeling they had a profound lack of voice or control over where they received their care, who they received it from, or how they received it. This could also reinforce feelings of powerlessness, which might echo previous experiences of abuse and coercive control. Most women reported they would like to feel more in control and be more involved in discussions on treatment options.

Women also experienced problems when leaving secure settings, particularly issues around a lack of ongoing support or aftercare, with many saying they felt that they had been "left to get on with it" when they left hospital. Some women described issues around "institutionalisation" and a struggle to adapt when back in the community after having been in inpatient mental health services. This was particularly pronounced for women with childcare responsibilities who could struggle to cope after they were discharged. Many said they would welcome more practical support at home; particularly those who lacked sufficient support networks, who were otherwise often vulnerable on discharge and left with very little support.

Research has found that secure care hospital services in England and Wales are primarily based on the needs of men, disadvantaging women because of their minority status (Bartlett & Hassell, 2001; Sarkar & Dilusto, 2011; Parry-Crooke & Stafford, 1999). Women are often detained in higher security settings than necessary (Parry-Crooke & Stafford, 1999), and that despite having different clinical needs to men (Corston, 2007; Stafford, 1999) often do not receive the type of care they need in secure settings (Centre for Mental Health, 2011).

Black, Asian and minority ethnic women (BAME) spoke powerfully about a perceived imbalance of power and authority between service users and providers, alongside cultural naivety, insensitivity and discrimination towards the needs of BAME service users. Interaction with services could also be impeded by language barriers for women for whom English is a second language.

Evidence similarly suggests that BAME women face additional barriers to accessing mental health support and services and that can affect the relationship between service user and healthcare provider (Memon et al., 2016). These include issues with recognising and accepting mental health problems, a reluctance to discuss psychological distress and seek help, negative perception of and social stigma against mental health as well as financial factors.



To provide a gendered response, women were clear that these experiences should be taken account of in their care and treatment, in particular the practical realities of their lives where they have caring responsibilities, and the profound impact that trauma can have on their mental health and recovery.

## **Women as mothers and carers**

Women's role as primary carers in many families can create additional barriers to their access to treatment, and their experiences as mothers and carers can also impact on their mental health. The Taskforce heard frequently that women's roles as mothers and carers, and the practical and emotional impact this can have on their lives, was not taken account of in the delivery of mental health services. Women could be prevented from seeking support, for fear of having their children removed from their care, and for those who no longer had their children with them, the impact this had had on their mental health was frequently overlooked.

### **As mothers**

The Taskforce frequently heard that services do not always recognise the role and identity that motherhood can play in women's lives. Women with lived experience described how consideration was not always given to the relationship between mother and child when a woman is in contact with mental health services, with one saying: "They don't seem to actually spend a lot of time discussing whether you're a parent or not."

Children and caring responsibilities can make it harder for women to engage with services, for instance making it practically challenging to attend appointments. Many women expressed difficulty in finding time to access or attend services alongside their other caring or childcare responsibilities, and spoke of limited provision in many services to respond flexibly to their caring responsibilities.

In contrast, the Taskforce also heard examples that demonstrate the positive impact of services that do recognise and support women as mothers. Many women voiced how much they value being supported in their role as a mother, with their concerns about the welfare of their dependents listened to. They spoke highly of services that enabled them to access care with their children, for example those offering childcare facilities alongside their services. This quote from one of the focus groups demonstrated the impact of this: "They realised that when it came to the summer holidays I wouldn't be going because my son wasn't old enough to look after. So, they said to me if you want to bring your child along, and I thought that was really, really nice."

Women also felt there was insufficient mental health support beyond the immediate perinatal period. While women can access mainstream mental health support there is less provision specifically catering for women with older children, women who are immediately beyond the perinatal period, and women without children. Indeed, a review of mental health services available for women in England and Wales found that the majority of mental health support was targeted specifically at women was for those who were pregnant or with very young babies (Agenda & AVA, 2017).

Alongside impacting on women themselves, a lack of appropriate support can have profound consequences for children. Children who have a parent with mental health problems have a higher risk of poorer outcomes across their childhood and adult lives, including their mental health (Bee et al., 2014), underlining the importance of ensuring that women who are mothers can access the support they need, for both their own wellbeing as well as that of their children.

Separation from children, or the fear of having children removed as a result of their mental illness, can have a profound and damaging impact on women. The Taskforce heard how the stigma associated with mental ill health meant many women did not access services at an earlier stage, as they were fearful of being judged by society or of their children being removed from their care if they were deemed to be a 'bad' parent. This could lead some women to not access help until they were in crisis.

Losing children is highly traumatic, leaving women with an enormous sense of loss and grief. Yet women who the Taskforce heard from who had had children removed or who had been separated from their children, especially young children, during an inpatient stay or through removal into social care, felt that services had not supported them with the trauma or grief of this experience. In many cases there was limited support for women to remain in contact with their children while in hospital, or to deal with the trauma of separation or the grief of loss. The Taskforce heard that mental health services and social services often failed to work together effectively in these instances to promote and support mother and child contact.

It is vital that the safety of children is paramount but we also know that children who go into the care system can have poorer outcomes. The Taskforce was clear that this must be recognised in our mental health system and support offered in response, with steps taken jointly by both mental health services and social services to ensure, where appropriate, there is not a loss of contact between a mother and her child/ren.

## **As informal carers**

As well as bearing the primary responsibility for childcare, women are also much more likely than men to be the informal primary carers of other relatives (Department

for Work & Pensions, 2018). Evidence shows that informal carers are more likely than those without caring responsibilities to develop mental health problems (Pinquart & Sorensen, 2003); the influence on mental health of caring is particularly evident for women who are 'intensive carers' (more than 20 hours per week) and for those with certain socio-demographic characteristics, such as old age (OECD, 2011).

The Taskforce heard, however, that the wider caring responsibilities women had could be overlooked in treatment they received, which could lead to poor experiences in their care. One woman, for example, described how she had felt her experience of caring for her husband was ignored whilst she was accessing mental health services: "[I just had] to get on with it, without help, [and my feelings were] just brushed to the side whilst I continued to care for my husband." Women were clear that they wanted more support to address and recognise all the caring responsibilities as part of greater recognition overall of the realities of their lives.

## **Gender-based violence and trauma**

There is a clear relationship between experiences of abuse and poor mental health, with women with mental health problems much more likely to have experienced abuse. Yet this reality is often not reflected in the approach to supporting women with mental health problems. Sadly, Taskforce members heard from women with lived experience that contact with mental health services could at times be re-traumatising, particularly where these experiences were not considered.

### **Gender specific experience of trauma**

Overall, women are twice as likely as men to experience interpersonal violence and abuse, and the more extensive the violence, the more likely that it is experienced by women rather than men (Scott & McManus, 2016). About one in every 20 women in England (1.2 million women) has experienced an extensive pattern of physical and sexual violence and abuse across their life, including being sexually abused or severely beaten in childhood by a parent or carer, many being raped as adults and suffering severe violence from a partner. Of these, over half (54%) have a common mental disorder and a third have attempted suicide (36%) (Scott & McManus, 2016).

It is estimated that 26% of women have experienced domestic abuse since the age of 16, compared with 14% of men (Office for National Statistics, 2017). Women are also nearly five times more likely to have experienced sexual assault than men. Research shows that there are clear links between domestic abuse and mental health, in both directions: being exposed to domestic abuse can lead to mental health problems such as depression and PTSD (Oram, Khalifeh & Howard, 2016;

Devries et al., 2013), and people with severe mental health problems face significantly increased risks of domestic abuse and sexual violence (Department of Health, 2014).

Studies also show that PTSD is higher in women of black ethnic origin and this association is related to the higher rates of sexual assaults that they experience (Black et al., 2011). Women of black ethnic origin are also less likely, however, to report or seek help for assaults or trauma (Ullman & Filipas, 2001).

Despite these connections, mental health practitioners and services do not appear to always understand the dynamics of abuse and its impacts on mental health. Women with lived experience shared alarming and distressing experiences with the Taskforce that suggested mental health services are often not operating in a trauma-informed way. These include witnessing or experiencing physical restraint, including in the face-down position, alongside other forms of restrictive practice.

For women who had experienced violence and abuse, to be physically restrained or put under one to one observation, often by male staff, could be profoundly distressing, triggering and humiliating. This impacted not only on their recovery but their long-term mental health, as well as their willingness to seek help again in future, having sometimes eroded their trust in the services designed to support them. Women felt that the role of male staff, including at critical points in their care, such as during observations, to need more careful management, particularly for women who had experienced abuse from men.

Some women described feeling unsafe in in-patient services, specifically in relation to the risk of sexual assault or harassment, from both members of staff and patients. Some found both the physical ward environment and the social/cultural environment on the ward to be problematic, with incidents that breached safety, such as unwanted sexual behaviour, not having been properly reported or responded to. Some women spoke about reduced sexual inhibitions when they were unwell leading them to become extremely vulnerable, and a lack of knowledge from health professionals on how to respond to this and ensure their sexual safety.

This is supported by evidence showing an alarming 457 incidents of sexual assault or sexual harassment in mental health services between April and June 2017 (Care Quality Commission, 2018). The Taskforce is clear that their findings and suggestions around sexual safety on mental health wards, and ensuring that sexual safety incident disclosures are taken seriously and given the attention and sensitivity they deserve, must be applied in full.

Routine enquiry

In order to be able to understand the women's experiences of trauma and reflect these in their care and treatment, the Taskforce heard that improvements need to be made to ensure professionals are aware of the links between abuse and mental ill health. It was clear from the evidence heard that too often, simple questions which could identify abuse, were not being asked.

Despite being recommended in NICE guidance (NICE, 2014), for example, 'routine enquiry' into domestic abuse, where trained staff ask those accessing certain services about their experiences, experiences of violence and abuse, is often not being carried out and experiences of abuse are often not detected by mental health services (Natcen, 2015). Research found that the majority of Mental Health Trusts that responded to a Freedom of Information request (18 of 35) had no policy on 'routine enquiry' about abuse, for example (Agenda, 2016).

Women experiencing domestic abuse tend to seek help via health services rather than via police and the criminal justice system (Coid et al., 2002), emphasising the need for mental health services to be responding appropriately to disclosures, ensuring these are being addressed in their care planning and referral pathways are in place to meet the needs of women who have experienced abuse and violence.

It is essential that these opportunities are not missed and that women get the appropriate support for both their mental health and their experiences of abuse and trauma. Evidence shows that most survivors of violence and abuse do not mind, and actually welcome, being asked about their history of violence and abuse (Natcen, 2015).

It was clear to the Taskforce that there can be some reluctance amongst professionals to ask these questions, with research suggesting this can be in part due to a lack of confidence in how to respond to disclosure (Natcen, 2015). In recognition of this, research at St George's University of London is currently underway<sup>6</sup> to look at the benefits of applying a peer-mentoring model for staff, to support staff to have open conversations and enquire about experiences of abuse, and use this to tailor and inform their support for the individual. The Taskforce welcomes initiatives of this kind to support and encourages staff in mental health

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<sup>6</sup> Researchers at St George's University of London are developing a portfolio of research examining domestic violence and a peer mentoring intervention. Further information available at: <https://sgul.ac.uk/research-profiles-a-z/nadia-mantovani>

services to better respond to abuse, and encourages others to take look to projects such as this to improve their own practice locally.

## **Misdiagnosis of Complex Post Traumatic Stress Disorder**

The Taskforce heard concerns that women with complex trauma may be given other diagnoses, including borderline personality disorder, potentially leading to increased stigma and them not receiving the most appropriate treatment.

Amongst adults who have suffered acute traumas, the psychological effects have long been recognised as Post-Traumatic Stress Disorder (PTSD), but it is only recently that such recognition has emerged of the typical psychological consequences of chronic or persistent trauma, particularly abuse and neglect of children including in the very early years. Therefore, the diagnostic category of Complex Post Traumatic Stress disorder (C-PTSD) has been introduced (ICD-11, WHO, 2018). This condition is associated with repeated and prolonged interpersonal trauma, abuse and neglect, particularly in circumstances from which escape is perceived as impossible or dangerous. Such experiences, in both childhood and adulthood, are common amongst women, and referred to throughout this document in association with poor child and adult mental health (Agenda, 2016).

People with this condition may receive diagnoses of somatisation disorder (and 'Medically Unexplained Symptoms'), dissociative disorder, anxiety disorder, depression, bipolar 2 disorder and emotionally unstable or borderline personality disorder. These may be co-occurring conditions, but as C-PTSD has only just been introduced in the classification system used in the UK (ICD-11), and the condition is a common one (Karatzias et al, 2018) there is likely to be significant numbers of people for whom a diagnosis, or at least a conceptualisation, of C-PTSD would be more accurate. Indeed, for many, this diagnosis and understanding are more helpful as they provide a plausible explanation for their difficulties and may indicate more appropriately tailored care and treatment.

The Taskforce heard examples of women who had been misdiagnosed with personality disorder, when they were showing symptoms of, and were later diagnosed with C-PTSD, alongside evidence that awareness of this new classification remained limited amongst mental health professionals. In some cases, having a diagnosis of personality disorder could be particularly problematic for women, as it is a label associated with additional stigma and sometimes barriers to services and support.

This issue also overlaps considerably with other themes in this document. For example, there is a high risk of exposure to further abusive relationships and therefore 'revictimisation' amongst people with C-PTSD (Ide & Paez, 2000), and

there is growing evidence of intergenerational effects of trauma and poor mental health, including the key elements of maternal childhood trauma and maternal mental health (Plant et al, 2018).

## **Multiple needs**

Women and girls who face violence, abuse, poverty and inequality are often deeply traumatised and can face other challenges alongside poor mental health, such as addiction and homelessness (McNeish et al., 2016). The Taskforce looked at the experiences of women with multiple needs in mental health services, including women with a 'dual diagnosis', a term used to refer to someone with a diagnosis of mental illness and substance misuse.

Of the one in 20 women in England who have experienced extensive physical and sexual violence as both a child and an adult, more than half (54%) have a diagnosable mental condition, 21% have been homeless, 31% have an alcohol problem and 8% are dependent on drugs (McManus, Scott & Sosenko, 2016). The needs of these groups of women can be very complex and overlapping - they are often at the sharpest end of inequalities.

Services are not always well set up to meet women's needs or be flexible to respond to where women are in their lives. Many services have been traditionally designed to address one issue at a time, working in siloes and often not working in partnership with others. They can operate to strict times, and refuse to continue working with a woman if she fails to keep to set appointment times, or with whom it is difficult to maintain contact.

As a result, rather than redesigning their own ways of working, some services can label women experiencing multiple disadvantage as 'hard to reach' or 'difficult to work with'. Staff do not always have the appropriate skills or qualities to meet the complexity of women's needs in a holistic way. The Taskforce heard that mental health services could struggle to do this. As one of the women from the focus groups described: "I would say that the profession as a whole should try and be more aware of those things and just how people can engage with services in different ways. And why they might not want to engage".

## **Dual-diagnosis - particular experiences of women**

The term 'dual diagnosis' is used to refer to someone with a diagnosis of mental illness and substance misuse. Experiences of abuse and addiction are often linked (Liebschutz et al., 2002), with women often using substances as a coping mechanism to deal with past or current trauma (Ullman et al., 2013). Women can

face greater shame and stigma around drug and alcohol use than men, as they can often be judged much more harshly because their behaviour goes against societal norms of what is expected of women (Hecksher & Hesse, 2009). Women who are mothers are often more afraid of accessing support for fear their children will be taken away (Jessup et al., 2003).

Women with multiple needs can be turned away from refuge provision because the service does not have capacity or resource to meet support needs relating to their substance misuse, mental or physical health, or disability (AVA, 2014). And women of Black, Asian and Minority Ethnic groups, as well as lesbian, bisexual and transgender (LBTQ+) women, can face additional barriers and stigma (Dinos, 2014).

The Taskforce also heard about women's needs being dealt with in isolation, without the holistic support needed to help them address the root causes of their problems or move on with their lives. Women with a dual diagnosis, for example, may be prevented from accessing mental health support if they are misusing drugs or alcohol. Similarly, drug and alcohol services can refuse to support those with untreated mental health problems, resulting in a failure to get support for either.

## **Eating disorders, self-harm and suicide**

Experiences of eating disorders, self-harm and suicide can be very different between women and men, and the solutions to addressing these are also likely to benefit from taking a gendered approach.

Eating disorders can be both complex and devastating. They are serious life-threatening conditions with some of the highest mortality rates of any mental health disorder. Studies have shown that eating disorders are more common among women and girls than men and boys, and that there are gender differences in the symptoms of eating disorders (Striegel-Moore et al., 2009). For example, women are more likely to report body checking and avoidance, binge eating, fasting, and vomiting.

Self-harming among young people, and especially young women and girls, has been increasing (McManus & Scott, 2016) and studies have shown that GP and hospital attendances for self-harm have also increased (Morgan et al., 2017). Self-harm is a complex issue and for some it may be a single event, while for others it may last weeks or months. However, for a few people, self-harming can develop into a cycle over their lifetime.

The reasons for self-harming are complex and will vary. Self-harm and eating disorders can be coping strategies to deal with experiences of violence and abuse. It can be an attempt to control a person's body, a form of self-punishment, or a



distraction from emotional pain. Issues such as pressures from school, bullying, body-image and issues with sexuality can also play a role (The Children's Society, 2018).

Young women and girls are more at risk of self-harm with around three times as many young women and girls aged 10-19 self-harming as men (Morgan et al., 2017). The reasons for this are not clear. We also know that self-harming can be a risk factor for suicide, although self-harming in itself does not mean that someone wishes to die. However, around half of people who have died by suicide have had a history of self-harm in their lifetime (Foster, Gillespie & McClelland, 1997).

While young men are still more likely to take their own lives than young women, the rates for young men have remained broadly similar for a number of years, while the rates for young women (those aged 20-24) has increased rapidly and is currently the highest on record (Office for National Statistics, 2018). The reasons behind suicide are highly personal and often complex, but some of the connections set out in this report, particularly between women's experiences of physical and sexual violence and their mental health problem, are likely to be factors.

## 6. Hearing women's voices: what matters to women

As part of their evidence gathering, the Taskforce experienced the power of women's own words through a series of focus groups with women with lived experience.

The Taskforce used the testimonies heard through these focus groups to develop a series of statements to powerfully capture what was important to women when experiencing mental health problems and accessing support. These statements were then shared and tested with women with lived experience to ensure they properly reflected the evidence heard.

It was clear from the women that contributed to these that, whilst some of the statements below could also improve outcomes for men in mental health services, these were particularly important to woman because of the ways in which these took account of women's life experiences.

Women were clear that the ability to have respect, choice and control when they had previously felt disempowered and not listened to throughout their lives was critical. Similarly, women stressed the need to address the range of issues in a woman's life that may be contributing to her mental health problems, as well as the importance of taking account of her identity as a mother or carer in treatment. For women who have experienced abuse or violence, the importance of gender-sensitive services that recognised this trauma, and enabled them to, for example, choose the gender of practitioner and receive support in a women-only space were stressed as vital for their recovery.

The Taskforce encourages practitioners, service providers and commissioners to use these statements, alongside the set of gender and trauma-informed principles set out in the following section, as a guide to consider what good mental health support means to the women they support<sup>7</sup>.

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<sup>7</sup> Details of how the focus groups were conducted can be found in Annex C - Focus group summary.

## **For commissioners, providers and practitioners to consider**

### Voice and control

"I am treated with respect and given the time to express how I feel, and not made to feel a burden when seeking help."

"I can take back control of my own life, be involved in my care and am able to discuss a range of options, which are personally suited to me, including alternatives to medication."

"I can choose who provides my care, am given a choice of male or female staff, and support is provided consistently."

### Accessibility

"Services work together to consider how best to support me in a way that is culturally appropriate and understanding of my sexuality."

"The support I receive is easy to access and provided in a non-stigmatised setting, including in primary care."

"I have a safe space at times of difficulty and easy and timely access to women-only support when I am in crisis."

"There is good mental health awareness in all key services together with practical support linking me in to the right services."

"I have ongoing support, particularly after discharge from hospital, to strengthen my resilience and ability to cope with difficulties in the future."

### Safety, respect and dignity

"I can access support from someone I trust and can speak to, who understands me and takes a holistic view of me every day and when in crisis."

"I meet with other people who have had experiences of mental health problems and who share my background."

### Understanding trauma

"I want therapeutic support with my current difficulties and past traumatic experiences including bereavement, sexual abuse and domestic violence."

Children and caring responsibilities

"I am valued for and supported in my role as a mother and/or carer, with my concerns about the welfare of those dependants are listened to."

## 7. Gender- and trauma-informed principles

As part of this process, the Taskforce heard clear evidence that experiences of trauma were common amongst women in mental health services and that trauma often underpinned many of the challenges women faced. This evidence suggested the value and importance of delivering services to women that are both gender- and trauma-informed. 'Trauma-informed' services can be understood as those which recognise the impact of trauma, often through violence and victimisation, avoid any likelihood of re-traumatisation for staff or service-users and which identify recovery from trauma as a primary goal.

Trauma-informed services are complementary to gender-informed services, which take account of and respond to the particular lives and experiences of women. They ensure that staff have the right competencies to work with women, that the environment makes women feel safe and welcome, and that appropriate structures are in place to be able to deliver this kind of service. These types of approaches also take account of the ways in which different parts of a woman's identity can overlap and result in different experiences of disadvantage.

In response to this evidence, the Taskforce developed a set of gender- and trauma-informed principles, intended to be used as a high level and strategic tool to help providers, practitioners and commissioners at a local level consider the specific needs of women with mental illness.

These principles have been designed to sit alongside the statements above, as to what women with lived experience of mental illness have said matters to them. They set out a number of themes developed by the Taskforce in response to women's experiences of mental health services, alongside examples of how in practice these can be addressed to ensure that services are appropriately meeting women's needs.

These gender and trauma-informed principles were developed collaboratively and iteratively, through consultation with key members and third sector partners, and were informed by the key themes that emerged through focus groups with women.

The content of the principles draws on existing evidence-based guidance relevant to the specific needs of women (e.g. the Equalities Act 2010, NICE Guidelines on domestic violence and routine enquiry, safeguarding requirements). The principles set out what services should be doing to improve support and promote best practice in working with women in mental health services and providing trauma-informed care. The principles also build on the work of previous key publications on women's

mental health, such as Into The Mainstream (Department of Health, 2002) and corresponding Implementation Guidance (Department of Health, 2006).

Although these principles offer useful guidance and indicators to help relevant service providers and commissioners to ensure that their service can become trauma- and gender-informed, these are to be used as a useful indicator rather than a prescriptive guide.

**The Taskforce encourages service providers and commissioners to apply these gender and trauma-informed principles to ensure they are supporting women in a gender- and trauma-informed way, and to embed and promote these in their work and organisations.**

Given that the principles are underpinned by evidence as to the value of gender-specific and trauma-informed ways of working, the **Taskforce also urges those beyond the mental health system to take note of these and apply them in their own fields to improve outcomes for women who have experienced trauma or mental ill health.** The Taskforce believes these are of interest, but not limited to, those working in the criminal justice system, addiction treatment, domestic and sexual abuse services, and housing and homelessness services.

Women's experience	Theme	Principle	Demonstrated by
<p><b>Women have distinct and specific needs which must be recognised if effective care is to be given</b></p> <p><b>Gender-specific issue - Women's needs and</b> experiences reflect their social position and background. Effective care needs to be grounded in an understanding of the needs of women from different backgrounds and with different experiences.</p>	<p><b>Governance and leadership</b></p>	<p><b>There is a whole organisation approach and commitment to promoting women's mental health with effective governance and leadership in place to ensure this.</b></p>	<p>Evidence of senior level buy in and accountability for gender equality ensuring a focus on women's mental health:</p> <p>Executive member with responsibility for gender equality and women's mental health</p> <p>Regular assessment of need, monitoring and reporting to the Board of experiences and outcomes for different groups of women leading to demonstrable improvements in quality. This should take into consideration all of the competing priorities facing the boards.</p> <p>A clear action plan, which links into other equality and diversity programmes, to increase the number of women from diverse backgrounds in the senior leadership and managerial team. A clear action plan, clinical strategy or the trust's operational plan for improving gender sensitivity and gender specificity in service provision.</p> <p>All policies to consider whether a focus on gender specificity and sensitivity is required.</p>

			<p>Policies work to drive equality and holistic services by considering all protected characteristics and adopting a broader organisational approach to equality and diversity.</p>
	<p><b>Equality of access</b></p>	<p><b>Services promote equality of access to good quality treatment and opportunity for all women</b></p>	<p>Evidence of:</p> <p>Commissioning that has engaged mental health providers in the process and women including those who are typically marginalised (migrant women, disabled women, women involved in prostitution, women with complex needs, older women, BAME women and LGBTI people and ex-offenders).</p> <p>Valuing and working in partnership with voluntary sector and women's organisations including those providing specific support for BAME women and Trans women.</p> <p>Recognition that achieving equality in access to services does not necessarily mean providing all with the same treatment</p>
<p><b>Women have a right to services that are safe, respectful and respond</b></p>	<p><b>Recognise and respond to trauma</b></p>	<p><b>Services recognise and respond to the impact of violence, neglect, abuse and</b></p>	<p>Evidence that:</p> <p>Women can access trauma-informed care and specific services to enable them to address</p>



<p><b>appropriately to trauma</b></p> <p><b>Gender-specific issue</b> - Women are at greater risk of experiencing abuse both outside and within mental health services and can also find services re-traumatising</p>	<p><b>Respectful</b></p>	<p><b>trauma</b></p> <p><b>Relationships with health and care professionals are built on respect, compassion and trust</b></p>	<p>experiences of abuse, neglect and trauma</p> <p>Staff are confident and sensitive at all levels in communicating with, supporting and empowering women who have experienced historical and current forms of abuse, including domestic and sexual violence.</p> <p>Staff are confident in recognising the various ways that trauma may present in women, such as difficulty with eating</p> <p>Provision of women-only inpatient care, women's centres and alternatives to medication</p> <p>Evidence that:</p> <p>Relationships are rooted in mutuality and compassion and that respect is at the centre of services.</p> <p>Women have a choice of a female worker.</p> <p>Staff are skilled in listening and responsive to the communication needs of female patients, taking care to ensure that women feel heard and empowered to speak up.</p> <p>All staff in services are knowledgeable and understanding about the needs of women.</p>
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	<p><b>Safe</b></p>	<p><b>Services provide and build safety for women</b></p>	<p>Medication is tailored to women’s needs.</p> <p>Evidence of:</p> <p>Zero tolerance of gender-based violence within services and commitment to ensuring safety for women who use and work in services.</p> <p>Staff understand how services can be re-traumatising and minimise the use of restraint and one to one observations.</p> <p>Robust processes for reporting and investigating sexual abuse and assault, with women being properly informed of the outcome.</p> <p>Women-only accommodation is available and easily accessed and provides safety.</p> <p>Recognition that violence between female service users exists and the negative impact that this can have on peer support and service engagement.</p>
<p>Women want to be in control of their lives</p> <p>Gender-specific issue - Women have often been disempowered</p>	<p><b>Empowerment through co-production</b></p>	<p><b>Services engage with a diverse group of women who use mental health services to co-design and co-produce services.</b></p>	<p>Evidence of:</p> <p>Co-production and meaningful involvement of girls and women in the development of services.</p> <p>Initiatives to enable women who are</p>

<p>and had control exercised over them, accompanied by feelings of low self-esteem and self-worth. Services should understand and seek to address this.</p>		<p><b>Services promote self-esteem, build on women's strengths and enable women to develop existing and new capacities and skills.</b></p>	<p>marginalised to co-produce appropriate support.</p> <p>Peer support and mentoring.</p> <p>Promotion of self-advocacy and advocacy for women who need support to ensure their voices are heard. Ensuring women have access to an appropriate support network</p> <p>Supporting women to access their care records and care plans</p> <p>Women have a choice of support and services</p> <p>There are opportunities for education, employment, greater financial security and better health.</p>
<p><b>Women want services that help them address the realities of their lives</b></p> <p><b>Gender-specific issue</b> - Women are more likely to be single parents or primary carers, survivors of sexual</p>	<p><b>Holistic</b></p>	<p><b>Services prioritise understanding women's mental distress in the context of their lives and experiences, enabling a wide range of presenting issues to be explored and addressed, including with a focus on future prevention</b></p>	<p>Evidence that the diversity of women's needs, experiences and backgrounds drives service and practice development:</p> <p>Services have a holistic approach to health and are able to respond to:</p> <p>Diversity: including sexuality, ethnicity, disability, faith and a woman's life</p> <p>The impact of loss</p> <p>Trauma</p>

abuse and domestic violence and to experience poverty and hardship. Mental health is linked to many aspects of women's lives and services need to recognise this and enable women to address the challenges they face and realise opportunities

Sexual and domestic violence

Self-harm

Perinatal mental ill health

Substance misuse (incl. alcohol)

Parenting and caring concerns and a woman's fear of losing her children

Health (including sexual health and well-being)

Financial concerns, debt and housing insecurity. This might relate to whether a woman is the household primary wage earner or not.

Services should consider the age-specific needs of a woman. For instance, they should consider how an adolescent girl will have different needs and experiences in comparison to a woman going through the menopause.

Services should, where possible, adjust their treatment duration according to the presenting need of the woman

Services and support are appropriate and community-based, wherever possible.

Provision of practical support to aid recovery.

Close partnerships with other services that

		<p><b>Services support women in their role as mothers and carers</b></p>	<p>enable women to get the support they require, notably women's centres, children's services, domestic abuse services, welfare advice, substance misuse services and specialist services for women.</p> <p>Evidence that:</p> <p>There is a focus on helping women maintain contact with their children including child friendly spaces for women to see and be with their children.</p> <p>Women's role as mothers and carers is considered as part of admittance, discharge and aftercare from hospital.</p> <p>Women's distress at being separated from their children, and concern about the welfare of their children or others for whom they care, is acknowledged.</p>
<p><b>Women want services that support their recovery and enable them to get on with their lives</b></p>	<p><b>Effective</b></p>	<p><b>Services are effective in responding to the gendered nature of mental distress</b></p>	<p>Evidence that:</p> <p>Staff are knowledgeable about gender and how it influences mental health, and are confident to include this in formulating a response to women's distress. Staff do not inadvertently label women as 'hysterical' or 'difficult'.</p>

**Gender-specific issue** -Women have multiple responsibilities and identities and recognising the causes of their distress needs to be central to their recovery

Statutory services work well with community and third sector support networks.

There is easy access to gender-specific crisis support

There is routine inquiry about violence and abuse; reproductive and sexual health; parenting and caring responsibilities and self-injury, by practitioners who have been trained how to ask and respond sensitively and safely.

Sexual abuse, domestic violence, body image, reproductive and life-stage elements of health & wellbeing are appropriately and sensitively addressed.

Latest guidance relevant to women's mental health and wellbeing is implemented.

There is consistency and ongoing support, particularly following hospital discharge

Women are encouraged to have self-advocacy when accessing services.

## 8. Commitments across the health system

As part of the process it has undertaken to bring about a step change in women's mental health, the Taskforce has involved and engaged with key national bodies with the power to influence policy and practice. This active engagement with stakeholders has resulted in input into existing government and Arm's Length Bodies' (ALBs)<sup>8</sup> programmes and policies as well as specific new commitments to supporting the work of the Taskforce to improve women's mental health in a variety of ways. The Taskforce has secured commitments from these important organisations, set out below, which will help promote and embed the learning from the work of the Taskforce across the system.

### NHS England

NHS England, which leads the National Health Service (NHS) and its commissioning in England, have several existing work streams that support the aims of the Taskforce.

NHS England has committed to:

- Piloting a new model of women's forensic inpatient services and introducing a financial incentive (through the Commissioning for Quality and Innovation Payment Framework) for trauma informed care in secure care programmes to support transition;
- Engaging with experts by experience, commissioners and providers to scope the development of a toolkit to support system leaders to practically address the health inequalities faced by those with protected characteristics (including sex and gender) and experiencing socio-economic disadvantage;
- Considering whether it would be helpful to broaden the focus of their annual conference on women's mental health in secure care services to look across the whole care pathway (not just secure care services) in the future.

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<sup>8</sup> The Department of Health & Social Care works through a number of arm's-length bodies which share in managing the use of resources across the NHS, public health and social care systems.

**Now that the Taskforce's work is complete NHS England will work with partners and stakeholders to ensure that their on-going work to improve services across all the protected characteristics will have a focus on women.**

In addition, NHSE are taking several steps that will support the mental health of women.

They are leading a transformation programme to ensure that by 2020/21 at least 30,000 more women each year can access evidence-based specialist mental health care during the perinatal period. In May 2018, NHS England confirmed that new and expectant mothers will be able to access specialist perinatal mental health community services in every part of the country by April 2019. Expanding the capacity of Mother and Baby Units will mean that more new mothers experiencing mental illness will not need to be separated from their babies during a critical time for bonding.

For eating disorders in adults, the National Institute for Health and Care Excellence has updated its guidelines and NHS England has recently completed a national review of provision. NHS England has also convened a working group to address the recommendations of the Parliamentary and Health Services Ombudsman report into the death of Averil Hart from anorexia nervosa (Parliamentary and Health Services Ombudsman, 2017). These recommendations will be considered when planning for future improvements to eating disorder services for adults.

The Secure Care Programme also aims to deliver the recommendations in the Five Year Forward View for Mental Health for care in the least restrictive setting, as close to home as possible, and with a stronger focus on recovery, which should enable women to stay with their families whenever possible.

Furthermore, NHS England, along with the National Collaborating Centre for Mental Health (NCCMH), are delivering an Equalities and Health Inequalities Webinar Series for health system leaders. A webinar on gender inequalities was held in November 2017 and a webinar on maternity and perinatal inequalities is planned for the future.

NHS England will also promote dedicated discussion about women's mental health in the full range of its transformation activities and ensure this is discussed at the Mental Health & Dementia' Programme Board.

## **Public Health England**

Public Health England (PHE), which brings together public health specialists to improve health and wellbeing, leads the Prevention Concordat for Better Mental



Health. This Concordat aims to facilitate local and national action around preventing mental health problems and promoting good mental health. PHE has committed to using the Concordat to practically endorse and promote the work of the Taskforce around women's mental health.

PHE has committed to:

- Produce briefing and guidance on how the NHS could promote the messages of the Taskforce;
- Drafting a formal statement to focus the work of their [Prevention Concordat](#) on taking a gender- and trauma-informed approach to services;
- Including sensitive references to domestic abuse in its [Every Mind Matters](#) online mental health awareness campaign (begun regionally in October 2018);
- Expanding their work on perinatal mental health and doing more work relating to women's mental health in sexual and reproductive health; and
- Making an explicit ask to focus on women's mental health through the additional funds given to the Health and Wellbeing Alliance (through the Prevention Concordat).

## **Care Quality Commission**

The Care Quality Commission (CQC), the independent regulator of all health and social care services in England, took forward a range of improvement projects following on from their [report on the state of care in mental health services](#) that was published in summer 2017. CQC has recently published its [report on sexual safety on mental health wards](#) and is continuing work to build on the learning from that and to eliminate mixed sex accommodation. The project on 'elimination of dormitories' (so that people admitted to mental health wards are not expected to share sleeping arrangements with strangers) is in its start-up phase, and CQC have committed to considering links to the work of the Taskforce throughout this project.

CQC have committed to furthering the objectives of the Women's Mental Health Taskforce by:

- promoting its work, particularly the gender and trauma-informed principles, through their [Long-Term Segregation project](#), which may have a focus on gender disparities;

- looking at how the Mental Health Act Code of Practice 'guiding principles' are applied to Long-Term Segregation settings in practice.

CQC is intending to publish a 'briefing-style' report with an analysis of their findings from the Long-Term Segregation project by the end of 2018.

## **NHS Improvement**

NHS Improvement, which develops improvement tools, resources and programmes to support the NHS to provide patients with consistently safe, high quality, compassionate care, is currently delivering a Mental Health Safety Improvement Programme for all mental health trusts. This programme was established by NHS Improvement, in collaboration with the Care Quality Commission, to address patient safety issues in mental health trusts. The overall aim of the programme is for every NHS mental health trust providing core mental health services in England to have understood their safety priorities and to have made a measurable improvement in at least one key area of mental health safety by 31st March 2020. A core component of the programme is a 'national sexual safety improvement collaborative' which all mental health trusts will be expected to participate in.

NHS Improvement has committed to:

- aligning their sexual safety work with the objectives of the Taskforce and building on the findings of the recent CQC report;
- promoting the use of the WMHTF Toolkit (due to be completed in Spring 2019) through the Mental Health Safety Improvement Programme to deliver more gender- and trauma-informed care;
- fully endorsing and promoting the positive impact that trauma-informed approaches have on mental health services and outcomes.

## **Health Education England**

HEE have committed to:

- engaging with Strategic Transformation Partnerships to raise the profile of gender and trauma informed care. It will promote the toolkit and findings of the Women's Mental Health Taskforce;
- using the implementation of the National Mental Health Workforce plan (which sets out a high-level road map and reflects the additional staff required to deliver

the transformation set out in the Five Year Forward View for Mental Health) as an opportunity to raise the profile of the work of the Women's Mental Health Task Force;

- exploring how women's mental health can be better supported in primary care; and
- promoting and disseminating this document by engaging both employers and education institutions (e.g. Royal Colleges and Higher Education Institutes) to cascade the information, and reviewing with Higher Education Institutes the inclusion of trauma-informed care in their curricula over time.

## **Future supporting work**

### **Wider leadership**

Throughout the life of the Women's Mental Health Taskforce, this important work been promoted across government and in parliament by the Parliamentary Under-Secretary of State for Mental Health and Inequalities, Jackie Doyle-Price. She has spoken about, and engaged colleagues to increase awareness of, a gender- and trauma-informed approach to mental health services through parliamentary and ministerial meetings, including the joint All Party Parliamentary Group meeting on Mental Health and Domestic Violence.

Building on the success of this Taskforce, over the next year, Jackie Doyle-Price is chairing a new Taskforce for Women's Health. It will continue to focus on the themes of gender- and trauma-informed care, broadening the focus to physical health services as well as mental health services. Jackie Doyle-Price is committed to ensuring that the new Taskforce builds on and learns from the work of this Taskforce including by looking at progress made on the commitments set out here, and the potential to go further.

### **Health and Justice Partnership**

Since 2015, the Ministry of Justice has been piloting a 'whole system approach' to divert female offenders away from the criminal justice system, and to better support them in custody and in the community.

NHS England, Public Health England, Her Majesty's Prison and Probation Service, the Ministry of Justice and the Department of Health and Social Care work together to ensure safe, legal, decent and effective care to improve health outcomes for prisoners and reduce health inequalities. The partnership is working on programmes

to help ensure people with mental health problems get the help they need in the right setting, for example:

- In Liaison & Diversion services, where NHS England are currently enhancing 'women's pathways' across all liaison and diversion services, with a women's lead appointed in each service to lead this work. These pathways are being co-designed with women with lived experience of the criminal justice system. Services will allow women coming into police custody to choose the gender of their practitioner, offer gender-sensitive tools for screening and provide effective onward referrals to gender-informed services. Consideration will also be given to addressing the barriers that particular groups, such as sex workers and foreign national women, face in accessing services.
- Partners have been supporting the testing of a protocol, and development of a new service model, to increase the use of Community Sentence Treatment Requirements enabling offenders to receive appropriate and co-ordinated treatment for mental health conditions, alcoholism and drug addiction in the community as an alternative to custody. This is currently being tested across five sites, one of which began as a women-only site operating out of a women's centre in Northampton. Partners plan to use the findings from the evaluation of this programme in late 2018 to explore the potential for further national roll-out, and to inform further work on gender-informed approaches for community sentences with treatment requirements.
- The women offender personality disorder pathway is an integrated network of services for women offenders managed by the National Probation Service (in custody and the community) with a diagnosis of 'personality disorder.' The aim of the pathway is to improve public protection and mental wellbeing, and address women's offending behaviour. Interventions are psychologically-informed, gender-informed and trauma-informed. DHSC has been working with NHS England to promote the delivery of this pathway, and services have increased threefold since 2013. Partners will work to replicate these holistic care models across prison healthcare in the Women's Estate.

The Ministry of Justice has recently published a [Female Offenders Strategy](#) (published July 2018) and a [Victims Strategy](#). Building on the work of the Taskforce, both these strategies encourage collaborative work to inform the design of gender and trauma informed mental health services.

## **Voluntary and Community Sector (VCS) and Academia**

The VCS provides a range of mental health services. The sector can engage people with mental health conditions throughout their pathway, and has an established

history of innovative care solutions. Taskforce members have utilised the sector's knowledge and strengths as a planning and delivery partner to achieve shared ambitions for women's mental health services.

The Voluntary, Community, and Social Enterprise Health and Wellbeing Alliance, a partnership between voluntary sectors and the health and care system to provide a voice and improve the health and wellbeing for all communities, will also extend the outputs of the Taskforce by publishing a toolkit based on the findings of this report. This toolkit will set out what thinking and action is required by service providers and commissioners to successfully operationalise the strategic principles on trauma informed care produced by the Taskforce. This toolkit is due to be completed in spring 2019.

In December 2018 a new network will be launched, funded by UK Research and Innovation: the Violence, Abuse and Mental Health: Opportunities for Change Network. The Network, led by Professor Howard, Section of Women's Mental Health, King's College London and Taskforce member, aims to facilitate cross-disciplinary understanding and research on domestic and sexual violence and abuse with mental health problems. Its initial activities include a research prioritisation exercise co-produced with survivors and the third sector, and a policy lab for policy makers.

## 9. Going forward: next steps

### Future strategic priorities

To continue to drive change and improve women's mental health outcomes across the system, the Taskforce has identified a number of national strategic priorities to address the key themes raised by their work. These should be owned and lead centrally by the Department for Health and Social Care, alongside its Arms' Length Bodies (ALBs), as well as supported and implemented locally by Mental Health Trusts, Commissioners and practitioners in mental health services.

In recognition of the fact that these priorities will also be of value of services supporting women experiencing mental ill health more broadly, the Taskforce encourages other relevant organisations and services to take note of these, including those across the criminal justice system, addiction treatment, domestic and sexual abuse, housing and homelessness services.

#### **The six strategic priorities for the direction of this future work are:**

1. Explicitly considering women's needs in all future mental health policy development, locally and nationally;
2. Further embedding trauma-informed care by raising expectations across services and awareness across the system and developing the evidence base to demonstrate this value of these approaches;
3. Supporting Routine Enquiry about violence and abuse in future policy development, including consideration of a requirement to gather and report data;
4. Using the principles of the Taskforce to inform service design and delivery so that there is better access for women and girls to gender-informed and gender-specific holistic services and after care, including through the women's sector. The Taskforce would like to see such support accessible in every area, providing specialist treatment for women including those from diverse groups e.g. BAME, LGBTQ+;
5. Recognising that women's identities, and often their roles as mothers and carers, are important in individual treatment and in-service planning. Awareness needs to be raised of this across the system.

6. Ensuring the safety of women in residential mental health care by ending breaches of single sex wards and pursuing robust policy, practice and reporting processes around sexual harassment and sexual violence.

**Taskforce members are committed to continuing the conversation around women's mental health in their own spheres.**

- The Department of Health and Social Care (DHSC) is continuing to raise the profile of women's health issues across government, and will continue to influence current and future government strategies and programmes.
- NHS England is about to publish their Long-term Plan which will set direction for the NHS for the next 10 years. This has been developed in the context of the work of the Taskforce, and taken account of the evidence heard.
- Other national NHS bodies such as the Care Quality Commission and Health Education England are taking the experience and work of this Taskforce into account in their work, as set out in the Commitments set out in the section above.

**The newly formed Women's Health Taskforce, which will focus on how improvements can be made to improve health outcomes for women, will build on and learn from the work of this Taskforce by looking at progress made on the commitments set out here, and the potential to go further.**

## **Research and data**

Taskforce members also explored what could be done to improve the value and utility of data and research around women's mental health.

This section outlines why improving the mental health of different groups of women requires a gender-sensitive, trauma-informed approach (as determined by the Taskforce) at every stage of the research and data process. The paper sets out suggestions for researchers and for research and data commissioners across sectors for how such approaches might be achieved, drawing on the views expressed by women in the consultations.

The latest report from England's mental health survey series, the Adult Psychiatric Morbidity Survey, showed that women continue to have higher rates of severe common mental disorder such as anxiety and depression than men. Into the Mainstream (Department of Health, 2002) called for women-friendly mental health service provision and, in 2010, Working towards Women's Well-being: Unfinished Business identified significant changes still needed to improve women's experiences

of mental health services. Now the Mental Health Research Framework<sup>9</sup> (Department of Health and Social Care, 2017) has outlined new directions for research and for data, highlighting the importance of a life-course approach and the need to examine many aspects of inequality.

However, most mental health research largely ignores sex (and gender) differences. This is problematic because a sex-neutral and gender-neutral approach is biased and risks undermining scientific validity and efficiency; and could contribute to a failure of health providers to deliver gender-sensitive mental health treatments and services, to the detriment of both women and men (Howard et al., 2016).

**The following suggestions for researchers, and for research and data commissioners suggest adjustments that could be made at different stages of the data and research process to improve the value and utility of data for understanding women's health.**

- **Study Design:** There are well-known difficulties around accessing and collecting data, due to complex issues around confidentiality and legal requirements. Additionally, most mental health research does not factor sex or gender into its design (Weinberger, McKee & Mazure, 2010). Consideration of sex and gender — and equal recruitment of women and men as participants — would facilitate greater generalisability and more efficient study design. Study design should therefore be informed by involving women and considering gender from the outset.
- **Collect Data:** Even when gender is considered in data collection, gendered risk factors are rarely included as covariates or moderators in studies of the epidemiology or treatment of mental disorders (Howard, et al., 2016). More should be done by researchers to collect data on topics that are relevant to women and their health, such as violence and abuse, poverty, physical health and the impact of different medications on women of different ages.

As has been adopted in 2016 by the US National Institutes of Health (NIH) in NIH-funded preclinical research, UK researchers could adopt a similar model where researchers must consider sex as a biological variable. Canadian health funding agencies integrate sex and gender science as a key component of

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<sup>9</sup> This framework provides a collective view of how mental health research should develop in the UK over the next decade <https://www.gov.uk/government/publications/a-framework-for-mental-health-research>



methodological rigour and reporting in health research, and this could be considered as a similar requirement in the UK.

- **Data Access:** To ensure data can be used to understand women's lives and use of services, access to data requires approval (e.g. through committees making decisions about data use) and to be affordable in order to be useful for research. This can be especially hard to achieve when datasets are to be linked, due to data protection, costs and lack of integration. To make progress in women's mental health research it is important to be able to access timely, affordable, research-quality, data.
- **Data Analysis:** Research gaps that currently limit understanding of women's mental health and their service needs must be identified and addressed. Further research into whether there is sufficient 'gender-sensitivity' in research commissioning and/or through intersectional approaches to take account of women's unique biochemistry, along with the multiple identities and range of experiences women have that can affect their mental health to enable analysis of the specificities and complexities of women's experiences, would be welcome.
- **Publish Data:** To ensure that information can be used by policy makers it is important that statistics and routinely collected data are published in meaningful and accessible formats. It is therefore important to publish meaningful information, disaggregated by sex and other characteristics. The first Mental Health Inequalities Report by NHS Digital is expected to become available in November 2018. This will, for the first time, provide an analysis of Mental Health Services Data Set<sup>10</sup> data by protected characteristics (including sex and gender).

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<sup>10</sup> The Mental Health Services Data Set (MHSDS) contains record-level data about the care of children, young people and adults who are in contact with mental health, learning disabilities or autism spectrum disorder services: <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set>

## 10. Conclusion

The Women's Mental Health Taskforce has been a vital opportunity to bring together experts in women's mental health, as well as women with lived experience of mental health services, to understand the challenges many women face in getting the right kind of support for their mental health, when they need it. This work has taken an important step forward in recognising the needs and experiences of women with mental ill-health and in sharing that learning with the health and care system.

Based on the learning of this work, the Taskforce has produced a set of principles to be used across the health system, to embed changes to move towards more comprehensive gender and trauma-informed mental health service provision. Members of the Taskforce have collectively committed to continue to raise the profile of women's mental health issues, and welcome the commitments of key national organisations within the health system to promote and embed the work and themes reported here. The members of the Taskforce look forward to seeing the improvements these commitments will bring.

It is important that everybody with a responsibility for delivering and improving mental health services for women take heed of the findings of this report, and maintain the momentum in driving forward change. It is all of our responsibility to continue the conversation on these issues and to keep making positive steps to improve experiences and outcomes for women.

# 11. Annexes

## Annex A – Membership of the Women's Mental Health Taskforce

Membership of the Taskforce included key national organisations responsible for policy, commissioning and delivery of services (health, social care, voluntary and community care), including system partners such as NHS England and Public Health England. Additionally, the Taskforce sought advice from women with lived experience of mental illness, key academics in the field and public sector policy leads in critical areas and.

The Taskforce was first convened in February 2017 and met five times in a 17-month period. A call for proposals was sent to Taskforce members in April 2017 seeking evidence-based actions for the Taskforce to take forward, this was used to shape some of the key themes that were explored. Taskforce members formed working groups which met regularly to collaborate and progress each priority, involving women with lived experience in developing and sense checking the outputs of the Taskforce.

### Co-Chairs:

- Katharine Sacks-Jones, Chief Executive, Agenda
- Jackie Doyle-Price, Minister for Mental Health, Inequalities and Suicide Prevention, Department of Health and Social Care

### The members were:

- Alain Gregoire, Chair, Maternal Mental Health Alliance
- Andrew Radford, Chief Executive, Beat
- Angela McNab, Chief Executive, Camden and Islington NHS Trust
- Carmel Bagness, Professional lead for Midwifery and Women's Health, Royal College of Nursing
- Caroline Hacker, Head of Mental Health Policy team, CQC
- Danielle Hamm, Associate Director of Campaigns, Rethink

## **The Women's Mental Health Taskforce: final report**

- Jacqui Dyer, Current Vice-Chair of England's Mental Health Taskforce, Mental Health Foundation
- Dr Karen Newbigging, Senior Lecturer Health Policy and Management, University of Birmingham
- Karen Turner, Director of Mental Health, NHS England
- Justine Faulkner, Programme Lead in Secure Care, NHS England
- Kathryn Abel, Professor of Psychological Medicine and Reproductive Psychiatry, University of Manchester
- Kathy Roberts, Chief Executive, Association of Mental Health Providers
- Laurie Oliva, Head of Participation, Young minds
- Lily Makurah, National Lead Public Mental Health - Public Mental Health and Wellbeing, PHE
- Linda Robinson, Head of Mental Health & Policing, Home Office
- Louise Howard, NIHR Research Professor in Women's Mental Health, Kings College London
- Lucy Thorpe, Policy Manager, Mental Health Foundation
- Madeleine Percival, Deputy Director Early Interventions, Women and Vulnerable Offenders Policy, Ministry of Justice
- Sally McManus, NatCen Associate, National Centre for Social Research
- Sarah Hughes, Chief Executive, Centre for Mental Health
- Sophie Corlett, Director of External Relations, Mind
- Tim Kendall, Mental Health National Clinical Director for NHS England and NHS Improvement
- Dr Wendy Burn, President, The Royal College of Psychiatrists

## **Annex B – List of contributors to the Taskforce**

### **Agenda**

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- Jessica Southgate

### **Department of Health & Social Care**

- Caroline Allnutt
- Caron Connolly
- Charlotte Lillford-Wildman
- Gina Radford (Deputy Chief Medical Officer)
- Peta Trussell
- Robyn Turnock
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- Simone Bayes
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### **Focus group facilitators**

- Hazel Alcraft, Clinks
- Lisa Dando, Brighton Women's Centre, Clinks
- Harri Weeks, LGBT Consortium
- Taz Edwards-White, Metro Charity
- Sarah Yiannoullou, National Survivor User Network
- Naomi James, National Survivor User Network
- Samir Jeraj, Race Equality Foundation
- Tracey Bignall, Race Equality Foundation

- Fiona Hill, Brent User Group (BUG), Race Equality Foundation
- Voluntary, Community, and Social Enterprise Health and Wellbeing Alliance

### **Health Education England**

- Josie Turner
- Lizzie Smith
- Lynne Hall
- Rebecca Burgess-Dawson

### **Members of Parliament**

- Helen Whately, MP
- Tracey Crouch, MP

### **Ministry of Justice**

- Hugh Howell
- Shena Clarke

### **NHS Confederation**

- Rebecca Cotton

### **NHS England**

- Karen Turner

### **NHS Improvement**

- Anthony Deery

### **NHS Providers**

- Georgia Butterworth
- Saffron Cordery

### **Third sector engagement**

## **The Women's Mental Health Taskforce: final report**

- Dania Hanif, Association of Mental Health Providers
- Emma Thomas, YoungMinds
- Joyce Kallevik, WISH
- Julie Bailie, Centre for Mental Health
- Katrina Jenkins, Mental Health Foundation
- LeI Proctor, Mind
- Nicky Lambert, Middlesex University
- Tutiette Thomas, NHS Southwark

### **University College London**

- Elma Fitzsimon

### **Women with lived experience**

- With thanks to all the women who took the time to participate in the focus groups, in particular to those who attended a meeting with the Taskforce to share their experiences.

## Annex C - Focus group summary

In June-July 2018, the Department of Health and Social Care (DHSC) Taskforce secretariat commissioned suitable organisations, via the [Voluntary, Community, and Social Enterprise Health and Wellbeing Alliance](#), to engage with women with lived experience of mental health services by facilitating focus groups.

The organisations commissioned to run the focus groups were: National Survivor User Network (NSUN), National LGBT Partnership, Race Equality Foundation, and Clinks.

Each organisation was invited to run two focus groups in total, a few weeks apart, with a cohort of up to eight women via their networks. The first focus groups explored women's lived experience of mental health difficulties. This provided an opportunity for key themes to be developed into draft first person statements of what mattered to women in their mental health care. The Taskforce reviewed and incorporated these statements and experiences of women into the 'principles' produced by the Taskforce. The statements and principles were discussed and refined with the women during the second focus groups.

This summary summarises the findings from all of the focus groups, drawing out the overarching themes.

### Descriptive statistics

A total of 31 women participated in the focus groups from Croydon, Brighton and Hove, Lewisham, Greenwich, Bromley, Bexley and Sutton. Most women were clustered in the 35-44 age range (youngest of 25-34 and eldest of 65+). Participants were mainly White British and Caribbean, other ethnic group includes a wide range from Asian (Indian and Pakistani), Greek to African and a mixed. There was an equal split of women who were single (never married), separated/divorced, and married/ in civil partnership. Over half of the women were identified as with disability. Only two participants were employed, three were full time carers, others were unable to work, out of work or stay at home parent. Most women received secondary education, with a small number also having a bachelor degree. Half of them were Christians and another quarter of them with no religion. Over half of the women were heterosexual, with the rest identifying as bisexual. Three participants self-identified as transgender.

Women in the focus groups had experienced multiple diagnoses throughout their life course, some of which required treatments. Most commonly reported mental health conditions amongst the women were depression (including post-natal depression), anxiety, bipolar disorder, schizophrenia, personality disorder and PTSD. The listed mental health conditions here may not be representative of women's current understanding and preferred descriptors of their struggles, but can act as a list of diagnoses at various points of their life through their contact with services – i.e. mental health charities, detained, NHS



and in-patient mental health ward and clinic. Many of the women had multiple challenges including serious and long term physical health conditions, which were discussed but not captured in the demographic data capture.

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