Women's Health Strategy Consultation Response
Agenda and Mind

About Agenda and Mind

Agenda and Mind welcome the opportunity to respond to this consultation on the *Women's Health Strategy*. Agenda is an alliance of over 100 organisations working in England and Wales to build a society where women and girls are able to live their lives free from inequality, poverty and violence.

Mind is the leading mental health charity for England and Wales. Mind believes no one should have to face a mental health problem alone, and provides advice and support to empower anyone experiencing a mental health problem, and campaigns to improve services, raise awareness and promote understanding.

Introduction

In order for the *Women's Health Strategy* to set an ambitious and positive agenda on women's health, **mental health must be a core strategic focus** and afforded parity of esteem – a principle enshrined in law by the Health and Social Care Act 2012 - with the mutually important and connected area of physical health.

Women and girls' unequal health outcomes must be framed as a gendered inequality, rather than as relating to biological distinctions alone. With this lens, the link between women and girls' experiences of multiple disadvantage, trauma, and their poor mental and physical health becomes clear. The Covid-19 pandemic has only exacerbated this disparity. In order to effectively meet women's health needs, both mental and physical, it is essential that a trauma-informed approach[i] be delivered across services to ensure women and girls get the support they need. Without effective support that responds to the complexity of women and girls' lives, problems can spiral - with devastating impacts on women, girls and their communities, and public services ultimately paying the price.

This strategy provides a vital opportunity to implement the recommendations made by the *Women's Mental Health Taskforce*.[1] The Taskforce was co-chaired by Agenda with the then Department for Health and Social Care (DHSC) Parliamentary Under Secretary of State for Mental Health, Inequalities and Suicide Prevention. The Taskforce was made up of key experts including Mind, Centre for Mental Health, YoungMinds, senior officials from across government, and leading academics. This strategy represents a vital opportunity to tackle the crisis in women and girls' mental health - which in itself is closely linked to poor physical health.

The DHSC *Covid-19 Mental Health Recovery Plan*[2] makes specific reference to the importance of the *Women's Health Strategy* properly addressing women and girls' mental health, with a particular focus on the inequalities in girls and young women's mental health. However, in the call for evidence for this strategy, mental health is not centrally prioritised, risking a missed opportunity to respond to the needs of women and girls. This joint submission makes a number of recommendations to ensure the strategy creates the ambitious step change it sets out to achieve. **The submission is supported by 34 leading organisations and individuals working with women and girls facing multiple disadvantage.**[ii] We are grateful to the women and girls who have contributed to this evidence, and are delighted to submit it in parallel with a separate submission by Agenda's 'Girls Speak' Young Women's Advisory Group.

Agenda and Mind's joint submission will focus on themes 1,3,5 and 6 of the Women's Health Strategy.

[i] See Annex 2: Glossary of terms
[ii] See Annex 1: Signatories

Theme 1: Women's voices

Agenda and Mind strongly believe that Women's voices are not always being heard within the health and care system when raising their mental health and additional health issues, which often has a detrimental impact on their care. There are many factors that cause this to happen:

Inequality and discrimination

Gender inequality is both a cause and a consequence of women and girls' unequal mental health outcomes. Women and girls face inequality and discrimination both in their daily interactions and through systems and institutions, which have often been designed around a male service-user by default, and can sometimes be male dominated (e.g. drug and alcohol services). Experiences of sexism and misogyny are often compounded by a woman or girls' intersecting experiences of discrimination on the grounds of their ability, age, class, ethnicity, gender identity, race, religion and sexual orientation - including racism, homophobia and transphobia. Health services, and public services more generally, are not delivered in a vacuum and can perpetuate this inequality and discrimination. Being systematically subordinated and disempowered has long-term psychological effects. There is wide research evidencing the links between experiencing discrimination and poor mental health: including depression,[3]anxiety and psychological stress,[4] and Post-traumatic stress disorder (PTSD).[5]

Marie, 23 [6]

"I just felt like I gained a stereotype… Like loud, Black girl... And instead of [being asked] "What's going on... are you okay?"... they ask[ed] me about school counselling once... It was a while after... It was just too late."

Violence and abuse

Many women and girls who have experienced violence and abuse, most often by male perpetrators, are deeply traumatised and go on to face multiple, complex issues.

The links between violence and abuse and poor mental health are unambiguous. Research by Agenda shows that over half (54%) of women with extensive experience of physical and sexual violence meet the diagnostic criteria for at least one Common Mental Disorder, and are also more likely to have multiple conditions with about one in seven (15%) having three or more mental disorders. Over a third (36%) of women in the extensive physical and sexual violence group have made a suicide attempt, and a fifth (22%) have self-harmed. One in ten (9%) have spent time on a mental health ward.[7]

Physical and sexual violence is perhaps the single most significant risk factor for poor mental health amongst girls and young women.[8] Research on the impact of sexual abuse on girls aged 6 to 16 years old demonstrates the range of negative developmental outcomes including: earlier onsets of puberty, cognitive deficits, depression, dissociative symptoms, maladaptive sexual development, more major illnesses, dropping out of education, persistent Post Traumatic Stress Disorder (PTSD), self-harm, drug and alcohol use, and domestic violence.[9]

Rachel's story[10]

"A family member began grooming me when I was ten. The assaults got progressively worse as he gained confidence, and he eventually raped me. Anxiety has been a continuous presence in my life since the abuse. I've had bouts of depression since I was a teenager - some worse than others. In 2014 things got a lot worse. That was when the PTSD symptoms fully emerged. I had a lot of nightmares and flashbacks, and experienced huge anxiety and panic. I self-harmed and drank heavily in an attempt to calm the horrific feelings and distract from the memories. I also starved myself and used food or the lack of it to try and get a sense of control. I was given antidepressants, but they didn't have much effect other than to numb me a little. My thoughts were extremely dark, and I fantasised about suicide constantly. The self-harm became so severe that I was regularly in A&E. After an episode of self-harm that led to me needing 40 stitches, I was admitted to a psychiatric hospital. I stayed in the hospital for three months, much of it under constant observation by nurses."

Women and girls facing multiple disadvantage

Women and girls facing multiple disadvantage experience a combination of complex and overlapping problems. We use the term multiple disadvantage to refer to any combination of: homelessness, violence and abuse, substance misuse, poor mental health, poverty and contact with the criminal justice system. However, there are many other outcomes that are commonly related to these experiences of disadvantage, for example involvement in 'survival sex', removal of children into social care, and poor educational outcomes. For many women and girls, their experiences of disadvantage are underpinned by a history of extensive violence and abuse. Agenda research shows that women are ten times as likely as men to have experienced extensive physical and sexual abuse during their lives, with one in 20 women affected.[11] That's 1.2 million women in England alone.

Multiple disadvantage

Women and girls' poor mental health is also closely related to gendered experiences of poverty, homelessness, addiction and contact with the criminal justice system.

Women make up a majority of people living in poverty.[12] 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.[13] Women in poverty who have experienced abuse are even more likely to experience poor mental health.[14] Girls and young women living in poverty are also disproportionately likely to experience poor mental health: research by Agenda shows that young women (aged 16–34) living in the most deprived households are five times more likely to self-harm compared with those in the least.[15] [iii]

To survive the trauma of violence and abuse, women and girls may adopt coping strategies that are harmful, including using substances. Agenda research shows women who have experienced extensive physical and sexual abuse are more than twice as likely to have an alcohol problem (31%) and are eight times more likely to be drug dependent than women with little experience of violence and abuse.[16] These coping strategies are detrimental to women and girls' mental health in the long-term. Substance dependency also increases the risk of other forms of disadvantage, such as homelessness and the criminal justice system.[17] Without the right support, women and girls can become trapped in a vicious cycle of poor mental health and multiple disadvantage.

Amanda

"I kept asking for help and support and I kept getting passed from one service to the next, to the next with no help from anyone. I was told because I was an addict I couldn't have mental health treatment. I knew nobody cared, not even the medical profession. Getting support was impossible. I felt so alone. Being on incredibly long waiting lists to be told no they can't help you is devastating. One of the most soul-destroying things in this whole process was having to tell my story, my history over and over and over because the forms needed to be filled in, that box has to be ticked. I was being re-traumatised, reliving the worst moments of my life, having to remember sequences and dates, so a form could be completed."

Placing women and girls' voices at the centre of their health and care

As part of their evidence gathering, the *Women's Mental Health Taskforce* heard directly from women with lived experience about what works for them in mental health services. Women were clear that the ability to have respect, choice and control from mental health support 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

[iii] Black and minoritised girls and young women disproportionately represented in low-income groups: in 2015/16, 50% of Bangladeshi households, 46% of Pakistani households and 40% of Black African/Caribbean households were living in poverty, compared to 19% of White British households. The term 'Black, Asian and Minority Ethnic' is commonly used in policy and commissioning contexts but can collapse together a broad range of differences between individuals, as well as reinforcing the idea that certain groups automatically occupy a minority position. Drawing on critical analysis of this term by services led by and for marginalised groups (see Thiara and Roy (2020), Reclaiming Voice: Minoritised Women and Sexual Violence, Imkaan), this literature review refers to 'Black and minoritised' girls and young women. Whilst groups can be 'minoritised' in a number of ways, we specifically use this term to highlight the way in which certain racialised or ethnic groups are constructed as 'minorities' through processes of marginalisation and exclusion.

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.[iv]

> *"I want therapeutic support with my current difficulties and past traumatic experiences including bereavement, sexual abuse and domestic violence."*
>
> *[I want to be] "treated with respect and given the time to express how I feel, and not made to feel a burden when seeking help."*

Many women who have used both single sex and mixed services express a preference for **women only spaces**. **Women-only peer support** is also critical. Agenda and Mind's *Women Side by Side* programme[18] highlights the importance of women-only peer support – led by women, in women-only spaces. Peer support offers an invaluable way of supporting women in their communities as part of their overall pathway to treatment and recovery. By supporting partnerships between women's and mental health services, the programme also enables vital relationships to develop locally for both types of service to learn from one another about the best ways in which to deliver effective support to women. [19]

Specialist services run 'by and for' the communities they serve provide vital support to marginalised women and girls. Women and girls from marginalised communities often report they do not feel comfortable or are not able to access support from statutory services or mainstream women's services, which do not always have the specialism or capacity to meet their needs.[v]

Theme 3: Women's health across the life course

To understand the drivers of women and girls' poor mental health, a life course approach that takes account of individual life circumstances and experiences – contextualised within wider structural inequalities – is essential.

It is clear that there are gender-related differences in mental health, and many women and girls want and need support for their mental health that is gender-specific and trauma-informed. However, health services do not consistently offer gender-, age- and trauma-informed responses to women and girls. Due to the complexity of the issues they face, women and girls have reported to Agenda and Mind that they often face barriers to support and poor responses if they do access services.

Barriers to delivering trauma-informed support:

- **A lack of holistic, joined-up support** that allows women and girls to address mental health needs in parallel with other needs, such as housing and substance use services. [vi] This can lead women and girls to be bounced between services, with women and girls feel forced to fit the services, rather than services flexibly adapting to the realities of women and girls' lives.
- **Fear of child removal and stigma**. Many women and girls are mothers and primary care-givers, and fear their child will be taken away from them if they seek support for their mental health.[20] Perpetrators of abuse may threaten child removal as a way to stop a woman or girl from getting a diagnosis and accessing support. Women and girls who are mothers and experiencing poor mental health face gendered stigma, such as being labelled as a 'bad mother', from both society and professionals.

[iv] For the complete collection of testimonies from women, please refer to the Women's Mental Health Taskforce Final Report.
[v] For example, Imkaan's 2018 report *From Survival to Sustainability* found that Black and minoritised women and girls often report dissatisfaction with the responses from statutory services, and report an overwhelming preference for specialist, women's services led by Black and minoritised women.
[vi] Research by Agenda and AVA found that only 19 areas in England (and none in Wales) offer services that allow women to address substance use, mental health, homelessness or offending simultaneously.

- **"Double** disadvantage**"**. Black and minoritised women often report experiencing "double disadvantage" with sexism and racism inside and outside mental health services contributing to stigma around mental health and seeking support.[21]
- **Long waiting lists and thresholds for support**. Statutory mental health services are unable to meet current demand. To meet thresholds for support, women and girls facing multiple disadvantage often report feeling the need to prove their 'worthiness'. Many women and girls fear sharing their story over and over in order to access services. Some women may be unable to access a service as her needs are considered too severe or complex.
- **A stretched voluntary sector and postcode lottery**. The voluntary sector delivers 43% of all the women's mental health services identified by Agenda and AVA in *Mapping the Maze*.[22] However, many of these organisations are overstretched and facing financial precarity.[23] There is no central strategic overview of provision for women and girls facing multiple disadvantage, meaning that many areas of the country are not covered by these services.[24] Voluntary sector services often report struggling to create the partnerships needed with mental health and other key statutory services, despite being expertly place to deliver this joined up support.[25]

Many women and girls facing multiple disadvantage will come into contact with statutory health services before specialist voluntary sector organisations, such as domestic abuse organisations.[26] Contact with the health and care system is a vital opportunity to get women and girls the support they need. However, women in Agenda's Advisory Group described NHS mental health services as "*broken*". Women and girls often report poor responses in statutory support, including from services that are:

- **Gender-neutral.** Only one NHS mental health trust who responded to an FOI request in 2016 had a strategy for providing gender-specific services to women. Most trusts provided no relevant policies or strategies in relation to gender specific services.[27]
- **Do not make routine enquiry into violence and abuse.** Despite NICE guidelines recommending that routine enquiry be embedded in mental health services, an FOI by Agenda in 2019 found that of 42 mental health trusts that responded, 15 had no policies on routine enquiry about domestic abuse. Where trusts do have policies on routine enquiry the effectiveness of these policies varies considerably - with one trust asking just 3% of patients about experiences of domestic abuse – when they should be asking everyone. This matters because 60-70% of women using mental health services have a lifetime experience of domestic abuse,[28] and making enquiries is proven to increases disclosures.[29]
- **Re-traumatising:**
  - Women and girls may be asked to share their story repeatedly, and forced to relive their trauma with multiple professionals.
  - Agenda research has evidenced the disproportionate use of restraint on women and girls in Adult Mental Health Services and Child & Adolescent Mental Health Services (CAMHS), including face-down restraint – often by male members of staff.[30] This is particularly re-traumatising for women and girls who have experienced violence and abuse.
  - Women and girls also report being disbelieved about the severity of their need or labelled as 'attention-seeking'. A recent inquiry into the support available for young people who self-harm drew attention to the normalisation of young women's distress, noting that there is "a danger of apathy among professionals" in services which consistently see high rates of self-harm amongst young women.[31]
- **Not age-appropriate:**
  - Despite the high level of need for mental health support amongst girls and young women, young women are consistently less likely to access mental health treatment than older, adult women.[32] Research by Mind shows that young people have a worse experience of all mental health care than their older adult counterparts.[33]
  - The transition from girlhood to adulthood could be a chance to get things right, preventing young women's needs becoming more complex and entrenched. In reality, girls turning 18 face an arbitrary cliff-edge in access to support,[34] with only 11% of mental health trusts identifying issues which have gender-specific impacts on girls at this age such as child sexual exploitation in their policies on transitioning between children's and adult's services.[35]

- **Lacking understanding / misdiagnosis**. Troubling gaps in data and staff understanding of symptoms of trauma can lead to poorer advice and diagnosis and, as a result, worse outcomes for women and girls. Women and girls often report being diagnosed with having serious psychotic illnesses and disorders,[vii] and being heavily medicated (often for years or even decades), when actually what they need is counselling. Women and girls in poverty do not have the option to pay for private treatment and access talking therapy, and a misdiagnosis can exclude them from getting the support they need.
- **Fail to understand the impact of discrimination.** Institutional and structural discrimination, including racism, leads to worse health outcomes for women and girls from marginalised communities. Within mental health services, models of 'recovery' can overlook the impact of forms of discrimination such as racism, thereby failing to connect women and girls' mental ill-health with the oppression they face.[36] Services can characterise reactions to racism as signs or symptoms of illness, meaning that this, rather than the ongoing discrimination women and girls face, is addressed.[37]
- **Lack understanding of women's identity as a mother.** A key finding from the *Women's Mental Health Taskforce* was 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.

Saima, 45
"Doctors turn a blind eye to the emotional impact of sexual violence and only treat the outward scars. Else they prescribe anti depressants. […] You are better off self-referring for counselling therapy."

A woman with lived experience[38]
"I find here if you are Black and you've got mental health issues you are going to segregation [general agreement] because you are a danger. But if you are white or you've got mental health issues you are on the wing – or you are in [in-reach mental health support service] and it's ok so when they kick off and have their little mood swings, she's got issues, it's OK…but a Black person with mental health issues you go to segregation."

Long-term impact of unmet need
Without the right therapeutic support, women and girls' mental ill-health can lead to them becoming entrenched in multiple disadvantage, increasing their risk of reaching crisis points and even hospitalisation. Enduring mental health conditions inevitably impact negatively on women and girls' physical health.

To cope with their mental health and block out traumatic experiences, women and girls may turn to using drugs and alcohol. This can make accessing mental health support even more difficult, as many mental health services won't work with someone who is currently using substances, and drug and alcohol services are rarely equipped to support someone whose mental health symptoms increase when they stop using. Survivors of severe trauma may not get the support they need when they stop using substances, and to cope with the feelings and symptoms that then surface, they may start using again.[39] Substance use and dependency can increase the risk of other traumatising experiences, such as women and girls being made homeless and having their children removed into social care.

As layers of trauma accumulate, women and girls are more vulnerable to experiencing a mental health crisis. Agenda's *Women in Crisis* report demonstrates the detrimental impact that detention can have on women and girls' mental health.[40] Black and minoritised women and girls are even less likely to receive appropriate early intervention for their mental health,[41] and so are detained in disproportionately high numbers.[42] Once in detention, Black and minoritised women and girls can face further discrimination which impacts negatively on their mental health.

[vii] Including disproportionately high levels of diagnosis of Borderline Personality Disorder.

Theme 5: Research, evidence and data

Despite having a world-class research and development system in the UK, women and girls have been systematically under-represented in research, particularly women and girls of ethnic minorities, older women, women and girls of child-bearing age, those with disabilities, Lesbian, Bisexual and Transgender women and girls, and the most disadvantaged women and girls. This has implications for the health and care they receive, their options and awareness of treatments, and the support they can access afterwards.

The crisis in women and girls' mental health is a public health emergency. Women and girls face disproportionately high levels of poor mental health, and this trend is only becoming more pronounced. Existing research, evidence and data shows that:

- **Girls and young women are at greatest risk of developing mental health problems**, with the gap between young women and young men steadily increasing.
  - Among women aged 16 to 24 years in 2000, one in 15 reported having self-harmed (6.5%); this increased to one in nine in 2007 (11.7%) and to one in five in 2014 (19.7%). In 2000, rates of self-harm were similar in young men and women. By 2014, young women were more than twice as likely to report self-harming as their male counterparts (19.7%, compared with 7.9% of 16 to 24 year old men). [43]
  - Girls and young women in this age group are three times more likely to be diagnosed with common mental health problem – like anxiety or depression – than their male counterparts. [44]
  - While men are still far more likely than women to die by suicide, suicide amongst girls and young women is on the rise: suicides of girls and young women aged 10 to 24 have almost doubled in the last 7 years. [45]
- **One in five women (19%) experience common mental health problems** (such as anxiety or depression), compared with one in eight (12%) men. Women were also more likely than men to report severe symptoms of common mental health problems – 10% of women surveyed reported severe symptoms[46] compared to 6% of men. [47] Since 2000, overall rates of common mental health problems in England have steadily increased in women, but remained largely stable in men. [48]
- **Black and minoritised women and girls are also at particular risk:** 29% of Black and Mixed race women, and 24% of Asian women have a mental health problem, compared to 21% White British and 16% White other women. [49]
  - Rates of self-harm are higher amongst young Black women (16–34) than any other group, but they are less likely to receive support for this. [50] Studies suggest South Asian young women (16–24) are significantly more likely to self-harm than white young women. [51]

The inequalities in physical and mental health outcomes for women and girls facing multiple disadvantage are closely linked. Complex trauma[viii] in childhood and adulthood increases the risk of developing physical health problems, including long-term or chronic illnesses. For example, women who have experienced extensive violence and abuse are also more likely to have a range of different physical health conditions, including stomach, bowel and bladder problems; asthma, allergies, migraine and skin problems; and back, joint and muscle problems. [52] Women and girls facing other, often overlapping, types of disadvantage, such as homelessness[53] and substance use,[54] also face sharp inequalities in physical health.

Theme 6: Impacts of COVID-19 on women's health

The Covid-19 pandemic has exacerbated the mental health crisis among women and girls. Research conducted by Agenda over the first year of the pandemic highlighted the severe impact of lockdown on women and girls' mental health, in particular describing concerns about increased isolation, loneliness, stress, anxiety, depression, complex trauma, self-harm, suicidal thoughts and attempted suicide. A serious and growling problem prior to the pandemic, evidence shows that girls' and young women's mental health has been particularly adversely impacted.[55]

[viii] See Annex 2: Glossary of terms

Research by Mind found that women and non-binary people were more likely to have poor mental health and to have seen their mental health get worse during the pandemic: 63% of women and 67% of non-binary people said their mental health got worse between March-June 2020, in comparison to half (51%) of men.[56] The most common coping mechanism for women and non-binary people was to over or under eat.

The additional barriers and challenges accessing services during the lockdown have left many and women and girls without support for over a year. As a result of this, 85% of organisations surveyed by Agenda think the pandemic will cause long-term mental health problems for women and girls.[57] This will create further strain on statutory mental health services, which are already stretched beyond capacity.

Progress update: Women's Mental Health Taskforce

The *Women's Mental Health Taskforce* set out a series of ambitions to meet women and girls' mental health needs. Since publication in 2018, there has been some important progress towards these aims, but there is still much more to do –the *Women's Health Strategy* could be critical to delivering on remaining/ outstanding objectives.

Objective	Update on progress
1. Explicitly considering women's needs in all future mental health policy development, locally and nationally	It is positive that the Covid-19 Mental Health Recovery Plan[58] identifies women and young women as groups that have been disproportionately impacted by Covid-19. However, despite young women being identified in particular in the introduction, actions set out to support "Children and young people" make no reference to gendered differences nor commits to addressing this inequality. This lack of a gendered approach in youth mental health policy is a continuation of a trend seen in other mental health funding announcements for children and young people, including the £79 million announced earlier this year.[59] As of yet, it is not clear how much of the £500 million allocated for the Mental Health Recovery will be allocated to gender-specific responses.
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	Agenda has been pleased to work with Health Education England (HEE) and Skills for Care to develop a Framework for Supporting Professional and Peer Support Workers in Trauma-Informed Practice - learning from which has the potential to be rolled out across the NHS. Some progress has been made in other departments, for example a Framework for Integrated Care is being delivered in partnership by NHS England and NHS Improvement, DfE, and HM Prison and Probation Service Youth Custody Service, which aims to influence culture change by providing trauma-informed care for those within the children and young people secure estate. While existing guidance[60] for health professionals is welcome, more evidence on the value of trauma-informed care and incentives for implementing it are needed to see health services properly embed trauma-informed care.
3. Supporting Routine Enquiry about violence and abuse in future policy development, including consideration of a requirement to gather and report data	The Violence Against Women and Girls Strategy 2016-20 set ambitious aims for embedding routine enquiry into mental health trusts, but progress in delivering this has been slow. Research by Agenda shows that despite existing guidance, there is still huge inconsistency in mental health trusts' policies and response to domestic abuse, 15 of the 42 mental health trusts that responded to an FOI reporting they had no policies on routine enquiry into domestic abuse.[61] The amendment that would introduce a statutory duty on public authorities to train frontline staff to make enquiries into domestic abuse was not adopted in the Domestic Abuse Act 2021, despite wide cross-party support.[62] It is not yet clear how prominently the statutory guidance accompanying the Act will advocate for embedding routine enquiry in health services.
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	Research by Agenda and AVA showed that almost half of gender-specific, holistic services that address women and girls' mental health needs are delivered by the voluntary sector. Whilst NHS mental health services include psychology, psychotherapy and trauma services, there was only one service identified as offering counselling or therapy service delivered in the NHS specifically for women.[63] It is positive that since 2018 the UK Government has funded the Pathfinder consortium, a 3 year-

gender-specific holistic services and after care, including through the women's sector.	pilot to embed a 'Whole Health' approach to domestic abuse in eight sites across England, which concluded in March 2020, however, this was the only grant made to a gender-specific service for women and girls between 2019-2020.[64]
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.	Despite the delay, the announcement of the 26 new dedicated NHS perinatal mental health hubs by 2024 as part of the NHS Long Term Plan is positive progress.[65] It is vital that action is taken to address the shortage in highly-skilled, mental health nursing staff, [66] and that support for women and girls with the most complex needs is made available. It is important that gender-specific mental health support goes beyond the perinatal period – including for women who are mothers. Research by Agenda and AVA found that mental health midwives, mother and baby units and perinatal mental health services (including two in the 'other mental health support' category) combined to account for 70 (55.1%) of all the identified support options specifically for women experiencing problems with their mental health.[67] More progress is needed in understanding how women and girls' other intersecting identities affect access to support and the type of support given, including race and ethnicity.[68] Data collection will be central to this
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.	Analysis by the CQC of nearly 60,000 reports found 1,120 sexual incidents involving patients, staff, visitors and others described in 919 reports – some of which included multiple incidents.[69] This importance of this issue was also highlighted in the Independent Review of the Mental Health Act.[70] It is positive that the UK Government has committed £400 million over the next 4 years to remove dormitory accommodation from mental health facilities.[71] However, this does not guarantee women and girls' safety because mixed shared spaces and thoroughfare still exposes them to risk of violence and abuse. More progress is needed on pursuing robust policy, practice and reporting processes around sexual harassment and sexual violence. Recent research by Agenda shows that 1 in 10 women experience sexual harassment in public services, with 6% of women polled reporting this took place in a GP clinic, general hospital, or mental health hospital.[72]

Recommendations for the Women's Health Strategy

To achieve its ambitions, and to reach parity of esteem between physical and mental health, the Women's Health Strategy should respond to the following:

1) Strategic focus

- **Strategically prioritise the mental health of both women and girls**, giving it equal consideration to the mutually important and connected area of physical health. This focus should take account of inequalities in access to and experiences of mental health care, including racialised health inequalities, building on work being done by the Advancing Mental Health Equalities Taskforce.
- **Be accompanied by a clear action plan** and involve a **central UK Government commitment to taking a cross-departmental and gendered approach to addressing mental health and the social and economic challenges** facing women and girls.
- **Appoint an Advisory Group of independent experts,** with representation from marginalised women and girls, to oversee DHSC's implementation of the *Women's Health Strategy.*
- **Explicitly address the mental health impact of violence against women and girls**. The Strategy should join up and pool funding with the refreshed Violence Against Women and Girls (VAWG) Strategy and the Tackling Child Sexual Abuse Strategy.
- **Advocate for national and local suicide prevention strategies and action plans to acknowledge and respond to self-harm among young women and girls,** with poverty considered as a central factor, and training for the range of professionals likely to be in contact with young women.

2) Response in mental health services

- **In line with NICE guidelines, Health Education England and all health trusts should ensure that training about violence and abuse is embedded in training programmes.** There should be a requirement to gather and report on data relating to policies, training, enquiries and referrals.
  - NHSE/I to review women's clinical pathways through mental health services and ensure routine asking about abuse, and violence is embedded across these.
  - CQC to undertake a review of the implementation of NICE guidance to routinely collect and report on data regarding abuse and violence.
- **Clear and safe information recording** and sharing about experiences of violence and abuse and related issues should be consistently implemented across health services to avoid the re-traumatisation of women having to repeatedly re-tell their stories.
- **All mental health trusts should develop a Women and Girls' Mental Health Strategy, overseen by a clinical lead with responsibility for women and girls' mental health,** drawing upon the gender and trauma-informed principles set out in the *Women's Mental Health Taskforce* report.
- **The Women's Health Strategy should promote age-, gender- and trauma-informed care** amongst all health and social care services and the development of policies and strategies to support this provision.
  - DHSC should lead a research and development programme in England to consolidate the evidence base on trauma-informed care, and produce guidance and resources that supports further consistency in approach.
  - Professionals in contact with girls and young women must be trained to understand that experiences of trauma, discrimination and inequality drive girls' and young women's poor mental health.
  - Youth services should prioritise early intervention accompanied by clear pathways into wrap-around support for girls at risk of poor mental health in a range of settings, including education and criminal justice.
- **Safety of women in residential mental health care** must also be ensured by:
  - **Ending the use of face-down restraint** and other forms of physical restraint used only as a last resort.
  - **Ensuring all women can access single-sex spaces** throughout mental health units.
  - **Pursuing robust policy, practice and reporting processes** around sexual harassment and sexual violence.

3) Care planning, treatment and service design

- **Mental health services to recognise girls and women's roles and identities as mothers and care-givers** during all parts of their treatment planning and care.
- **DHSC to include clear steps to addressing the disproportionate detention of Black and minoritised women and girls under the Mental Health Act,** and unequal treatment throughout the health and social care system.
- **Mental Health Trusts to commit to co-production and meaningful involvement of girls and women** in the development of services.
- **Mental health practitioners should always explore therapeutic alternatives to medication with women and girls** where a woman or girl has disclosed current and historic experiences of violence, abuse and trauma.

4) Funding and commissioning

- **Dedicated funding for statutory Child and Adolescent and Adult Mental Health services to develop gender- and trauma-informed services** for women and girls with complex needs in partnership with the women and girls' voluntary sector.
- **Sustainable funding for holistic, girl- and women-only services in the community**. These services must be available in every area to provide safe, therapeutic spaces for women and girls to address their mental health in parallel with other overlapping needs. This must include ring-fenced funding for specialist services for girls and young women, and those run 'by and for' the most marginalised groups of women and girls.
- **DHSC to require local commissioning bodies to adopt trauma- and gender-informed commissioning principles for the services for which they are responsible.** Commissioning frameworks should make achieving this goal an explicit expectation of a service when they commission it.
- **Women-only peer support to be commissioned and delivered as a core component of all wider interventions to support women and girls' mental health**. Peer support and its value should be recognised in all future policy frameworks and delivery plans to support mental health for both the UK and Welsh Governments, and be built into all local priorities and action plans of Mental Health Trusts, commissioners and practitioners in mental health services.

5) Data

- **Improve data collection.** Population-wide survey data is needed in both England and Wales to understand the factors that drive inequalities in health. Such surveys should cover experiences of poverty, debt, self-harm, and violence and abuse, alongside assessing mental health, be large enough to support ethnic and gender disaggregated analysis and a specific focus on young women, and include people experiencing homelessness and who are in the criminal justice system. This should include continuing the Adult Psychiatric Morbidity Survey (APMS) series in England, and an equivalent survey being commissioned in Wales.

Annex 1: Signatories

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Annex 2: Glossary

What is *'complex trauma'?

Complex trauma (sometimes called Complex Post-Traumatic Stress Disorder) can occur when a woman or girl has been exposed to persistent abuse, neglect, violence or abandonment over a period of time, particularly as a child. A woman or girl may have experienced multiple traumas, including the harmful effects of oppression and racism.

What are 'complex needs'?

A woman or girl with 'complex needs' experiences two or more needs affecting her physical, mental, social or financial wellbeing.[73] These needs typically interact with and compound one another, meaning that if they are not addressed holistically and early enough, women and girls' problems can become even more severe and complex. Women and girls with high complexity of need are often at or vulnerable to reaching crisis point. This in turn can mean they face barriers to accessing services, as a result of thresholds determining who a service can work with.

What does reaching 'crisis' mean?

As a woman or girls' problems become more severe and complex, and layers or trauma accumulate, they may be vulnerable to experiencing a mental health crisis. While this can mean many things, it generally means a woman or girls' mental health has deteriorated to the point where she needs urgent help from support services. In the most severe cases, this may result in her being hospitalised.

What is 'trauma-informed'?

Trauma-informed practices understand and respond to the high prevalence of trauma and its effects, as well as understanding that experiences of trauma can lead women to developing coping strategies and behaviours that may appear to be harmful or dangerous. Key principles for commissioners and services to adopt are set out in the *Women's Mental Health Taskforce* report.[74]

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